

### Small Group Discussion Notes

**Topic:** Translating research to practice in diverse settings – Specialty Care

| Existing Resources   | New Resources Needed from TA Centers  |
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|  | <ul style="list-style-type: none"> <li>• Invite federal funding agencies as collaborators with MCHB grantees (e.g. Department of Education)</li> <li>• Facilitate foundation, corporate, individual funding – understanding, access, approaches. The art of the ask.</li> <li>• Help leverage community resources to serve underserved populations</li> <li>• Sharing successful practices to increase show rates in clinic</li> </ul>  |
| Obstacles or Challenges Experienced  | Lessons Learned   |
| <ul style="list-style-type: none"> <li>• Getting hospital to know how to bill for reimbursement for grant-funded specialty care that children/families receive.</li> <li>• Clinical care requires reimbursement in ways that are not considered in research.</li> <li>• Knowing what services are billable, reimbursement for researched services are slow (scaling up to evidence-based reimbursement takes 17 years)</li> <li>• Change is not unidirectional – is impacted by research, funder, hospital system, insurance company, sustainability. May be trying to live up to research standards that are not up to clinical care, or the opposite.</li> <li>• Competing priorities &amp; multiple masters – decrease wait list, increase access, decrease health disparities, increase show rates.</li> <li>• Systems are in place that were set up when incidence of autism was far lower. Used to take more time to diagnose when autism was 1:10,000, now takes far less time as is 1:68 – diagnosis should be faster, as more likely to have it.</li> <li>• Need function-based assessment instead of DSM-5 diagnosis</li> <li>• Shortage of well-trained clinicians to meet need</li> <li>• Mismatched communication &amp; common goals between systems – especially medical/educational – where some</li> </ul> | <p>For reimbursements: Research funded by NIDILRR shows that some specialty care outcomes are good enough for insurance companies to cover – give them ICD-10 codes, proxy codes for prescriptions, and they can identify which of their patients have those diagnoses – work with them to cover those services</p> <p>For increasing show rates: For families who have difficulty getting paperwork done, do in-person social work intake visit, get social &amp; educational services set up as needed, then found that they had better response and follow-up rate from family. Some of these services were billable; physicians increased billable rate to cover social worker’s salary that wasn’t billable. Families had immediate needs met.</p> |

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| <p>systems may want to restrict services. Need improved system collaboration and communication.</p> <ul style="list-style-type: none"> <li>• Use of specialty care could be reduced, if specialty &amp; primary care providers could be reimbursed for time spent consulting with each other to reduce need for family to visit specialty care provider.</li> <li>• Funding cuts for LEND programs decrease ability to fund trainees, and decrease trainee experience. Less \$ = less trainees, not less faculty FTE, as faculty are still needed for seminars, etc. Some experiences can be cut, community based project to cut faculty mentoring time. Cannot grow program. Quality gets eroded, get busy trying to bring \$\$ in other ways.</li> </ul> |  |
| <p><b>Opportunities for Grantee Collaboration</b></p> <p>Multi-site research, longitudinal research (though funding often doesn't allow). Maybe one less R40 from MCHB may allow for some multi-site studies</p>   | <p><b>Outside Collaborators</b></p> <p>Collaboration with educational, other front-line service systems AND their funders! Invite federal funding agencies as collaborators with MCHB grantees.</p> <p>Build capacity of primary care to diagnose autism, given its increased prevalence. For example, when ADHD was first identified, it was diagnosed by specialist. When became more prevalent, then primary care could diagnose.</p> |

Recommendations for future action by each grantee group

**Research**

1. Models of care developed, tested, best practices may not be sustainable because cannot be paid for. Need more attention to sustainability for new models of care.
2. More emphasis on participatory research strategies

**State Systems Change**

1. More state implementation grants that break down silos and work collaboratively across systems. For states not ready for implementation grants, start with planning grant for less commitment of \$ and build platform of invested partners in state.

**Training**

1. Increase turning out well-trained trainees
2. Increase use of telehealth