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	Backg	ro	und
 Current formats for diagnostic evaluation of autism spectrum time-consuming and can contribute to long wait times. At Seattle Children's Autism Center (SCAC), we utilize an in evaluation model, in which two providers of different disciple evaluate a patient collaboratively, following a neurodevelop This model allows two patients to be seen by a team in a demonstrates high provider satisfaction, maintains consirates, and results in fewer billed hours than psychology-cal., 2018). After implementing the model at SCAC, team providers the consideration of: Streamlining evaluations for younger children, who get and fewer records to review Identifying a different approach for patients with clinic profiles 			
Objectives			
 To explore the effectiveness of a single-day team evaluation years, without the initial neurodevelopmental intake. To determine whether intake providers can reliably predict the evaluation of children ages 6+ years ("standard" vs. "expansion") 			
Methods			
Two Diagnostic tracks were evaluated:			
 Patients ≤ Beginn group visit. Number visit. Number number weekly Outcorrincomi value of pace wisit. Wait timpatient - 4/24/evalua Estinitia Consistination - 5 times 	≤5 Years and 10/1/18, patients in this age were sent directly to interdisciplinary evaluation, foregoing an initial intake ar and date of new referrals and er of closed referrals were tracked a through EPIC. The variable of interest was the ratio of ng:outgoing referrals, in which a of 1 suggests that the clinic is keeping with the number of incoming referrals. The was calculated for $n = 191$ as aged ≤5 years seen from 1/1/2018 (2019 by clinicians who primarily te this age group mated as number of days between al referral date and date of feedback. Inpared wait times before and after the rack launched on 10/1/18.		Patients 6+ Patients rec for developr records. The to interdiscip <i>Table 1.</i> In our pilot, i surveyed ab Whether could be evaluation would ne reasons f Initial diag ASD). Team evalua about diagno follow-up ap to come to a reasons)
Table 1. Interdisciplinary Team Evaluation Template		•	Blind ratings were compa
Hour 1 Hour 2 Hours 3-4 Hour 5* * If diagnosis is	Developmental History, Adaptive Fx (ABAS) ADOS Rounds/record review/write report Feedback		from interdis teams). Data from 40 collected, of evaluation (4 to continue v
teacher, etc.).			(<i>Mean</i> =1

Age-Based Diagnostic Tracks are Effective in Interdisciplinary **Team Evaluation for Autism Spectrum Disorder**

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Im disorder (ASD) can be

- interdisciplinary team lines, with expertise in ASD, omental intake.
- a single day, and
- istency in ASD diagnostic only evaluations (Gerdts et
- have recommended
- enerally have less history
- cally complex diagnostic

on model for patients ≤ 5

the length of time needed for nded").

Years

- ceived an initial clinical intake mental history and to collect e intake provider then referred plinary team evaluation. See
- intake providers were out:
- they anticipated the patient served in a standard team on or whether the evaluation ed to be longer, along with for their opinion;
- ignostic impression (ASD v No
- ation providers were surveyed ostic outcome and whether a ppointment(s) was necessary diagnostic decision (and
- s from intake providers (*n*=11) ared to evaluation outcomes sciplinary teams (n=22)
- 0 pilot patients were which 34 returned for team 4 not referred on, 2 opted not with evaluation)
- ranged in age from 6-18 years 0.74 years, 71% male).



Results: 6+ Track

- 4.87, *p*=.027.
- reports from teacher/educational records (n = 2).
- diagnostic outcome in 71% (20/28) of patients, $\chi^2 = 7.53$, p = .006.
- ultimately diagnosed.

Primary Findings

children 5 years of age and younger, which shortened wait times in this age group. patients 6 years and older.

- pilot to improve diagnostic services at SCAC.
- beginning preschool, etc.).

<u>Limitations:</u> Pilot data were small. Extracting meaningful clinical and systemic data (e.g., wait times, referral patterns) from electronic medical records is a tedious process and has been difficult to algorithmicize. QI data will be essential.



Intake providers believed 35% of patients would require an "expanded" evaluation; however, only 18% (6/34) of patients ultimately required further information after team evaluation for diagnostic determination (ASD v No ASD) to be made.

Intake providers' estimate of evaluation length corresponded to ultimate length of evaluation in 71% (24/34) of patients-- a marginal relationship, $\chi^2 = 3.14$, p = .076. <u>Gender was a better predictor of ultimate evaluation length: 40% of girls ages 6+</u> required more time to come to a diagnostic decision, compared to 8% of boys, $\chi^2 =$

Most common reason(s) necessitating return were: complicated psychiatric history (n = 4), determination of intellectual functioning (n = 2), and the need for collateral

Intake providers' initial diagnostic impression corresponded significantly to ultimate

Of note, intake providers' initial impression was 89% accurate when ASD was

* Providers were more efficient in evaluating ASD in * There were mixed results in predicting how complicated an ASD evaluation would be at intake for

Discussion

• We stratified diagnostic referrals based on age: ≤5 years and 6+ years. Modifying ASD diagnostic evaluations based on patient age was effective in a

For patients ≤ 5 years: streamlining SCAC's standard team evaluation model to forego an initial neurodevelopmental intake shortened wait times by 3.6 months and improved efficiency over time in responding to referrals for diagnostic evaluation. • Next Steps: formally examine diagnostic outcomes and survey providers for quality assessment in this shortened model. Anecdotally, providers report they are confident in making diagnostic decisions in this amount of time. If not, it is often to monitor development over time (e.g., after intervention, getting older,

For patients 6+ years: 18% of pilot patients required additional information to decide on ASD diagnosis after a standard SCAC team evaluation, yet intake providers believed 35% of patients would need an expanded evaluation. Intake providers' impressions were moderately associated, whereas gender was significantly associated with evaluation length (Providers could decide on ASD diagnostic status in 60% of girls v 92% of boys using the standard SCAC team evaluation approach). • **Next Steps:** Consider predictors of expanded evaluation to use at intake, including gender, intake providers' diagnostic impression, complicated psychiatric hx, and intellectual functioning. Refined efforts at record collection are needed.