Bridging the Path Between Autism Spectrum Disorder Diagnostic Evaluation and Access to Treatment

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Agenda

- Review DSM-5 criteria for ASD
- Highlight best practices for accurate, useful ASD evaluations
- Discuss differential diagnosis
- Identify common challenges from referral to diagnosis and treatment
- Explain how evaluation findings support access to treatment across the lifespan, with emphasis on ABA
- Show how evaluation results guide individualized treatment, care level decisions, and re-evaluations
- Differentiate focused vs. comprehensive ABA based on individual symptoms and needs
- Discuss barriers to ABA access and strategies to use evaluation findings to improve care

DSM-V-TR Criteria for ASD: Social Communication & Interaction

A. Persistent deficits in social communication and social interaction across multiple contexts, currently or by history, including:

All 3 must be present

1) Deficits in social-emotional reciprocity (e.g., limited back-and-forth conversation, reduced sharing of interests or emotions, difficulty initiating or responding to social interaction).
2) Deficits in nonverbal communication for social interaction (e.g., reduced or abnormal eye contact, body language, gestures, or facial expressions; difficulty coordinating verbal and nonverbal communication).
3) Deficits in developing, maintaining, and understanding relationships (e.g., difficulty adjusting behavior to different social situations, challenges with imaginative play or friendships, limited interest in peers).

DSM-V-TR Criteria for ASD: Restricted & Repetitive Behaviors

B) Restricted or repetitive patterns of behavior, interests, or activities, currently or by history

****At least 2 must be present****

- **Repetitive movements, object use, or speech** (e.g., motor stereotypies, lining up objects, echolalia, repetitive phrases).
- **Insistence on sameness or inflexible routines** (e.g., distress with small changes, difficulty with transitions, rigid thinking, ritualized behaviors, needing the same routes or foods).
- **Highly restricted or fixated interests** that are unusual in intensity or focus (e.g., strong attachment to unusual objects or very narrow interests).
- **Unusual responses to sensory input** (e.g., over- or under-sensitivity to sounds, textures, pain, or temperature; excessive smelling or touching objects; fascination with lights or movement).

DSM-V-TR Criteria for ASD: Restricted & Repetitive Behaviors (con't)

C. Symptoms are present in the early developmental period, though they may become more noticeable when social demands increase or may be masked by learned strategies later in life.

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of functioning.

E. Symptoms are not better explained by intellectual disability or global developmental delay. When both autism and an intellectual disability co-occur, social communication deficits must be greater than expected for the individual's general developmental level.

Clinical Specifiers

- With or without accompanying intellectual impairment
- With or without accompanying language impairment
- Associated with another known neurodevelopmental, mental, or behavioral disorder (including ADHD or learning disabilities)
- Associated with a known medical or genetic condition or environmental factor
- With catatonia

Severity Levels for ASD

Level 1 - Requiring support

Social Communication

- Difficulty initiating social interactions
- Reduced interest in social exchanges
- Appears socially awkward or atypical without support

Restricted/Repetitive Behaviors

- Inflexibility causes noticeable interference
- Difficulty switching between activities
- Problems with planning and organization

Level 2 – Requiring substantial support

Social Communication

- Marked deficits even with supports
- Limited initiation of social interaction
- Reduced or abnormal response to others

Restricted/Repetitive Behaviors

- Inflexibility and repetitive behaviors are obvious to others
- Distress or difficulty coping with change
- Behaviors interfere with functioning across settings

Level 3 – Requiring very substantial support

Social Communication

- Severe deficits in verbal and nonverbal communication
- Very limited initiation or response to social interactions

Restricted/Repetitive Behaviors

- Extreme inflexibility
- Repetitive behaviors markedly interfere with all areas of life
- Extreme difficulty with change

Comprehensive Diagnostic Evaluations (CDE)

Multidisciplinary Assessment

- A comprehensive autism evaluation uses a multidisciplinary approach and includes information from multiple sources.

Collateral Information May Include Input From:

- Parents and caregivers
- Teachers or school staff
- Speech-Language Pathologist
- Developmental Pediatrician
- Psychiatrist or Medical Psychologist
- Occupational Therapist

Key Components of a CDE

- **Developmental History**
  Detailed history of early development, behavior, communication, and social functioning.
- **Speech, Language, & Communication**
  Assessment of expressive language, receptive language, pragmatic language, and social communication.
- **Intellectual Functioning**
  What the individual **is capable of doing** (cognitive ability).
- **Adaptive Functioning**
  What the individual **actually does in daily life** (daily living, social, and practical skills).
- **Executive Functioning**
  Skills such as planning, organization, attention, self-regulation, and problem-solving.

Differential Diagnosis and Co-Existing Conditions

Differential and Co-Occurring Diagnoses

- Psychiatric
- Medical
- Trauma
- Genetics

- Feeding or PICA
- Sleep Disturbance
- GI difficulties

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Bridging the Gap between CDE and Accessing ASD Intervention

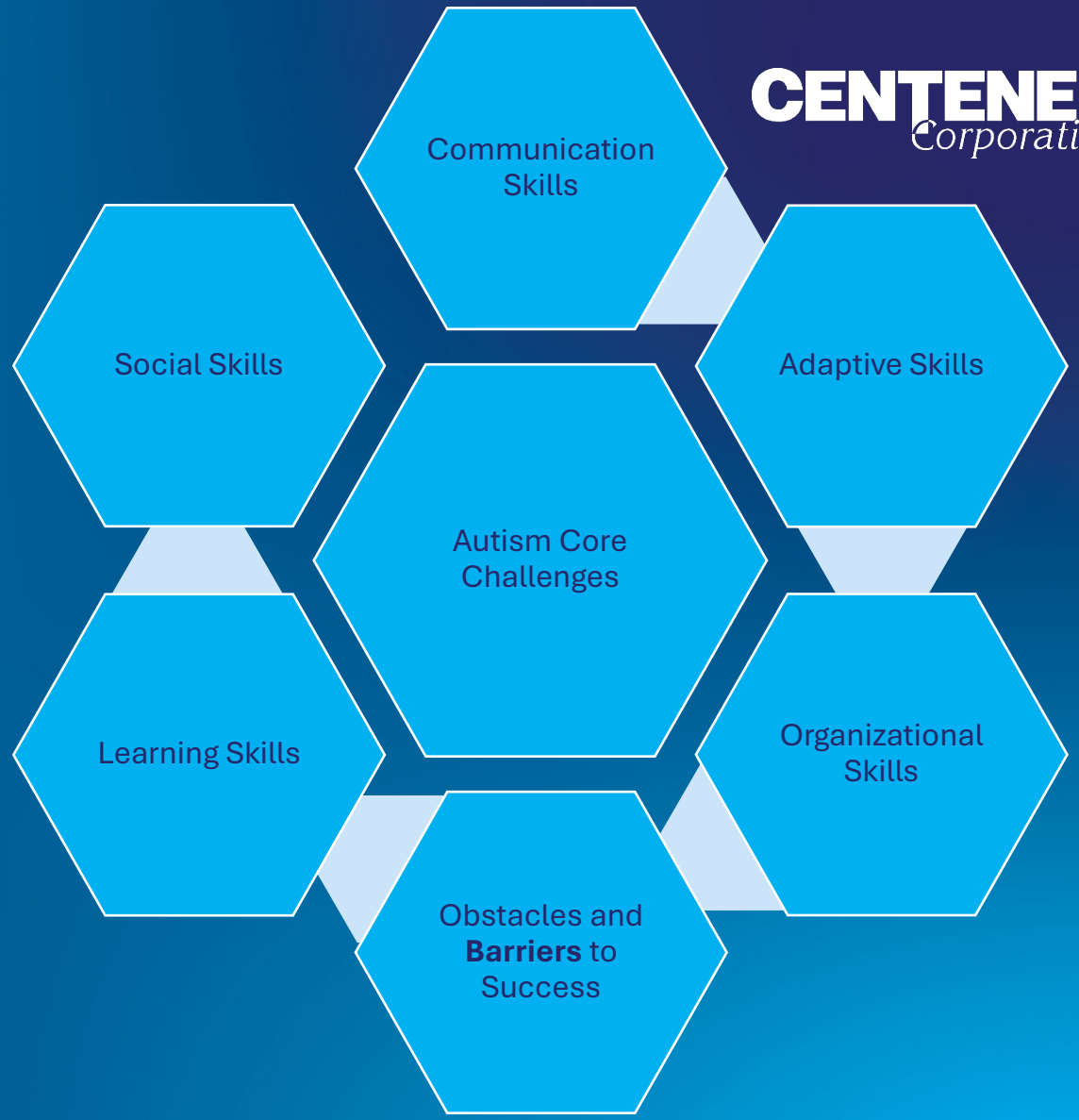
Making Treatment Recommendations

Important to make individualized treatment recommendations based on specific symptomology and challenges

Helps guide the family to know next steps and their treatment options following initial diagnosis

Helps the family understand changing intervention needs following re-evaluations throughout the lifespan

Intervention to address primary and secondary ASD symptoms



Individualized Treatment: Primary and Secondary Symptoms/Challenges

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- Explains some of the “why” maladaptive behaviors occur
- Not meant to be an excuse or a way to say behaviors is “appropriate”
- Lay groundwork for what intervention strategies to recommend
- Explains why some intervention strategies may not work
  - Not addressing all areas of need
  - Too Reliant on Language and Communication
  - Too reliant on social Exchanges

Common Interventions for ASD

Behavioral

- Applied Behavior Analysis (ABA)
- Social Skills Training
- Early Start Denver Model

Psychological, Educational, Therapeutic

- Acceptance and Commitment therapy (ACT)
- Cognitive-Behavioral Therapy;
- Relationship Development Intervention (RDI)
- Developmentally Based individual Difference Relationship Based Intervention (DIR/Floortime)
- Speech therapy
- Occupational Therapy; Sensory Integration;

Biomedical

- Medications to mainly address secondary symptoms (anxiety, irritability, sleep, attention, etc.)

Appropriateness of Intervention

Individualized Assessment

Determining ABA appropriateness requires evaluating each person's unique clinical presentation and responsiveness to treatment.

Variable Effectiveness

ABA therapy benefits vary widely, and not all individuals with similar diagnoses respond the same way to treatment.

Resource Optimization

Careful assessment ensures therapy resources are used effectively and that interventions are truly beneficial to individuals.

Matching Intensity to Needs

ASD treatment is NOT one-size-fits all!

Customized Intensity of Services

ABA treatment dosage is not based solely on diagnosis. Intensity is tailored to the individual's clinical presentation and developmental profile.

Collaborative Treatment Planning

Active participation of individuals and caregivers in treatment planning ensures relevance and consent/assent.

Ongoing Re-evaluation

Regular reassessment of clinical needs and treatment intensity is essential and should be adapted over time based on current clinical need.

Levels of Care

Comprehensive Level of Care

Involves 30-40 hours weekly for individuals needing treatment to address many areas of skill acquisition and behavior reduction.

High Intensity/Comprehensive Scope: extensive support across many areas to build essential skills and to address complex, dangerous behaviors and barriers.

Typically, 32- 40 hours a week.

Lower Intensity/Comprehensive Scope: less intense comprehensive level of care for individuals needing support across various areas to build essential skills and further reduce behavioral excesses for behaviors and barriers. This can be a phase following EIBI initiation when barriers have decreased but treatment needs remain across many areas and to address less complex/less frequent challenging behavior.
Typically, 27- 32 hours a week.

Levels of Care (con't)

Focused ABA Treatment

Involves 10- 25 hours or less per week of direct care targeting specific goals like social skills, job skills development, independent daily living skills, reduction of mild/infrequent behaviors, and/or self-regulation, etc.

High Intensity / Focused Scope: Direct intervention to address a moderate level of skill development areas and challenging behaviors.

Typically, 15-25 hours a week of direct services.

Low Intensity /Focused Scope: Direct Intervention to address few skill deficit areas or skills that do not require high rates of repetition with few barriers to treatment progress. Often paired with high levels of caregiver training to ensure generalization.

Typically, 5-15 hours a week of direct services.

Consultation / Caregiver Training Model

Minimal direct treatment with emphasis on caregiver training and consultation across setting to support child's progress. Typically, 2-5 hours a week.

Barriers to Accessing CDEs & the interventions that follow

Barriers to Accessing CDE

- Shortage of providers who conduct CDEs –
- Funding Barriers
- Age Barriers
- Long waitlists for CDE
- Limited Access for Reevaluations
- Access in Rural Areas

Barriers to Accessing Treatment

- Families are unclear on prioritization of treatments to pursue or knowing what they are leads to delays
- Waitlists
- Appropriate Treatment Settings
- Limitations on age
- Limitations regarding severity and complexity of challenging behavior

Funding Barriers – Medical Necessity

Coverage Variations

Coverage for ABA services varies including eligibility, diagnosis providers, and diagnostic tools.

Diagnosis Requirements

Many funding sources require a formal Autism Spectrum Disorder diagnosis from an approved professional for ABA eligibility.

Recommendation for ABA Treatment

A licensed professional qualified to render diagnosis of ASD must recommend ABA treatment based on the individual's symptoms and test results. In some insteances, the recommendation for ABA treatment needs to be updated regularly (e.g., each year).

Funding Barriers- Medical Necessity

Re-Evaluation Timeline Requirements
Typically, the CDE is considered outdated after 5 years.
More frequent updates are needed if symptoms change, following time in intervention, or when meeting developmental milestones (e.g., adolescence).

CDE Updates
Show any diagnostic changes or additions.
Show what treatments are recommended based on current symptoms and response to treatment.
Show continued medical necessity for ABA- a clear recommendation is needed with each CDE if ABA continues to be a recommended treatment.

Updated CDEs must meet same requirements as the initial.

Overcoming Barriers

- **Knowing the requirements for the CDEs needed to access care.**
- **Clearly informing families of what is recommended and what the priorities are for their child.**
- **Providing resources and contacts for options to access while on waitlists for intensive services, like ABA.**
- **For younger children, connect to early intervention services.**
- **Encourage parents to contact school system for an IEP evaluation when appropriate to access services.**

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Thank you!

Questions