From:	Durocher, Jennifer S., Ph.D.
To:	solicitation.questions
Subject:	Response to RFI for the SMCC Program
Date:	Friday, June 3, 2022 6:04:14 PM
Attachments:	Response to RFI ACHA.pdf
	response to RFI redacted.pdf

Please see attached response to RFI.

Thank you!

Best,

Jennifer S. Durocher, Ph.D.

Clinical Associate Professor of Psychology & Pediatrics

University of Miami

56665 Ponce de Leon Blvd

Coral Gables, FL 33134

305-284-6557

June 3, 2022

Cody Massa
Procurement Officer
solicitation.questions@ahca.myflorida.com

Early Child Development and Long-term Population Health

This response to the SMMC RFI for innovative ideas and best practices focuses on the following domains:
- Enhance specialty health plans services to improve outcomes for recipients. Increase the number of plans to address target populations with specific health conditions or needs
- Improve mental health outcomes (e.g., developmental, behavioral, etc.) for children and adolescents.
- Consider innovative delivery methods, including care bundling, that empower recipients in making more informed health care decisions.
- Increase timely access to providers and services.
- Improve recipients' experience with the SMMC Program.
- Improve providers' experience with the SMMC Program.

Key Ideas
- **The health and well-being of children, including those with neurodevelopmental disorders (e.g., autism spectrum disorder, ADHD) is critical to our state.**
- **Medicaid is one of the largest investments in children in the state budget, and with the next SMMC procurement there is an opportunity to address barriers to diagnosis and access to services for children with neurodevelopmental disorders to improve outcomes for such children.**

Background

Autism Spectrum Disorder (ASD) is a neurodevelopmental disability involving deficits in social communication and social interaction, as well as restricted, repetitive behaviors (American Psychiatric Association, 2013). Current prevalence estimates indicate that 1 in 44 children in the U.S. are diagnosed with autism spectrum disorder (Maenner et al., 2021). ASDs are generally considered lifelong developmental disabilities (Croen et al., 2015; Roux et al., 2014), with a high level of diagnostic stability over time (Giseman-Kiss & Carter, 2020; Hyman et al., 2020; Lord et al., 2006; Turner et al., 2006; Zwaigenbaum et al., 2016).

Despite evidence that ASD can be accurately diagnosed by age 2 (Gordon-Lipkin et al., 2016; Turner et al., 2006; Zwaigenbaum et al., 2016) or even younger (Zwaigenbaum et al., 2009; Zwaigenbaum et al., 2013; cited in Zwaigenbaum et al., 2015a), diagnosis is often not made until closer to 3 to 4 years of age (Fountain et al., 2011; cited in Zwaigenbaum et al., 2015b; also Daniels & Mandell, 2014; Maenner et al., 2021). Significant disparities exist in the diagnosis of ASD, with children from racial and ethnic minority groups as well as lower socioeconomic backgrounds being diagnosed later (Benevides et al., 2021; Constantino et al., 2020; Hyman et al., 2020; Keehn et al., 2021; Mandell et al., 2010).

Research highlights that there are significant barriers to diagnosis which impact access to treatment for families of children with ASD. These include long wait times for specialized evaluations once concerns are identified through screening (Wiggins, Baio, & Rice, 2006; cited in Zwaigenbaum et al., 2016) or failure to refer for follow-up diagnostic testing due to the way that early intervention systems are structed (Williams et al., 2021). Other barriers include the time and cost related to conducting diagnostic evaluations, provider shortages and comfort level with making a diagnosis (Gordon-Lipkin et al., 2016).

Additionally, Keehn and colleagues (2021) highlight the "critical role that insurers play in limiting intervention access" by requiring the use of "specific assessment tools(s) instead of allowing qualified clinicians to use a flexible evidence-informed evaluation process" (p. 599). To this end, many insurers specifically require the Autism Diagnostic Observation Schedule-Second Edition (ADOS) as part of the comprehensive diagnostic evaluation (CDE) in order to authorize interventions for ASD and have limitations on the use of telehealth evaluations for this purpose (Keehn et al., 2021); these practices increase wait times for evaluation, delaying diagnosis and access to services (Gordon-Lipkin et al., 2016; Keehn et al., 2021). However, while the ADOS is considered to be a 'gold standard' diagnostic tool (Gordon-Lipkin et al., 2016), no single diagnostic tool is appropriate or sufficient for all cases (Keehn et al., 2021; Hyman et al., 2020).

Given that the "ultimate goal of early detection and screening is to ensure that children with autism spectrum disorder (ASD) can access evidence-based interventions to provide the best opportunity for optimal development and outcomes" (Zwaigenbaum et al., 2009; cited in Zwaigenbaum et al., 2015c, p. S61), delays in acquiring a diagnosis will certainly impact prognosis. Further, as with diagnosis, there is evidence for disparities in access to treatment; there is a greater likelihood of "unmet service needs" among families who are "generally underrepresented in service systems on the basis of race, ethnicity, and income level" (Smith et al., 2020; cited in Hyman & Iadarola, 2020, p. 2). Hyman and Iadarola further note that these "disparities are exacerbated by Medicaid restrictions for insurance mandates, which may disproportionately affect populations that are already underserved" (p. 2).

With respect to intervention, there is sizable empirical support for behavior analytic (e.g., ABA) interventions as efficacious and evidence-based practices (Reichow et al., 2018; cited in Hyman & Iadorola, 2020; Smith & Iadarola, 2015 and Spreckley & Boyd, 2009; cited in Gordon-Lipkin et al., 2016; Steinbrenner et al., 2020). However, it is important that intervention approaches be individualized to meet child and family needs, values and preferences as there is "insufficient evidence to assume a single approach is effective for all individuals with ASD" (Hyman & Iadorola, 2020, p. 2).

As with diagnostic tools, there should not be a 'one size fits all' approach to intervention. In this respect, there is an increasing evidence base for interventions that are not usually "covered by insurance mandates" (Hyman & Iadorola, 2020, p. 1). These include naturalistic developmental behavioral interventions (NDBIs; Schreibman et al., 2015; Steinbrenner et al., 2020; Williams et al., 2020) and other intervention approaches including augmentative and alternative communication, peer-based instruction and interventions, cognitive-behavioral instructional strategies, and social skills training (Steinbrenner et al., 2020). Recently, there has been an emphasis on parent-implemented/parent-mediated interventions as an evidence-based and empirically supported treatment approach for children with ASD (Steinbrenner et al., 2020; also see Hyman et al., 2020 for a review). Interventions which incorporate parent-implemented components along with clinician-delivered strategies, have been found to improve outcomes (Landa et al., 2018; cited in Williams et al., 2020). Some empirically supported parent-implemented approaches include Parent-Child Interaction Therapy (PCIT; Allen et al., 2022), Improving Parents as Communication Teachers (Project ImPACT; Ingersoll & Dvortcsak, 2019; Stadnick et al., 2015) and the RUBI Autism Network (Bearss et al., 2015a; Bearss et al., 2015b, Bearss et al., 2018) among many others (Steinbrenner et al., 2020).

Further, there is increasing empirical support for the use of telehealth procedures for diagnosis (Stainbrook et al., 2019; Juárez et al., 2018; cited in Keehn et al., 2021), an area which grew significantly in response to the additional barriers created by the COVID-19 pandemic. Such procedures are needed, since the ADOS cannot be adequately administered via telehealth and its scoring is not valid when administered in-person with PPE (Dattaro, 2021; see also Berger et al., 2021 and Jang et al., 2021; cited in Keehn et al., 2021). Some novel measures with empirical support include the TELE-ASD-PEDS (Wagner et al., 2021) and the Brief Observation of Symptoms of Autism (BOSA; Dow et al., 2021). The Childhood Autism Rating Scale, Second Edition (CARS-2) is another diagnostic tool which has been empirically validated and which has good diagnostic agreement with the ADOS (Dawkins et al., 2016; Chlebowski et al., 2010; Reszka et al., 2014; cited in Hyman et al., 2020). A benefit of the CARS-2 is that it can be rated by clinicians based on observation conducted via telehealth. There has also been an emergence of research supporting the efficacy of telehealth-based interventions (see Hyman et al., 2020), which has the potential to improve access to care by being more cost-effective, reducing wait times for services, and reducing barriers for families who may have difficulty traveling to clinics for services (Gordon-Lipkin et al., 2016; Keehn et al., 2021).

Recommendations

Based on the above considerations, we recommend that AHCA consider the following:

 Diagnosis:
- Identification of children at risk for ASD should first include screening by a medical provider (e.g., neurologist, pediatrician), a birth-3 intervention program, or mental health professional, and should include the administration of an **ASD-specific screening measures** (e.g., MCHAT-R, STAT, CSBS, SCQ; Lipkin & Macias, 2020; Norris & Lecavalier, 2010). They would identify those children at most risk for ASD and refer for a comprehensive assessment.

- ASD diagnoses should be made on the basis of a ***comprehensive assessment***, which includes careful review of the child's behavioral and developmental history **and** direct observation of symptoms (e.g., ADOS-2, CARS2, BOSA, TELE-ASD-PEDS; Hyman et al., 2020).
  - The history of symptoms of ASD can be supported by questionnaires such as the Social Communication Questionnaire (SCQ), Social Responsiveness Scale (SRS) and/or the Autism Spectrum Rating Scale (ASRS). None of these questionnaires is sufficient alone to make a diagnosis of ASD, but all provide a structured approach to elicit symptoms of ASD.
  - Observation of ASD symptoms should include the administration of an observational (and play-based for young children) ASD-diagnostic tool such as the ADOS-2, CARS2, BOSA, or TELE-ASD-PEDS, **through telehealth, in-person, and/or hybrid models**.
    - Anyone with a master's degree (MA, MS, MSW, CAGS) in psychology, school counseling, occupational therapy, speech-language pathology, social work, education, special education, or a related field can administer the ADOS-2 (or similar measure) if properly trained.
    - Short clinical visits may not be sufficient, even for experienced clinicians, to accurately recognize symptoms of ASD (Gabrielsen, et al., 2015).
  - A comprehensive evaluation should also include formal assessment of language, cognitive or developmental skills, and/or adaptive abilities.

- The integration of historical information **and** objective observation by a clinician trained to diagnose autism and related conditions to inform the DSM-5 diagnostic criteria is the critical element to diagnostic evaluation.

- Although most children will need to see a specialist (such as a child psychologist, developmental-behavioral or neurodevelopmental pediatrician, neurologist, or psychiatrist) for a diagnostic evaluation, general pediatricians **using the diagnostic clinical best practices outlined above** can make an initial clinical diagnosis (Hyman et al., 2020).

- Medicaid should cover the cost of a comprehensive assessment when such assessment is warranted based on identification of risk for ASD by a medical professional, early intervention birth-3 provider or mental health professional using ASD-specific screening measures (e.g., MCHAT-R, STAT, CSBS, SCQ)

- Since ASD is a lifelong neurodevelopmental disorder with high stability over time (Giseman-Kiss & Carter, 2020; Hyman et al., 2020; Lord et al., 2006; Turner et al., 2006; Zwaigenbaum et al., 2016), Medicaid should not continue to require periodic re-evaluations [i.e., comprehensive diagnostic evaluations (CDEs)] once a diagnosis has been established in order to maintain authorization for services. This creates a burden for families, is not cost-effective, and adds to the long wait times for specialized evaluations for children seeking initial diagnoses.
  - Instead, determining whether services should continue to be re-authorized should be based on continued need for services, such as continued functional impairment, maladaptive behaviors and/or adaptive functioning. These could be completed by the current ABA or other services provider.

Intervention

- ABA should be covered for children with behavioral concerns associated with other diagnostic groups, other than ASD (e.g., ADHD)

- Coverage should be expanded to include evidence-based approaches that have been highlighted in the National Clearing House on Autism Evidence & Practice (Steinbrenner et al., 2020), a report based on a systematic review of intervention research studies published between 1990 and 2017.

  - These include many approaches that have not traditionally been covered by insurance mandates (Hyman & Iadorola, 2020) but for which significant evidence exists for their efficacy, including (but not limited to):
    - Naturalistic Developmental Behavioral Interventions (NDBIs; Schreibman et al., 2015). Some examples include:
      - Pivotal Response Treatment (PRT; Koegel et al. 1987; Hardan et al., 2015; Suhrheinrich et al., 2018)
      - Joint Attention Symbolic Play and Emotion Regulation (JASPER; Kasari et al., 2006; Kasari et al., 2021)
      - Early Start Denver Model (Fuller et al., 2020; Howard & Dawson, 2020; Rogers & Dawson, 2009)
      - Social Communication/Emotional Regulation/Transactional Support (SCERTS; Prizant et al. 2003)

    - Parent-mediated treatment or parent management training. These are evidence-based approaches appropriate for young children with ASD and/or developmental concerns and/or co-occurring conditions (e.g., maladaptive behaviors; Hyman et al., 2020). Some examples include:
      - Parent-Child Interaction Therapy (Allen, et al., 2022)
      - Improving Parents as Communication Teachers (Project ImPACT; Ingersoll & Dvortcsak, 2019; Stadnick et al., 2015)
      - RUBI Autism Network (Bearss et al., 2015a; Bearss et al., 2015b, Bearss et al., 2018)

Medicaid financing is one of the most powerful mechanisms that state and federal governments have to improve child health and well-being, especially among children who face challenges due to neurodevelopmental disorders. As healthcare systems transition to value-based arrangements, health-policy leaders at AHCA have the opportunity to improve outcomes for children with the potential for long-term impact. The next SMMC procurement is an opportunity to explore how align best practices in the diagnosis and intervention of autism spectrum disorders with innovative approaches to decrease barriers, increase cost-effectiveness, and improve access to care, and ultimately, child outcomes.

References

Allen, K., Harrington, J., Quetsch, L.B. et al. (2022). Parent–Child Interaction Therapy for Children with Disruptive Behaviors and Autism: A Randomized Clinical Trial. *Journal of Autism and Developmental Disorders*. https://doi.org/10.1007/s10803-022-05428-y

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders*; 5th edition.

Bearss, K., Johnson, C., Smith, T., Lecavalier, L., Swiezy, N….et al. (2015a). Effect of parent training vs parent education on behavioral problems in children with autism spectrum disorder. *Journal of the American Medical Association, 313*(15), 1524-1533. https://doi.org/10.1001/jama.2015.3150

Bearss, K., Burrell, T.L., Stewart, L. & Scahill, L. (2015b). Parent training in autism spectrum disorder: What's in a name? *Clinical Child and Family Psychology Review, 18*(2), 170-82.

Bearss, K., Johnson, C.R., Handen, B.L., Butter, Lecavalier, L., Smith, T. & Scahill, L. (2018). Parent Training for Disruptive Behavior: The RUBI Autism Network, Clinician Manual. Oxford University Press.

Benevides TW, Carretta HJ, Rust G, Shea L (2021) Racial and ethnic disparities in benefits eligibility and spending among adults on the autism spectrum: A cohort study using the Medicare Medicaid Linked Enrollees Analytic Data Source. PLoS ONE 16(5): e0251353. https://doi.org/10.1371/journal.pone.0251353

Constantino, J. N., Abbacchi, A. M., Saulnier, C., Klaiman, C., Mandell, D. S…et al. (2020). Timing of the diagnosis of autism in African American Children. *Pediatrics*, *146*(3). https://doi.org/10.1542/peds.2019-3629

Croen, L. A., Zerbo, O., Qian, Y., et al. (2015). The health status of adults on the autism spectrum. *Autism, 19*(7), 814–823.

Daniels, A. M., & Mandell, D. S. (2014). Explaining differences in age at autism spectrum disorder diagnosis: A critical review. *Autism,18*(5), 583–597. https://doi.org/10.1177/1362361313480277

Dattaro, L. (2021). Virtual autism assessments are likely here to stay. *Spectrum.* *https://www.spectrumnews.org/news/virtual-autism-assessments-are-likely-here-to-stay*

Dow, D., Holbrook, A., Toolan, C., McDonald, N., Sterrett, K., Rosen, N., Kim, S. H., & Lord, C. (2021). The Brief Observation of Symptoms of Autism (BOSA): Development of a New Adapted Assessment Measure for Remote Telehealth Administration Through COVID-19 and Beyond. Journal of autism and developmental disorders, 1–12. Advance online publication. https://doi.org/10.1007/s10803-021-05395-w

Fuller, E.A., Oliver, K., Vejnoska, S.F., Rogers, S.J. (2020). The Effects of the Early Start Denver Model for Children with Autism Spectrum Disorder: A Meta-Analysis. *Brain Science, 10*(6). 368. https://doi.org/10.3390/brainsci10060368

Giserman-Kiss I, Carter AS. Stability of autism spectrum disorder in young children with diverse backgrounds. *Journal of Autism and Developmental Disorders*. 2020;50(9):3263-3275. doi:10.1007/s10803-019-04138-2

Gordon-Lipkin, E., Foster, J. & Peacock, G. (2016). Whittling down the wait time: Exploring models to minimize the delay from initial concern to diagnosis and treatment of autism spectrum disorder. *Pediatric Clinics of North America, 63,* 851-859.

Hardan, A. Y., Gengoux, G. W., Berquist, K. L., Libove, R. A., Ardel, C. M., Phillips, J., Frazier, T. W., & Minjarez, M. B. (2015). A randomized controlled trial of Pivotal Response Treatment Group for parents of children with autism. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 56*(8), 884-892. https://doi.org/10.1111/jcpp.12354

Howard, J., Dawson, G. (2020). The Early Start Denver Model (ESDM). In: McClain, M., Shahidullah, J., Mezher, K. (eds) Interprofessional Care Coordination for Pediatric Autism Spectrum Disorder. Springer, Cham. https://doi.org/10.1007/978-3-030-46295-6_23

Hyman, S.L. & Iadarola, S. (2020). Simpler than possible: Insurance mandates for autism spectrum disorders. *Pediatrics, 146* (4):e20193447

Hyman, S.L., Levy, S.E., & Myers, S.M. (2020). AAP COUNCIL ON CHILDREN WITH DISABILITIES, SECTION ON DEVELOPMENTALAND BEHAVIORAL PEDIATRICS. Identification, Evaluation, and Management of Children with Autism Spectrum Disorder. *Pediatrics, 145 (*1): e20193447

Ingersoll, B. & Dvortcsak, A. (2019). T*eaching social communication to children with autism and other developmental delays: The Project ImPACT guide to coaching parents and the Project ImPACT manual for parents* (2 book set; 2nd ed.). Guilford Press.

Kasari, C., Freeman, S., & Paparella, T. (2006). Joint attention and symbolic play in young children with autism: A randomized controlled intervention study. *Journal of Child Psychology and Psychiatry, 47*(6), 611–620.

Kasari, C., Gulsrud, A.C., Sire, S.Y. & Strawbridge, C. (2021). The JASPER Model for Children with Autism: Promoting Joint Attention, Symbolic Play, Engagement, and Regulation Annotated Edition. The Guilford Press.

Keehn, R.M., Tomlin, A. & Ciccarelli, M.R. (2021). COVID-19 pandemic highlights access barriers for children with autism spectrum disorder. *Journal of Developmental and Behavioral Pediatrics, 42*(7), 599-601. doi: 10.1097/DBP.0000000000000988

Howard, J., Dawson, G. (2020). The Early Start Denver Model (ESDM). In: McClain, M., Shahidullah, J., Mezher, K. (eds) Interprofessional Care Coordination for Pediatric Autism Spectrum Disorder. Springer, Cham. https://doi.org/10.1007/978-3-030-46295-6_23

Lipkin, P.H. & Macias, M.M. (2020). Promoting optimal development: identifying infants and young children with developmental disorders through developmental surveillance and screening. *Pediatrics*, 145(1): e20193449

Lord C., Risi, S., DiLavore, P.S., Shulman, C., Thurm, A., & Pickles, A. (2006). Autism from 2 to 9 years of age. *Archives of General Psychiatry*, 63(6), 694-701. doi:10.1001/archpsyc.63.6.694. PMID: 16754843.

Maenner, M.J., Shaw, K.A., Bakian, A. V., Bilder, D.A., Durkin, M.S…et al. (2021). Prevalence and characteristics of autism spectrum disorder among children aged 8 years - Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2018. *Morbidity and Mortality Weekly Report. Surveillance Summaries, 70*(SS-11), 1–16. http://dx.doi.org/10.15585/mmwr.ss7011a1

Mandell, D.S., Morales, K.H., Xie, M., Lawer, L.J., Stahmer, A.C. & Marcus, S.C. (2010). Age of diagnosis among Medicaid-enrolled children with autism, 2001-2004. *Psychiatric Services, 61*(8), 822-829.

Norris M., & Lecavalier, L. (2010). Screening accuracy of level 2 autism spectrum disorder rating scales. A review of selected instruments. *Autism.* 14(4): 263–284.

Prizant, B.M., Wetherby, A.M., Rubin, E.M.S., Laurent, A. (2003). The SCERTS Model, A Transactional family-centered approach to enhancing communication and socioemotional abilities of children aith autism spectrum disorder. *Infants & Young Children, 16*(4), 296-316

Rogers, S.J. & Dawson, G. (2009). Early Start Denver Model for Young Children with Autism: Promoting Language, Learning and Engagement. The Guilford Press.

Roux, A. M., Shattuck, P. T., Rast, J. E., Rava, et al. (2015). *National autism indicators report: Transition into Young Adulthood. Life course Outcomes Research Program*. Philadelphia, PA: Life Course Outcomes Research Program, A.J. Drexel Autism Institute, Drexel University.

Schreibman, L., Dawson, G., Stahmer, A.C., Landa, R., Rogers, S., McGee, G., Kasari, C., Ingersoll, B., Kaiser, A., Bruinsma, Y., McNierney, E., Wetherby, A., Halladay, A. (2015). Naturalistic developmental behavioral interventions: empirically validated treatments for autism spectrum disorder. *Journal of Autism and Developmental Disorders, 45*(8), 2411–2428.

Stadnick, N. A., Stahmer, A., & Brookman-Frazee, L. (2015). Preliminary Effectiveness of project ImPACT: A parent-mediated intervention for children with autism spectrum disorder delivered in a community program. *Journal of Autism and Developmental Disorders, 45*(7), 2092-2104. https://doi.org/10.1007/s10803-015-2376-y

Steinbrenner, J. R., Hume, K., Odom, S. L., Morin, K. L., Nowell, S. W., Tomaszewski, B., Szendrey, S., McIntyre, N. S., Yucesoy-Ozkan, S., & Savage, M. N. (2020). Evidence-based practices for children, youth, and young adults with Autism. The

University of North Carolina at Chapel Hill, Frank Porter Graham Child Development Institute, National Clearinghouse on Autism Evidence and Practice Review Team.

Suhrheinrich, J., Chan, J., Melgarejo, M. Reith, S., Stahmer, A., & AFIRM Team. (2018). Pivotal Response Training. Chapel Hill, NC: National Professional Development Center on Autism Spectrum Disorders, FPG Child Development Center, University of North Carolina. Retrieved from http://afirm.fpg.unc.edu/pivotalresponse-training

Turner, L.M., Stone, W.L., Pozdol, S.L. & Coonrod, E.E. (2006). Follow-up of children with autism spectrum disorders from age 2 to age 9. *Autism, 10*(3), 243-265).

Wagner, L., Corona, L.L., Weitlauf, A.S., March, K.L., Berman, A.F…et al. (2021). Use of the TELE-ASD-PEDS for autism evaluations in response to COVID-19: Preliminary outcomes and clinician acceptability. *Journal of Autism and Developmental Disorders, 51,* 3063-3072. https://doi.org/10.1007/s10803-020-04767-y

Zwaigenbaum L, Bauman, M.L., Choueiri, R., Fein, D., Kasari, C…et al. (2015a). Early identification and interventions for autism spectrum disorder: Executive summary. *Pediatrics, 136*(S1), S1-S9. www.pediatrics.org/cgi/doi/10.1542/peds.2014-3667E

Zwaigenbaum L, Bauman, M.L., Stone, W.L., Yirmiya, N., Estes, A…et al. (2015b). Early intervention for children with autism spectrum disorder under 3 years of age: Recommendations for practice and research. *Pediatrics, 136*(S1), S61-S81. www.pediatrics.org/cgi/doi/10.1542/peds.2014-3667E

Zwaigenbaum L, Bauman, M.L., Choueiri, R., Kasari, C., Carter, A…et al. (2015c). Early intervention for children with autism spectrum disorder under 3 years of age: Recommendations for practice and research. *Pediatrics, 136*(S1), S61-S81. www.pediatrics.org/cgi/doi/10.1542/peds.2014-3667E

Zwaigenbaum, L., Bryson, S.E., Brian, J, et al. (2016). Stability of diagnostic assessment for autism spectrum disorder between 18 and 36 months in a high-risk cohort. *Autism Research, 9*(7), 790-800. doi:10.1002/aur.1585