

## **DIAGNOSIS AND EARLY SCREENING SUB-COMMITTEE**

September 17, 2008

Meeting called to order at 10:05

In attendance: Hanes Swingle, Alice Widgeon, Jim Wrye, Nancy Parker, Laura Klinger, Angie Barber, Felicia Houston, Sharis LeMay, Karen Dahle, Cam Ward and Jennifer Muller.

Felicia Houston brought her consultation and training team from Glenwood to observe.

Nancy Parker reviewed **Early Intervention eligibility criteria**. Eligibility for services is a separate (but related) issue from diagnoses made by health care providers.

Children are immediately eligible for EI services if one of the following criteria is met:

1. A physician has made a child a qualifying diagnosis.
2. A child is 25 % delayed on two screening instruments used by EI.
3. A child is 20-25% delayed and a clinician feels services are needed.

The autism spectrum disorders (autism, PDD-NOS, AS) are all qualifying diagnoses, but most young children referred to EI by pediatricians have not yet been diagnosed. Early Intervention will accept reports from non-EI testers to qualify children for services, but EI needs 2 reports. Several individuals in the room were unaware that all they needed to do was to administer a second test so that the children they referred to EI would automatically qualify for services -- if the child is delayed by 25% on both tests.

A minimum of a Bachelor of Arts (BA) degree in a human service field is required by the EI evaluators who conduct eligibility assessments. EI is working on requiring documentation of previous training in assessments.

Early Intervention utilizes two plans to provide services:

Plan A-EI programs provide the assessments and services

Plan B-EI contracts with private agencies to conduct evaluations and provide services

EI has an assigned person in the state office to work directly with district coordinators to provide quality assurance.

Alabama Early Intervention does not currently have the capacity to serve all eligible children. Many EI private contractors are "over capacity" and are providing services to children beyond what is stated in their contracts. There are at least 350 children above the contracted capacity of private EI providers, which means that EI coordinators and contracted agencies are providing supports and services to children without guarantee of payment.

EI has a 45 day time line from date of referral until the report is received.

Discussion centered on the forms that are used for eligibility, training EI providers to screen for ASD (M-CHAT and CSBS were discussed) and providing a “risk assessment” for kids who don’t meet criteria. Currently, Alabama is not an “at risk” state, i.e., it does not provide services to a child because the child is at significant risk of developing delays. EI will provide services if a 20-25% delay has been noted and there is a clinician’s recommendation that services be provided.

Karen Dahle discussed **Eligibility for School Based Services:**

After age 6 a child’s parents have the choice of keeping the Developmental Delay eligibility or having them re-evaluated and served under one of the 18 Federal qualifying conditions.

Handouts were distributed; Proposed Changes AL Admin. Code May –June 2008 Dr. Dahle pointed out on pg. 497 that the state has taken out the interview with the primary caregiver and replaced it with what has been in the Federal Legislation. This is good because it requires a structured interview and an observation of the child.

How are eligibility criteria applied across systems? Each district defines these individually and there is NOT uniformity across the state.

When independent evaluations are conducted on children -- schools are required to note that these outside evaluations were received and read. Schools are not required to comply with outside evaluators’ recommendations.

It will be important for these issues to be addressed within the Task Force.

Glenwood uses the GARS in their in school assessments, in addition to others. Their experience is that the schools are understanding the need for the ADOS, etc. When the schools are monitored they are required to have the elements required in state law, which for autism includes using an instrument with a scale.

Education performance covers the following domains: social, communication, behavior, adaptive, functional. The way the school interprets educational performance is not always the same as we (parents and clinicians) would.

BBSST-came about in 2000, and requires that a child be in the General Ed classroom for 6 weeks before the child can be referred to BBSST. This is a General Ed function and is not done by special education teachers. The general education classrooms are required to implement a behavior plan they have designed and have it reviewed by BBSST. The general education teacher can go to a special education instructor for help on the behavior plan. Many schools are able to get children into special education services before the 12 week period, others are not. Parents can write and request a referral to special education. The intention of BBSST was to get help for those children that might not otherwise get help. Having appropriate behavioral plans can keep children with autism spectrum disorders in the general education classrooms.

The transition process of moving children from EI to school was discussed. Alabama has trained those that are responsible for transitioning to Part B. Ms. Parker noted that Alabama EI does an exceedingly good job of coordinating these transitions. A plan is written by the time a child is 30 months. The families of children that are going to be referred get a standard letter sent to LEA (1 out of 10 parents of children receiving EI do not want a letter of notification sent to the school) and they have 90 days to respond. The parents and school have a face to face meeting, if the parents follow thru. If a child is referred to EI after 30 months and the child is eligible for services, the process of transitioning the child from EI to the local education agency will still occur. It takes longer if a parent initiates the referral to the LEA, so clinicians should refer children between 30-36 months of age to EI if the clinician suspects a child has significant delays.

If children are identified by EI as having significant delays, they don't have to go thru BBSST and can be transitioned directly to special education services. EI has a synopsis of their materials online. It would be helpful to invite Abby Felder to come to this group at some point.

**Barriers to Physician screening were discussed.** Pediatricians report that not knowing which screeners to use and then how to proceed after a child fails a screener are barriers to them implementing the AAP recommendations for general developmental and autism specific screening.

Angie Barber spoke about the **CSBS Infant Toddler checklist**, which can be used for children between the ages of 9-24 months. The CSBS is a screener used to detect social communication delays in children. Ms. Barber noted that the CSBS is easy to administer and score. Computerized scoring is also available. There is a 2<sup>nd</sup> stage CSBS that can be used to diagnose specific language disorders. Parents bringing children to well child visits are asked to complete the CSBS every 3 months. CSBS is available to physicians on-line free of charge. If a pediatrician uses the CSBS and the child fails the screening, that child should be referred for an autism specific evaluation and to EI.

The AAP recommends autism specific screening at 18 and 24 months. Ms. Barber reported that Dr. Wetherby at Florida State University uses the CSBS and her data show that this instrument is good for identifying children with autism. Although the CSBS is not listed as an autism specific screener by the AAP, Dr. Klinger suggested that the CSBS could be used as an autism specific screener. Ms. Barber offered to provide the sub-committee data on the positive predictive value (PPV) of the CSBS with regards to autism.

**The STAT** is a level II screening instrument for autism spectrum disorders that EI providers could use to screen for autism, if EI's evaluators received training. Regional Autism Centers could provide training in the use of the STAT or other autism screening instruments.

**The M-CHAT** is an autism specific screening instrument, which only has an 11% positive predictive value in a general pediatric setting. The sub-committee members do not favor recommending the M-CHAT to pediatricians, although it was noted that the M-CHAT is currently the most widely used autism specific screener by general pediatricians. The M-CHAT has a positive predictive value of greater than 60% in the population served by Early Intervention, which makes it an acceptable tool for use by EI. A secondary screener, such as the STAT, may have an even higher PPV. Use of screening instruments with high PPV is needed to avoid unnecessary referrals to diagnostic centers, which already have long waiting lists.

What is being used after 24 months in Florida?

Dr. Klinger reported that her clinic uses the Mullen in place of a Bayley III for children between the ages 2 and 3 and finds this test more helpful for evaluating cognitive functioning in children with autism spectrum disorders.

Headstart and Earlystart- our sub-committee needs to think about autism screening that could be conducted within these programs.

Dr. Martinez, a medical geneticist from USA, will be reviewing the genetic work-up of children with autism at our November meeting.

Our next meeting will be held on October 15<sup>th</sup> at 10:00 a.m. in the State House. Everyone is encouraged to e-mail Hanes ([hswingle@usouthal.edu](mailto:hswingle@usouthal.edu)) with their ideas for our sub-committee's recommendations and/or bring their ideas to the next meeting. We need to make sure our recommendations can be implemented throughout the state, in both rural and urban communities. Our final recommendations will be presented to the state legislature in February.

Meeting was adjourned at 12:00.