MDwise Hoosier Alliance
Suite N
5604 Fortune Circle South
Indianapolis, IN 46241

Toll Free: 1-888-961-3100
Fax: 1-888-465-5581
www.hoosieralliance.org

MDwise Hoosier Alliance Pervasive Developmental Disorders Disease Management Program

Purpose

MDwise Hoosier Alliance (MDHA) disease management programs are designed to empower members, family members, and their providers with knowledge and tools to better manage and reduce the interference of the disease on the members' daily activities and quality of life. The focus is on improving member health status by promoting member and provider compliance to evidence-based care guidelines, plans of care and self-management strategies. Strategies focus on providing proactive and personal support to create and sustain lifestyle behavior changes and self-management skills.

The purpose of the Pervasive Developmental Disorders (PDD) program is to guide the appropriate diagnosis and treatment of PDD in children and adolescents. PDD includes the autism spectrum of disorders listed below in the Rationale section. Early identification and intervention is critical in the treatment of PDD. A complete and thorough assessment will prioritize the needs of the member, thereby allowing the treatment team to devise an individualized care plan and connect the member to the needed resources and supports.

PDD is one of ten (10) chronic conditions that MDHA manages. The managed conditions are:

- Asthma
- Depression
- Pregnancy
- Attention Deficit/Hyperactivity Disorder (ADHD)
- Autism/Pervasive Developmental Disorder
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Chronic Kidney Disease
- Congestive Heart Failure
- Diabetes

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Rationale

Autism Spectrum Disorders (ASD) are neuro-developmental disabilities that are generally suspected, or identified, before a child is three (3) years of age. Children with ASD usually start exhibiting signs of the disability around 18 to 24 months of age, but unfortunately many of these children are not clinically diagnosed until the preschool years, or later. In fact, the average age of diagnosis in the United States for ASD is age 6. In the United States, 60,000 to 115,000 children under the age of 15 meet the criteria for an ASD (i.e., roughly 1 in every 150 children).[1] This high frequency indicates that these children oftentimes present in the primary-care clinic, preschool, daycare, and community school settings. It is also noteworthy that ASD is more prevalent in boys than girls, with a ratio of 4:1.

ASD is a spectrum of disorders that have varying clinical presentations, based on the severity of the symptoms. Typically, children who are affected by an ASD/PDD exhibit significant delays in social interactions, as well as both verbal and non-verbal communication. Other characteristics associated with autism are engagement in repetitive activities and stereotypic movements, resistance to environmental change or changes in routines, and unusual responses to sensory experiences. Deficits in social skills can include an inability to maintain eye contact, a preference for being alone, failure to need connectedness with family members or peers, failure to partake in social or emotional reciprocity and few if any friends. Deficits in communication can range from complete lack of speech, to delays in speech, failure to carry on conversations, and/or an inability to engage in social play that would be consistent with the child's developmental stage. Children with ASD/PDD also have restricted interests. This can include stereotyped or repetitive focus on an object, narrow interests and/or a devotion to unpractical routines.

Because of the disorders' complicated presentation, treatment of ASD/PDD is multi-disciplinary and comprehensive. The need to develop a disease management program for ASD/PDD derives from the complexity of the disorder, the number of providers who may be involved and the amount of services needed as treatment can become quite costly.

The spectrum of disorders includes the following ICD-9 codes (per DSM IV –TR):

- 299.00 Autistic Disorder
- 299.80 Asperger's Disorder
- 299.80 Pervasive Developmental Disorder, Not Otherwise Specified
- 299.80 Rett's Disorder
- 299.10 Childhood Disintegrative Disorder

Objectives

- To improve the health and quality of life for members/consumers affected by an ASD by emphasizing the use of evidenced-based treatment in the management of autism
- To ensure there is collaboration between the patient and family, the community-based primary care home (medical home if available) and the behavioral health provider(s)

[1] Centers for Disease Control and Prevention, 2009

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- To develop and emphasize cross-organizational relationships in order to improve coordination of care for our members who have to work frequently with their primary care physician, behavioral health provider, and other medical specialists such as neurologists, geneticists, developmental pediatrician, child and adolescent psychiatrists
- To develop a care coordination process that is proactive, planned and comprehensive through the identification of a lead clinician/care coordinator
- To provide the most cost effective treatment by efficient use of resources (e.g., referring to the appropriate level and intensity of treatment depending on the assessment and prioritization of needs)
- To promote empowerment of the member by embracing self-care behaviors that include identification of environmental triggers, ongoing monitoring of symptoms and target behaviors, recognizing deterioration of symptoms and/or behaviors and actively developing a treatment plan that is continuously updated
- To educate members/consumers/caregivers on the importance of compliance with medication and therapeutic interventions from speech therapy, physical therapy, occupational therapy, and vocational therapy
- To reduce the number of preventable emergency room visits, hospitalizations, readmissions, and out-of-home placements

Outcome Measurements

- Reduce inpatient admission per 1000 rate by 3% for identified population
    - Baseline = 2010 claims data for similar population (children with ADHD diagnosis)
    - Measurement is claims based and compared against baseline
- Reduce Inpatient Readmission rate by 1% for identified population
    - Baseline = 2010 claims data for similar population (children with ADHD diagnosis)
    - Measurement is claims based and compared against baseline
- Increase from baseline the percentage of members with PDD diagnosis referred to early intervention/special education programs
- Increase from baseline the percentage of members referred for evidence-based therapies, such as Applied Behavioral Analysis (ABA), Floor Time (also known as Developmental, Individual Differences, Relationship-Based Approach or DIR), Treatment and Education of Autistic and Related Communication – Handicapped TEACCH, Picture Exchange Communication System (PECS), speech, physical, occupational and sensory integration therapies

Population Identification and Stratification

The criteria for enrollment in the MDHA PDD Disease Management Program are: all members between the ages of 3 and 17 with at least one claim with PDD or PDD NOS (Not Otherwise Specified) as the primary diagnosis (ICD-9 code 299).

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Members are identified proactively and retroactively for case management needs. Referrals sources include:

- Internal referrals from the utilization management reviewers
- Provider discharge planners
- Utilization reports and data collected through the Utilization Management (UM) process
- Claims data mining (includes medical, Behavioral Health [BH] and pharmacy claims)
- Hospital discharge data
- Internal referrals from the medical team
- Provider referrals
- Member self-referral
- MDwise referrals

MDHA integrates member information from the following systems to facilitate continuity of care:

- Disease and Case/Care Management System (Pre-certification, Concurrent, Hospital, Discharge and Claims, Data)
- Utilization Management System (Pre-certification, Concurrent Review and Discharge Data)
- ManagedCare.com
- Claims (Hospital Admission and Discharge Data) (Diagnostic Cost Group (DxCG) risk scoring

In accordance with National Committee for Quality Assurance (NCQA) requirements, MDwise systematically identifies members in the disease management program on at least on a monthly basis from its claims warehouse as follows:

New Membership

- MDwise Customer Service administers the Indiana State Office of Medicaid Policy and Planning (OMPP) Health Risk Screener (HRS) to new MDwise members
- Each condition of interest utilizes a validated condition-specific questionnaire when available to assess the member's disease risk and clinical control and assign a risk status. These validated condition-specific questionnaires are incorporated into the HRS, as well as, incorporated into follow-up clinical assessments by case and care management when applicable. Each questionnaire is described in the applicable Condition of Interest Program Description.
- New members are assigned to the risk status that corresponds to the score or result of the condition-specific questionnaire
- New membership that qualifies under a predefined —trigger" will be assigned the corresponding follow-up action, some of which may include stratification to moderate or high risk interventions

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- New members who are referred by themselves or via providers, as well as newly diagnosed members, are stratified to moderate risk for follow-up and assessment by a health advocate
- HRS scores of new membership are electronically communicated to the CM/DM programs registries every two weeks. The CM/DM team(s) subsequently extracts the data and assigns the membership to care management (high risk), and case management (moderate risk) interventions.

Existing Membership

- MDwise Quality Improvement in coordination with MDwise Health Care Programs contracts DxCG predictive modeling application and creates clinical data logic for use in stratifying existing members with available claims and data sources.
- DxCG is utilized to identify membership risk status based on all available claim types (including pharmacy) and data regardless of condition of interest. Members are assessed an overall health risk score and are stratified into low, medium or high risk levels of intervention.
  - **Low Risk**—DxCG Score 0-240: Ability to manage current health care needs, stable environment, self-management goals met
  - **Moderate Risk**—DxCG Score 241-400: Members with newly diagnosed conditions, increasing health services or emergency services utilization, evidence of pharmacy non-compliance or quality issue for chronic conditions and identification of special health care needs
  - **High Risk—**DxCG Score ≥401: Members with complex care needs, recently discharged from facility, unstable conditions, acute deterioration in health status
- In addition to members being stratified by overall health status via the DxCG predictive modeling software, members with an applicable condition of interest are stratified according to clinical logic developed by MDwise Health Care Programs as described in the applicable Condition of Interest Program Descriptions
- Each Condition of Interest contains logic for stratification by claim AND assessment sources. Stratification is a dynamic process and a stratification level can change as a member's condition changes. Therefore, change is captured via claims and assessment sources to best stratify the member to the appropriate level of risk and corresponding intervention(s).
- Additionally, MDwise develops pharmacy quality edits that are programmed into the Program Management Tool (PMT) for identification of members with pharmacy utilization that requires assessment and potential intervention. Pharmacy quality edits are developed for each Condition of Interest Program and address adherence and inappropriate utilization, or lack thereof, for pharmaceuticals for a specified Condition of Interest. These elements are refreshed monthly along with updates in member identification.

Stratification

- **Low risk (population based):** Members identified with a PDD. These members receive population- based interventions by MDwise.

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- **Moderate risk (case management):** Members identified with a PDD that require more intensive services due to but not limited to members with newly diagnosed conditions, increased health or emergency services utilization, evidence of pharmacy non-compliance for chronic conditions and identification of special health care needs. These members are identified based on DxCG levels 250-400, clinical and pharmacy utilization history, health risk screener information, clinical assessments and referrals. These members receive case management interventions by MDHA.
- **High risk (care management):** Members identified with a PDD and one of the following:
    - One or more behavioral health inpatient claims with PDD as the primary diagnosis
    - One or more claims with PDD diagnosis and comorbid oppositional defiant disorder (313.81), conduct disorders (312.81, 312.82, 312.89), anxiety disorder NOS (300.00), generalized anxiety disorder (300.02), depressive disorder NOS (311), major depression (296.2, 296.3), dysthymic disorder (300.4), bipolar disorders (296.4, 296.5, 296.6, 296.7, 296.8), schizoaffective disorder (295.7), substance abuse (305.0, 305.9, 305.7, 305.8, 305.4, 305.2, 305.6, 305.3 305.5), in a rolling 12-month period

  These members have experienced a critical event or diagnosis that require the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. These members are identified based on DxCG levels 401 and above, clinical and pharmacy utilization history, health risk screener information, clinical assessments, and referrals. These members receive care management (aka complex case management) level interventions by PerformCare behavioral health case managers.

Member Participation

Members are educated about the disease management programs in their member handbook as well as on the MDwise and the MDHA Web sites. Members are informed about how they become eligible to participate in the disease management program, how to use the services and how to contact someone if they have questions.

Identified, eligible members are considered enrolled in the program and receive interventions without having to specifically request participation. Participation is voluntary and members have the ability to ―opt out" of disease-specific interventions. Information on how to opt out is provided to the member verbally. Members who opt out may re-enter the program at any time simply by contacting MDHA either by phone or in writing.

Any member with a discharge from a behavioral health inpatient admission will continue to be enrolled in high risk care management for at least 180 days from the behavioral health inpatient discharge date.

During the initial assessment with the member, the member is informed about the program services provided and how to use them.

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Interventions and Activities

- **Population-based Interventions**
  Members with conditions of interest or the parents of children with conditions of interest will be engaged through disease specific and preventive care population-based interventions, including educational materials and appointment and preventive care reminders. All pregnant members shall receive standard pregnancy care educational materials, OMPP-approved tobacco cessation materials and access information for 24-hour nurse call lines. All members receive materials no less than semi-annually. Materials may be delivered by mail, the MDwise Web site, member portal and telephonically. MDwise makes some or all of these interventions available to every MDHA member.
- **Case Management**
  In addition to population-based disease management educational materials and reminders, these members receive more intensive services which assist them in navigating the health care system. Services include direct consumer contacts to assist the member with scheduling, location of specialists and specialty services, transportation needs, 24-hour nurse line, general preventive and disease specific reminders, pharmacy refill reminders, tobacco cessation information, referrals to community resources, interventions to assist with primary care provider reassignments and education regarding the use of primary care and emergency services. All members receive materials no less than quarterly. Materials may be delivered by mail, the MDwise Web site, member portal, and telephonically. Members in case management will be reassessed at least annually with either general or disease specific screeners. MDHA provides all case management interventions for MDHA members enrolled in case management for any condition of interest.
- **Care Management**
  In addition to population-based and case management interventions, members in care management have a single care management plan developed to address all identified conditions, including both behavioral and medical problems, in order to decrease fragmented care and promote an interactive approach to care management. OMPP requires that all care plans must be signed by the medical director overseeing care management services. This signature may be handwritten or an electronic signature with attestation that medical director approved the plan.

Assessment

Members in care management are reassessed at least semi-annually. An initial complex assessment is completed no later than thirty (30) days from the date the member is referred for complex care management. Assessment results for each factor below must be clearly documented in the care management notes, even if a factor does not apply to the member.

- Initial assessment of member health status, including condition-specific issues as well as comorbidities such as depression
- Documentation of clinical history, including medications
- Initial assessment of the activities of daily living

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- Initial assessment of mental health, including cognitive functions
- Initial assessment of life-planning activities
- Assessment of health behaviors that may impede a member's ability to manage a condition (e.g., tobacco use)
- Assessment of psychosocial issues that may impede a member's ability to manage a condition (e.g., homelessness, religious beliefs, etc.)
- Evaluation of cultural and linguistic needs, preferences or limitations
- Evaluation of visual and hearing needs, preferences or limitations
- Evaluation of available benefits from the organization and from community resources
- Identification of barriers to meeting goals or complying with the plan
- Development of a schedule for follow-up and communication with members
- Development and communication of member self-management plans
- Process to assess progress toward care management planned interventions
- Review of the member's claim history
- Contact with the member's family and health care providers with permission from the member to evaluate caregiver resources and involvement
- Identification and communication of information regarding high risk, high cost members to delivery system leadership in order to allow for reinsurance evaluation
- Identification of Healthy Indiana Plan (HIP) members who meet Enhanced Services Plan (ESP) screening guidelines and collection of provider signed ESP referral paperwork

Ongoing Management

- Goals and interventions are based on the above member assessment
- Development of an integrated care management plan, including prioritized goals that take into account member and caregivers' goals, preferences and desired level of involvement in care management program
- Addressing the identified barriers to meeting goals and complying with the plans
- Facilitation of member referrals to resources, including follow-up process to determine whether members act on referrals
- Development of a schedule for follow-up and communication with members
- Development and communication of member self-management plans
- Assessment of progress against case management plans and goals and modification as needed
- Condition monitoring, including all identified medical and behavioral health comorbidities and other health conditions (e.g., cognitive deficits, physical limitations)
- Documented communications to the member on the importance of communicating with their providers, including the development of a member-provider communication schedule

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MDwise is committed to an integrated approach to manage our members. The care managers consult with the member's physical and behavioral health providers to facilitate the sharing of clinical information and the development of a coordinated physical/behavioral health treatment plan individualized to the member's needs.

The elements of the PDD Disease Management Program serve to engage, educate and empower the member and the family. Education focuses on the importance of controlling contributing factors, medication safety and compliance, counseling and therapy, and coping skills. Members and their families are encouraged to participate in parent training, social skills training and a healthy lifestyle that includes sufficient rest and a proper diet. The care manager facilitates a team approach that includes teachers, parents, the therapist and the prescribing provider. Education about comorbid conditions and the warning signs of the same is provided. The family is connected with relevant supports in the community (e.g., About Special Kids, or ASK) and MDwise resources that are found on the MDwise Web site. Preventive care is emphasized.

Care Management for Members at Risk for or Discharged from Psychiatric Inpatient

Care management services are provided for any member at risk for inpatient psychiatric or substance abuse hospitalization, and for members discharged from an inpatient psychiatric or substance abuse hospitalization, for no fewer than 180 calendar days following the inpatient hospitalization.

Upon receiving notification of a member's inpatient behavioral health hospitalization, the Clinical Care Manager collaborates with the inpatient and aftercare providers to schedule an outpatient follow-up appointment to occur no later than seven (7) calendar days following the inpatient behavioral health hospitalization discharge.

Upon notification, with appropriate consent, care managers notify the primary medical provider (PMP) when a member is hospitalized for behavioral health issues, including substance abuse within five (5) calendar days of the hospital admission. The PMP is also sent a copy of the discharge review including diagnosis, aftercare appointments and medication prescribed on discharge.

The member's utilization is monitored to determine whether the member is under- or over-utilizing behavioral health services and a plan is implemented to address the utilization. Over- or under-utilization is defined as members who are more than two (2) standard deviations outside the MDwise mean utilization for behavioral health services.

- **Priority Interventions**
  - Ensure the member has been thoroughly assessed and all the data is included in a developmental profile held by the lead treatment clinician/care coordinator
  - The diagnosis of a PDD requires a multi-disciplinary evaluation that includes screening with the PMP for comorbid medical conditions as well as baseline labs, etc. if psychotropic therapy is being considered

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- Obtain a thorough history that includes:
  - language development
  - occurrence of repetitive movements
  - problem relating to others, objects and/or environment
  - sensitivity to sensory input
  - difficulty adjusting to changes in routine
  - perseverating/unusual focus on an object or particular subject
- Referral to specialists
  - psychologist
  - behavior specialist
  - speech/physical/occupational therapist
  - sensory integration specialist
- Applicable ratings scales
  - Childhood Autism Rating Scale (CARS)
  - Checklist for Autism in Toddlers (CHAT)
  - Autism Screening Questionnaire
- Ensure there is a lead clinician/care coordinator assigned to work with the family and help them navigate the system
  - Coordinate between PMP, psychologist, behavior specialist, speech therapist, occupational therapist, etc.

- **Multi-disciplinary Therapies**
  - Refer member to evidenced-based behavioral therapies such as Applied Behavioral Analysis (ABA), Floor Time (also known as Developmental, Individual Differences, Relationship-Based Approach or DIR), Treatment and Education of Autistic and Communication Handicapped Children (TEACCH) and Picture Exchange Communication System (PECS) with qualified providers
  - Refer member for needed speech, physical, occupational and sensory integration therapies
  - Assess for need of psychotropic therapy: medication may be appropriate based on the severity of the symptoms and level of impairment in functioning
- **Self Management**
  - Promoting empowerment of the member by embracing self-care behaviors
  - Family should develop an individualized safety or crisis plan that includes identification of environmental triggers, ongoing monitoring of symptoms and target behaviors, recognizing deterioration of symptoms and/or behaviors and how to respond
  - Promote compliance with medication and therapeutic interventions from all therapies and providers
  - Family should attend scheduled appointments

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Documentation System

All interaction with the member and provider is documented in the integrated case management documentation system, which automatically includes the staff member's name and credentials as well as the date and time of the action in the member's medical record. Automated prompts for follow-up contacts with the member are addressed in the member's plan of care. Clinical Care Guidelines are used to develop assessments with algorithms in the case management documentation system. The staffing ratio for care management is 1:200.

Provider Notification and Involvement

In-network providers are notified about the program in several ways:

- The MDwise Provider Manual
- The MDwise Hoosier Alliance Web site (www.hoosieralliance.org)
- The MDwise Provider Web site (http://www.mdwise.org/providers.html)
- Indiana Health Coverage Programs (IHCP) Provider Bulletins
- Case management outreach encounters and updates with the provider
- Notification to the PMP of psychiatric inpatient admission

Providers receive the following written notification regarding their patients' participation in the PDD Disease Management Program:

- Notification of high-risk member enrollment in one-on-one care management, along with a copy of the plan of care goals
- Notification of a change in risk level of members enrolled in care management
- Notification of members eligible for PDD disease case management that the care manager was unable to contact, either initially or for follow-up, to collaborate on patient demographics and update of any relevant clinical findings
- Notification of members who graduate from the PDD Disease Management Program

Annual Evaluation

The PDD Disease Management Evaluation is conducted collaboratively by the Senior Director of Clinical Services, Case and Disease Management Supervisor, Supervisor of Quality Improvement and the Chief Medical Officer. The program is evaluated annually and presented in the first quarter of the following year to the Physician Advisory Committee. Quarterly statistics are reported to the Physician Advisory Committee.

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Objectives, activities, processes and outcomes are evaluated at a minimum of annually in order to:

- Calculate annual active member participation rate
- Determine whether the PDD Disease Management Program has demonstrated improvement in the services and quality of care provided to members
- Evaluate the overall effectiveness of the PDD Disease Management Program
- Allow for exploration of barriers and limitations of the PDD Disease Management Program
- Revise areas as needed to improve effectiveness of the PDD Disease Management Program
- Obtain feedback from members regarding satisfaction with care management as well as to analyze member complaints and inquiries
- Implement intervention(s) to improve performance

MDHA also reviews and updates its case management processes and resources to address member needs. Policies are reviewed annually during the Quality Service Committee.

Supporting Clinical Guidelines and References

- MDwise Clinical Care Guidelines for Pervasive Developmental Disorders
  http://www.mdwise.org/docs/providerbehavioralhealth/gl-pdd.pdf
- National Autism Center – The National Standards Project – Addressing the Need for Evidence-based Practice Guidelines for Autism Spectrum Disorders
  http://www.nationalautismcenter.org/affiliates/
- Centers for Disease Control (CDC) Autism A.L.A.R.M. Guidelines
  http://www.medicalhomeinfo.org/downloads/pdfs/AutismAlarm.pdf
- Centers for Disease Control (CDC) Autism Recommendation and Guidelines
  http://www.cdc.gov/ncbddd/autism/hcp-recommendations.html
- Centers for Disease Control (CDC) Autism Treatment Recommendation
  http://www.cdc.gov/ncbddd/autism/treatment.html
- American Academy of Pediatrics Policy Statements and Clinical Papers
  http://aap.org/healthtopics/autism.cfm
- American Academy of Child and Adolescent Psychiatry Practice Parameter for the Assessment and Treatment of Children, Adolescents and Adults with Autism and Other PDDs
  http://www.aacap.org/galleries/PracticeParameters/Autism.pdf
- American Academy of Neurology Practice Parameter: Screening and Diagnosis of Autism
  http://www.neurology.org/content/55/4/468.full.pdf