Improving Access to Services to Identify & Manage Children with Autism Spectrum Disorder and Other Developmental Disabilities

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Disclosures

We have no financial relationships or affiliations to disclose
Objectives

• Define barriers for obtaining comprehensive diagnostic assessments for children with complex developmental and behavioral profiles
• Describe different care pathways to increase capacity of primary care providers to manage children with ASD/DD
• Introduce intake team, enhanced intake processes and coordination of services
• Demonstrate an understanding of the purpose and practice of ECHO to support the management of children with ASD/DD within their Medical Homes
Estimated Autism Prevalence 2020
National Problems

• Likelihood of having a developmental disability has increased to ~18%

• 1 in 6 children between 2-8 years have developmental, behavioral, and/or mental health problems

• Shortage of developmental behavioral pediatricians
Colorado and Its Children

1. Bisection of state by front range and Rocky Mountains
2. Paucity of providers in more remote areas of state
3. Travel difficult, especially in winter
Colorado Pediatric Population

1. 87% population in metro areas
2. 6% of children live in rural regions
3. 3% of children live in frontier regions
Colorado Health Care Access Survey

• 33% of CYSHCN unable to get timely healthcare provider appointment

• 38% not able to obtain transportation or office too far away

• Racial disparities: 42% Hispanic CYSHCN without medical home
Board Certified DBP Physicians in U.S.
Pediatric Physicians Workforce Data Book. 2019-2020, ABP

- Ever board certified: N=904
- Lapsed: N=198
- Current: N=706
Regional DBP Workforce

Ever DBP board certified ≤ 70 years

(2019 – 2020)

- 0 – Wyoming, North Dakota
- 1 – Idaho, South Dakota
- 2 – New Mexico, Utah
- 3 – Nevada, Montana
- 14 – Colorado (~7 in 2019)
  - 1.1 DBP/100,000 children

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Developmental Pediatrics Challenges

- Long wait lists
- Not enough providers to meet need
- Open MD positions
- Intake questionnaire of limited value
- Models of care needed re-evaluation
- Plan of care not developed until assessment complete
- PCPs referring patients with "diagnose and treat" only
8 Coordinated Care Pathways

1. Coordinated Intake and Initial Telehealth Assessment
2. Clinic Model
3. Telehealth
4. ECHO
5. STAT training
6. e-Consults
7. PCN Model
8. Outreach Rural PCPs

Rural PCPs
Pathway # 1
Current State: Coordinated Clinical Intake Team

Centralized Intake Process

First Contact

Registration / Phone Queue

Clinical Coordination Team

Nursing, Social Work, Health Navigator, Admin Staff

- Determine EPDC
- Coordinate completion of intake questionnaire
- Coordinate upload of all pertinent Records/Evaluations/IEPs
- Key current interventions
- Escalate as appropriate
- Resource to community physicians
- Adaptive Care Plan
  - Schedule patient for appropriate specialty

Gather all appropriate records, evaluations, tests, etc and store in Epic

Care Plan in Epic / MyChart

Appropriate Referral Based on Above

- Pediatric Mental Health Institute
- Developmental Peds
- Speech and Learning
- Occupational Therapy
- Child Health Clinic
- Special Care Clinic
- Community Resources

Partner with PCPs (Care Plan, Results, Questions, Support, etc)

Parent/Guardian able to access Care Plan in MyChart

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Pathway #1
Coordinated Intake Team Improvements

1. **Resource Team** - Referral Coordinator, Health Navigator, RN Nurse Care Coordinator, LCSW and Care Coordinator

2. New Referral Process has been implemented

3. Resources offered pre/post evaluation and ongoing support for services

4. New Tools Implemented - EPIC referral tool, MyChart Questionnaire, telehealth visits

5. Education on Community Resources for PCP’s through ECHO and PCN
Pathway #1
Initial Assessment Model

Findings:
- 27% of all patients seen with initial assessment do not need further follow up
- 73% of 7-9 year olds do not need further follow up

Pivot to telehealth initial assessment
- Telehealth during COVID continues to support advantage of initial assessment model
- ~30% continue to need no further follow up
Pathway #2
Clinic Model Improvements

1. Template Utilization
2. Nursing/MD Bookends
3. Expanded clinic model
4. Initial Assessment telehealth model
5. PCN Model
Pathway #3
Telehealth

1. 2018-2019
   One or two Weekly telehealth initial assmts

2. 2/2020
   In-home telehealth initial assmts began

3. 3/2020
   In-home telehealth MD follow up visits began

4. 3/2020
   COVID Requires pivot to telehealth

5. 4/2020 - 4/2021
   ~ 65% of all Dev Peds visits telehealth
Pathway #3
Telehealth/In-person Assessment Model

Telehealth Appointment

Resources
Referrals
Therapies
Other CHCO Services

In-person Interdisciplinary Assessment
Telehealth Informing Conference

19
Pathway #4

Autism ECHO

Extension for Community Health Outcomes: Autism Community of Practice ECHO

1. 6 Autism ECHO Cohorts
   109 participants
   22% Rural
   22 Counties
   65% Underserved

2. Community of Practice Monthly Case Review
   20 Participants

3. New Model for Autism ECHO Cohort 7: Expanded to 2 Series, 5 sessions each
ECHO: Changes in Reported Skill Levels
“Very much appreciate these trainings - high quality information and skills building, as well as networking with experts....for those of us in the far reaches of the state.”

“I definitely feel supported by the pros at CHC, but also by the others in similar practices facing the same issues.”

“In this rural area, I have learned the process of gaining intervention for children with ASD...at a much earlier age. I feel confident in helping families with sleep and feeding disorders related to ASD.”
"I love that you have several of the providers from the different fields (MD, PhD, PharmD, MSW) providing guidance"

"Info on diagnosis and assessment...specific behavioral strategies—it was all great"
What changes do you plan to make?

“More consistent screening. Better teaching points for parents for anticipatory guidance”

“More routine follow up for my autistic patients”

"Being more direct when discussing the diagnosis and my concerns about a child"

"Focusing on early diagnosis and referrals"

"I think it gave me more knowledge to be able to identify these children and also to feel more comfortable regarding starting a medication."
Pathway #5

STAT Training
(Screening Tool for Autism in Toddlers)

1
1st Training
November 2018
4-hour Online Tutorial w/ In Person Training on Diagnosis and Management
11 Providers

2
2nd Training
May 2020
1.5 Day In Person converted to Virtual
19 Providers

3
3rd Training
Summer 2021
1.5 Day Virtual
Add Booster Sessions
Pathway #6
e-consultations

1. Roll out to CHC began 6/2019
2. First e-Consult 7/2019
3. All Peds Connect practices
4. e-consults to date = 77
Pathway #7
Developmental Pediatrics
PCN Model

Expedited patient access to academic medical experts by partnering and educating primary care providers

1. Psychologist provides in-person training and follow up visits to PCN practices
2. Practices provided with dev history templates and support
3. PCP begins evaluation in home office; patient is expedited to DP to complete assessment
4. PCN Provider given feedback letter to further support assessment skills and refine referrals
5. Patient triaged to appropriate next steps: resource team, NP/MD appt, other services
Program Feedback

Over 90% of participants reported improvement in the following areas:

• Knowledge of how to identify ASD
• Knowledge of how to manage children with ASD
• Confidence in identifying red flags for ASD
• Confidence in speaking to families about ASD
• Confidence in helping families access ASD resources
Program Feedback

Statistically significant increases were found in the following practice behaviors after the training:

• Monthly concerns for ASD (nearly double)
• Monthly referrals to Developmental Pediatrics
• Monthly consultations with Developmental Pediatrics
Program Feedback

• “I feel more comfortable in my knowledge for potential autism diagnosis...my confidence is significantly increased.”

• “Extremely useful...it has changed my practice.”

• “Outstanding and invaluable - one of the best learning sessions I have attended and so applicable to my practice.”

• “Very useful, honestly the discussion was far more helpful than I could have ever imagined.”

• “Thank you so much for seeing [my patient] in your PCN clinic and reaching out to me with your feedback. I am beyond thrilled with this opportunity you have provided for us and for our patients...I reflected a bit after our conversation on the phone and really think that I would not have even thought about ASD as a dx for him (especially after his twice already evaluations) if it were not for you and your training sessions. I am so grateful.”
2020 Program Updates

1. Fast Access to Resource Only Appointment
2. Telehealth Hybrid Model
3. Advanced Provider Trainings through Project ECHO
Expedited Access to Resource Team

PCP Referral

Appointment with the Resource Team

~ 15 completed via direct referral
Telehealth Hybrid Model
(April 2020 – December 2020)

• ~ 60 evaluations

• Average wait time 6 months (and increasing)

• ~ 70% diagnosed with Autism

• ~ 30% completed via telehealth appointment alone
PCN Advanced Autism ECHO Series

- Six 1-hour weekly training sessions
- Didactic topics chosen according to feedback provided by PCPs
  - BEHAVIOR MANAGEMENT
  - MED MANAGEMENT
  - GENETIC COUNSELING
  - SLEEP
- Case discussion and opportunities for ongoing consultation
- Staffed by multidisciplinary expert panel
Pathway #8
Outreach Clinics
Rural and Frontier Primary Care Clinics

- Outreach focused on improving skills and comfort with ASD/DD
- Practices identify underserved patient with high needs
- Partner with providers who have engaged in our training activities

![Map showing Current Partners and Future Partners]
Prior to Pathway Model

- PCP
- Admin Intake
- Dev Peds MD/APP
- Psychologist
- Family

Referral

Limited questionnaire

- Autism Discussion
- Developmental History
- Adaptive Interview
- Specialist Physical Exam
- Medical/Genetic Workup

- Autism Evaluation
- Paper Questionnaires

Informing Feedback
What has changed?

1. Expanded Education and Partnerships with PCPs: ECHO, PCN, Outreach Clinics
2. Coordinated Intake
   - MyChart Parent Questionnaire
3. Expansion of Dev Peds Resource Team
   - Genetic Counselor
   - RN Care Coordinator
   - Health Navigator
   - Child Life Specialist
4. Changes in Clinical Models of Care: Telehealth, RN Bookend
5. Expansion of e-Consults
The Future

1. Expansion of current outreach clinics
2. Broaden PCP educational efforts with use of ECHO
3. Expansion to Colorado Springs, Southeast and Northeast regions of state
4. Improved clinical efficiency