A Better Way to Assess Developmental Needs in Early Childhood Systems:

Mid-Level Developmental Assessment

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About the Child Health and Development Institute of Connecticut:

The Child Health and Development Institute of Connecticut (CHDI), a subsidiary of the Children's Fund of Connecticut, is a not-for-profit organization established to promote and maximize the healthy physical, behavioral, emotional, cognitive, and social development of children throughout Connecticut. CHDI works to ensure that children in Connecticut, particularly those who are disadvantaged, will have access to and make use of a comprehensive, effective, community-based health and mental health care system.

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Executive Summary

Mid-level Developmental Assessment (MLDA) is designed to promote efficient identification of needs and linkage to helpful services for children with mild and moderate behavioral and developmental concerns, who will not qualify for publicly funded early intervention services. It is family-centered, strength-based, uses standardized assessment tools, and results in a set of recommendations that can help ensure children arrive at kindergarten ready to learn.

Although national and state mandates suggest that a system of early identification and linkage to services is in place for young children, gaps in follow-up assessment services, stringent eligibility requirements for publicly funded programs, and lack of comprehensive system coordination cause many children to miss out on helpful early services that could put their development on a positive trajectory toward school and life success.

It is estimated that while approximately 13% of young children have severe delays warranting intensive intervention, a far greater proportion

of children (approximately 30%) have delays that are mild to moderate.[1] In some states, as many as 35% of children who receive full developmental evaluations following identification of developmental concerns do not qualify for publicly funded services.[2] Parents and providers, upon learning that a child is not eligible for early intervention programs, may not pursue any further services, and concerns go unaddressed until kindergarten, when children are already far behind their typically developing peers. MLDA closes the gap between development surveillance and screening and full evaluation for children with mild and moderate delays.

This IMPACT examines how Connecticut and communities in four other states are using MLDA to optimize the screening, assessment, and linkage processes for children with mild to moderate behavioral and developmental concerns. It reviews core components of MLDA, successes and challenges in implementing the MLDA model, and provides recommendations to inform further expansion in communities and states committed to addressing the needs of young children at risk for delays. The report extends work previously supported by the Child Health and Development Institute to demonstrate the value of MLDA for children unlikely to be eligible for publicly funded intervention services.[3] MLDA as part of a comprehensive early childhood system, which includes early detection through screening and surveillance and linkage to services, is the central theme of the work reviewed.

The implementation of MLDA across several communities highlights important considerations for further diffusion of the service. These recommendations are further explored within the IMPACT:

1) Embed MLDA within a broad continuum of resources to which young children and families can be referred for assessment and evaluation.

2) Reimburse a range of personnel who perform MLDA.

3) Implement MLDA within early childhood services that have mechanisms for early identification of children at risk for delay.

4) Expand community resources to address the needs of children who will not qualify for Part B or Part C programs.

5) Support MLDA with care coordination to ensure that children and families are linked to services.

6) Reframe and develop policy to support the role of early childhood assessment services from one of determining eligibility to one of identifying needs and linking to services to ensure healthy development.

BRANDON – Age 3

Referral

Brandon sees a pediatrician at the Community Health Center for routine pediatric visits. Following administration of the Pediatric Evaluation of Developmental Status (PEDS) screening at his 30-month well child exam, Brandon's pediatrician referred him for a Mid-Level Developmental Assessment (MLDA). The PEDS showed "red flags" about Brandon's behavior and language skills. The pediatric provider believes that Brandon is unlikely to be eligible for the state's Part C Early Intervention Program, Birth to Three in Connecticut, and seeks an assessment that will yield other service recommendations.

Parent Interview

Brandon's mother and father brought him to a community agency for an MLDA, reporting that he knows many words, but they are often difficult to understand and he doesn't always speak in sentences. They report that he often becomes angry, and exhibits temper tantrums with kicking and screaming at home and in his preschool program. Brandon has been expelled from two previous preschool programs, and his parents are worried about his escalating behavior issues.

Both parents complete a Parent Stress Index (PSI) questionnaire as part of the evaluation. Their scores are similar and suggest that they experience only average (35th percentile) levels of stress in their parental roles. Both parents report clinically significant levels of stress in their relationship with Brandon (approaching the 99th percentile) and in their perceptions of him as a difficult child (above the 99th percentile).

Developmental Findings

MLDA staff evaluated Brandon with the Infant and Toddler Developmental Assessment (IDA2) measure. Findings showed mild delays in two domains: Language (25th percentile) and Social-Emotional (30th percentile).

Service Plan Recommendations

(1) Help Me Grow will facilitate connections to services at the local school-based Family Resource Center.
(2) The community-based mental health agency will provide therapeutic treatment for Brandon.
(3) The clinic behavioral health specialist will support Brandon's preschool teacher to improve classroom behavior.
(4) The Community Health Center, which is Brandon's medical home, will monitor Brandon's developmental and behavioral progress.

As the pediatric health care provider had surmised, Brandon was not eligible for any publicly funded early intervention programs. This case example is a typical and all too common example of a child who likely would have "fallen through the cracks" after screening without the availability of MLDA and its capacity to connect children with mild to moderate needs to services. As a result of the timely assessment and connection to services, Brandon's behavior and development was just about on par with his peers when he entered kindergarten at age 5.

Introduction

Developmental screening has become a hallmark of pediatric primary care, early care and education, and home visiting services over the past decade.[4,5] Screening uses formal, validated measures[6] to identify young children whose development in one or more domains is not on par with typically developing children and who need further evaluation in order to inform programming to meet their developmental needs. Screening is not intended to be diagnostic or to be conducted in isolation without additional information from parents and other caregivers. Screening alone cannot accurately identify conditions and inform appropriate referrals to effective interventions without more thorough assessment. While isolated screening is not beneficial to children with, or at risk for, developmental delay, it can serve as a critical step in identifying children in need of developmental services at an early age, when intervention can be most effective and cost efficient. James Heckman, a Nobel laureate economist, estimated that the return on investment of intervening early for children with mild delays and at risk for school failure is seven dollars for every dollar spent on quality, early services.[7]

Within the United States, all states have services for young children with development delays, as required in Parts B and C of the Individuals with Disabilities Education Act (IDEA).[8] IDEA Part C services are intended for children ages birth to age 3, and Part B services are intended for children ages 3 to 5. States delineate their own rules for eligibility for Part B and Part C services, with an option to also serve children at risk for developmental delay and without full manifestations of delay. As a result, eligibility for Part B and Part C services varies across states; anywhere from 2% to 78% of children with delays are eligible for their state's Part C services.[9]

Communities also offer developmental services for young children that are independent of services covered under IDEA Part B and Part C. These include, for example, preschools, parenting groups, library programs, and private therapy provided by behavioral health, speech and language, physical, and occupational therapy professionals. Navigating this diverse array of services can be difficult for families, but is facilitated by comprehensive approaches to ensuring early detection, referral, and linkage, such as Help Me Grow (HMG), a program of the Connecticut Children's Medical Center's Office for Community Child Health where the HMG National Center is housed. HMG maintains a centralized portal of entry to community-based programs and services and is staffed by care coordinators trained to support families in identifying needs and accessing appropriate early childhood services. Complementary emphases on family, community, and child health provider outreach, as well as ongoing use of data to drive system enhancement, ensure the infrastructure reaches families across child-serving systems.

More than twenty-five states have implemented HMG systems to ensure successful linkage of children at risk for developmental delays to services and to strengthen parental protective factors, such as knowledge of child development and concrete support in times of need.[10]

Although it appears that a system of early identification and linkage to services is in place for young children, gaps in follow-up assessment services, stringent eligibility requirements for publicly funded programs, and lack of comprehensive system coordination cause many children to miss out on helpful early services that could put their development on a positive trajectory toward school and life success. While HMG offers a strategy to ensure access to developmental screening as well as linkage to needed resources, the interactions between HMG staff and families are typically brief and intended to support care coordination, rather than the thorough developmental assessments needed to identify the most appropriate services. Further, existing assessment capacity available through specialty services is not sufficient to reach the approximately four out of ten young children at risk for developmental delay.[11] It is estimated that while approximately 13% of children will present with severe delays warranting intensive intervention, a far greater proportion of children (approximately 30%) have delays that are mild to moderate.[12]

MLDA can effectively and efficiently identify children with mild to moderate developmental needs who can benefit from intervention, but who are unlikely to be eligible for publicly funded services, and can ensure that more young children arrive at kindergarten ready to learn. It is an innovative model for determining the needs of young children with mild to moderate developmental or behavioral concerns. It is briefer and less costly than a full multidisciplinary developmental or behavioral/mental health evaluation and fills an identified service gap. When developmental surveillance or screening identifies children in need of further evaluation, MLDA provides comprehensive developmental assessment and connection to community-based services such as family resource centers, parent education, home visiting services, developmental play groups, and therapeutic treatment.

MLDA includes a set of protocols with procedures and a formal assessment measure that covers the full range of child development and psycho-social domains. It is designed for children up to age 6 to deepen understanding of a child's competencies and concerns, resources within the caregiving and learning environments, and related health and wellness factors. MLDA is not intended to result in diagnosis, but rather to determine specific areas and levels of developmental and behavioral risks, intervention strategies, and to support connection to recommended services.

Without such a strategy, children who screen positive for developmental concerns in pediatric primary care, early care and education, or home visiting generally experience one of two pathways to receiving follow-up care. In one scenario, children whose developmental screening shows concerns are referred to Part B or Part C services depending on their age. These programs provide full developmental evaluations using validated measures designed to identify children eligible for publicly funded services. When children with mild delays are found ineligible for Part B or Part C services, parents often perceive that their concerns were unfounded, or that their child is developing normally and will grow out of any concerns identified through screening. In reality, the concerns often do warrant supportive services to ensure optimal outcomes, despite such concerns not being sufficient to meet established eligibility criteria for publicly funded services. In such instances, children will not have their developmental needs met at a time when intervention is most effective and may arrive at kindergarten with deficits in social, behavioral, and cognitive skills that are more obvious and problematic by the time school starts.[13] For these children, the opportunity for early services that could promote healthy development has been lost, and their difficulties may be more severe and more costly to address, with less promising outcomes.

In a second scenario, their parents or providers seek further evaluation outside of the public system; for example, from developmental pediatricians, neurologists, psychologists, or psychiatrists. The challenge here is two-fold. First, these pediatric specialists are in short supply in nearly all communities. The demand these added evaluations place on specialty evaluation services contributes to long wait lists for all children, including those with severe delays who are most in need of timely assessment and services. This further limits the capacity of the system to serve children in the right setting, at the right time, with the right provider.[14] A second concern in this scenario is that the services of these pediatric specialists are expensive and often not fully covered by commercial insurance, especially when families have high deductible insurance plans. To the extent that resource utilization should align with level of need, there is a clear rationale for a more cost-effective assessment option that can appropriately serve children about whom there are mild or moderate concerns.

Mid-Level Developmental Assessment (MLDA) addresses the needs outlined above. It offers a level of assessment that can ensure children with mild to moderate developmental needs receive assessment services that are designed to identify their needs and services available to meet their needs, rather than an evaluation to determine their eligibility for publicly funded services

under Part B or C. Provided in the right setting, MLDA can also offer a cost-effective alternative to more expensive evaluation services such as those available by developmental pediatricians, psychologists, or psychiatrists. Lastly, it can ensure that parent concerns following identification of risk through developmental screening can be addressed, avoiding parental stress in situations in which the concerns identified are not severe enough to warrant intensive early intervention.

From 2009 to 2011, the Child Health and Development Institute (CHDI) led an effort to test MLDA models in three community settings in Connecticut: a privately owned primary care practice, a behavioral health agency, and a hospital pediatric clinic.[3] In each setting, pilot MLDA programs were established in an effort to create a novel assessment option, capable of assessing child development across multiple domains as well as identifying appropriate services in the event of concerns. Positive outcomes were observed across all three sites:

- Fewer than 20 percent of children receiving MLDA following identification of developmental or behavioral concerns needed further evaluation. The MLDA identified needs that could be met through community-based services for the majority of children.
- MLDA was less costly than full evaluations by pediatric subspecialists; MLDA was estimated to save, on average, $540 per child by forgoing the use of specialty evaluation services.
- MLDA was most effective when it was integrated within the broader system of early childhood services, which included screening in health and other settings and care coordination through a centralized service to ensure connection to community-based intervention services.
- Payment for MLDA providers' services, including care coordination costs for connecting children to follow-up care, was recognized as a need to ensure that recommendations from MLDA are implemented.

This IMPACT reviews: 1) principles and core components of the MLDA model as further developed beyond the pilot work; 2) efforts to build on the pilot work by disseminating the model through United Way 211 Child Development Infoline in Connecticut; and 3) progress to date in embedding MLDA within targeted HMG communities across the country. The report closes with recommendations for further adoption of MLDA.

Principles of the MLDA Model

The MLDA model recognizes the unique challenges of assessing young children and is built on a set of core principles that are appropriate to assessing developmental and behavioral needs:

- Young children have limited or no verbal skills to simply say what they know or think.
- Each area of development is influenced by, and interacts with, every other domain of development.
- Young children develop and change at a rapid rate.
- Any judgement made about developmental status must be done with sensitivity to the cultural influences and values affecting behavior.
- Developmental problems in young children can be subtle; it takes experience and broad knowledge of infant and young child development to accurately observe and interpret assessment findings from parental stress measures, play-based assessment, and input from other providers (e.g., pediatricians, child care providers).

Core Components of MLDA

MLDA organizes information from multiple sources into a comprehensive service plan based on assessment findings considered in the context of what is known about the child and family. MLDA requires a series of family and child contacts that may be made in one or more visits, depending upon agency practice, and encompasses four essential components:

1) MLDA assessments are performed by two early childhood professionals with thorough understanding of child development and credentialed in a developmental discipline (e.g., health, education/child development, behavioral health).

2) Parents/caregivers are integral partners in the MLDA process and are acknowledged as the experts about their own child. Service planning builds on family strengths.

3) An MLDA protocol consists of:

- Gathering and review of existing collateral information about the child (e.g., previous screenings and/or concerns expressed by pediatric, early care/education, and other providers)
- Bidirectional information sharing and planning with the child health care provider
- Parent/caregiver interview and caregiver stress assessment using a reliable and valid measure
- Developmental play-based assessment, using a reliable and valid measure, that covers the full range of developmental skills and psycho-social development; i.e., Infant Toddler Developmental Assessment (IDA2)[15], Developmental Assessment of Young Children (DAYC[16])

- Case review to integrate MLDA findings, identify specific area(s) of developmental and/or behavioral concern, identify family strengths and challenges, and determine service recommendations
- Family feedback session to share MLDA findings, recommendations, and plans for connection to services

4) Based on the results of the assessment, a Family Service and Recommendation Plan with connection to recommended services through HMG or a similar entity with capacity to provide care coordination and linkage to services.

Successful implementation of MLDA requires community partners, each with a unique function in the assessment process. A community organization or practice must provide clinical, fiscal, and administrative oversight of the program. Such functions can reside in a variety of settings, including behavioral health agencies, family service organizations, or pediatric clinics. Clinical requirements for professionals completing MLDA vary depending on community standards for professional practice and insurance payment requirements. MLDA providers may also access payment under Part B and Part C services of some states' Individuals with Disabilities Education Act programs.

MLDA was estimated to save $540 per child by forgoing the use of specialty evaluation services in initial pilot testing of the model in Connecticut.

The Village for Families and Children: Developer of MLDA for Connecticut

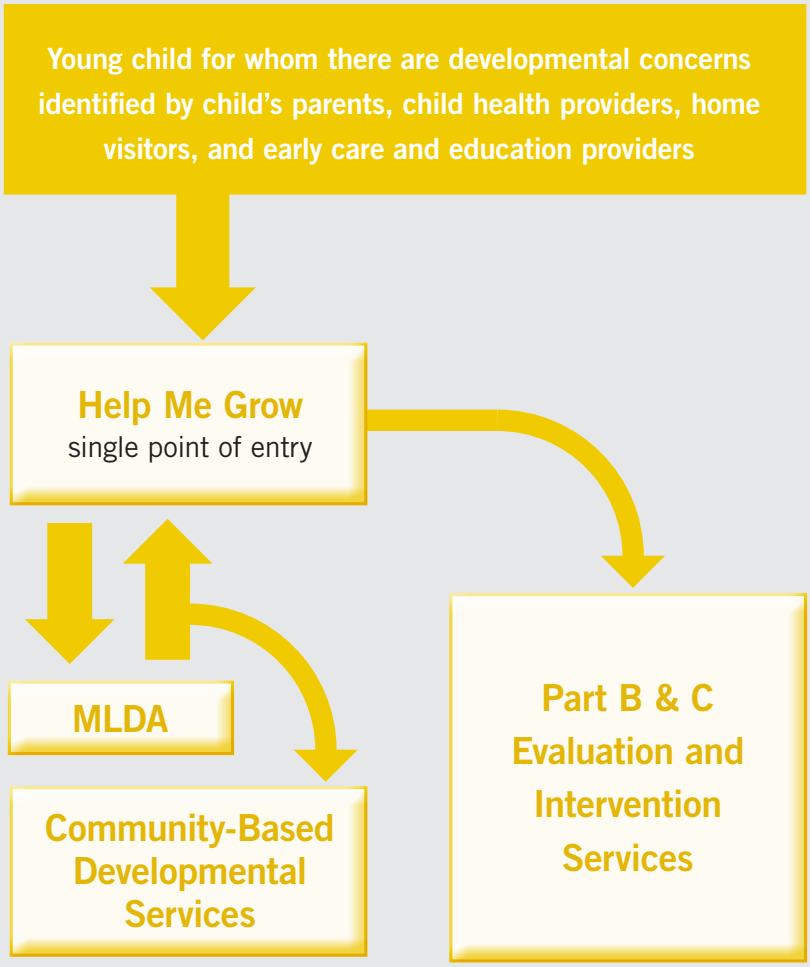
The Village for Families and Children in Hartford, Connecticut, early developer and adopter of MLDA, recognized the gap in developmental assessment services and designed and piloted the MLDA model in partnership with CHDI and Connecticut Children's Medical Center Office for Community Child Health. The Village provides a full range of behavioral health treatment, foster care and adoption, and community support services for children and their families in the Greater Hartford region. MLDA is fully implemented and integrated within The Village clinical and family services, and regular training in the model is provided.

When parents, pediatric providers, or other Village programs identify concerns about a child's development, learning, or behavior, MLDA referrals are made through the Child Development Infoline (the centralized access point for HMG in Connecticut) or directly from Village providers to their own MLDA process. A review of 139 MLDAs over an eighteen-month period found that the majority of children (82%) assessed exhibited mild to moderate developmental concerns as opposed to more intensive mental/behavioral health diagnoses such as autism or behavioral disorders. With parent/caregiver permission, the MLDA findings and recommendations were referred back to Child Development Infoline for care coordination and connection to services. Most MLDA recommendations were for more than one service; among the 139 completed MLDAs, total referred services ranged from three to seven (i.e., family resource centers, medical/dental care, early care/education, community recreational activities/sports).

Agencies interested in accessing MLDA training materials and support can contact Sandy Kyriakopoulos PsyD, at skyriakopoulos@thevillage.org.

A Better Way to Assess Developmental Needs in Early Childhood Systems

Mid-Level Developmental Assessments (MLDA)



Help Me Grow identifies and refers children that would benefit from MLDA, and, following the MLDA, ensures children and families are connected to the services and supports recommended.

HMG: An Infrastructure to Support MLDA

Help Me Grow (HMG) is a system that supports developmental promotion, early detection, and referral and linkage for children at risk of developmental delay. HMG promotes developmental surveillance and screening in pediatric sites, triages children and families to the appropriate level of follow-up after concerns are identified, and works with communities to strengthen early childhood services available through child care, preschools, family centers, and other community venues. In Connecticut, HMG serves young children and families statewide to support those children for whom there are concerns regarding learning, development, or behavior in accessing helpful community-based services and resources. As described above, HMG care coordinators trained to work with young children and families operate within a centralized access point and facilitate navigation of the array of programs and services to which families may be referred.

MLDA is one assessment process to which families that come in contact with HMG may be referred. MLDA, as a clinical assessment, likely results in a more appropriate set of services and supports for the family than might be identified without such an assessment. Though this assessment takes place within entities external to HMG, such as a behavioral health or family service agency, HMG fulfills needed care coordination activities

by supporting linkage. Thus, in a typical early childhood system, HMG identifies and refers children that would benefit from MLDA, and, following the MLDA, ensures children and families are connected to the services and supports recommended as part of the Family Service and Recommendation Plan.

Connecticut Children's Medical Center Office for Community Child Health (OCCH), home of the Help Me Grow National Center, recognized the critical infrastructure provided by HMG to support MLDA. The HMG National Center took the lead in testing implementation of MLDA within Connecticut's Birth to Three program as well as in five other communities across four additional states.

Disseminating the MLDA Model

Connecticut Dissemination

In 2015, with support from the LEGO Community Fund U.S., Connecticut Children's Medical Center's Office for Community Child Health recognized the value of expanding MLDA across the state and integrating it with the resources available through HMG. The Office convened leaders from the state's early childhood sector to guide further implementation of MLDA in Connecticut. As of 2015, The Village for Families and Children maintained the only operational MLDA program in the state. The Village worked with key partners critical to accomplishing the cross-sector systems change needed including: Child Development Infoline, HMG, and Birth to Three (Connecticut's Part C early intervention program managed by the Office of Early Childhood). Leaders from each of these agencies convened to review and agree upon approaches to maximizing the contribution of MLDA to the state's Early Intervention system. Discussions included strategies for identifying cases eligible for MLDA and embedding MLDA within the broader early childhood sector, particularly within Birth to Three agencies, where Early Intervention evaluations take place.

Three Birth to Three agencies were selected to implement the MLDA model in Connecticut. Technical assistance providers from the HMG National Center, The Village, Birth to Three, and Child Development Infoline supported these early adopters by: 1) offering training and technical assistance to sites to effectively administer MLDA; and 2) creating an understanding of the role of MLDA within the context of other early childhood service providers, including HMG. Stakeholder engagement and cross-sector planning enabled the dissemination of MLDA to the initial cohort and engendered collaboration among statewide partners essential to ensuring sustained leadership support for MLDA.

The further expansion of MLDA beyond the original pilot enabled a more robust evaluation of the impact of MLDA, using clinical and administrative data and input from families on their experiences with MLDA. The Connecticut Children's Medical Center's Department of Research conducted a two-year evaluation of MLDA as implemented by The Village. Table 1 shows the array of services to which 139 families were connected following MLDA. In addition to community-based programs, MLDA also highlighted the need for medical and dental services for many children.

In addition to community-based programs, MLDA also highlighted the need for medical and dental services for many children.

Table 1. Services to which Families were Connected following MLDA

Recommendation Domain	Number of Referrals[17]
Non-Clinical, Community Services (e.g. parenting education, play groups, family support services)	478
Mental/Behavioral Health	118
Further Evaluation[18]	25
Medical and Dental Services	282

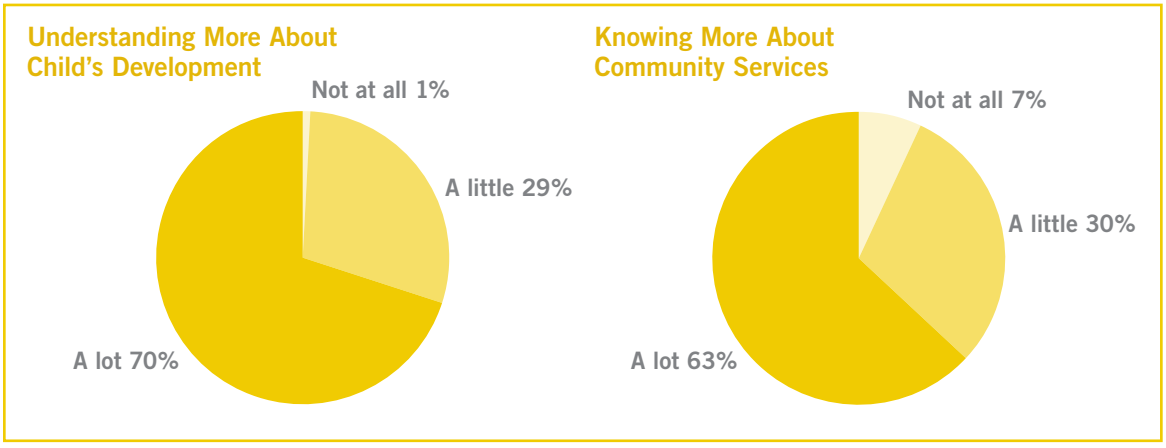
There was a high level of satisfaction with MLDA among families, with an average satisfaction rating of 95%

Satisfaction surveys were distributed to English- and Spanish-speaking families that participated in MLDA. The surveys assessed overall satisfaction with MLDA, the number of visits attended (out of 3), their satisfaction with the number of required visits, helpfulness of the Family Service and Recommendation Plan, and perspectives on the impact of MLDA on their own functioning as well as their child's.

Eighty-six families that participated in MLDA completed a satisfaction survey at the conclusion of their final MLDA session. There was a high level of satisfaction with MLDA among families, with an average satisfaction rating of 95%. Respondents reported attending between one and three of the three required appointments, with an average of 2.4 visits across the recipients. Only two percent of respondents reported being unsatisfied with the three-visit requirement.

Families were also asked about the helpfulness of the Family Service and Recommendation Plan that was provided to them at the conclusion of the MLDA process. Only one respondent indicated that they had not received the report. Among those that received the report, the majority (91.6%) found the report either helpful or very helpful. Finally, families reflected on the impact of MLDA on their overall knowledge of their child's development, as well as their awareness of services in the community (Figure 1). These two factors are among five protective factors identified by the Center for the Study of Social Policy[19] as contributing to resilience and positive developmental outcomes. The majority of families responded "a lot" when asked whether MLDA increased their understanding of child development (70%) and their knowledge of community resources (63%).

Figure 1. Impact of MLDA on Knowledge of Child Development and Relevant Community Services



The evaluation also assessed the degree to which MLDA was embedded within the early childhood service system, as evidenced by Child Development Infoline referrals to MLDA. Among all MLDA referrals, 50.3% came from Child Development Infoline, and 49.7% of referrals were made internally from The Village programs and staff. The volume of referrals from Child Development Infoline to The Village varied over the course of the data collection period, suggesting variation in either the number of families coming in contact with Child Development Infoline deemed appropriate for MLDA and/or the extent to which staff at Child Development Infoline followed consistent protocols for referral for MLDA. This suggests the need to train staff at a centralized access point on the specific criteria that suggest a MLDA referral is warranted. As MLDA is further built out across an early childhood system, data from the centralized access point can play a critical role in determining the prevalence of children with mild or moderate concerns likely to benefit from MLDA, as well as the outcomes of those children following MLDA completion and service referral and delivery.

Lastly, a key aspect of MLDA implementation and sustainability is the availability of a reliable funding mechanism to support service delivery over time. The Village model structures MLDA over three in-person agency visits with a staff of two early childhood professionals. An analysis of the provision of MLDA according to this structure indicates that the approximate cost of MLDA is $700-800 per child in a behavioral health setting (costs per child are higher in a hospital or clinic-based setting). Approximately 60% of the costs of MLDA at The Village were covered through third-party insurance reimbursement. Unreimbursed services were

offset using additional private and/or grant funds. Agencies considering MLDA model adoption should consider the billing structures and mechanisms that can be used to offer and sustain an MLDA program, which may vary at each agency.

Integration with State Mandated Early Intervention Services

The focus of the Connecticut dissemination of MLDA was to introduce the MLDA model to Birth to Three agencies in Connecticut. Three agencies served as an initial cohort for the MLDA model. Their participation consisted of an in-person training for agency staff, followed by their provision of MLDA in a pilot capacity for a limited number of cases. All three agencies successfully administered MLDA to children and families over the course of the project; their experience indicated a number of considerations relevant to future adoptions of the model in Connecticut and elsewhere:

- Given the alignment between the MLDA assessment and a traditional Birth to Three (Part C) eligibility evaluation, there may be opportunity to further consider how to blend the two models. For example, Part C programs may consider their eligibility assessment as a way to both 1) assess for eligibility and 2) assess for other services that may be helpful to the child and family, to ensure that, particularly for children not eligible for Part C, families benefit from access to community-based resources.
- Differences in clinical and administrative workflows between an early intervention setting and a behavioral health agency such as The Village suggest the need for tailored implementations of MLDA that account for such variation. For example, it is appropriate to conduct MLDA in the home setting among Part C providers as opposed to the agency setting, as is the typical approach in a behavioral health agency. Similarly, differences in reimbursement opportunities across agencies may have implications for implementation of MLDA.

MLDA Diffusion in Other States

In 2014, with support from the W.K. Kellogg Foundation, the Help Me Grow National Center launched a national initiative to diffuse the MLDA model to HMG affiliate communities. Interested affiliates applied to the HMG National Center to be part of a learning collaborative designed to support implementation of MLDA. The learning collaborative consisted of training and tailored technical assistance to support HMG affiliates in adopting the MLDA model. Key project activities included webinars, technical assistance calls, and provision of relevant resources.

As with the Connecticut implementation efforts, The Village, as the model developer, served as a key collaborator and lead technical assistance provider in the national diffusion of MLDA. In this role, The Village provided learning collaborative members with support in planning for and implementing their MLDA service. Over

HMG maintained a key role in both referring children for MLDA and, based on the assessment recommendations, connecting families to services recommended in the service plan.

the course of the three-year project, five HMG affiliates participated in the learning collaborative and received a comprehensive MLDA manual and participated in webinars and individual consultation: Florida, Vermont, Washington, and two California county-level affiliates, Fresno and San Joaquin.

To support successful implementation, and mirroring the approach used in Connecticut, each of the sites leveraged well-established interagency connections and existing local and state leadership to ensure needed planning, buy-in, and development of supportive protocols. In all participating communities, HMG maintained a key role in both referring children for MLDA and, based on the assessment recommendations, connecting families to services recommended in the service plan. The Fresno MLDA team highlighted the importance of this connection and reported that "Help Me Grow is the best pathway to services, particularly for children who do not meet Part B or C eligibility; but without MLDA there would be less reason for parents and professionals to call as there would be no assessment services other than those that lead to traditional eligibility."

Table 2 summarizes implementation across sites and highlights the variety of approaches that HMG affiliates used throughout the learning collaborative.

Table 2. Summary of National Learning Collaborative Participant Approaches to MLDA

	SITE1	Fresno (CA)	San Joaquin (CA)	VT	FL	WA
MLDA APPROACH	**Organization Providing Clinical, Fiscal, and Administrative Oversight**	First 5 Fresno County & Department of Public Health	United Cerebral Palsy	Early Childhood Special Education programs in 2 School Supervisory Unions; Part C	Jewish Community Services South Florida	The Arc of Whatcom County, Opportunity Council PeaceHealth Pediatrics
	Referral Sources	Help Me Grow, DPH internal programs and services, primary care providers, community-based providers, parents or caregivers	Primary care providers, community-based providers, parents or caregivers, Help Me Grow, Regional Center (when children do not qualify for mandated services at intake), High Risk Infant Follow Up Clinic	Help Me Grow, parents or caregivers, community-based providers, primary care providers, other internal programs and services	Help Me Grow; other internal programs and services	Primary care providers
	Target Population	Children birth to 5 years of age who do not or may not meet eligibility for Part B or Part C Services	Children birth to 5 years of age with needs noted at ASQ screening who do not clearly qualify for mandated services or exhibit a sensory or other need not indicated/met in the IEP or by the primary care setting	Birth to 5 and suspected of having mild to moderate developmental delays	Children birth to 5 years of age who do not or may not meet eligibility for Part B or Part C Services	Children birth to 15 years of age with behavioral/ developmental concerns
	Funding Strategies Explored	Third parties, foundations, and grants	Third parties, foundations, and grants	Part B and Part C	Third parties, foundations, and grants	Part C, third parties, foundations, and grants

*Third-party funders include Medicaid, EPSDT, and commercial insurance

Despite a variety of implementation approaches, HMG affiliates in the learning collaborative shared two major characteristics:

1) Recognition of Unmet Population Need
All sites reported recognition of an unmet assessment need for a similar target population: children from birth to age 6 or 8, at risk for or with mild to moderate developmental and/or behavioral or mental health concerns, not eligible for Part B or Part C services, and not in need of the more intensive tertiary-level evaluation.

2) State and Local Systems Planning and Collaboration
Participants typically leveraged HMG in the implementation of their MLDA services, with a bidirectional referral loop between MLDA and the HMG centralized access point. Further, MLDA was implemented as an essential service within formal systems planning initiatives (e.g., California First 5, Vermont Comprehensive Integrated System, Whatcom Taking Action). Stakeholder partners were systematically brought together for planning around identifying MLDA need, target population, and selecting assessment partner(s). All sites recognized the need to incorporate MLDA into the system of care in close collaboration and coordination with other assessment services.

Implementation across communities yielded varying degrees of uptake of MLDA and referral to MLDA from the HMG centralized access point. Table 3 shows the number of children referred to MLDA for each quarter of the learning collaborative.

Table 3. Total Number of Children Referred to MLDA through HMG Centralized Access Point

	1/1/16–3/31/16	4/1/16–6/30/16	7/1/16–9/30/16	10/1/16–12/31/16	1/1/17–3/31/17
Florida	0	10	4	0	0
Fresno County	14	0	13	34	40
San Joaquin	29	13	67	6	35
Vermont	0	0	20	0	22
Washington	59	42	44	34	50
Average across MLDA sites	20	13	30	15	37

Note: Florida data are not included in Average across MLDA sites for the timeframe January 1, 2017 to March 31, 2017, as organizational transition closed the MLDA program during that quarter.

MLDA implementation sites created protocols that leveraged the centralized access point as a formal partner in making referrals to the MLDA program, though the total number of those referrals varied by site. During the 15-month period between January 1, 2016 and March 31, 2017, the number of children referred to MLDA through the centralized access point steadily rose, from an average of 20 to an average of 37 by the end of the learning collaborative period. Referral trends over this period among most of the individual HMG affiliate communities appear to roughly mirror the trend across the learning collaborative, reflecting the expected programmatic development and fortification of the organizational relationships and workflow between HMG and MLDA over time.

During the learning collaborative period, the highest number of referrals to MLDA occurred at the San Joaquin site between July 1, 2016 and September 30, 2016. San Joaquin leadership attributes the volume to a quality improvement initiative instituted in June of that year that brought HMG care coordination and MLDA program staff together for monthly meetings to process referrals and discuss any pending or questionable referrals or challenges.

A key component of MLDA is the use of HMG to link families and children to community services that could be helpful in promoting development per the concerns identified in the MLDA. There was significant variation across sites in the proportions of total MLDA referrals linked back to HMG and resulting in successful connection to community-based programs or services during the learning collaborative period. As evident in Table 4, not only does successful connection to services vary significantly between sites, but sites also experienced substantial variation across time with inconsistent trends. For example, Florida reported that all (100%) of MLDA referrals were linked back to the HMG centralized access point and successfully connected to community-based programs during quarters two and three (from

Table 4. Percent of total MLDA referrals that are linked back to HMG Centralized Access Point and successfully connected to community-based programs or services

	1/1/16–3/31/16	4/1/16–6/30/16	7/1/16–9/30/16	10/1/16–12/31/16	1/1/17–3/31/17
Florida	N/A	100%	100%	N/A	N/A
Fresno County	58%	N/A	8%	82%	50%
San Joaquin	45%	100%	95%	33%	100%
Vermont	N/A	N/A	0%	N/A	0%
Washington	83%	93%	98%	100%	90%

The MLDA diffusion experience confirms an identified gap in service between screening and tertiary-level evaluation and underscores the need for continuing efforts to bring to scale MLDA as a novel assessment option with the potential to address this gap.

April 1, 2016 through September 30, 2016), but during all other quarters this linkage was not observed. This fluctuation came about as a result of a transition in Florida's MLDA design, as the organization providing backbone support for the program closed its doors and was acquired by another organization in January 2017. Fresno County's trend line reflects changes in stakeholder engagement in MLDA and ability of MLDA providers to adjust referrals with fluctuating funding streams.

Lessons Learned from State and National Implementation

The MLDA diffusion experience confirms an identified gap in service between screening and tertiary-level evaluation and underscores the need for continuing efforts to bring to scale MLDA as a novel assessment option with the potential to address this gap. MLDA identifies children who may otherwise not be assessed and connected to needed resources, and furthermore, supports the early childhood system in meeting the needs of the "right population at the right time."

Central to successful implementation of MLDA is engagement in state, regional, and/or local early childhood system initiatives that facilitate efforts to identify developmental assessment needs, define the scope of the target population, select assessment partner(s), and implement MLDA in alignment with other assessment services.

Organizations and practices that have been identified as best positioned to successfully implement and adopt the MLDA model include: behavioral/mental health programs, family services, rehabilitation services, and pediatric practices. This variety of options offers flexibility as communities plan implementation within their systems of care. Sites with some level of existing assessment services are found to be the most ready and able to quickly adapt the model at the "new" mid-level and begin MLDA implementation.

Collaboration across several sectors is key to successful MLDA adoption. Engagement of those who perform developmental surveillance and screening must recognize the value of next level assessment even when concerns are in the mild or moderate category. The implementation of MLDA also requires that community-based assessment providers can shift their activities from high-end evaluations designed to determine eligibility for publicly funded services to assessments that are tailored to identify needs likely to be met in community-based services. At the same time, community service providers need to have capacity to accept referrals based on identified needs that are in the mild to moderate range. Key to meeting

children's needs across the screening, assessment, and service continuum is a centralized access point that can link families to assessment services, and when assessments are completed, to community-based developmental promotion programs.

Challenges in Implementing MLDA

Successful implementation of MLDA requires the coordinated activities of a number of diverse stakeholders and, as such, represents a moving target. Efforts to embed MLDA in existing systems of care require a broad view of the early childhood system, beyond the perspective of a single agency or child-serving sector. As with any complex system-building effort, certain challenges have emerged that merit further consideration for communities considering implementing or expanding the MLDA model:

- **Ensuring a phased approach to implementation.** As MLDA is brought to scale in new sites, it must result in a sufficient number of cases for assessment agencies to achieve efficiency and economies of scale, but not so large a volume as to jeopardize the existing infrastructure. A number of possible strategies enable a phased approach: introducing MLDA to a community in a pilot capacity prior to widespread implementation, working with partners to develop and test a protocol that enables shared agreement on cases appropriate for MLDA, or adopting an emphasis on continuous quality improvement to regularly assess progress and adopt course corrections where needed.
- **Acquiring data from across the system.** MLDA is just one component of a broader system of agencies working to meet the needs of children with developmental and behavioral concerns. Yet, understanding how MLDA best fits within and adds value to this broader system requires data about the experience of children from multiple sectors. Key questions include: How does the proportion of children eligible for early intervention change as MLDA is brought to scale? What proportion of children referred for MLDA are subsequently referred to early intervention and eligible to receive services? Are children who receive MLDA and connected to community services likely to be more ready for kindergarten than children found ineligible for early intervention on a first evaluation, but later go on to exhibit more intense delays that qualify them for Part B or Part C services? These are just a subset of questions essential to clearly articulating the impact of MLDA on ensuring children go on to receive the most appropriate level of services. However, answering these questions requires the integration of data across many sectors, and in

some cases, over several years. Building new or bridging existing data systems can overcome these challenges; the appropriate "owner" of such efforts and related mechanisms to address privacy and data sharing concerns merits further exploration.

- **Refinement of the MLDA model.** The MLDA model as conceptualized and brought to scale within The Village consists of three components, as described above. To maximize the operationalization of MLDA in the busy practice setting and to meet clinical revenue demands, the three distinct MLDA components are delivered across three distinct in-person visits. Though this is the most efficient approach within The Village, there may be other, more tailored delivery methods that require fewer visits and better meet families' needs. Ensuring that the MLDA process can be completed in as few visits as possible increases the number of families likely to be reached through MLDA. Future areas of focus include identifying revenue and operational solutions that maintain clinical efficiency while minimizing the burden to families.
- **Identifying MLDA Cases.** The MLDA model is designed to serve as a novel assessment option for children with mild or moderate concerns that are unlikely to qualify for intense level services. However, identifying in advance which children

are likely to be eligible or ineligible for services such as those available through Part B or Part C is difficult. MLDA, when performed outside of these settings, cannot serve as the eligibility assessment, so some children will require a more extensive evaluation and eligibility assessment after MLDA. Our experience in Connecticut highlighted the difficulty of identifying criteria that accurately determine which children would benefit from MLDA in lieu of a referral to early intervention; however, in the future, such criteria can be further tested and refined. In addition, there is opportunity to explore implementations of MLDA such as those adopted in Vermont, in which the eligibility assessment for early intervention adopts the core principles of MLDA in ensuring a focus on assessing both for eligibility as well as for overall service need, so that children may be effectively linked back to HMG and referred on to community-based services in the event they are not eligible for early intervention services.

Conclusion

To make MLDA the standard of care for all children at risk for developmental delay, the value of stakeholder engagement and buy-in cannot be underestimated. Without a shared willingness to consider ways to improve support to young children and families among agencies and stakeholders, the work described in this report would not have been possible. Going forward, it is critical both in Connecticut and elsewhere that MLDA advocates engage early childhood partners in programmatic and policy requirements to support MLDA adaptation and implementation to meet communities' changing needs. In addition, the value of HMG, given its centrality to the process of early detection and referral of children with concerns, to MLDA adoption is key to ensuring successful integration of MLDA within a broader system and meeting the needs of children at risk for delay but unlikely to qualify for Part B or Part C services. HMG systems also benefit from the integration of MLDA as the service fills a gap in ensuring that children at risk for delay can be efficiently and effectively connected to community services following early detection efforts.

Recommendations

Attention to the following recommendations can ensure that MLDA optimally contributes to early childhood systems:

1) MLDA must be embedded within a broad array of resources to which young children and families can be referred for assessment and evaluation. For MLDA to be successful and serve the right children, it should complement, rather than duplicate, other evaluation services. Essential to MLDA integration is that Part B and Part C services accept the assessments performed under MLDA and add to those to determine eligibility, further needs, and appropriate plans of care.

2) Financing for MLDA must consider the range of personnel who contribute to assessment. As states and private insurers move to valued-based payment models, there will be an emphasis on efficiency rather than volume in service delivery. The MLDA model uses personnel other than pediatric subspecialists (neurologists and psychiatrists), and many of these providers are not on insurance panels. Educational specialists, speech and language clinicians, and occupational and physical therapists, for example, can all inform MLDA work, but may not be reimbursed for their services outside of traditional medical and behavioral health settings (e.g., hospitals, mental health agencies). MLDA can most easily be integrated into the system of early childhood evaluation when it exists alongside Part B, Part C, and other evaluation services, which rely on a range of early childhood personnel and do not depend on billing for the services of individual providers. The diversion of evaluation services to MLDA can save dollars as lower-cost personnel are supported for doing assessments.

3) MLDA has maximum benefit when it is implemented within a comprehensive early childhood system that has mechanisms for early identification of children at risk for delay. Screening to identify children at risk for developmental and behavioral delay happens in many settings, including early care and education, home visiting, and pediatric primary care. MLDA can be most efficient when mechanisms exist to support identification and referral of children regardless of where they are screened. HMG as a single portal of entry to MLDA assessments and subsequent needed services is ideally suited to respond to referrals from across all sectors that serve young children.

4) MLDA requires community resource capacity to address the needs of children who will not qualify for Part B or Part C programs. A basic premise of HMG is that a variety of services exist in communities for families with young children. These include library programs, family resource centers, early care and education sites, and an array of health and mental health services. It is incumbent on communities that are committed to implementing MLDA to inventory their opportunities to promote development among their community's children and monitor availability of resources. It is this investment in community resource capacity that well positions HMG affiliates to serve as a vehicle for the further diffusion of the MLDA model.

5) MLDA requires care coordination to ensure that children and families are linked to services. Such linkage can occur within the settings that generate initial referrals to MLDA, within MLDA sites, or in centralized call centers dedicated to ensuring young children's developmental needs are met. HMG provides the latter. Other models, such as Project DULCE,[20] embed care coordination specialists in pediatric practices to provide connection to assessments as well as follow-up to ensure implementation of care recommendations.

6) Implementation of MLDA requires a rethinking of the role of early childhood assessment services. Since enactment of Part B and Part C services, states have worked to define eligibility criteria to serve children in need of intervention to ensure their readiness for kindergarten and promote optimal lifelong outcomes. A variety of evaluation strategies have been used for eligibility determination, but MLDA is about determining children's and families' needs and, when integrated within a comprehensive early childhood system, meeting needs early when delays are in the mild to moderate range. State and federal agencies that oversee early childhood services can embrace a novel goal for assessment services and craft regulation that supports this new mindset about assessments, focused on identifying needs rather than determining eligibility. State and federal policy can also be expanded to support early childhood services for children at risk, not only those with extensive delays.

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