

# Maryland Behavioral Health Integration in Pediatric Primary Care (MD BHIPP)

*Friday, April 14<sup>th</sup>, 2023*

## Autism Spectrum Disorder and the PCP's Role in Coordinating Care

Antonia Girard, PsyD, BCBA, LBA



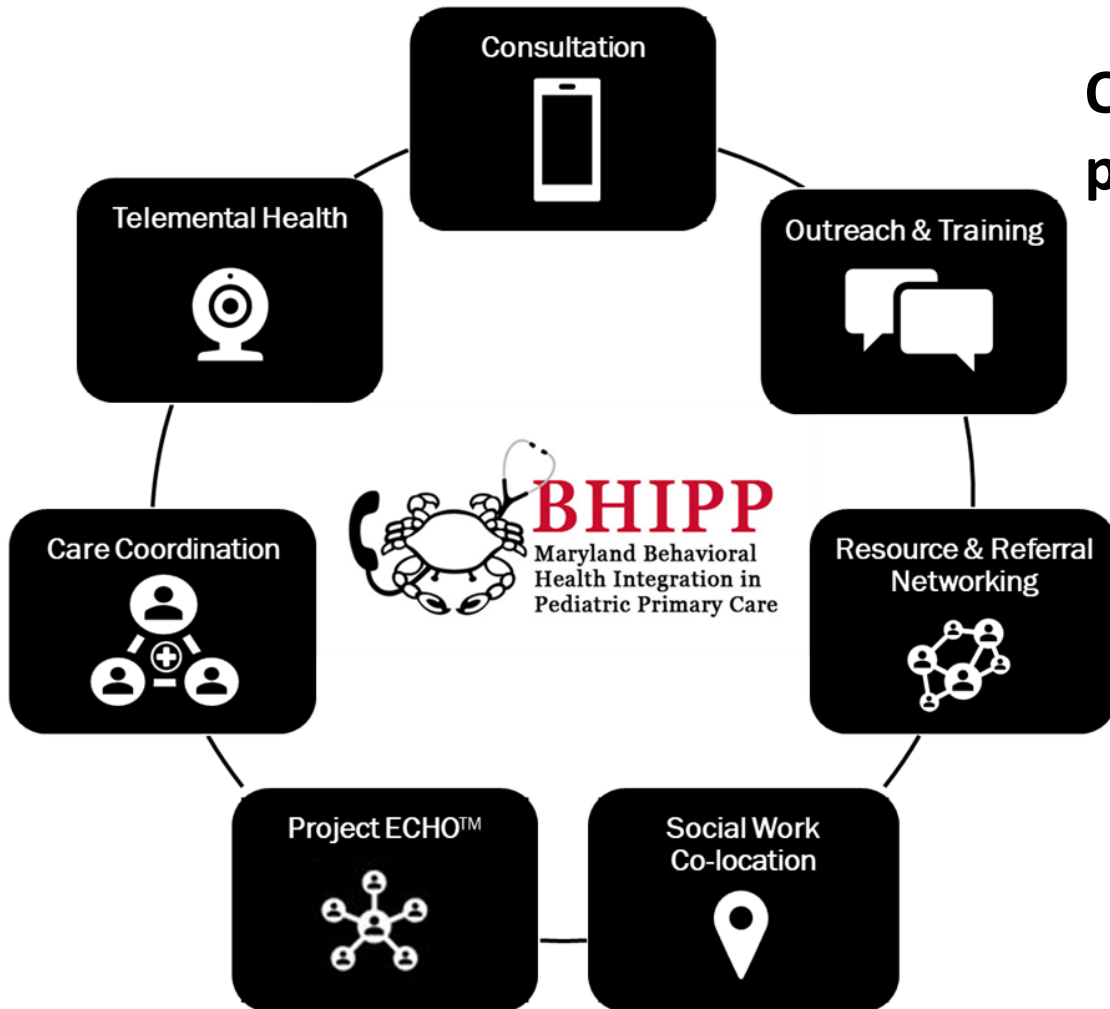
Maryland BHIPP Resilience Break Presentation

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# Who We Are – Maryland BHIPP



**Offering support to pediatric primary care providers through free:**

- Telephone consultation (855-MD-BHIPP)
- Resource & referral support
- Training & education
- Regionally specific social work co-location (Salisbury University and Morgan State University)
- Project ECHO®
- Direct Telespsychiatry & Telecounseling Services
- Care coordination

# Partners & Funding

- BHIPP is supported by funding from the **Maryland Department of Health, Behavioral Health Administration** and operates as a collaboration between the **University of Maryland School of Medicine**, the **Johns Hopkins University School of Medicine**, **Salisbury University** and **Morgan State University**.
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# BHIPP is Available to Provide Support to PCPs During the Pandemic



**BHIPP is open.**

*The BHIPP phone line remains open during this challenging time to support primary care clinicians in assessing and managing the mental health needs of their patients.*

**1-855-MD-BHIPP**  
(1-855-632-4477)

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- Visit our COVID-19 Resource Page:  
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# Meet The Presenter



Antonia Girard, PsyD, BCBA, LBA is an Assistant Professor and Licensed Psychologist within the Division of Child and Adolescent Psychiatry at the University of Maryland School of Medicine. She graduated from Nova Southeastern University in Ft. Lauderdale, FL in 2014 and completed her postdoctoral fellowship at Mt. Washington Pediatric Hospital in Baltimore, MD. During her time there following her fellowship she developed an Early Intervention Program and psychology's role within multidisciplinary pediatric clinics.

She currently conducts psychological evaluations through the Center for Infant Study and the Maryland BHIPP TAP and supervises HealthySteps specialists (early childhood development experts) embedded in pediatric primary care and family medicine practices.



# Disclosures

- Dr. Girard has no potential conflicts of interest
- Faculty at the University of Maryland School of Medicine

# Learning Objectives

- Identify when and how to screen for autism spectrum disorder
- Determine how to discuss screening results with families
- Review next steps in terms of referrals for early intervention services and further evaluation



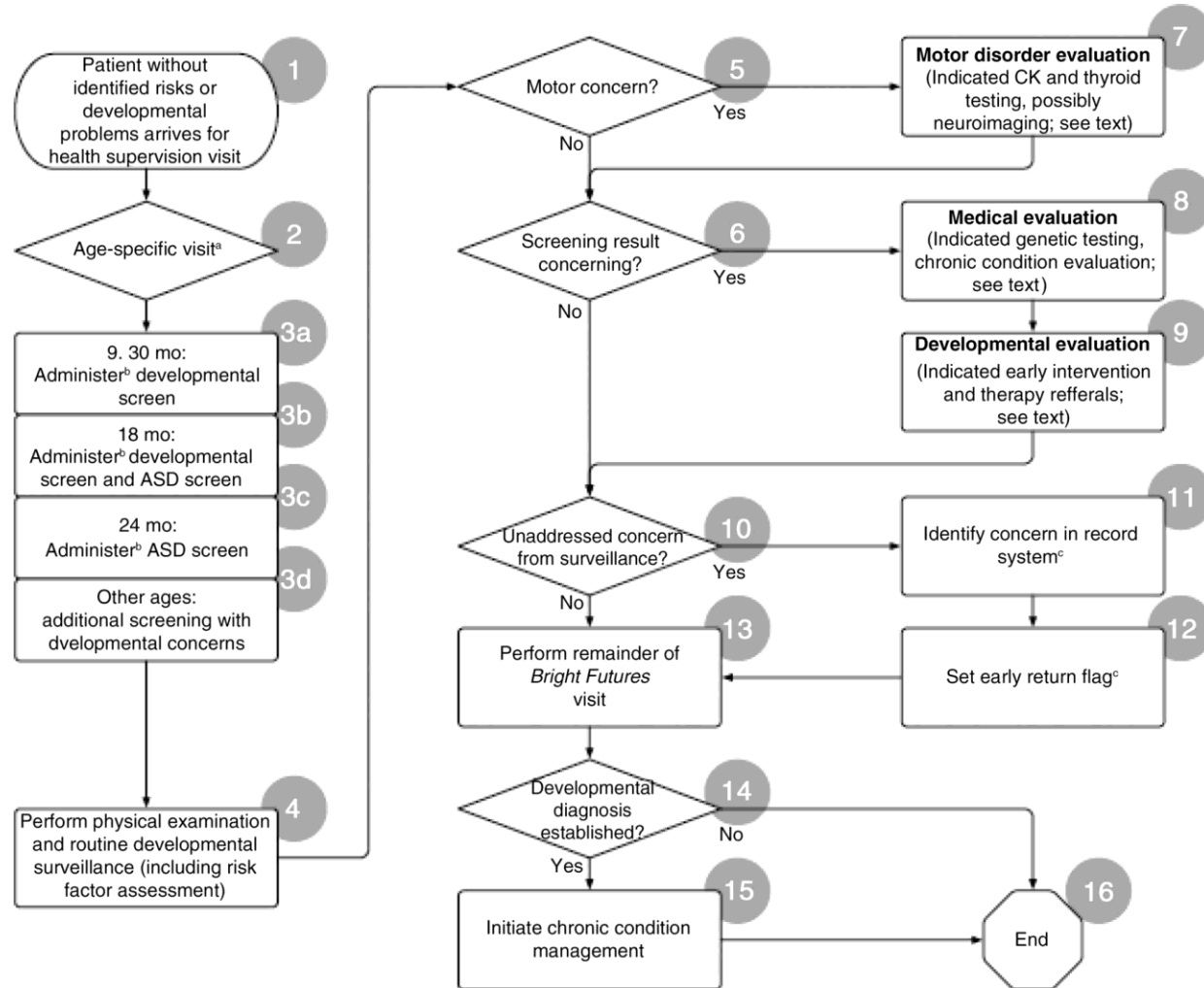
# Autism Screening



# Surveillance and Screening

- Screening is the first step in getting children the support or services needed
- Continuum from developmental guidance and watchful waiting to referral for assessment and treatment





# MYTH

VS

# FACT

There are no adequate screening tools for preschoolers



Many screening tools have sensitivities and specificities greater than 70%

A great deal of training is required to administer screening tools accurately



Training requirements are not extensive for most screening tools. Most can be administered by nurses, office staff and paraprofessionals.

Screening takes a lot of time



Many screening tools take less than 15 minutes to complete and less than 2 to score

Tools that rely on parent report are not valid



Parent concerns are generally valid and predictive of developmental delays

# Selecting the Right Screening Tool

- Reliability and validity
- Sensitivity and specificity
- Evidence-based
- Administration time
- Literacy levels



# Autism Screening

# When to Screen

Routine ASD surveillance should happen at every well-child visit. The AAP recommends that all children receive a standardized developmental screener at:

- **9 months**
- **18 months**
- **30 months**

In addition, all children should be screened specifically for ASD at:

- **18 months**
- **24 months**



# Social Communication Questionnaire (SCQ)

## Description

- Parent –completed
- Identifies children at risk for autism

## Age range

- 4+ years

## Administration

- 40 items
- 5-10 minutes

## Access information

- Available for purchase via [www.wpspublish.com](http://www.wpspublish.com)

# Modified Checklist for Autism in Toddlers, Revised with Follow-Up (M-CHAT-R/F)

## Description

- Parent –completed
- Identifies children at risk for autism
- Follow-up clinician administered questions

## Age range

- 16-30 months

## Administration

- 20 items
- 5-10 minutes

## Access information

- Available for free download via [www.mchatscreen.com](http://www.mchatscreen.com)



# Instructions for Use

- **M-CHAT-R/F** designed to be used with **M-CHAT-R**
- Once parent completes M-CHAT-R
  - Score instrument
  - Select Follow-Up items to administer based on which items the child failed on the M-CHAT-R
- Follow flowchart format and ask questions until a **PASS** or **FAIL** is scored

### 3. Does Matthew play pretend or make-believe?

Yes

No ✓

Please give an example of his/her pretend play. (If parent does not give a PASS example below, ask each individually.)

#### Does he/she ever...

- |   |   |  |
|---|---|--|
| • Present to drink from a toy cup?  | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| • Pretend to eat from a toy spoon or fork?  | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| • Pretend to talk on the phone?   | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| • Pretend to feed a doll or stuffed animal with real or imaginary food?                 | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| • Push a car as if it is going along a pretend road?                                    | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/>            |
| • Pretend to be a favorite character?   | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| • Put a toy pot on a pretend stove?   | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| • Stir imaginary food?  | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| • Put an action figure or doll into a car or truck as if it is the driver or passenger? | Yes <input type="checkbox"/>            | No <input type="checkbox"/>            |
| • Pretend to vacuum the rug, sweep the floor, or mow the lawn?                          | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/>            |
| • Other (describe)  | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |

No to all

FAIL

Yes to any ✓

PASS

# Problems relying on the “cutpoint”

High rates of false positives

Test characteristics vary with population

Many false negatives, especially when asked separately about parental concerns

Physicians are also more likely to identify concerns for ASD in children of educated parents

# Reviewing Screening Results



# How to discuss results:



Focus on concerns



Don't be definitive



Explain why they are referred

# Reviewing Results

- Regardless of results
  - Restate your motivation to ask them to fill it out, and that it's a place to start a discussion
  - Ask if they had any ideas or concerns while filling it out
    - Follow up with them if "yes"
    - Can probe for misunderstanding or confusion about any items
  - If everything is negative
    - Comment on this and ask one more time for concerns
    - Can say that we know we can't ask every question so don't always capture every possible issue
    - State your willingness to talk about these things in the future

## If there are some positive items or an overall positive score

- “I see that you’ve marked \_\_\_\_\_, can you tell me more about that?”
- Ask about impact on function (school, home, peers)

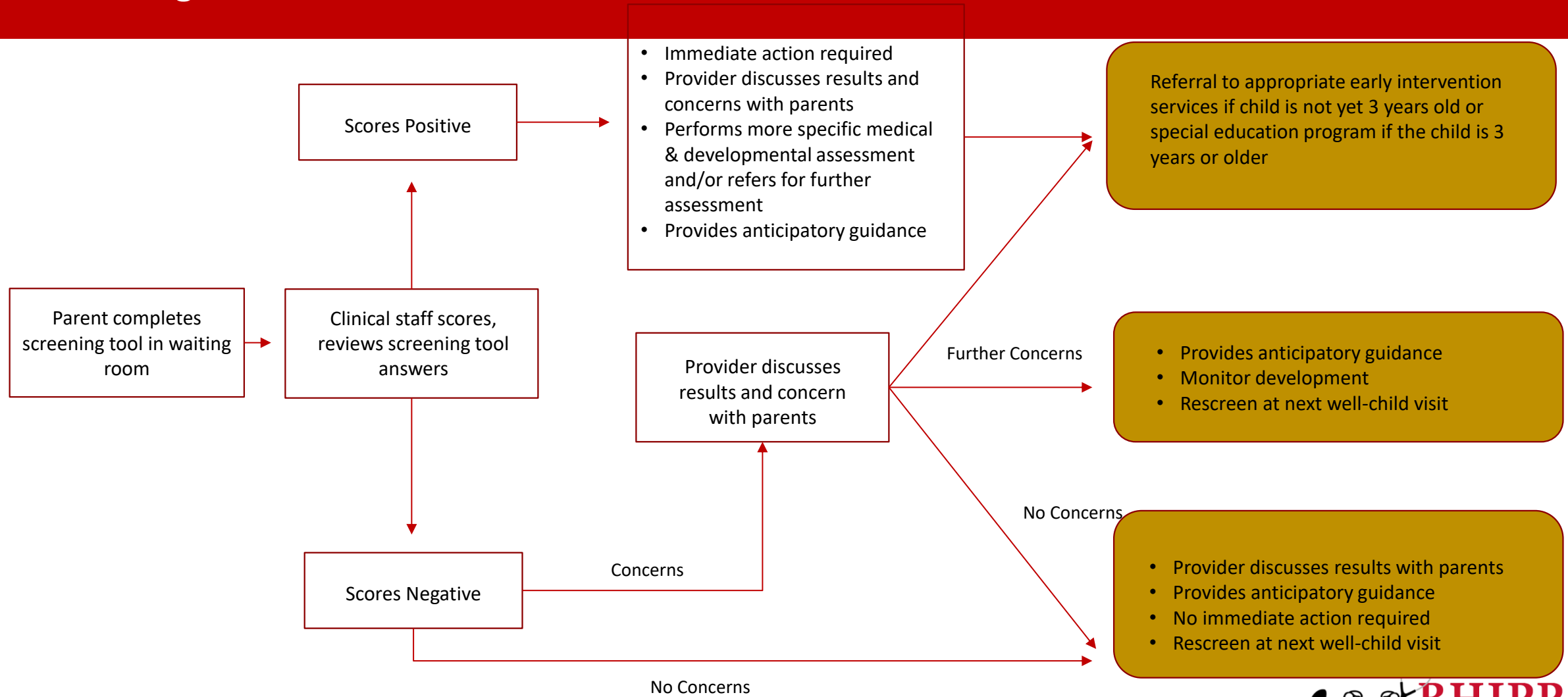




- If screener is positive, it **does not** mean child will receive a diagnosis
- If screen is normal, but you still have worries, **refer** for further evaluation



# Pediatric Developmental Screening Flowchart



# Referrals for further evaluation and services

# IDEA Part C

- Provides free early intervention services to children with disabilities from birth to age 3.
- Eligibility requirements:
  - Delay of 25% or more
  - Atypical development
  - Diagnosed condition that is likely to affect development



# How to Initiate Early Intervention Services

- Submit a referral to the local early intervention program.
  - Can be submitted by primary care provider, caregiver, childcare provider, etc.
- Contact information by state can be found at: <https://www2.ed.gov/policy/speced/guid/idea/monitor/state-contact-list.html>

# Early Intervention Services

- Special Instruction
- Speech and Language Services
- Physical Therapy
- Occupational Therapy
- Hearing and Vision Screenings/Services
- Social Work
- Family Counseling
- Nursing Care
- Nutrition Counseling



# IDEA Part B and Individualized Education Programs (IEP's)

# Child Find

- Special education services provided to identify children from ages 3 to 21 suspected of having an educational disability and may be eligible for special education and related services.



# Related Services

**A child may require any of the following related services in order to benefit from special education:**

- Audiology services
- Counseling services
- Early identification and assessment of disabilities in children
- Medical services
- Occupational therapy
- Orientation and mobility services
- Parent counseling and training
- Physical therapy
- Psychological services
- Recreation
- Rehabilitation counseling services
- School health services
- Social work services in schools
- Speech-language pathology services
- Transportation



# IDEA Part C Contact List by State

<https://www2.ed.gov/policy/speced/guid/idea/monitor/state-contact-list.html>

# Psychological Evaluations

# Referral Guidelines

Psycho-Educational	Psychological	Neuropsychological
<ul style="list-style-type: none"><li>Presenting concern is related to academics/learning disability</li></ul>	<ul style="list-style-type: none"><li>Cognitive/developmental concerns</li><li>Autism spectrum disorder</li><li>Mood disorders (anxiety, depression)</li><li>Behavior disorders (e.g., ODD)</li><li>Trauma</li><li>Giftedness</li></ul>	<ul style="list-style-type: none"><li>Cognitive/developmental concerns are present</li><li><b>In addition to</b> a known medical, genetic, developmental condition or brain dysfunction is suspected cause of cognitive/behavioral difficulties</li><li>Examples: TBI, genetic disorders, epilepsy, tumors, leukemia, stroke, CNS infection, hydrocephalus, congenital heart disease, history of prematurity</li></ul>

# Developmental Pediatricians



# Developmental Pediatricians



- Board certified in General Pediatrics and sub-board certification in Developmental-Behavioral Pediatrics
- Evaluate and monitor progress in children at risk for developmental and behavioral disorders on basis of biological and social factors.
- Typical evaluations include:
  - Detailed history of child
  - Medical exam
  - Observe and talk with child
  - Ask about child's behavior in various settings
  - Seek feedback from schools/daycares

# Developmental Pediatricians

- May make a diagnosis
- May refer for additional evaluations with specialists
  - (e.g., Neuropsychologist, occupational therapist)
- Can prescribe and monitor medication

# Developmental Pediatricians

Address a variety of developmental and behavioral difficulties, including:

- Learning disorders
- ADHD
- Tics, Tourette syndrome
- Regulatory disorder (e.g., sleep, feeding, toilet-training issues)
- Developmental disabilities (ID, ASD, cerebral palsy, spina bifida, visual and hearing impairments)
- Delayed development of language and motor skills
- Behavioral and developmental problems complicated by chronic illness and disabling conditions (e.g., genetic disorders, prematurity, epilepsy)

# Genetic Testing

- Consensus that genetic testing should be offered to all patients with global developmental delay, intellectual disability, and/or autism spectrum disorder.
- Data suggest that a minority of children with ASD and ID have undergone genetic testing.
- Pediatric providers (general practitioners, neurodevelopmental pediatricians) can order genetic testing.





# Genetic Testing

- Identification of an underlying genetic etiology for a child's neurodevelopmental diagnosis can provide both clinical and personal utility to patients and their families, including:
  - Information about prognosis.
  - An understanding of potential areas of need and opportunities for increased support.
  - Access to etiology-specific treatments.
  - Risk counseling for the family to inform reproductive decision making.

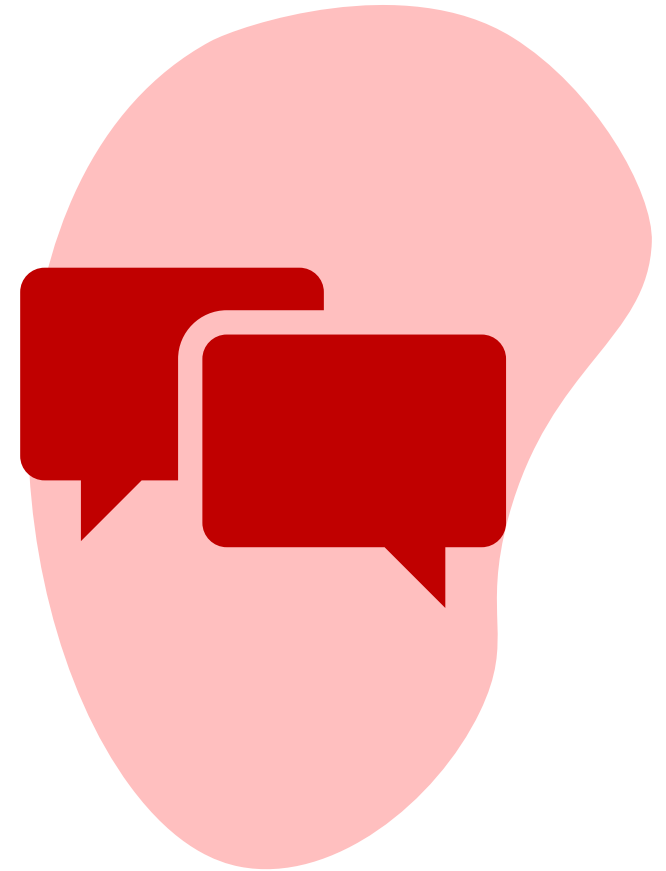
# Genetic Testing

- Identifying an etiology can also provide psychosocial benefit to families, including:
  - Explanation for child's developmental history may bring an end to the child's “diagnostic odyssey” that might have included years of uncertainty, anxiety, and evaluations.
  - Guide patients and families to condition-specific resources and supports.
  - Receipt of a diagnosis has been shown to increase knowledge, provide a sense of empowerment, result in peace of mind, increase parental quality of life, decrease parental guilt, and foster increased acceptance.

# Speech-Language Pathologists

# Speech Therapy

- Primary care provider's (PCP's) play an integral role in identifying language delays.
- Before initiating speech therapy services, a referral indicating medical necessity is required from a PCP.



# Occupational Therapists



# Occupational Therapy

Occupational therapy (OT) helps people work on cognitive, physical, social, and motor skills.

**Goal: improve everyday skills to increase independence**

For autism specifically, interventions typically target:

- Play skills
- Learning strategies
- Self-care
- Sensory sensitivities

# Occupational Therapy

- Primary care provider's (PCP) play an integral role in identifying fine motor delays and sensory processing challenges.
- Before initiating occupational therapy services, a referral indicating medical necessity is required from a PCP.

# Physical Therapists



## Infants and children may benefit from physical therapy if they display any of the following:

1. They are behind on developmental skills (crawling, rolling, walking, jumping)
2. Head shape appears flattened or asymmetrical
3. Preference of one side (turning their head only to the left, rolling only to their right, difficulties feeding on one side, only using one hand to play with toys)
4. Walks on tip-toes, trips over their feet, or walks in an atypical/awkward manner
5. Appears clumsy, frequently falls or walks into objects, or not aware of their surroundings
6. Coordination difficulties (throwing, catching, kicking, hopping, skipping, jumping jacks)
7. Avoids running, playgrounds, climbing, swings, or can't keep up with their peers
8. Appears to have muscle weakness or is “double-jointed”
9. Tends to “slouch” over instead of sitting or standing straight
10. Recent injury /surgery or frequently complains of/appears to be in pain

# Medical Conditions Often Requiring Physical Therapy

Autism  
Spectrum  
Disorder

ADHD

Torticollis,  
Plagiocephaly,  
Brachycephaly

Neurological  
conditions

Genetic  
syndromes

Orthopedic  
conditions

Walking  
difficulties

Heart and lung  
conditions

Vision or  
hearing  
impairments

Childhood  
obesity

# Physical Therapy

- Primary care providers (PCP) play an integral role in identifying gross motor delays.
- Before initiating physical therapy services, a referral indicating medical necessity is required from a PCP.
- PTs also consult with other disciplines, including medical, psychology, and school personnel about an IEP.

# Feeding Programs

# When to refer to a Feeding Program

## **If a provider or parent notices that an infant/child:**

- Is not gaining weight or growing
- Refusing to eat or drink
- Frequently spits up or throws up
- Cries or fusses during meals
- Arches their back when feeding
- Has trouble breathing while eating or drinking
- Has problems chewing, coughs, or gags during meals
- Has a gurgle, breathy, or hoarse voice during or after meals
- Eats less than 10 different foods

## **Conditions that may lead to feeding and swallowing disorders:**

- Being premature or having a low birth weight
- Reflux or other stomach problems
- Breathing problems (e.g., asthma)
- Cleft lip or palate
- Muscle weakness in the face and neck
- Medicines that suppress appetite
- Autism or sensory issues
- Medical/genetic diagnoses (e.g., cerebral palsy, cystic fibrosis, Down's Syndrome, meningitis)



# Feeding Therapy

- Primary care providers (PCP) play an integral role in identifying feeding problems (e.g., failure to thrive, food selectivity related to texture).
- Before initiating physical therapy services, a referral indicating medical necessity is required from a PCP.

# Collaborative Care

# Addressing Practice/Systemic Barriers

**In order to best meet the needs of their patients, providers should:**

- Assume accountability for coordinating their patients' care
- Reach out to care partners to build relationships and clarify their roles and services
- Track referrals to ensure they are up to date and meet the needs of the patient
- Use a shared electronic medical record to easily communicate and access/share information with other providers



# Case Study: What's Next?

1. Follow up with the family in a few weeks.
  - Make sure that the family has followed through on the referral.
  - If not, identify the family's barriers and problem solve.
2. Reassess developmental milestones at next visit.

Thank you!

Questions?



Thank you!

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