

SERIES:

An Integrated Approach to Supporting Child Development

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EXECUTIVE SUMMARY

Developmental delays affect between 10 and 13 percent of U.S. children under the age of three; however, only two to three percent of children in this age group receive Early Intervention (EI) services.¹⁻³ An approach that identifies concerns early and links children to services is vital. Many efforts have focused on implementing developmental screening in primary care, and have contributed valuable information about the feasibility and effectiveness of this strategy.⁴⁻⁸ However, few studies have evaluated the success of screening beyond the identification of a developmental concern and the initiation of a referral.⁹ Those studies that have looked beyond referral show significant gaps between the identification of a concern and the receipt of developmental services by children and families.^{10,11} This has prompted increasing awareness of the need for better care coordination across systems involved in meeting the developmental needs of children.¹²

To promote a more coordinated approach to meeting children's developmental needs, this brief proposes the adoption of the SERIES paradigm of developmental screening in which each step—**Screening, Early Identification, Referral, Intake, Evaluation, and Services**—is seen not as an isolated activity, but rather an integral component of a single process. SERIES challenges all systems serving young children to broaden their focus to include practices that promote shared responsibility for ensuring that each child successfully completes the entire pathway from screening to services.¹³ This brief does not aim to be a comprehensive review of the evidence around developmental screening, as such reviews already exist.^{1,14,15} Instead, the brief explores barriers that may prevent children from completing the SERIES, highlights promising approaches for collaboration, and proposes practice and policy actions that may offer useful guidance for planning, financing, and delivering early childhood services.

ISSUE	RESPONSE
Rates of developmental screening by primary care providers remain low.	<ol style="list-style-type: none">1. Reimbursement should incentivize screening and care coordination.2. The federal government should support the development of public domain screening tools.
Significant drop-off occurs when children move between primary care and developmental services.	States and provider sites should prioritize cross-system information exchange.
There is a missed opportunity to help children who are identified by screening but not eligible for Early Intervention (EI).	States should coordinate the eligibility and intake processes of multiple early childhood systems to expand access to developmental services.
Existing quality metrics on developmental screening provide limited information as to whether children receive services.	Comprehensive developmental screening metrics that address receipt of EI services are needed to inform quality improvement.

INTRODUCTION

Developmental disabilities affect an estimated 13 to 17 percent of children in the United States (U.S.),^{16, 17} and between 10 and 13 percent of U.S. infants and toddlers experience developmental delays.^{1, 2} There is strong evidence that infants and toddlers with developmental delays are at elevated risk for learning and cognitive disabilities, speech and language difficulties, and behavioral problems at school age. The impact of these delays can extend well beyond the childhood years; children with such delays are more likely to be in poor health, have low educational attainment, and have lower income as adults relative to their peers who do not face such challenges.^{1, 18-20} However, evidence shows that the timely receipt of early intervention services can be effective in improving developmental outcomes.²¹⁻²⁵

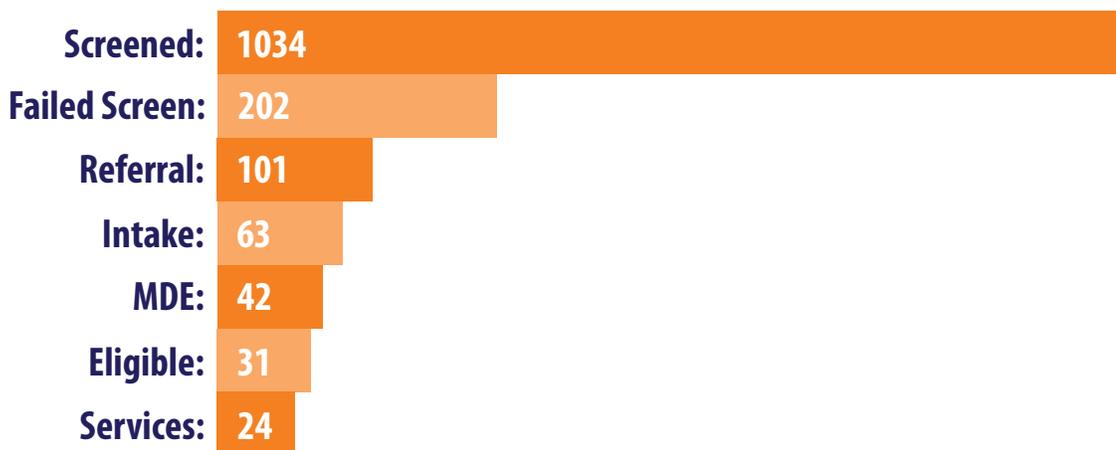
Recognizing the benefits of intervening early to address developmental delays and disabilities, in 1986 Congress amended the Education for all Handicapped Children Act, later renamed the Individuals with Disabilities Education Act (IDEA), to require states to extend the services they are mandated to provide for children with disabilities to infants and toddlers under the age of three.^{26, 27} By including these early childhood provisions, now incorporated as Part C of IDEA, Congress acknowledged the importance of identifying and addressing developmental needs early in life to reduce the individual and societal consequences of untreated developmental delays.^{11, 28} A growing body of literature from fields as diverse as neurobiology and economics support the view that investing in early intervention is a more cost-effective strategy than waiting until children are older, at which point the effects of delays become more difficult – and more expensive – to address.^{21, 29-32}

Role of Primary Care

Primary care sites are central to efforts to support child development, particularly for children who are not of school age.^{15, 33-36} In 2009, 88.7 percent of children under the age of five had a well-child visit with a health care provider at some time in the past year.³⁷ Recognizing the central role of primary care, in 2006, the American Academy of Pediatrics (AAP) issued a policy statement recommending developmental screening of all children from birth through the age of three as a routine part of well-child care.³⁸ Citing the importance of early identification and intervention for children with developmental delays or disabilities, the AAP urged providers to use standardized developmental screening tools to detect concerns, and to refer children who fail a developmental screen for further evaluation and services. In 2010, the Affordable Care Act (ACA) codified the importance of addressing developmental needs early in life by requiring health insurers to pay for developmental screening and other preventative services at no cost to patients.^{39, 40}

Despite the AAP's guidance, as well as recent improvements in insurance coverage of developmental screening and evidence that performing developmental screening with a standardized tool increases detection of developmental delays, national screening rates remain low and many providers still base their assessment of children solely on clinical observation.⁴¹⁻⁴³ Additionally, evidence suggests there is still significant unmet need for the treatment of developmental delays in young children.¹¹ Although 10 to 13 percent of children under the age of three are affected by developmental delays, EI serves only two to three percent of children in that age group nationally.¹⁻³ In fact, the majority of children eventually identified as having developmental concerns are not identified before they enter school, at which point they are likely to have already fallen behind their peers.^{4, 44-46}

Figure 1: Results from the Translating Evidence-based Developmental Screening study



SERIES

This brief draws from PolicyLab's recent experience implementing developmental screening in four urban primary care practices as part of the Translating Evidence-based Developmental Screening (TEDS) study. The TEDS study was a randomized, parallel-group controlled trial that enrolled 2,100 children under the age of 30 months from December 2008 to June 2010 to assess the feasibility of implementing developmental screening into primary care. The study also compared the effectiveness of standardized developmental screening, using the Ages and Stages Questionnaire (ASQ),⁴⁷ with that of routine developmental surveillance. In collaboration with primary care providers and EI agencies, TEDS tracked children from their attendance at well-child visits through the subsequent process of screening, identification, referral, intake, evaluation, and receipt of services. The results of this tracking are shown in Figure 1.

Of the 1,424 well-child visits that fell within the AAP recommended screening schedule, an ASQ was administered at 1,034 (72.6 percent) of them. Overall, 19.5 percent of these screens were failed and a provider referred the child 50 percent of the time. Only 66.7 percent of children referred completed the first step in EI intake involving the assignment of a service coordinator and, subsequently, only 66.7 percent of children assigned a service coordinator ever completed a multidisciplinary evaluation (MDE) to determine their developmental needs and eligibility for services. Ultimately, only 11 percent of those who failed a standardized developmental screening measure ever received services.

The SERIES paradigm of developmental screening aims to address these drop offs by engaging all systems involved in meeting a child's developmental needs. Core to the SERIES approach is increased coordination among health care and EI systems.

SERIES FRAMEWORK

S screening

Evidence strongly supports the continued emphasis on improving developmental screening rates in primary care. The use of a validated screening tool consistently improves providers' ability to correctly identify children with developmental delays.^{5,9,44,48} Despite challenges to widespread practice change as evidenced by persistent low rates of developmental screening nationally,^{5,10,33,41,49} the 72.6 percent rate achieved in the TEDS study and similar, if not greater, successes of other targeted screening efforts attest to the feasibility of developmental screening in primary care.^{5,6,8,50,51}

Addressing the barriers to developmental screening in primary care is vital to increasing the number of children whose developmental needs are met. While beyond the scope of this brief and not specific to the developmental screening process, it is important to recognize that the low 58.6 percent attendance rate at AAP recommended well-child screening visits experienced in the TEDS study identifies a significant initial barrier to screening children in primary care offices and may support a policy shift towards opportunistic screening at all well-child visits or, additionally, at sick visits. When children do attend well-child visits, however, health care providers cite time, cost, reimbursement uncertainty, and insufficient training as concerns related to incorporating developmental screening into their practices.^{6,8,34,50,52-56} Characteristics such as insurance type and place of care may also influence whether or not a child is screened.⁴¹

Evidence suggests that some of the perceived barriers to screening – though deserving of discussion – may be largely modifiable.⁵⁷ Studies examining

the duration of well-child visits in which a developmental screening is completed and those in which surveillance is completed have found no significant increase in time as a result of using a developmental screening tool.^{8,15,57} The issue of reimbursement for developmental screening has also seen movement toward resolution with health insurance plans required to cover all screenings that are part of Bright Futures at no cost to patients.^{39,40} However, educating provider practices about the specifics of when and how to bill appropriately must be a focus of developmental screening implementation efforts.

Other barriers to screening are less resolved and may require system changes to address. First, most validated screening tools are copyrighted, and the costs associated with purchasing developmental screening instruments for a practice can be substantial. Most tools must be purchased for an initial sum for each site at which they will be administered. A review of some of the instruments most commonly used in primary care practices found initial purchasing costs ranging from \$30 to \$325.⁵⁸ These costs are often compounded by the need to purchase language-specific versions of tools as well as multiple licenses for large practices. Additionally, these tools are re-standardized regularly which, while necessary to maintain validity, requires sites to purchase new versions whenever an update occurs. Several studies examining the cost-benefit of developmental screening have concluded that while there are potentially significant cost savings related to the long-term societal benefit of addressing developmental delays early, the compensation to practices for their role in the process is not always proportional.^{5,52,59}

Early Identification

Increasing the effectiveness and efficiency of developmental screening efforts relies on improving a provider's ability to correctly identify children in need of developmental support. Once screening is incorporated into practice, the appropriate and timely identification of a child with a developmental concern is highly reliant on the characteristics of the screening tool being used. There is great variability in the tools most commonly in use; some are broadband, focusing on several domains, while others are more targeted and evaluate for a specific condition or delay.^{58, 60, 61} Additionally, the sensitivity and specificity of tools vary, resulting in the identification of development delays in different numbers of children and, at times, even different groups of children.^{38, 62, 63} In the TEDS study, 19.5 percent of ASQ screenings resulted in failures; it is likely that this rate would vary if another instrument were used to assess the same group of children. Within the tools themselves, sensitivity and specificity also vary across age groups, so a tool that is highly effective at identifying delays in children six months old may be less effective for children 18 months old.⁶⁴⁻⁶⁶ Therefore, the likelihood of a child being identified as having

a developmental delay and referred for further evaluation and services may be directly related to the specific characteristics of the tool in use in the practice that child attends.

Among concerns raised by this variation in rates of identification of developmental delay across standardized tools is the potential to over-identify delays in children. However, research exploring this issue suggests that over-identification is less of a problem than may be perceived. While noting that validated tools will result in false positives for 15 to 30 percent of children – meaning that a child who fails a screen is subsequently found ineligible for EI – one study finds that these children perform significantly lower on measures of intelligence, language, and academic achievement than children who did not fail a screen.⁶⁷ This finding suggests that children who fail a developmental screening instrument comprise a group that, while not eligible for EI in many states due to eligibility criteria, is likely at greater risk for poor outcomes than their peers and might benefit from other developmental supports.¹⁴

Referral

In most cases, in order for a child who has failed a developmental screening to continue on the road to receipt of services, a provider must refer that child to EI for additional evaluation. However, evidence shows that even when provider sites have high rates of screening, referral rates are generally low and vary based on provider and child characteristics.^{6, 42, 68} Findings from the TEDS study are consistent with this observation; only 50 percent of children who failed the ASQ at their well-child visit were referred to EI within 30 days of the failure.

Several studies exploring this trend have reported that the specific domain (e.g., communication, fine motor) that is failed, the severity of the delay, and the age and sex of the child are associated with the probability of referral.^{4, 14, 35, 42, 69} Additionally, provider distrust of developmental screening tools, belief in a “watch and wait” approach, and concerns that families will not follow through with referrals are often cited as reasons providers do not refer children who have failed a screening.^{68, 70, 71}

As discussed above, evidence suggests that a child identified by a screening tool as having a developmental concern is likely to perform poorly on measures of school success and to have more psychosocial risk factors than his or her peers.⁶⁷ Therefore, a child who fails an instrument and is not referred for further evaluation and services at the time of the failure is at risk of having unmet developmental needs. Evidence is strong that timely and appropriate intervention for these children has the potential for significant academic, social and economic benefits;^{3, 72} Early intervention has been shown to prevent or limit decline in cognitive development during the first five years of life.^{73, 74} Notably, some studies suggest that these benefits are stronger the earlier a child receives services.^{75, 76} Additionally, effects have been shown to be long lasting, with low-income students who had early intervention in preschool outperforming students without it in reading and math, with less grade retention and fewer assignments to special education by age 15 years.⁷⁷ The projected savings to society as a result of the receipt of timely services to meet children's developmental needs have been estimated at \$30,000 to \$100,000 per child.³²

I ntake

Perhaps the least studied component of SERIES is the step that gets a child, once referred, to reach the intake and evaluation process with EI or another agency. In the TEDS study, only two-thirds of referrals resulted in a successful EI intake. The significance of these low rates is apparent when one considers that only 50 percent of ASQ failures ever resulted in a referral and it is therefore likely that these children who had been referred had developmental needs of specific concern to their families or provider. There is little evidence as to what increases the chances of a successful referral completion. However, likely barriers can be grouped into two general categories: logistical and behavioral.

Logistical barriers refer to impediments to successful receipt of the referral from the provider to the EI specialists or the successful contact of a family to schedule a comprehensive evaluation. EI and health care providers often report that parents are difficult to reach or do not

follow up with EI as recommended.^{6, 9, 78} Providers report frustration with lack of communication from EI about the receipt of referral and ongoing status of the child's case.^{6, 79, 80} Some parents report difficulties or delays in obtaining initial services.⁸¹

A less explored and potentially more challenging barrier is some families' reluctance to engage in the intake process. Several studies have explored what prevents a parent from completing intake. EI specialists report that parents who decline to follow through with an intake evaluation often do not understand the reason for the EI referral and/or do not wish to have their child receive EI services.^{6, 9, 78} Additionally, parents report being concerned about having their parenting judged and surrendering control to services like EI.^{82, 83} More research is needed to understand how best to communicate with families about developmental delays and facilitate the transition from provider referral to EI intake.

E valuation and Eligibility

A child who makes it past the intake stage must then be evaluated to determine his or her specific developmental needs. In most circumstances, providers refer children at risk of developmental delay to a state's official EI program and the resulting MDE assesses the child only for eligibility for that specific program. As discussed earlier, a percentage of children who fail a developmental screener will not be eligible for these services; however, evidence suggests that these children are still at risk of ongoing developmental concerns.⁶⁷ In the TEDS study, of the 42 individual referrals that made it to the eligibility step of the SERIES, 31 (73.8 percent) were deemed eligible for EI services.

Examinations of eligibility criteria across states report significant variation in EI eligibility thresholds as states have the authority to set their own definitions for qualifying severity of risk within the parameters set by IDEA.^{3, 11, 84} One review of children with special

health care needs found that children with the same needs either do or do not receive services based on their state of residence.⁸⁵ This and other studies showing state-to-state variation suggest that children's receipt of services may reflect state eligibility policy in addition to child need.⁸⁶

For children who are not eligible for EI services, there are several other effective developmental support services for which these children may be eligible, including Early Head Start, high quality childcare centers, and for those approaching their third birthday, Head Start and high quality preschool.^{3, 87, 88} However, in most states, evaluation for eligibility for these services is a separate process from EI evaluation and requires a parent, provider, or care coordinator to seek out alternative services proactively if a child is not eligible for EI. Often this requires a separate referral and intake process, which likely presents many of the same barriers in referral completion as the EI process.

S ervices

Ideally, the successful completion of SERIES results in a child receiving appropriate, effective services in a timely manner. However, while all states have programs that provide services for children with developmental delays, the types, cost, and eligibility criteria for these services vary widely from state to state.⁸⁴ Services can be limited especially for children who, at evaluation, are determined to be ineligible for the state's EI program but are at risk of developmental delay. Notably, Part C of IDEA does include a provision allowing

states to extend services to this "at risk" group and several states have taken advantage of this provision.¹¹ While children who are covered by Medicaid – and in some cases, the Children's Health Insurance Program (CHIP) – may be able to receive developmental support services under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) rather than Part C, families of these children often face additional barriers due to limited numbers of providers and lack of care coordination supports.^{13, 89}

DISCUSSION AND RECOMMENDATIONS

Developmental screening was introduced into primary care to support early childhood development and better meet the needs of children with developmental delays. Doing this successfully requires not only making developmental screening standard practice, but, ultimately, getting children appropriate services in a timely manner. The SERIES paradigm of developmental screening as outlined in this brief emphasizes the importance of each component in the developmental screening process – Screening, Early Identification,

Referral, Intake, Evaluation, and Services. In this paradigm, success is measured not simply by whether a child is screened, but whether that child also receives services that meet his or her developmental needs. The following recommendations target critical challenges along the pathway and highlight novel approaches used by states, cities, agencies, and providers to address some of these challenges.

Issue: Rates of developmental screening by primary care providers remain low nationally.

Response:

1. Reimbursement practices from payers will need to better incentivize screening and care coordination.

In order to better support the incorporation of developmental screening into standard primary care practice, public and private insurers will need to strengthen reimbursement policies. Reimbursement rates for these screenings vary greatly across states, impacted by state Medicaid policies, the policies of managed care organizations, and procedural definitions of developmental screening and testing.⁹⁰ Additionally, states and managed care organizations vary on whether payment for screenings are bundled together with the cost of a well-child visit or can be billed as an additional service and thus result in additional reimbursement.⁹¹ Establishing incentives for performing developmental screening by increasing the flexibility of billing codes and/or tying reimbursement for well-child visits to the completion of a developmental screening tool has the potential to influence provider practice and increase the proportion of children screened.

Additionally, several states have leveraged Medicaid funds to support care coordination and case management activities aimed at helping families access EI and other developmental support services for their children.^{13, 92, 93} Some state Medicaid programs have created financial incentives around case management activities while others have expanded eligibility for Medicaid reimbursement to community-based agencies that can then assist providers in linking families to needed resources. Oregon has added a Current Procedural Terminology (CPT) code to the Medicaid list of Prioritized Health Services that enables reimbursement for medical team conferences with community agencies such as EI.⁹² Using EPSDT and other case management funding mechanisms within Medicaid can provide support and coordination between primary care and child-serving systems that may improve a child's likelihood of completing the SERIES.^{13, 91}

2. The federal government should support the development of public domain developmental screening tools.

The cost of purchasing screening tools for use in primary care practices presents a potential barrier to the implementation of universal screening for children. More public domain screening tools should be available to practices trying to implement evidence-based developmental screening. This could be achieved by the federally funded development of a tool or, taking advantage of the abundance of existing research, the acquisition of some of the best validated and most commonly used tools for use in the public domain. Similar to the clinical growth charts administered

by the Centers for Disease Control and Prevention (CDC),⁹⁴ a federally administered, public domain screening tool would help address the issue of variability across tools and provide opportunity for better standardization and quality control of developmental screening efforts across states and provider practices. This could also better facilitate the incorporation of these tools into electronic health records and improve provider ability to incorporate screening into workflow.

Issue: Significant drop off occurs when children move across systems.

Response:

States and individual provider sites should prioritize cross-system information exchange when developing new data sharing capacities afforded by health information technology and health information exchanges.

Providing a child with timely and appropriate services that support his or her optimal development requires close coordination between multiple child-serving systems. To facilitate these interactions, some states are piloting electronic screening and referral processes or referral pathways developed by providers and EI specialists collaboratively.⁷⁹ On a larger scale, as part of the Assuring Better Child Health and Development (ABCD) initiative, several states are exploring ways to create electronic tracking systems that allow for the exchange of data between medical, EI, and other service providers to facilitate communication and care coordination.⁹² Oklahoma is piloting a “web portal” that allows pediatric and community providers to make and track referrals across systems. The portal allows each agency to see the status of a child’s referral and sends e-mail alerts about a child’s status at each stage in the referral and evaluation process. A referral is not “completed” until a provider has reviewed the result of the child’s evaluation and service plan and closed the referral.^{92,95} While many of these efforts are nascent, their progress should be observed as potential guides for electronically-facilitated care coordination. With the

development and advancement of state health information exchanges under meaningful use requirements,⁹⁶ it is an opportune time for states to expand data linkage efforts to include other systems of care beyond the medical provider.

This effort will not be simple; for example, such cross-system linkages will inevitably create confidentiality issues that are handled quite differently between health and educational systems. One system is guided by Health Insurance Portability and Accountability Act (HIPAA) regulations, the other by Family Educational Rights and Privacy Act (FERPA) regulations. While both laws have the laudable goal of protecting the confidentiality of children that receive services, they have also created some unanticipated conflicts related to sharing information between agencies and primary care. To address these, some states such as Oregon have created parent consent forms that satisfy both sets of requirements, thereby facilitating the timely sharing of information across all involved agencies.⁹⁷

Issue: Current developmental screening metrics provide limited information about whether developmental screening effectively connects children with appropriate services.

Response:

Implementing standardized and comprehensive evaluation metrics will be necessary to improve the evidence base around best practices in developmental screening and inform quality improvement efforts.

While many states, agencies, and primary care provider sites have implemented innovative strategies to address barriers to SERIES, the evidence of the effectiveness of these strategies is limited. A lack of comprehensive evaluation metrics for developmental screening is a primary impediment to the growth of an evidence base for developmental screening efforts. Significant progress in this area has occurred in recent years with the inclusion of developmental screening rates as one of the 24 measures in the initial core set of children’s health care quality measures defined by the Centers for Medicare and Medicaid Services (CMS).¹⁰⁷ However, as illustrated in this brief, a

single metric measuring the rate of developmental screening achieved in a primary care setting may provide limited information as to the system’s effectiveness in meeting the developmental needs of children.

The foundation of an evidence base is rooted in robust tracking and monitoring. Standardized reporting of the number of children progressing through each step of the SERIES will allow for the more accurate evaluation of both the prevalence of need at each step as well as the systems’ successes and challenges in supporting children through the entire process from screening to receipt of services.

Issue: There is a missed opportunity to help children who are identified by screening but not eligible for EI.

Response:

States should better coordinate the eligibility and intake processes of diverse child-serving systems to improve the systems' ability to provide timely and appropriate services to children with a range of developmental needs.

Most states have multiple developmental support services available to children, including, but not limited to, EI, EPSDT services, Early Head Start, Head Start, and high quality childcare and preschools. However, due to diverse funding mechanisms and application and eligibility criteria, these programs are often administered independently, creating a system that is hard for providers and families to navigate when trying to determine the most appropriate services to meet a child's developmental needs. In an attempt to improve coordination, many states have developed evaluation models that assess child eligibility for a range of services that have been shown to benefit child development.

This "spectrum of referral" approach is in place in different forms at various hospitals and agencies nationally. Several programs specifically target children who are at risk of developmental delay but not eligible for EI services.⁹⁸⁻¹⁰² Help Me Grow, for instance, provides additional information and/or connection to services for children identified as at-risk.^{103,104} This program, begun in Connecticut, has now been replicated in California, Iowa, Colorado, Kentucky, New York, Oregon, and South

Carolina, and several sites have reported providing over 85 percent of at-risk children with additional information and/or services to meet their developmental needs.¹⁰⁰ Similarly, at Children's Hospital Boston, providers refer children identified as at-risk to the Advocating Success for Kids (ASK) program team, which assesses the child and refers him or her to the most appropriate services.¹⁰⁵ Several ABCD III states, in particular Illinois and Oklahoma, have developed referral forms that facilitate information sharing and referrals across various community service providers in addition to pediatric providers and EI.^{13, 92} In a particularly innovative example, Vermont has created Child Integrated Services, merging child-serving agencies such as EI, childcare, and child mental health under a single enrollment process and establishing confidentiality agreements that allow for better coordination of care.¹⁰⁶ Regional pilots in that state are also blending funding streams among child-serving agencies in an effort to create a financing infrastructure that promotes coordinated, efficient, and appropriate service delivery.¹⁰⁴

CONCLUSION

Meeting the developmental needs of children requires the ability to identify children with developmental concerns and provide them with appropriate services in a timely manner. This process is often impeded by procedural barriers and poor coordination across child-serving systems, resulting in large numbers of children dropping off along the pathway from screening to services. By reframing this pathway to consider each step not as an isolated activity, but rather

an integral component of a single process, the SERIES paradigm of developmental screening challenges states and provider agencies to improve coordination across systems and promotes a shared responsibility for each child completing the entire SERIES on his or her way to developmental success

ABBREVIATIONS

- AAP:** American Academy of Pediatrics
- ACA:** Affordable Care Act
- ASQ:** Ages and Stages Questionnaire
- ABCD:** Assuring Better Child Health and Development Program
- CDC:** Centers for Disease Control and Prevention
- CMS:** Centers for Medicare and Medicaid Services
- CHIP:** Children's Health Insurance Program
- CPT:** Current Procedural Terminology
- EPSDT:** Early and Periodic Screening, Diagnosis, and Treatment Program
- EI:** Early Intervention
- FERPA:** Family Educational Rights and Privacy Act
- HIPAA:** Health Insurance Portability and Accountability Act
- IDEA:** Individuals with Disabilities Education Act
- MDE:** Multidisciplinary Evaluation

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The aim of PolicyLab at The Children’s Hospital of Philadelphia is to achieve optimal child health and well-being by informing program and policy changes through interdisciplinary research.

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