Autism Commission - Adult Sub-Committee

500 Harrison Avenue

December 19, 2016 – 1:00pm – 3:00m

Present at the meeting were Janet George, Kathy Sanders, Todd Garvin, Mark Dumas, Maria Stefano, Carolyn Kain, Dianne Lescinskas, Lea Hill, Lisa Saba, Gail Gillespie and Kathy Stern.

Accessing the meeting remotely: Dave Tobin, and Deb Johnson.

Janet George stated that the meeting was subject to the Open Meeting Law and that the Sub-Committee members present would need to vote to approve the remote participation of some members because of their geographic location, whenever any members were utilizing video and/or tele-conferencing. Remote access was approved unanimously. Minutes from November have not been reviewed and will be disceminated to the group prior to next meeting.

Janet started the meeting by asking the group to go around the table and introduce themselves. She said she would like to begin to shape recommendations since this will be a by-product of the Autism Commission. She had reviewed some of the recommendations around DDS from the Autism Commission report and from Ms. Kains report to the Commission and wanted to touch base on where we are now.

Two recommendations stood out. 1. DDS and DMH working together on the expansion of mental health care and eligibility for dually diagnosed individuals. 2. The expansion of MCPAP and Autism friendly teams in the Emergency Room. She asked Todd and Ms. Kain if they had any thoughts on proceeding in this direction and they both replied that it was a good place to start.

Carolyn asked Dr. Sanders to explain what MCPAP was and she said the acronym stands for Massachusetts Child Psychiatry Access Project. It originated at DMH and last year expanded to another model called MCPAP for Moms, which is focused on OBGYN, health care and having children. You can connect with MCPAP through a pediatrician and they have a child psychiatrist readily available for inquiries. Carolyn asked if they cover the psychopharmacology piece and Dr. Sanders replied yes and that it is usually the biggest question.

Carolyn asked if the child psychologists have knowledge of Autism and Dr. Sanders responded, maybe or maybe not but it is an opportunity for professional development. She said the centers are at Children’s, Tufts, MGH and UMass Medical. The physicians are on call from 9-5 and they do four hours shifts. They are paid to be available when needed. Janet George asked about the cost of creating MCPAP teams and Dr. Sanders responded that it is not her expertise but will speak to Chris Fluid about the details on how to expand. Carolyn asked if it is an issue of training or being overtaxed if we were to expand. She also commented that she has worked with families who were looking for this kind of service but she had never heard of it. Dr. Sanders thought that pediatric offices were aware of MCPAP. Janet suggested setting up a time to meet with Chris Fluid.

Janet asked if we could start a MCPAP for children with Autism and then start to think about the adult version.

Dr. Sanders stated that MCPAP is a national model and has been used widely in the field. They are currently seeing good results with MCPAP for moms. It is transferable but we don’t quite know what the need would be for the adult population with autism. Janet asked if other than the MCMOM are there other adult programs. Dr. Sanders responded no but they are thinking of one for geriatrics population.

Carolyn asked about funding MCPAP and Dr. Sanders responded that some funding comes from Medicaid, legislative supplements and most recently there has been a tax put on private insurers – now they are paying in proportion to their use.

Carolyn discussed that Special Education students are billed through Medicaid for some services in school. Why not look at this model for the mental health arena? Dr. Sanders responded that you cannot bill two doctors in one day – this is for mental health care.

Janet asked the subcommittee if it made sense to move forward with looking at creating a template for the expansion of MCPAP for adults with ASD. She said it could start with expanding the use with youth first and then move to adults. Dr. Sanders agreed that it would be good to explore and we would need to be patient, this is a start and we are in the discussion phase.

The discussion moved to ED boarding and how we can improve the Emergency Room experience for ASD patients. Dr. Sander’s response was to prevent people with autism from going to the ER and being proactive with mobile services in an emergency crisis. Dave agreed and said that the overstimulation of emergency departments is difficult for everyone. Is there a way to develop a separate space in the ER?

Carolyn said that ED boarding has been going for months and there needs to be a multidisciplinary approach on how to deal with these situations. More communication and training is need for the staff and possibly create an intake for parents to share information with the staff.

Dr. Sanders replied that more needs to be done to divert a crisis and asked if there are units that could deescalate behaviors. Carolyn said that if you have ASD and an intellectual impairment they need to rule out a medical situation first; the behavior could be due to the pain that a patient is experiencing but cannot express. Janet talked about a unit that was run in the past, expensive but successful. The average length of stay was 13 days. We should go back to ESP and mobile crisis and take a look at the diversion team.

Dr. Sanders said there is an invested interest in looking at the cause of the behavior and this could be done through ESP. There is a shortfall since there is no MD level that can frontline, they are only available by telephone and they need to have a certain level of expertise. Most ESP’s are staffed by master level social workers and clinicians. Carolyn said that through her experience schools will only call if they have Mass Health since it is not covered by private insurance. The schools end up calling 911 and the police will take them to the ED. Janet replied that schools won’t call at all and won’t look into the insurance. Dr. Sanders responded that many ESP’s have contracts with private insurance. Carolyn asked if we should cast our net in a broader way to address the insurance companies. What level of government could look at this issue?

Dr. Sanders suggested that she, Janet, and Carolyn meet with Medicaid and Mrs. Baer from ESP. She said that Emergency Room care doesn’t work but keeps the patience’s safe.

Carolyn agreed and suggested that training needs to be given to employees in the ER. There is no communication in place. Experts need to get involved during the evaluation process. Dr. Sanders agreed and said that we are trying to get a certain amount of care but it is in the wrong environment.

Discussions took place regarding the multi-care facility in Maine; everything in one location, people were much more stabilized. Maine has an interesting funding structure which we don’t have in Massachusetts.

UMass had a specialized unit which closed due to lack of funding. Patients would wait for beds because the care was so good.

Dr. Sanders spoke about a women’s recovery center in Taunton which is an alternative for drug addicts instead of sending them to the Framingham jail system. It’s an incredible program which is open 7 days a week and offers after care counselors.

David asked “What are the particular needs being met?”

Janet mentioned we are talking about various people at various levels with aggression, behavioral/medical issues, school issues, sitting in the ER, different drugs administered, folks who have expressed self-destruction or people who threaten to harm others.

Janet discussed CBHI which addresses emotional disturbances and ABA family therapy. They teach families basic skills and mobile crisis is a part of CBHI, but wasn’t designed for ASD patients.

Carolyn mentioned that CBHI has a much more in-depth understanding the impact of the disability.

The next few meetings were scheduled for the following days; Monday, January 30th, Monday, February 27th, and Monday, March 27th. All meetings will take place from 1:00pm to 3:00pm.

Maria said that we need behavioral data at the ER and we should start to collect history on behavior. Todd asked if the sensory issues fall in this category. Janet responded if a person is coming from a program it is unrealistic that they would be bringing data to the ER.

Discussion regarding (Bay State….) admissions came from family homes and residential providers, people went home with high class medical care, and social workers were really committed – there was also 1:1 staffing available. The only reason it closed was lack of funding and the reimbursement from Medicare made it very expensive.

Janet asked Carolyn if the 14-22 subcommittees had any insight regarding schools and if the changes in leadership at DESE will make a difference. Carolyn responded that she is meeting with the interim person from DESE this week and will report back to this group at the next meeting.

Maria said that she liked the checklist idea and will draft a simple questionnaire which could be used in the ER.

Carolyn suggested they start with a baseline.

The meeting adjourned at 2:45pm.