Blue Ribbon Commission Recommendations	Workgroup questions to frame problem / identify possible solutions (roadmap)	March 12 discussion notes	Who else needs to be involved in the discussion?
Early identification and intervention	• How can OC identify as many children with Autism as early as possible and ensure appropriate referral? • How can we make screening available to all children (i.e. screening, evaluation, treatment)? • What are the protocols for screening that we endorse (i.e. Early Start / Denver)? • What is the role of the primary care provider (trust / relationship)? • Do available community resources include children at risk (prevention)? • Are resources available to address identified needs of children (S/L, PT, OT, etc)? • How can we better support the family structure with: - Building parent intervention skills - Recognizing supports needed (varied demographics) - Emphasis on social skills	1) Endorse and continue work of the developmental / behavioral pathways to ensure that all children are screened. Ensure diverse options for screening including physician and other community screening strategies. Autism needs to be part of developmental screening. 2) Review, endorse and continue work of the speech / language planning group. 3) What are the tools for "communication" between partners implementing screening: avoid duplication and leverage the work of each other – screening completed. Could there be a central registry? Across sectors (medical, schools, etc) 4) Registry for screening, care coordination, electronic health record, public health data – Rhode Island has a good example of this. Assist in ensuring that children don't fall through the cracks, provide information for a better coordinated care plan, better to manage resources. Include ability to	Education (IEP, IEPP, therapy)

		communicate between registry and parent / providers (ie due for an updated screening). 5) Direction of medical – individual care plans around the child which reflects all of the needs of this particular child. This has been a direction with seniors; to be managed by a team including: Dr,, the patient / family, case manager, behavioral health specialist, social services person with specialty in coordinating community resources. Recommend developing a similar plan for children. 6) Need to articulate between plans, CCS, Regional Center, etc including similar care plan development. 7) Potential to participate in a pilot / demonstration project to pool dollars. 8) Potential to find dollars in our own systems to redeploy resources in ways that make sense to improve patient care. 9) Establish a recommended quality of care for children with autism. Ensure transitions	
Public awareness campaign	1) The state of autism knowledge is confusing. What messages do we need to communicate / educate, and	1) Need to address fears, suspicions, anger and concerns with both parents and providers about information sharing	

	how? In order to disseminate accurate and age related findings, we need to look at the research and evidence (and costs): o Research based approaches o Quality issues (behavioral / educational) o Understanding the issues of age 2 and below o Understanding results related to the issues	across sectors. 2) Establish forums in community so that we can identify needs and match to resources that already exist in the community, that we may not be tapping into such as services provided by unexpected partners (is transportation). 3) Enhance communication across sectors re: developmental screening and status. 4) Implement a developmental screening campaign (ie month) and leverage Pretend City venue 5) Develop strategies for physicians / ER's / clinics to distribute PEDS in parent waiting areas / develop central resource for scoring and linking to services.	
Resolution of service disputes	2) What services are available (and funding) for needed family support? 3) Can we develop a matrix of responsibility for shared responsibility and resources across the systems and sectors (education, medical, regional center, etc)? 4) Can we develop an approach to monitor outcomes to ensure that we are in implementing our strategies?	1) Adopt a model such as the Mental Health multidisciplinary care team (convened at Social Services) to explore approaches for complex cases. Any sector can refer complex cases.	
Payment Systems		Articulate needs in terms of payment for	

		case management / care coordination	

Topics

- Review, endorse and support the recommendations of the Developmental / Framework Planning Group and Speech / Language Planning Group. – email plan and status
- Identify and address gaps in intervention resources (ie mental health services)
- Review available validated tools and recommend tools for community use
- Review approaches to implementing a screening / care coordination registry and recommend approach to implementing in Orange County (what information would need to be in there – screening vs results)
- Develop recommendations for an individual care plan approach in Orange County, and transitions to the school system
- Establish a quality of care (vision) for children with autism
- Develop communication strategies to address parent and providers information sharing concerns
- Develop strategies for community resource sharing
- Develop and adopt a model for multidisciplinary team model to develop care plans for challenging cases, include articulation with primary care
- Identify / redeploy resources to support recommendations

Next Steps

- Survey to schedule meeting dates
- Prioritize agenda topics, who else needs to be involved, lead for topics
- Schedule conference call mid meeting to discuss prioritization
- Email Framework plan & update and Speech Language plans

Clarification – focus on birth – three?
Explore products of other regional groups and CA.
Provide matrix of responsibility to workgroup and insurance group

Explore medical home models from other states and “life course” best practice models of care and payment, standard of care (insurance work group). New Jersey and New York