

OREGON COMMISSION ON AUTISM SPECTRUM DISORDER
UPDATED POSITION PAPER ON ASD EVALUATIONS
DURING COVID-19 SOCIAL DISTANCING MEASURES
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ABSTRACT

Prompt and accurate identification has always been a top priority for the Oregon Commission on ASD (OCASD) because early initiation of services is associated with better outcomes for individuals with ASD. Covid-19 social distancing measures have made it impossible to conduct in-person ASD evaluations with many of the informal observations and standardized evaluation tools in use before the pandemic. This has led to delays in identification and to deviations from best practice evaluations in both health care and educational settings. Best practice for ASD evaluations remains the same: in-person evaluation with close, unmasked interaction between the evaluator and individual being evaluated, using standardized tools in accordance with the developers' instructions. However, OCASD recognizes the need to complete ASD identifications in a timely manner while social distancing measures are in effect. This paper offers guidance on conducting quality remote and in-person evaluations that permit accurate identification to the maximum extent possible. Tools, techniques, and considerations are reviewed to assist evaluators with decision-making, conducting remote or in person socially distanced evaluations, and understanding associated cautions and limitations.

Notes on terminology: “**Social distancing measures**” includes, depending on the context, remote assessments and in-person assessments using masks or other personal protective equipment (PPE) or personal interaction at a distance or observations of the individual being evaluated from behind a physical barrier, such as a window into an observation room. “**Individual**” means the individual being evaluated for ASD. “**Parent**” includes immediate family members and other primary caregivers.

I. INTRODUCTION

Prompt and accurate identification of ASD has always been a high priority for the Oregon Commission on Autism Spectrum Disorder (OCASD). The covid-19 pandemic has resulted in the imposition of social distancing practices that are currently in effect throughout Oregon and that significantly interfere with evaluations for ASD. Although some measures have been lifted in all parts of the state, some social distancing practices could well have to be maintained for a period of several years. This Position Paper replaces an earlier version. It was prepared by an interdisciplinary group of ASD experts who are current and former members of the Screening, Identification, and Assessment Work Group of the Oregon Commission on Autism Spectrum Disorder (OCASD). A list of contributors follows Appendix 4. ***We expect to update this guidance periodically in order to share evolving best practices*** with all of our Oregon stakeholders. ***IF YOU OR YOUR COLLEAGUES HAVE DEVELOPED STRATEGIES THAT WORK WELL IN YOUR PROFESSIONAL CONTEXT BUT THAT ARE NOT LISTED IN THIS PAPER, PLEASE LET US KNOW BY EMAILING staff@orcommissionasd.org .***

The rest of this paper is divided into four main parts. Section 2 sets forth in summary the main conclusions and recommendations. Section 3 discusses general considerations and provides the detailed basis for OCASD's conclusions and recommendations. Section 4 provides specific guidance with respect to each element of an ASD evaluation. Appendices 1-4 set forth prior OCASD evaluation recommendations, OAR 581-015-2130, two resources for families that don't require a diagnosis, and sample evaluation protocols suitable for children in different age groups.

II. SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS.

2.1 Continued need for accuracy. The need for accurate identification of ASD while social distancing measures are in effect remains undiminished in order to ensure that individuals receive services that address their needs. The pandemic has not changed the standard for determining whether an individual has ASD. It has only changed the methods used to gather sufficient information for the identification decision. In all cases, evaluators must have a reasonably high level of confidence that the individual meets all of the criteria set forth in the Diagnostic and Statistical Manual of Mental Conditions, 5th Ed. (DSM-5)¹ for health care and included in OAR 581-015-2130 for education.

2.2 Questionable reliability of identifications made exclusively through remote means. Many elements of an ASD evaluation can be completed remotely. However, standardized ASD-specific assessments have not been validated for remote administration. Best practice continues to require direct interaction with the individual in close proximity to the evaluator. Accordingly, there is good reason to question the reliability and validity of any evaluation that is completed purely by remote means.

2.3 Reliability considerations when assessment tools are not administered in accordance with developers' instructions. Standardized instruments in use before the pandemic have not been standardized or normed on the range of evaluation conditions that may apply during the COVID pandemic. Evaluators should continue to follow the developers' published instructions for the administration of assessment instruments. Evaluators should clearly state in their evaluation reports the circumstances in which tests were administered and observations were made. They should also state whenever they did not administer a test in accordance with the developers' instructions and whether results can be validly interpreted for purposes of diagnosis or eligibility decision-making.

2.4 Importance of experience and training of evaluators. The highest level of accuracy comes from those who have greater familiarity with the scientific literature on developmental psychology and mental disorders and who have been trained to differentiate between ASD and other developmental and emotional disorders. Inaccurate identification associated with insufficient evaluator experience and/or expertise is exacerbated by reliance upon assessments conducted remotely or in person using social distancing and PPE.

2.5 Impact of pandemic on behavior of individuals and families. OCASD urges all evaluators to consider the impact of the pandemic on an individual's and their family members' behavior and memory.

2.6 Provisional diagnoses and identifications made with partial information. OCASD does not endorse the use of provisional diagnoses and recommends against special education ASD eligibility determinations of ASD using partial or incomplete information. In both education and health care, if evaluators cannot initially collect enough information to confidently make an ASD identification but they continue to believe that the individual may have ASD, OCASD urges them to actively seek out alternative sources of information over time until they are certain or have a high level of confidence about the correct identification.

2.7 Services that can be supported in the absence of an ASD evaluation. Most services needed by children with ASD can be obtained without an ASD identification. In **health care** OCASD strongly endorses the provision of all services that can be supported by diagnoses other than ASD. In **education**, if a child is made eligible for special education services under a category other than ASD but the team believes that the child may ultimately be determined to have ASD, OCASD recommends that school and EI/ECSE teams provide effective services and supports typically associated with ASD (e.g., social narratives, visual schedules, functional communication supports) based upon student need, regardless of eligibility. The best strategy to obtain **developmental disability (DD) services** for children under 5 is to ensure that the child receives a valid standardized and normed early childhood assessment.

2.8 Re-evaluation after social distancing measures are lifted. OCASD strongly recommends that evaluators consider re-evaluating all children with standardized tools and direct, in-person observations when social distancing measures are no longer in effect.

III. GENERAL CONSIDERATIONS AND RECOMMENDATIONS

3.1 Continued need for accuracy in ASD identification. OCASD, like well-respected national organizations, does not recommend ASD identifications unless there is a reasonably high level of confidence in their accuracy. Inaccurate identification can deprive a child with another condition of the services they need and may reflect a misunderstanding of what ASD really is, thereby undermining appropriate services for those who in fact do have ASD. Accordingly, in 2010, OCASD issued recommendations to the Governor on the components necessary for an accurate identification of ASD. These components remain consistent with those recommended by the American Academy of Pediatrics². Most have also been incorporated into the current special education administrative rules for ASD evaluations. Both the OCASD recommendations and OAR 581-015-2130 are set forth in Appendices 1 and 2.

Accuracy in ASD identification depends on several factors, including the complexity of the child, the expertise and experience of the evaluator, and the use of a variety of assessments (e.g., observation, direct interaction, interview, and use of standardized rating scales and

assessments). The criteria for ASD are based on the scientific literature on developmental psychology and mental disorders. The highest level of accuracy comes from those who have greater familiarity with this literature and have been trained to differentiate between ASD and other developmental and emotional disorders. That is why OCASD has recommended that evaluation teams possess certain knowledge elements set forth in Appendix 1. Problems of misidentification associated with limited evaluator expertise may be exacerbated by evaluation within a social distancing context. The risk of false negative and false positives increases when evaluators with lower levels of expertise and experience are forced to rely exclusively upon assessment information collected remotely or in person with social distancing and PPE.

Under normal circumstances it can be challenging to decide on the best fit identification in some cases, so evaluators may make an identification but ask that additional testing be performed at a later time. In the educational setting there are mandatory 3-year re-evaluations that provide the opportunity for reconsideration of an eligibility determination made with social distancing practices. ***If an identification of ASD is made while social distancing measures are in effect, OCASD recommends that all evaluators (whether in education or health care) consider performing additional observations and administering standardized ASD tests that require in-person, close proximity procedures once social distancing procedures have been lifted. This is especially true where there is a history of co-occurring conditions, trauma, or other adverse childhood experiences. See also Section 3.7 below.***

3.2. Services that do and don't require a formal diagnosis or eligibility determination of ASD.

A formal diagnosis or eligibility determination (identification) of ASD is required for some, but not all, services an individual with ASD may need. Appendix 3 describes two free resources for parents of children with social communication challenges that don't require a formal diagnosis.

3.2.1 Health care. Some practitioners are making provisional diagnoses of ASD for young children because of the importance of early intervention and of getting parents engaged with their child's condition. However, parents and practitioners alike should be aware of the limitations of a provisional diagnosis. Currently, the Oregon Health Plan requires that an individual be diagnosed with ASD or be engaged in self-injurious behavior in order to obtain coverage for ABA services.³ A provisional diagnosis is not a diagnosis. Similarly, state insurance law requires that commercial health insurance plans and state-sponsored employee health insurance plans cover ABA only if there is a diagnosis of ASD "by a licensed neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or psychologist."⁴ Commercial plans theoretically could cover ABA absent a formal diagnosis, but likely will not because it is not in their financial interest to do so. ***Where a firm diagnosis of ASD cannot be made, OCASD encourages health care practitioners to make all supportable diagnoses and treatment recommendations in order to secure services that do not require a formal ASD diagnosis.***

3.2.2 Education. Neither IDEA nor state law conditions any particular special education service on the child's eligibility category. **Therefore, even if a child does not qualify for an ASD eligibility, if a child qualifies for another eligibility, they can be provided services that are ordinarily considered for children with ASD.**

3.2.3 Developmental Disabilities Services. The eligibility requirements and type of eligibility for DD services varies by age and the type of disability a child has. (The definition of developmental disability for purposes of DD services is different than the category of developmental disabilities under the DSM.) This section discusses eligibility for DD services on account of ASD alone.

In all cases, OAR 411-320-0080(5)(a) explicitly rules out provisional diagnoses as a basis for eligibility: “The individual must meet the full criteria for the diagnosis of the developmental disability. Individuals with a "provisional", "partial", "rule-out", or "unspecified" diagnosis do not meet the full criteria.” In all cases, there must also be documentation of significant impairment in adaptive functioning, but the precise documentation varies by age. ***For children under 5, the best strategy to ensure eligibility is to administer a valid standardized and normed early childhood assessment. This will ensure eligibility without the need for a diagnosis until age 9.***

(a) Full eligibility for adults. Under ORS 427.005(4), to be eligible for developmental disability services an individual must have a formal diagnosis of ASD “by a qualified professional.” Qualified professionals include only those with specified medical licensure.⁵ Applicants for adult services must also have evidence of functional impairment as set forth in OAR 411-320-0080(5)(a), (b). Adult services begin at age 22.⁶

(b) Early childhood. Individuals who apply for eligibility before age 7 and who have not had school age testing⁷ can receive provisional eligibility if they have

(i) either a diagnosis of ASD by “a licensed medical practitioner” plus a statement to the effect that the child’s ASD “causes or is likely to cause impairment in at least two or more areas of the adaptive behavior (adaptive, self-care, or self-direction; receptive or expressive language or communication; learning or cognition; gross and fine motor; or social),”

(ii) or “A valid standardized and normed early childhood assessment, completed by a professional with at least a master's degree and training to administer early childhood assessments.” The assessment must establish that the functioning of the child is at least two standard deviations below the mean in two or more areas of adaptive behavior [adaptive, self-care, or self-direction; receptive or expressive language or communication; learning or cognition; gross and fine motor; or social]”.⁸ ***If either a medical or school evaluation team can administer a valid standardized and normed early childhood assessment, a diagnosis of ASD is not needed.*** School-age testing is defined by OAR 411-320-020(47) as: “any type of standardized test that may be administered for use in school supports or services beginning in Kindergarten.” DD Services interprets this rule to mean that the age range for which the instrument is valid includes children 5 years old and older. However, if the instrument is also valid for younger children and was administered at a younger age by an individual qualified to administer early childhood evaluations but not school age evaluations, DD Services will accept the assessment without requiring retesting or a diagnosis until the child turns 9.

(c) School age. Children who first apply for DD services when they are age 5 years old or older and have had school-age testing must have both a diagnosis by a qualified professional and a formal assessment of adaptive functioning.⁹ The definition of school-age testing is discussed in subsection (b) above. School-age children with ASD receive only provisional eligibility, so eligibility must be redetermined between the ages of 17 and 22 in order for an individual to continue receiving DD services. There is a temporary rule in effect that allows DD Services to give presumed eligibility to individuals who have already received a diagnosis of ASD or another qualifying condition, but for whom not all of the other paperwork has been completed. The rule also extends eligibility for those children whose redeterminations cannot be completed due to the pandemic, although the program may require a physician’s statement “identifying areas of adaptive behavior in OAR 411-320-0020(3) that are most likely significantly impaired by the qualifying condition.”¹⁰

3.3 Provisional diagnoses for health care. OCASD does not endorse provisional diagnoses for several reasons. The primary reasons are that (a) the long-term integrity of the diagnostic process is extremely important, (b) there is no professional consensus on what is required for a provisional diagnosis or what the term means, (c) a provisional diagnosis does not result in insurance coverage of ABA or access to DD services, (d) diagnoses (both regular and provisional) are more difficult if there are co-occurring conditions or adverse childhood experiences, and (e) entering autism in the Problems field of electronic medical records will automatically carry it forward for years (possibly without the word “provisional”, even if “provisional” is appended to it in the original note), and even if it is later determined that the individual does not have ASD. That being said, OCASD encourages evaluators to share their clinical impressions and belief that the child *may* ultimately be diagnosed with ASD. Parents who have the resources to self-pay for services should not be discouraged from doing so as long as they understand that future evaluation may determine that their child does not have ASD. Whether or not they can self-pay for services, Appendix 3 describes two free online resources that can help parents gain knowledge and work with their children, regardless of the child’s ultimate identification.

3.4 Provisional individualized family service plans for early intervention. For children birth through age 2, the United States Office of Special Education and Rehabilitation Services has announced that children may be made eligible for a provisional IFSP if a full evaluation cannot be completed due to the covid-19 pandemic.¹¹ Currently, there is no equivalent flexibility for early childhood or K-12 special education.

3.5. General limitations of online testing and observations. During the covid-19 restrictions on in person, face to face interactions, the ability to complete ASD evaluations has been significantly curtailed. Many activities, whether in education or medicine, are being performed remotely. Research on remote ASD evaluations shows that they may in the future be supported by scientific evidence, but the research is still preliminary.¹²

Much of the information needed for an ASD evaluation can be gathered remotely. However, the reliability of remotely administered assessments that involve the participation of the

individual being evaluated has not been determined. Accordingly, there is good reason to question the reliability and validity of any evaluation that is completed purely by remote means. This conclusion is based on the following:

(a) The identification of ASD requires that evaluators have the opportunity to observe subtle differences in nonverbal communication and reciprocity, as well as repetitive language and body use that may not be readily observable remotely. For example, the position of the camera in relation to the screen distorts interaction and eye contact, even among individuals without ASD or other mental health conditions.

(b) Most instruments used in ASD evaluations (both ASD-specific and function-specific) have not been normed or validated to be used via telehealth or any distance administration.¹³

(c) Remote testing that has been validated requires a trained on-site proctor to be in the room with the person being evaluated. At this time, it is rarely possible for a trained on-site proctor to be in an individual's home. Evaluators should adhere to the proctoring requirements for any instruments they administer remotely, and should contact the publisher directly if they are in doubt.

(d) For those tests that have been validated with an on-site proctor, parents or other family members cannot act as proctors. Most standardized tests are designed to be administered so that the individual is alone with the examiner, and when parents are present, they are not to otherwise engage unless directed by the examiner.

(e) The technology involved in telehealth assessments can interfere with the evaluation process. Individuals with ASD may react differently and in unanticipated ways during such evaluations.

(f) Although some test publishers have developed online stimulus materials, they have not been standardized and there is no research on their validity.

Before the current pandemic, there were several evaluation methods for very young children (under age 3) that were being evaluated for accuracy, reliability, and validity. These included the Systematic Observation of Red Flags (SORF) created by researchers at Florida State University, and the TELE-ASD-PEDS out of Vanderbilt University. These evaluation methods do not yet have adequate normative information or strong enough evidence of reliability and validity to be seen as acceptable substitutes for current tools designed for in person administration. Also, they do not address the evaluation needs of individuals over age 3, who constitute the majority of individuals referred for ASD evaluations. As a result of the pandemic, Dr. Catherine Lord, a co-developer of the ADOS accelerated development of the Brief Observation of Symptoms of Autism (BOSA), an instrument for gathering and rating either in person or video observations. Like the SORF and the TELE-ASD-PEDS, the BOSA lacks adequate normative data and evidence of reliability to substitute completely for established standardized tools designed for in person administration. In Oregon, Dr. Robert Nickel, a professor of

pediatrics at Oregon Health and Science University, has modified an observation protocol used to train pediatricians for use in remote and in-person evaluations, the Observation of Play Screener –Home Edition (OOPS-HE). Despite their lack of evidence basis, evaluation teams have begun to use these tools as the best available alternatives while social distancing measures are in effect. They are discussed in greater detail in Section 4 below.

3.6 Impact of social distancing and personal protective equipment on in-person evaluations.

As with remote administration, none of the currently available interactive direct observation instruments used to evaluate the presence of ASD symptoms has been normed or validated for in person evaluations in which participants were wearing personal protective equipment (PPE) or interacting six feet apart. Therefore, it is impossible to know the magnitude of any reduction in reliability due to PPE use and in person distancing. There is also no scientific data on the impact of these measures on the behavior of individuals being evaluated for other types of functioning, e.g. cognitive functioning. Finally, there is no scientific data on the impact of PPE and distancing on the observations of evaluators with respect to interactions that are not part of formal evaluation procedures.

3.7 Impact of stay at home orders and social distancing on families and individuals being evaluated. Even before the pandemic, conscientious evaluators attempted to gauge whether the behavior seen during evaluation was typical or affected by either extraneous factors or the unfamiliar conditions of the evaluation itself. In addition to this ongoing concern, the pandemic has intensified the need for evaluators to gauge the gap between behavior seen in the evaluation and the individual's typical behavior before the pandemic. It has been widely reported that stay at home orders, unemployment, social distancing, and being compelled to work in unsafe conditions have created enormous stress and an increase in mental health problems for many people, effects that are expected to outlast stay at home orders for some time. Added stress can affect the behavior and memory of both the individual being evaluated and family members. Evaluators should therefore attempt to understand and weigh the impact of stress or other attendant mental health conditions on individuals being evaluated and their families. Finally, compassionate explanation of the reasons for delay in reaching a final determination of ASD may help to reassure individuals and families who are understandably eager to complete the evaluation and obtain services.

3.8 Evaluation reports during the pendency of social distancing measures. Where evaluation reports are required, evaluators should take additional steps to document the social, physical and environmental conditions during assessment as well as provide a summary of any potential impacts on the reliability and validity of findings resulting from unique assessment conditions.

IV. SPECIFIC GUIDANCE ON EVALUATIONS DURING PENDENCY OF STAY AT HOME AND SOCIAL DISTANCING MEASURES.

The following discussion is designed to offer guidance to maximize the reliability of ASD evaluations during social distancing. It is organized around the elements of an evaluation recommended by OCASD for both health care and education, as well as OAR 581-015-2130,

which governs ASD evaluations for special education. ***In all cases, instruments should be administered in accordance with the developers' instructions (whether these tools are still under development or not).*** If the instructions are not followed, the results should be accorded no greater weight than informal observations.

Appendix 4 sets out sample evaluation protocols for children of different ages.

Note on organization. This Position Paper is designed for a mixed audience of health care and educational professionals. The following discussion is organized around OCASD's original recommendations for evaluations (which were intended for both audiences) and around the provisions of OAR 581-015-2130, which was revised after OCASD's recommendations were made and incorporates most, but not all of them. OCASD recognizes that educators are bound by OAR 581-015-213 and other administrative rules, but not by OCASD's recommendations.

4.1 Parent/Caregiver interviews. Parent/caregiver interviews can be administered remotely (by a combination of telephone, written questionnaire, or videoconference) or in-person using masks. **Pros:** All of the information required can be acquired remotely. **Cons:** Use of remote technology can make it harder to establish empathy and encourage parents/caregivers to reveal such personally sensitive information as trauma and substance use.

4.2 Observations and interaction between evaluator and individual. Observations and interactions between the evaluator and individual are the most challenging parts of an ASD evaluation to accomplish while social distancing measures are in force. Within education, observations of a child in home and/or school settings is mandatory, including direct interaction between the evaluator and the child. However, OAR 581-015-2130 does not require the use of a standardized tool for observations. Also, "direct" is not defined by rule, so it does not appear to preclude interaction through videoconferencing or in-person using masks. Within healthcare, evaluators frequently obtain family videos of a child's behavior under various circumstances, but typically do not make direct observations outside of the clinic setting. As stated above, none of the current tools for making standardized observations has been standardized and normed for remote administration or while using social distancing measures in person. Evaluators with the highest level of expertise continue to recommend standardized observation tools when they can be administered according to the developers' instructions, because they help to ensure that appropriate observations are made and appropriately weighed in each case. Nonetheless, OCASD has identified the following measures that, while imperfect, ***may, but not necessarily will,*** provide sufficient information to make a reliable identification during social distancing.

Caveat on parent-administered tools. Observation tools that rely on parents interacting directly with their child depend as much on the parents' ability to participate effectively in the evaluation as the children's ability to respond appropriately. This is true for both remote and in person observations. **Potential solutions:** conduct practice sessions, with coaching, in advance of the "real" session; provide a video training module for parents on how to set up and conduct a remote assessment; if questions remain as to whether the observations adequately reflect

the child's abilities, explicitly so state in the evaluation report (without explicitly attributing the cause to the parent).

4.2.1 Early childhood observations. The younger the child, the more social interaction is centered on family members. Generally speaking, therefore, the younger the child, the more observation of child behavior with family members yields a reliable sample of a child's social communication abilities. This includes remote observations. **Caveats:** since family members are more inclined to scaffold social interactions with a child, evaluators should intentionally consider this factor in every observation of a child with their family members. Even apart from scaffolding, children may appear much more typical in their interactions with a primary caregiver than with others.

(a) Early childhood remote observations.

(i) Technological and environmental considerations.

(A) Remote technology. Remote observations depend on multiple factors, including the positioning of the camera to capture the behavior, image size, image quality, sound quality, and the reaction of the child to the technology itself. For real-time remote observations, the availability of an internet connection with sufficient bandwidth and a computer, iPad, or phone with the right software are also considerations. **Possible solutions.** Delivery of testing materials, an iPad, and a mobile hotspot to families; plus real-time coaching on set up and practice sessions to resolve potential issues and accustom the child and family member to the technology; use of devices that automatically move to track the child. **Pros:** Enhances the probability of high-quality observations and protects against virus spread. **Cons:** May not resolve all of the issues of videography in the home.

(B) Environmental considerations. Environmental considerations include privacy concerns and the availability of sufficient undisturbed space in the child's home to take an accurate sample of the child's communication. **Possible solutions:** these must be developed on a case by case basis with the families involved. For example, arrangements may be made to have other family members go somewhere else temporarily or else the observation could take place in person but outdoors.

(ii) Content considerations.

(A) For evaluators who were trained on or using the ADOS-2 before the pandemic: The BOSA is a modified version of the Brief Observation of Social Communication (BOSCC) designed to be used for either remote or in-person observation. It involves a few different evaluation materials than for the ADOS, and it requires the use of an ADOS-2 protocol for scoring, but is otherwise free. BOSA training is available here: <https://www.youtube.com/watch?v=WqzCm8roJy8> **Pros:** it provides a uniform set of tasks and scoring protocol for remote and in-person observations; it requires minimal additional training.

Cons: it is not a substitute for the ADOS; it involves some additional expense to acquire new materials; it has not been standardized and normed, although efforts to do so are underway.

(B) For other evaluators:

(1) TELE-ASD-PEDS: The TELE-ASD-PEDS is a tool designed for use by providers and families during a telehealth assessment for autism. Using the TELE-ASD-PEDS, a provider walks a parent through several basic tasks with their child. These tasks allow the provider to watch for the presence of autism symptoms. Administration is meant to take 10-20 minutes. The TELE-ASD-PEDS was designed for use with children under 36 months of age who have been referred due to concerns for possible autism spectrum disorder. Materials and forms are available for free at <https://vkc.vumc.org/vkc/triad/TELE-ASD-PEDS/>¹⁴ **Pros:** it provides a uniform set of tasks and scoring protocol for remote and in-person observations. **Cons:** *This measure may not be appropriate for children with flexible phrase speech (e.g., once a child is appropriate for an ADOS-2, Module 2).* It is not a substitute for the ADOS. It has not been standardized and normed, although efforts to do so are underway.

(2) CARS-2: The CARS-2 can be administered remotely for children age 2 and older, but is subject to the limitations set forth in footnote 9.

(3) The Observation of Play Screener: Home Edition (OOPS:HE): This is a relatively brief interactive measure that contains many of the social communication items helpful in diagnosing autism in young children. It is intended for use with children 12-36 months of age as part of a virtual diagnostic evaluation for autism spectrum disorder during which parents interact with their children. It can be obtained from Dr. Robert Nickel, nickelr@ohsu.edu. **Pros and cons:** similar to TELE-ASD-PEDS.

(4) Systematic Observation of Red Flags: The members of OCASD and its Screening, Identification, and Assessment Work Group lack personal experience with the SORF, but the team that has developed it is led by a preeminent autism researcher and other prominent evaluation teams across the country have used it during the pandemic. The SORF is an observational measure designed to detect 22 red flags for ASD in toddlers based on DSM-5 diagnostic criteria, with 11 items from each domain—Impairment in Social Communication and Social Interaction (SC) and Restricted Repetitive Behaviors, Interests, and Activities (RRB). The initial version of the SORF included 29 items derived from DSM-IV diagnostic criteria and research on the early signs of ASD in young children. Items were revised or removed based on the initial research findings, and new items were added to capture additional behaviors and align with DSM-5 diagnostic criteria. The SORF is available online at <https://autismnavigator.learnercommunity.com/SORF-Resources>

(C) For all evaluators: (1) Request videos of daily routines (getting up and getting dressed, mealtimes, playing with a parent or sibling, going to bed, etc.). Video should represent typical child behavior for these routines and/or describe deviations and their cause. (2) Request videos

of the individual interacting with extended family members, especially those who are near the same age.

(b) Early childhood in-person observations.

(i) Technological/environmental considerations. In-person observations carry the risk of virus spread, which is probably greater in areas with the highest per capita infection rates. Although there is little available evidence on the transmissibility of the virus from and among very young children, there is growing evidence that children can become infected with SARS-CoV-2, and that they can in turn transmit it.¹⁵ The Oregon Health Authority does not recommend face masks for children under the age of 2 and has made them optional for children between the ages of 2 and 5.¹⁶ **Possible solutions:**

(A) Require covid-19 testing for parent and child before evaluation. Pros: If test results are negative, the risk of virus spread is greatly reduced. **Cons:** Unreliable where test results are not available within two days; may require travel and time off of work that is not practicable for families; adds expense that may not be covered by health insurance.

(B) Observation of unmasked parent and child in a room with one-way window or other arrangements to block airborne spread. Pros: Removes technological and environmental barriers to live observation. **Cons:** Requires sterilization of evaluation materials and disinfection of room after each use. Still does not involve direct interaction between evaluators and the child.

(C) Interaction of masked evaluator and masked or unmasked child. Anecdotally, use of masks in the home prior to evaluation may reduce distortion of social communication due to masking in the evaluation setting. **Pros:** Allows for direct observation by evaluator. **Cons:** It is unclear how much mask use by the evaluator alters the child's and evaluator's social communication; same sterilization and disinfection routines as for observations where both parties are masked.

(D) Observe parent and/or sibling interactions with child in a park or other outdoor setting. Pros: Avoids the need for sanitization of the evaluation area. **Cons:** May be difficult during bad weather.

(ii) Content considerations. All of the instruments mentioned in Section 4.2.1(a) may be used in-person as well as remotely.

4.2.2 Observations of school age children. Most of the issues with older children are the same as for those in early childhood, but detection of ASD is more dependent on interaction between the child and peers or adults who are not part of the family. The BOSA can be used for school aged children who might be candidates for ADOS-2 modules 1 through 3. The CARS-2 can also be used for older children. In addition, the following observation protocol may be used for socially distanced interaction.

(a) Vanderbilt University TRIAD Social Skills Assessment (SSA): The SSA is a semi-structured assessment of a variety of social skills including emotional identification, joint attention, theory of mind, and social understanding through a variety of different activities. All necessary materials and the administration protocols are free from Vanderbilt University. The SSA requires that the child be verbal and able to participate in table-top assessment activities. It is most appropriate for children ages 5-12. **Pros:** assesses a wide range of skills known to be problematic for individuals with ASD; skilled clinicians can add specific probes for conversation, coordinated communication, social reciprocity that are not necessarily part of the protocol; based on research; easy to administer; free. **Cons:** does not provide scores, cutoffs, or classifications; does not map onto the DSM-5; does not explicitly assess the RRB prong of an ASD diagnosis. The TRIAD SSA can be found at: <https://vkc.mc.vanderbilt.edu/assets/files/resources/tssamannual.pdf>

4.3 Developmental Assessments.

(a) Cognitive testing. Although it is not required by OAR 581-015-2130, OCASD has recommended cognitive testing in order to determine whether a child’s social communication behavior is significantly lower than the child’s developmental age. Experts consider this to be essential to differentiate ASD from intellectual disability¹⁷, language disorder, and other neurodevelopmental delay affecting global problem-solving skills. Cognitive testing is currently being done in person with PPE; OCASD recommends against remote administration of cognitive testing for the reasons stated in Section 3.5 above. Like standardized observation instruments, instruments that evaluate cognition have not been normed in children using PPE and social distancing. If a child scores within the average range, there is no need to repeat cognitive testing. If, however, the child obtains a score that is below the average range, further evaluation, or re-evaluation with a similar instrument, should take place when social distancing measures are lifted.

(b) Adaptive functioning. Caregiver- and teacher-completed questionnaires are the recommended standardized instruments, as they do not require close interaction between the evaluator and the individual being evaluated. While interview-administered adaptive behavior measures may be completed via telehealth platforms, including video or telephone, they are standardized for in-person administration and should be used sparingly and interpreted with caution.

(c) Functional communication, including speech and language. The viability of conducting functional communication assessments remotely and the validity of the conclusions arising therefrom varies considerably based upon a number of variables, including the construct(s) being measured and the characteristics of the individual being evaluated.

(i) Remote testing of formal language. Evidence suggests that scores from remotely administered tests of formal language (e.g., the Clinical Evaluation of Language Fundamentals – 5th edition) differs little from the scores obtained when they are administered in-person

without social distancing.¹⁸ Behavior rating scales (i.e., questionnaires), such as the Children’s Communication Checklist – 2nd edition (CCC-2) can be completely remotely with relative ease, yielding information that can be highly informative for ASD evaluations. The Test of Pragmatic Language (TOPL) can also be administered remotely, but it appears to be less effective at distinguishing children with ASD from those who are solely language disordered.¹⁹

(ii) Remote assessments of contextual social communication. Contextual assessments of social communication and functional communication (e.g., observation, direct interaction/dynamic assessment, ecological assessment) are critically important in providing SLPs with the data necessary to assist with an ASD identification. For the reasons stated in Sections 3.5 and 4.2 above, conducting these assessments remotely is exceedingly difficult, and infeasible in some circumstances. The specific guidance set forth in Section 4.2 is generally applicable to contextual assessments of functional communication. Parents may be coached to engage in the types of social communication elicitation activities (e.g., Prizant’s communicative temptations) that the SLP would have used in person with the child or youth. For an older, verbal individual, the SLP may be able to successfully conduct an interview (direct interaction) for the purpose of assessing various pragmatic and social cognitive constructs. Such assessments should be interpreted with high degree of caution, however. There will be some situations in which it is simply not appropriate for SLPs to conduct their assessments for an ASD evaluation solely via remote methods, in which case the team should carefully consider other options.

(iii) In-person assessments. Assessments of formal language can be performed in person using masks. Contextual assessments of functional language, however, are subject to the same considerations and guidance set forth in Section 4.2 above. As with remote observations, parents may be coached to engage in the types of social communication elicitation activities (e.g., Prizant’s communicative temptations) that the SLP would have used in person with the individual.

(d) Sensory processing. This element of an evaluation should not be affected by social distancing measures, when a caregiver-reported sensory profile is collected. If an in-person sensory evaluation is completed by a qualified professional, the aforementioned PPE and social distancing limitations apply.

(e) Social and emotional skills. Some aspects of social and emotional skills can be garnered by parental/caregiver report, but most depend on close interaction with the evaluator or a parent and are covered under Section 4.2 above.

9.4 Medical/Other Health Assessments

Medical and other health assessments should not be affected by social distancing measures.

APPENDIX 1

OCASD RECOMMENDATIONS ON ASD EVALUATIONS

SIAC 4.3 The standard evaluation for the identification of an ASD will include at least the following elements:

- A. Diagnostic interview, including family history, with pertinent people such as child/person, parent/caregiver, and education staff.
- B. Standardized observation using research-based, autism-specific instrument(s). Currently, the ADOS, ASIEP-3 (interaction assessment and sample of vocal behavior module), and CARS-2 meet these criteria. This list will be updated periodically by the entity responsible for best practice (see Goal SIAC 5).
- C. Observation of the individual in unstructured activity, to include at least one observation outside of the team evaluation setting, which might include any of the following:
 - a. Familiar setting
 - b. Unfamiliar setting
 - c. Unstructured peer interaction
 - d. Unstructured independent activities
- D. A developmental assessment, using the best available standardized tools, (based on current research and updated regularly to reflect best practice), appropriate to the age and developmental level of the individual, for:
 - a. Cognition: thinking and reasoning
 - b. Adaptive functioning
 - c. Functional communication, including speech and language skills
 - d. Sensory processing
 - e. Social and emotional skills
- E. A formal hearing test for those up to age 5, for the first evaluation, if none has been done in the previous 6-12 months AND one or more of the following is true:
 - a. No newborn screen was done, or the child failed a screen without follow up
 - b. There is a family history of progressive hearing loss; or
 - c. There is a recent history of recurrent ear infections or persistent serous otitis (middle ear fluid). Note: A hearing assessment should be appropriate to the age and developmental level of the individual.
- F. Vision screening, if indicated.
- G. Once identification has been made; reports will be made available to caregivers in accessible language and format, with specified content areas included regarding the findings.
- H. Once identification has been made, there will be a “starter pack” of information for families regarding next steps and available resources.

SIAC 4.4 The identification team as a whole must possess at least the following specific knowledge elements for applying the DSM criteria for identification of individuals with an ASD:

- A. Typical child development
- B. Atypical child development

- C. Psychopathology appropriate to the age of the person being evaluated and sufficient to differentiate an ASD from other conditions (such as intellectual disabilities, anxiety disorders, reactive attachment disorder, ADHD, and mood disorders).
- D. Formal (structured) and informal (observation/interview) assessment practices.
- E. Characteristics of ASD appropriate to the age of the person being evaluated.
- F. Assessment tools/methods for ASD and differential identification sufficient for referral for further evaluation.
- G. Family and environmental dynamics/systems (e.g. maternal depression, abuse, culture).
- H. Knowledge sufficient to identify red flags indicating need for further referral.

APPENDIX 2

OAR 581-015-2130

Autism Spectrum Disorder

(1) If a child is suspected of having an autism spectrum disorder, the following evaluations must be conducted:

(a) Developmental History as defined in OAR 581-015-2000(8).

(b) Information from parents and other knowledgeable individuals regarding the child's historical and current characteristics that are associated with an autism spectrum disorder, including:

(A) Deficits in social communication and social interaction across multiple contexts as manifested by deficits in social-emotional reciprocity, nonverbal communicative behaviors used for social interaction, and developing, maintaining, and understanding relationships; and

(B) Restricted, repetitive patterns of behavior, interests, or activities, as manifested by stereotyped or repetitive motor movements, use of objects, or speech; insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior; highly restricted, fixated interests that are abnormal in intensity or focus; hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment.

(c) Observations. Three observations of the child's behavior; at least one of which involves direct interactions with the child, and at least one of which involves direct observation or video of the child's interactions with one or more peers in an unstructured environment when possible, or with a familiar adult. The observations must occur in multiple environments, on at least two different days, and be completed by one or more licensed professionals knowledgeable about the behavioral characteristics of autism spectrum disorder.

(d) Social Communication Assessment. Assessments conducted by a speech and language pathologist licensed by the State Board of Examiners for Speech-Language Pathology and Audiology or the Teacher Standards and Practices Commission, in reference to developmental expectations and that address the characteristics of autism spectrum disorder to develop a profile of:

(A) Functional receptive and expressive communication, encompassing both verbal (level of spoken language) and nonverbal skills;

(B) Pragmatics across natural contexts; and

(C) Social understanding and behavior, including social-emotional reciprocity

(e) Standardized Autism Identification Tool. One or more valid and reliable standardized rating scales, observation schedules, or other assessments that identify core characteristics of autism spectrum disorder.

(f) Medical Examination or Health Assessment. A medical examination or health assessment shall be completed for children age birth to five for initial eligibility determinations, and may be completed for children above age five, as determined necessary by the team. The purpose of a medical examination or health assessment is to ensure consideration of other health and/or physical factors that may impact the child's developmental performance for a child age 3-5 or the child's educational performance for a child age 5-21. A medical diagnosis of autism spectrum disorder is not required to determine eligibility.

(g) Vision and Hearing Screening. Review existing screening, or if none conduct a new screening.

(h) Other.

(A) Any additional assessments that may include, measures of cognitive, adaptive, academic, behavioral-emotional, executive function/self-regulation, or sensory processing necessary to determine the impact of the suspected disability:

(i) On the child's developmental progress for a child age 3 to 5; or

(ii) On the child's educational performance for a child age 5 to 21.

(B) Any additional evaluations or assessments necessary to identify the child's educational needs.

(2) To be eligible as a child with an autism spectrum disorder, the child must meet all of the following minimum criteria:

(a) The team must have documented evidence that the child demonstrates a pattern of characteristics defined as all three social communication deficits, and at least two of the four restricted, repetitive patterns of behavior, interests, or activities contained in this section:

(A) Child demonstrates persistent deficits in social communication and social interaction across multiple contexts, as evidenced by the all of the following, currently or by history (examples are illustrative, not exhaustive):

(i) Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions;

(ii) Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication; and

(iii) Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

(B) Restricted, repetitive patterns of behavior, interests, or activities, as evidenced by at least two of the following, currently or by history (examples are illustrative, not exhaustive):

(i) Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases);

(ii) Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take the same route or eat the same food every day);

(iii) Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests); or

(iv) Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

(b) Characteristics are generally evident before age three, but may not have become fully evident until social demands exceed limited capacities, or may be masked by learned strategies.

(c) The characteristics of autism spectrum disorder are not better described by another established or suspected eligibility for special education services. A child may not be eligible for special education services on the basis of an autism spectrum disorder if the child's primary disability is an emotional disturbance under OAR 581-015-2145. However, a child with autism spectrum disorder as a primary disability may also have an emotional disturbance as a secondary disability.

(3) To be eligible for special education services as a child with an autism spectrum disorder, the eligibility team must also determine that:

(a) For a child age 3 to 5, the child's disability has an adverse impact on the child's developmental progress; or

(b) For a child age 5 to 21, the student's disability has an adverse impact on the student's educational performance.

(c) The child needs special education services as a result of the disability.

(d) The team has considered the child's special education eligibility, and determined that the eligibility is not due to a lack of appropriate instruction in reading, including the essential components of reading instruction (phonemic awareness, phonics, vocabulary development; reading fluency/oral reading skills; and reading comprehension strategies); and is not due to a lack of appropriate instruction in math; and is not due to limited English proficiency.

APPENDIX 3

ONLINE RESOURCES FOR PARENTS WHEN A RELIABLE ASD DIAGNOSIS OR ELIGIBILITY CANNOT BE MADE DUE TO SOCIAL DISTANCING PRACTICES

Help Is In Your Hands

“Help is in Your Hands” is an excellent new resource for families with young kids with symptoms of or diagnosed on the autism spectrum, as well as for early-intervention providers. It is a free website with 16 web-based video modules to help parents add simple intervention practices to their everyday routines at home. It also offers several webinars for providers on coaching parents to support their young children with autism or with social communication problems.

Here are examples of several modules:

- Module 1: Increasing Children's Attention to People
- Module 2: Increasing Children’s Communications
- Module 3: Joint Activity Routines to Increase Your Child's Learning & Communication
- Module 4: The ABCs of Opportunities for Learning

Sign in here: <https://helpisinyourhands.org/course>

Online Research Study on Reciprocal Interaction Therapy: Mirror Me

Open Access Mirror Me Research Study (Rush University Medical Center): This is a free research opportunity available for caregivers of children ages 16 months to 7 years of age who are at risk for autism and have difficulties with social engagement and social imitation. During this time families from anywhere will be able to use the Mirror Me Online program to learn about Reciprocal Imitation Training (RIT) an intervention that teaches engagement and imitation. Families will first be asked to complete an informed consent and a short questionnaire and then will be given a personal user account for the Mirror Me program. They will be sent some follow up questionnaires about 5 weeks later. We are interested in learning about how and when families engage with the Mirror Me website. If you are interested in participating, you can complete this short Interest Form and someone from the team will reach out to you soon!

Allison Wainer, PhD

Assistant Professor | Department of Psychiatry

Research Director | AARTS Center

A PowerPoint introduction to Mirror Me for parents can be found at the Oregon Commission on Autism Spectrum Disorder’s website: <https://www.orcommissionasd.org/Page/46>

Link to interest form

https://rushpsych.co1.qualtrics.com/jfe/form/SV_6DwclU1FDzpCZE1

APPENDIX 4 SAMPLE EVALUATION PROTOCOLS FOR DIFFERENT AGES

The following protocols are samples, and do not include all the assessment tools available to evaluate each area of functioning. A variety of screeners or evaluation tools may be used to complete evaluations. Also, the sample protocols only address whether or not a child has the characteristics of ASD set forth in the DSM-5 and OAR 581-015-2130(2)(a). They do not address medical assessment of an individual or the additional requirements for special education eligibility.

1. Sample Evaluation Protocol for Children 5 and Younger.

Medical and developmental history*

Review of DSM-5 criteria*

Cognitive Assessment: Mullen Scales of Early Learning – AGS Edition (age 0-5 years, 8 months),

OR

Bayley Scales of Infant Development, 4th Edition (age 0-3 years, 6 months)

Language Assessment: Preschool Language Scale, 5th Edition (age 1 month-7 years, 11 months),

OR

Receptive-Expressive Emergent Language Test (REEL) (age 0-36 months) – for children with limited language

Adaptive Assessment: Vineland Adaptive Behavior Scales, 3rd Edition **OR**

Adaptive Behavior Assessment System, 3rd Edition

Sensory Processing Assessment: Sensory Profile

Assessment of Co-occurring symptoms: Behavior Assessment System for Children, 3rd Edition

OR Child Behavior Checklist

ASD specific Assessment: Brief Observation of Symptoms of Autism **OR**

TELE-ASD-PEDS (age 36 months or younger ONLY) **OR** both

Informal play with examiner

Review of videos from home - child participating in routine activities with parents and/or siblings

Standardized ASD instrument: Completion of the Childhood Autism Rating Scale-2-ST (CARS-2) by the entire evaluation team based on *all* information gathered

2. Sample Evaluation Protocol for Children 6 to 12 or 13

Medical and developmental history*

Review of DSM-5 criteria*

Cognitive Assessment: Wechsler Intelligence Scale for Children, 5th Edition, Kaufman Assessment Battery for Children-2nd Edition, or Woodcock Johnson Test of Cognitive Abilities, 4th Edition

Language Assessment: Clinical Evaluation of Language Fundamentals, 5th Edition, **OR** Comprehensive Assessment of Spoken Language, 2nd Edition, **OR** Oral and Written Language Scales, 2nd Edition, **OR** Children’s Communication Checklist, 2nd Edition – for children that cannot complete standardized testing

Adaptive Assessment: Vineland Adaptive Behavior Scales, 3rd Edition **OR** Adaptive Behavior Assessment System, 3rd Edition

Sensory Processing Assessment: Sensory Profile or Sensory Processing Measure
Assessment of Co-occurring symptoms: Behavior Assessment System for Children, 3rd Edition
OR Child Behavior Checklist
ASD specific Assessment: Brief Observation of Symptoms of Autism **AND** Vanderbilt University
TRIAD Social Skills Assessment
Standardized pragmatic language test - (Social Development Language Test-Elementary **OR**
Adolescent version, **OR** Test of Pragmatic Language, 2nd Edition, **OR** Clinical Assessment of
Pragmatics)
Selected subtests from NEPSY-II (Social Perception, Executive Functioning)
Double Interview and other informal techniques from Michele Garcia Winner
Review of videos from home - child participating in play-based activities with parents and/or
siblings
Standardized ASD instrument: Completion of the CARS-2-ST or CARS-2-HF by the entire
evaluation team based on ALL information gathered

3. Sample Evaluation for Adolescents and some Adults

Medical and developmental history*

Review of DSM-5 criteria*

Cognitive Assessment: Wechsler Intelligence Scale for Children, 5th Edition, Kaufman
Assessment Battery for Children-2nd Edition, or Woodcock Johnson Test of Cognitive Abilities,
4th Edition (for adults only - Wechsler Adult Intelligence Scales, 4th Edition or Wechsler
Abbreviated Scale of Intelligence, 2nd Edition)

Language Assessment: Clinical Evaluation of Language Fundamentals, 5th Edition, **OR**
Comprehensive Assessment of Spoken Language, 2nd Edition, **OR** Oral and Written Language
Scales, 2nd Edition, **OR** Children's Communication Checklist, 2nd Edition – for children that
cannot complete standardized testing (Oral and Written Language Scales, 2nd Edition is only
language assessment with adult norms)

Adaptive Assessment: Vineland Adaptive Behavior Scales, 3rd Edition **OR** Adaptive Behavior
Assessment System, 3rd Edition

Sensory Processing Assessment: Sensory Profile (use appropriate protocol based on age – there
is an adult version)

Assessment of Co-occurring symptoms: Behavior Assessment System for Children, 3rd Edition
OR Child Behavior Checklist (cannot use either for adults – consider Symptom Checklist 90,
revised)

ASD specific Assessment: Brief Observation of Symptoms of Autism **AND** Vanderbilt University
TRIAD Social Skills Assessment

Standardized pragmatic language test - (Social Development Language Test-Elementary **OR**
Adolescent version, **OR** Test of Pragmatic Language, 2nd Edition, **OR** Clinical Assessment of
Pragmatics) (cannot use any of these instruments with adults)

Selected subtests from NEPSY-II (Social Perception, Executive Functioning)

Double Interview and other informal techniques from Michele Garcia Winner

Review of videos from home - child participating in activities with parents and/or siblings

Standardized ASD instrument: Completion of the CARS-2-ST or CARS-2-HF by the entire
evaluation team based on ALL information gathered

*There are some structured and semi-structured templates for conducting the developmental and medical history, as well as the DSM-5 diagnostic interview but most professionals use an informal or self-derived format for collecting needed information. A sample developmental history form for special education eligibility for ASD can be found at <https://docs.google.com/document/d/1RdcBAE9ZLyOgie2yOvD15x8NIOT7bxXa0V0aLdm8hr4/edit> (health care professionals could use this template as well).

4. Other Guidance for Educators.

For guidance on evaluating the need for specially designed instruction and the impact of a child's disability on their educational performance, please consult the Oregon Department of Education's Autism Spectrum Disorder Technical Assistance Paper, https://www.oregon.gov/ode/students-and-family/SpecialEducation/RegPrograms_BestPractice/Documents/autismtap.pdf The Oregon Department of Education has also issued guidance on discipline-specific (but not ASD-specific) services via telehealth. Some of this guidance is applicable to evaluations. Links to this guidance can be found under the Mental Health, Physical Health, and Social Support caption at the following link: <https://www.oregon.gov/ode/students-and-family/SpecialEducation/Pages/covid19forspecialeducation.aspx>

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¹ American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed), pp. 50-51.

² Hyman, S., Levy, S., & Myers, S., AAP Council on Children with Disabilities, Section on Developmental and Behavioral Pediatrics. (2020). Identification, evaluation, and management of children with autism spectrum disorder. *Pediatrics*, 145(1):e20193447. <https://DOI.org/10.1542/peds.2019-3447> .
<https://pediatrics.aappublications.org/content/145/1/e20193447>

³ Oregon Health Authority. Steps to Applied Behavior Analysis (ABA) treatment.
<https://www.oregon.gov/oha/HSD/OHP/tools/Steps%20to%20ABA%20Treatment%20-%20For%20OHP%20families%20and%20clients.pdf>

⁴ Sections 2 and 22, chapter 771, Oregon Laws 2013, *codified at the end of ORS Chap 143A.*"

⁵ OAR 411-320-020(4).

⁶ OAR 411-320-0080(7)(b).

⁷ OAR 411-320-080(6)(a), (7)(a).

⁸ OAR 411-320-0080(6)(a)(i).

⁹ OAR 411-320-0080(7).

¹⁰ OAR 411-320-0080(1).

¹¹ <https://www2.ed.gov/policy/speced/guid/idea/memosdcltrs/qa-evaluation-timeline-idea-part-c-07-06-2020.pdf>

¹² Alfuraydan, M., Croxall, J., Hurt, L., Kerr, M., & Brophy, S. (2020, July 23). Use of telehealth for facilitating the diagnostic assessment of autism spectrum disorder (ASD): A scoping review. *PLOS One*,
<https://doi.org/10.1371/journal.pone.0236415>

¹³ The Autism Diagnostic Observation Schedule, 2nd Edition (ADOS-2) is considered to be one of the most accurate ASD evaluation tools. The publisher of the ADOS-2, Western Psychological Services, discourages the use of the ADOS-2 via telehealth platforms. It also discourages the administration of the ADOS-2 while wearing a face mask or shield, or through a protective barrier such as plexiglass. Email from Kailey Bax, Product Support Specialist, Western Psychological Services, to Darryn Sikora, Providence Children's Development Institute (May 20, 2020) (available on request).

Similarly, the Childhood Autism Rating Scale, 2nd Edition (CARS-2), often used in educational settings, is an OCASD recommended observation tool. In order for the CARS-2 to be valid, the following guidelines must be adhered to:

- 1) To complete CARS-2 ratings, convergent information from multiple sources, **must** be used. Parents or teachers should **not** complete the forms.
- 2) Only well-informed professionals should complete the ratings. The professional must have a good understanding of each of the criteria used for each rating **and be in a position to collect information from multiple sources**, including direct observation, parent and teacher interview, prior assessments of cognitive functioning and adaptive behavior, and information from the CARS-2 Questionnaire for Parents/Caregivers.
- 3) CARS-2 ratings should be considered as only one part of a multimodal, multidisciplinary decision-making process.
- 4) Direct observation and a developmental history **must always** be included in the assessment process.

¹⁴ Information on TELE-ASD-PEDS can be found at <https://vkc.vumc.org/vkc/triad/TELE-ASD-PEDS/>

¹⁵ (2020, August 9). At least 97,000 children in the U.S. tested positive for the coronavirus in the last two weeks of July. *New York Times* , <https://www.nytimes.com/2020/08/09/world/coronavirus-covid-19.html?action=click&module=Top%20Stories&pgtype=Homepage#link-6dbc15a3> . Green, A. (2020, August 4). Outbreak hits bible camp near Corbett. *The Oregonian*, A01. Szablewski C., Chang K., Brown M., et al. (2020, July

31). SARS-CoV-2 transmission and infection among attendees of an overnight camp — Georgia, June 2020. *MMWR Morb Mortal Wkly Rep.*, <http://dx.doi.org/10.15585/mmwr.mm6931e1>

¹⁶ Oregon Health Authority. (2020, July 24). Statewide mask, face shield, face covering guidance. <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le2288K.pdf>

¹⁷ DSM-5, p. 58.

¹⁸ Kester, E. (2020, June 10). Conducting student speech-language evaluations via telepractice. *LeaderLive*, <https://leader.pubs.asha.org/doi/10.1044/leader.SCM.25062020.36/full/> .

¹⁹ Volden, J., and Phillips, L. (2010). Measuring pragmatic language in speakers with autism spectrum disorders: comparing the Children's Communication Checklist-2 and the Test of Pragmatic Language. *Am J Sp-Lang Path*, 19(3):204-12.