

**Early Identification as Prevention:
Improving Access to Comprehensive Evaluations for Children and Youth with Disabilities
in the District of Columbia**

Ni'Aisha Banks

American University

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Guiding question: *How can improving access to comprehensive evaluations function as a prevention strategy to improve educational outcomes and reduce disciplinary exclusion for children and youth with disabilities in DC?*

Executive summary

The decision facing DC is not whether evaluation matters. Federal and District rules already require timely, individualized evaluation when disability is suspected (Individuals with Disabilities Education Act [IDEA], 2004; Office of the State Superintendent of Education [OSSE], 2025d). The policy question is whether children and families can reach the right evaluation, understand the result, and obtain support before unmet needs compound into academic failure, disengagement, crisis, or exclusion. DC needs a clearer account of how children move from a noticed concern to the right evaluation and then to implemented support. Federal and District rules establish school-based evaluation duties, while clinical and neuropsychological pathways operate through different providers, financing systems, and standards. AJE's direct-service and network-mapping work describes families carrying substantial coordination burdens across education, healthcare, payer, and community systems (Advocates for Justice and Education [AJE], 2026a).

The available evidence identifies a system-performance and evidence problem. For FFY 2023, DC reported that 2,511 of 3,426 initial evaluations were completed within the applicable timeline, while 915 were not (OSSE, 2025a). Students with disabilities also continued to experience higher out-of-school suspension rates than students overall (OSSE, 2025c). These facts establish urgency and disparity; they do not prove that an evaluation delay caused an individual disciplinary outcome.

Recommended next move: AJE should convert its existing RWJF research concept into a grant-ready DC evidence plan with verified claims, defined measures, a feasible pilot, explicit community governance, and documented partner responsibilities.

AJE is positioned to connect policy advocacy with a stronger evidence agenda. Its Parent Ambassador Program, Community Health Advisory Panel (CHAP), direct-service knowledge, youth engagement, and partnership with Children’s National Mental Health CORE provide a foundation for community-governed research. This brief therefore offers two connected products: five policy directions for DC and a grant-readiness agenda for testing the barriers, pathways, and outcomes that public data cannot currently answer.

Priority findings at a glance

Finding	Best evidence	What it establishes	What it does not establish
Timeliness	73.29%; 915 late	DC missed a 100% compliance target for reported FFY 2023 initial evaluations	Why every delay occurred or whether every late case had the same consequence
Civil rights	OCR, March 2026	Federal investigators identified policy and implementation concerns involving timely evaluation and services	That the proposed resolution alone has already corrected practice
Discipline	<20% → nearly 30%	Students with disabilities remain overrepresented among suspended students	That evaluation delay caused each suspension.
Geography	OSS: Ward 7 9.5%; Ward 8 8.3%	SY 2024-25 school-level suspension rates differed substantially by ward	A student's home ward, individual risk, or disability-specific rate
Coverage	EPSDT + DC fee schedule	Medicaid has a broad child diagnostic benefit and DC publishes neuropsychological testing rates	Actual network adequacy, denial rates, wait times, or family out-of-pocket costs in DC

The policy opportunity

The central problem is not simply whether evaluations exist. It is whether a child's concern reaches the right evaluation, on time, across systems that often use different standards, timelines, funding streams, and records. When the process stalls, access to specialized instruction, accommodations, related services, healthcare treatment, and family understanding may stall with it.

DC has strong legal protections and multiple capable institutions, but families may still function as the default coordinators among schools, pediatricians, specialists, insurers, Medicaid, and community organizations. That burden is least manageable for families already facing cost, language, transportation, time, or provider-access barriers.

Narrowing the intervention point does not erase discipline. Exclusionary discipline remains a downstream outcome and an accountability lens. A critical policy analysis also asks whether routines institutionalized under older policies continue through repackaged language or discretionary practice, even after formal reforms limit exclusion.

Early identification is not about labeling children sooner. It is about understanding strengths and needs sooner so support can begin before academic, behavioral, and emotional challenges intensify.

What the evidence shows

Federal and local duties already exist. IDEA requires Child Find and a full and individual evaluation when disability is suspected, and a parent may request an initial evaluation at any time (IDEA, 2004; 34 C.F.R. §§ 300.111, 300.301). RTI or MTSS may continue, but it cannot be used to delay or deny an evaluation when disability is suspected (Office of Special Education Programs [OSEP], 2011; U.S. Department of Education, 2021).

Comprehensiveness matters. A school-based evaluation must use a variety of assessment tools and strategies and assess all areas related to the suspected disability (34 C.F.R. § 300.304). Developmental, educational, clinical, and neuropsychological evaluations answer different questions; one pathway does not automatically replace another.

DC's implementation data reveal consequential gaps. In FFY 2023, 2,511 of 3,426 initial evaluations were completed within the required timeline, or 73.29 percent, leaving 915 reported evaluations outside the required timeframe (OSSE, 2025a).

The current civil-rights context raises the stakes. In March 2026, the U.S. Department of Education's Office for Civil Rights announced findings that DCPS discriminated against students with disabilities, including concerns related to timely evaluation and services, and identified corrective measures involving oversight, procedures, and training (U.S. Department of Education, Office for Civil Rights [OCR], 2026a).

Outcome inequities remain substantial. In the 2025 DC CAPE results, 11.9 percent of students with disabilities met or exceeded expectations in ELA and 9.1 percent did so in mathematics (OSSE, 2025b). In SY 2024–25, students with disabilities represented less than 20 percent of enrollment but nearly 30 percent of suspended students (OSSE, 2025c).

The causal claim must remain disciplined. These data establish urgency and inequity. They do not prove that evaluation delay caused each academic or discipline outcome. The defensible claim is that timely, appropriate evaluation creates an earlier opportunity to match support to need.

DC data in view

Timeliness is the first gate. The statewide compliance measure shows that more than one in four reported initial evaluations fell outside the required timeline in FFY 2023.

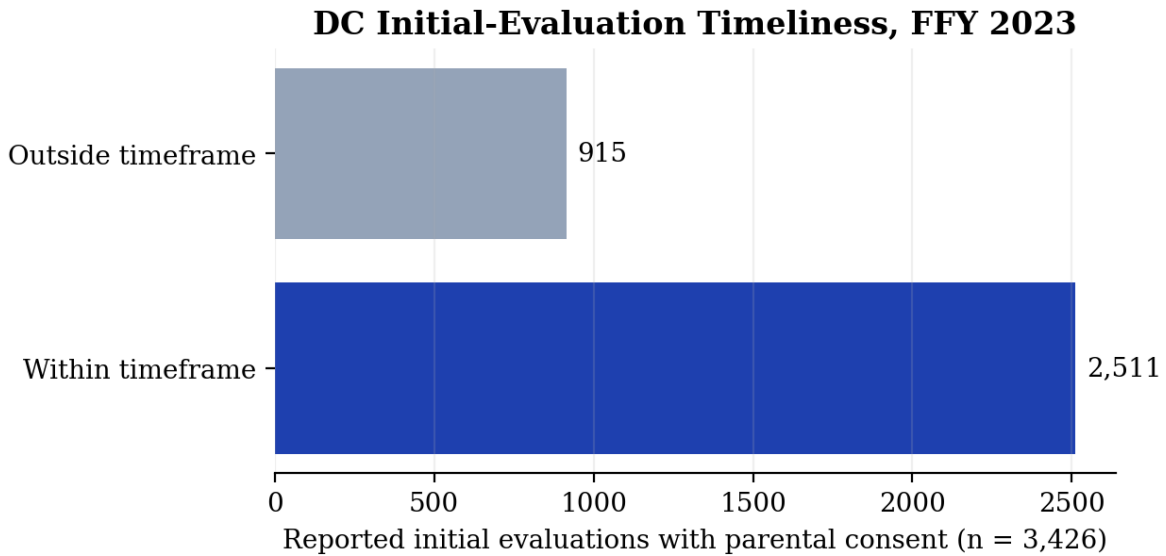


Figure 1. DC initial-evaluation timeliness, FFY 2023. Source: OSSE 2025 IDEA Part B SPP/APR.

Discipline is a downstream equity check. The gap narrowed slightly across three school years, but students with disabilities continued to experience out-of-school suspension at a substantially higher rate.

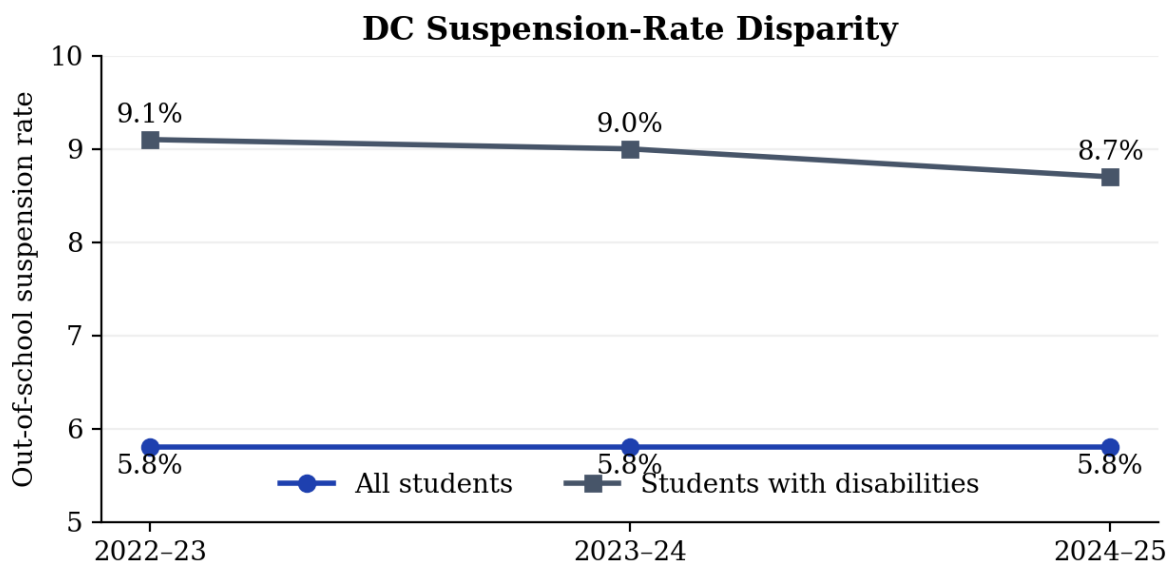


Figure 2. DC out-of-school suspension rates, school years 2022–23 through 2024–25. Source: DC Report Card.

Note. The suspension-rate measure shown here differs from the representation measure used elsewhere in the brief. The 8.7 percent figure represents the out-of-school suspension rate among students with disabilities in SY 2024–25, while the “nearly 30 percent” figure describes the share of suspended students who were students with disabilities. Together, the measures show both a higher rate of exclusion for students with disabilities and their disproportionate representation among students experiencing suspension (OSSE, 2025c).

Interpretation: these charts show system performance and disparity. They do not establish that evaluation delay caused an individual suspension or academic outcome.

The legal and policy baseline

Child Find is affirmative. IDEA requires public agencies to identify, locate, and evaluate children suspected of having disabilities (IDEA, 2004; 34 C.F.R. § 300.111). The duty does not depend on a family first obtaining a private diagnosis (U.S. Department of Education, 2021).

DC's clock has distinct stages. LEAs must begin reasonable efforts to obtain parental consent within 10 business days of referral, complete those efforts within 30 calendar days, and determine eligibility within 60 calendar days after consent (OSSE, 2025d).

Evaluation must be individualized and comprehensive. Teams must use multiple tools, avoid relying on a single measure, use culturally and linguistically appropriate procedures, and assess all areas related to the suspected disability (34 C.F.R. § 300.304).

MTSS cannot become a waiting room. Instructional intervention may continue, but federal guidance states that RTI or MTSS may not be used to delay or deny an evaluation when disability is suspected (OSEP, 2011; U.S. Department of Education, 2021).

Section 504 has a separate protection. Schools must evaluate before initial placement or a significant change in placement when a student, because of disability, needs or is believed to

need special education or related services (34 C.F.R. § 104.35). A medical diagnosis is not a precondition to a Section 504 evaluation, and when a school determines that a medical assessment is necessary to complete the evaluation, the school must ensure that assessment is provided at no cost to the parents (U.S. Department of Education, Office for Civil Rights [OCR], 2026b).

Medicaid EPSDT is broad, but access remains an implementation question. The EPSDT benefit provides comprehensive screening, diagnostic, and treatment services for Medicaid-enrolled children under age 21, including medically necessary services to correct or ameliorate identified conditions (Centers for Medicare & Medicaid Services [CMS], 2024). Coverage rules, prior authorization, provider participation, and appointment availability can still affect whether that entitlement becomes practical access.

Four pathways that must be distinguished

Families often hear the word “evaluation” used as though it describes one service. In practice, they may encounter developmental screening, IDEA evaluation, Section 504 evaluation, and clinical or neuropsychological assessment, each with different purposes, legal standards, decision-makers, and funding arrangements (34 C.F.R. §§ 300.301–300.304; 34 C.F.R. § 104.35; CMS, 2024). A usable DC pathway should clarify those distinctions without requiring families to identify the correct system on their own.

Pathway	Primary question	Typical components	Primary responsibility	Key access risk
Developmental screening	Is development on track, or is further assessment warranted?	Standardized screen, observation, developmental history	Healthcare, early-childhood, and early-intervention systems	A positive screen does not produce a completed referral or service
IDEA school evaluation	Does the student have an IDEA disability and	Multiple tools across all suspected	The responsible LEA, at no cost to the family	MTSS delay, incomplete domains, missed

	need special education?	educational and related-service areas		timeline, or capacity shortage
Section 504 evaluation	Does an impairment substantially limit a major life activity, and are aids or services needed?	Information sufficient to understand disability-related need; no medical diagnosis is automatically required	The school system, at no cost when it determines assessment is necessary	Families are incorrectly told to obtain or update medical documentation first
Clinical / neuropsychological	What cognitive, learning, emotional, behavioral, developmental, or medical factors explain functioning?	Clinical interview, records, standardized testing, and integrated diagnostic interpretation	Healthcare providers and payers, subject to medical-necessity and coverage rules	Cost, prior authorization, narrow networks, provider shortages, and long waits

No-cost school responsibility is a guardrail: clinical information may inform educational decision-making, but schools may not shift their IDEA or Section 504 evaluation obligations onto families by requiring a privately purchased diagnosis or neuropsychological evaluation as a precondition to evaluation (34 C.F.R. §§ 300.15, 300.301–300.304; OCR, 2026b).

Financing and capacity: what the evidence supports

AJE’s organizational context identifies cost as a central barrier. That concern is credible, but the public DC evidence is not yet sufficient to estimate the number of families seeking neuropsychological evaluations, their average out-of-pocket cost, coverage-denial rate, network wait time, or the share who abandon the process. The appropriate policy response is to pair immediate navigation and accountability work with a targeted data request rather than repeat an unverified market-price range as though it describes every DC family.

Medicaid creates an entitlement, not an automatic appointment. EPSDT requires states to provide or arrange medically necessary screening, diagnostic, and treatment services for

Medicaid-enrolled children under age 21 (CMS, 2024). DC Medicaid reimbursement materials also list neuropsychological testing codes in specified behavioral-health contexts (District of Columbia Department of Health Care Finance [DHCF], 2025). A fee schedule alone does not establish family-level coverage or access; actual access may still depend on medical necessity, benefit design, authorization, provider participation, language capacity, appointment supply, and successful completion.

Education capacity must be addressed separately. Insurance coverage does not discharge an LEA's duty to evaluate a student across all suspected areas (34 C.F.R. §§ 300.301-300.304). OSSE and LEAs need sufficient school psychology, educational assessment, speech-language, occupational therapy, behavioral, developmental, and other expertise. A clinical-access strategy and a school-capacity strategy should be coordinated, but neither should be allowed to substitute for the other.

Financing questions AJE should put to DC

- Which neuropsychological and related diagnostic services are covered for children in fee-for-service Medicaid and each managed care plan, under what medical-necessity and authorization rules?
- How many in-network pediatric providers perform each type of assessment, by language, age range, and accessibility needs?
- What are the median and 90th-percentile times from referral to completed report, and how often are referrals denied, redirected, or never completed?
- What do families pay out of pocket, including deposits, noncovered services, transportation, missed work, and repeated testing?

- Which school evaluation domains experience the longest delays or highest contractor dependence, and how do those patterns differ by LEA?
- When a school team determines that a medical assessment is necessary for a Section 504 evaluation, how is the no-cost obligation implemented and tracked?

The prevention logic and its limits

The strongest defensible claim is a pathway claim, not a promise that evaluation alone prevents suspension or guarantees academic success. Developmental research supports early identification and intervention as opportunities to respond to children's needs earlier, but outcomes depend on the supports that follow identification (National Research Council & Institute of Medicine, 2000). Earlier, appropriate assessment can therefore shorten the path from a noticed concern to a better-informed response.

Stage	System responsibility	Failure mode	Measure
Notice	Recognize patterns without waiting for crisis or relying on stereotypes	Concern is minimized, racialized, punished, or treated as lack of motivation	Time from first documented concern to team response
Evaluate	Use timely, comprehensive, culturally and linguistically appropriate methods	Delay, incomplete suspected areas, inaccessible process, or family cost-shifting	Timeliness, domains assessed, participation, and completion
Interpret	Explain strengths, needs, uncertainty, and options in plain language	A report is delivered without shared understanding or youth voice	Family/youth understanding and documented priorities
Act	Match instruction, accommodations, services, or treatment to findings	Recommendations remain paperwork, or responsibility is disputed across systems	Time from report to implemented support
Monitor	Review progress and revise the response when it is not working	The plan remains unchanged despite nonresponse, new information, or exclusion	Progress reviews, adjustments, engagement, and discipline indicators

Why discipline remains in scope

The project no longer treats restorative practice, PBIS, or FBA/BIP implementation as separate research streams. Discipline remains relevant for two reasons. First, exclusion can be a downstream signal that needs were misunderstood, unsupported, or addressed too late. Second, formal policy reform may leave older punitive structures intact through discretionary codes, informal removals, shortened days, repeated early pickup, or intervention language that still removes access to instruction. AJE should therefore use discipline as an accountability lens without claiming that evaluation delay explains every disciplinary event.

Equity safeguard. Earlier identification must not become broader surveillance or more subjective labeling of Black children, multilingual learners, or students whose behavior is interpreted outside its cultural and contextual setting. The safeguard is not less evaluation when disability is suspected; it is better evaluation: multiple methods, appropriate language, qualified staff, family and youth knowledge, strengths-based interpretation, and review of disproportionality at each decision point.

Geography should also remain part of the equity analysis. In SY 2024–25, school-level out-of-school suspension rates varied across the District, including rates of 9.5 percent in Ward 7 and 8.3 percent in Ward 8 (OSSE, 2026). These figures reflect the ward of the school, not a student's home ward, and they are not disability-specific rates. They therefore should not be interpreted as evidence that geography itself causes exclusion. They do, however, reinforce the need to examine whether access to evaluation, provider capacity, implementation, and disciplinary experiences vary across DC communities.

Where access breaks down

Barrier	What families experience	System consequence
Cost and coverage	High private neuropsychological costs, coverage denials, narrow networks, or unclear Medicaid pathways	Families with fewer financial and service options may face longer waits or fewer feasible evaluation pathways
Capacity	AJE's family-facing and network-mapping work identifies long waitlists, transportation barriers, language-access concerns, and geographic inequities as recurring access concerns (AJE, 2026a)	Concern escalates while the referral remains open
Eligibility and scope	School and clinical systems use different standards; suspected areas may not all be assessed	Families receive partial answers or are bounced between systems
Coordination	AJE's family-facing work and this cross-system analysis identify repeated information-sharing burdens, weak handoffs, and unclear responsibility for follow-through as implementation risks (AJE, 2026a)	A referral is made, but the loop never closes
Implementation	A report is completed, but recommendations are not translated into instruction, services, or monitoring	Evaluation becomes paperwork instead of a turning point

Health Policy Camp: a community relevance check

The July 23, 2026 Health Policy Camp poll provides limited but useful feedback on whether the research themes reflected participant concerns. Eleven participants answered the barrier question. Coordination was selected most often (45.5 percent), followed by cost (27.3 percent), eligibility or scope (18.2 percent), and capacity (9.1 percent) (Advocates for Justice and

Education [AJE], 2026d). The result does not estimate the prevalence of barriers across DC. It does, however, challenge a cost-only framing and supports examining how financing, eligibility, provider and school capacity, and cross-system handoffs interact.

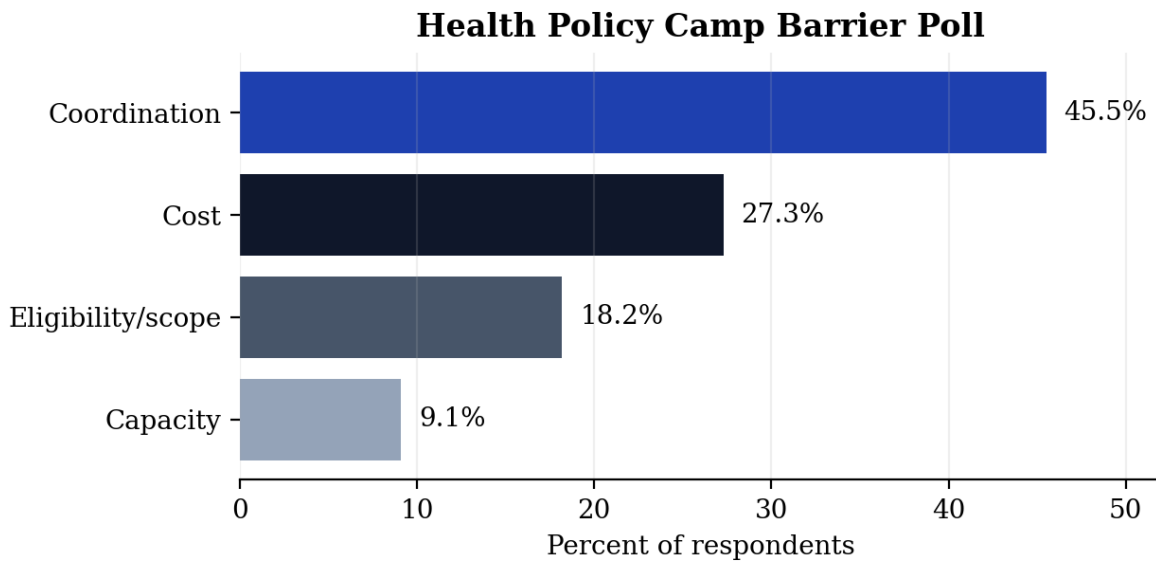


Figure 3. Health Policy Camp barrier poll. Source: AJE Health Policy Camp Zoom poll export, July 23, 2026.

Only three respondents answered the age-of-identification question, and only two answered whether the evaluation occurred when needed (AJE, 2026d). Those responses are too few to support a substantive conclusion and are not used as evidence for the recommendations (AJE, 2026d).

Five recommendations for DC

Recommendation standard. Each action below connects a documented barrier to an accountable owner, an implementation step, and a measure of improvement.

1. Create one understandable DC evaluation pathway

OSSE should coordinate with DCPS, public charter LEAs, DC Health, DHCF, healthcare partners, family organizations, and youth to publish a shared pathway that distinguishes

developmental screening, school evaluation, Section 504 evaluation, clinical assessment, and neuropsychological evaluation.

- Use AJE's Parent Ambassador Program to test whether the pathway is understandable and usable in real family contexts
- Use AJE's Community Health Advisory Panel (CHAP) to align education, healthcare, behavioral health, and advocacy partners
- Establish a compensated youth advisory role within the pilot so that young people with disabilities can test the pathway, identify barriers adults may overlook, and participate in decisions about how evaluation findings and recommendations are communicated to youth
- Name the responsible entry point, expected response, records needed, next step, and escalation route
- Embed the pathway in school, pediatric, and community referral practices rather than relying on families to find it

Owner and measures: OSSE should convene; DC Health, DHCF, DCPS, charter LEAs, providers, families, youth, AJE and peer organizations should co-design. Track pathway use, language accessibility, referral completion, and family- and youth-reported understanding.

2. Make warm handoffs and closed-loop referrals the default

DC agencies and participating providers should adopt a consent-based minimum handoff protocol so that a referral has a named owner, confirmation of receipt, a follow-up date, and a documented disposition.

- Allow support to begin while a child waits for a specialized evaluation
- Use existing secure systems where possible; do not build a new platform before testing the workflow

- Define what information may be shared, with whom, and under what consent

Owner and measures: participating LEAs, providers and managed care organizations should operationalize; OSSE/DHCF should align expectations. Track referral acceptance, time to appointment, lost-referral rate, and percentage of loops closed.

3. Strengthen Child Find and evaluation accountability

OSSE should make timely, comprehensive evaluation a visible results-and-compliance priority across LEAs, with technical assistance and public reporting that goes beyond a single statewide timeliness percentage.

- Report timeliness and completion by LEA and relevant student groups while protecting privacy
- Audit whether evaluations address all suspected areas and whether MTSS practices create delay
- Examine whether exclusionary or punitive practices persist through discretionary codes, informal removals, shortened days, or repackaged intervention language
- Pair enforcement with capacity-building, model tools, and root-cause support

Owner and measures: OSSE should lead monitoring, technical assistance, public reporting, and escalation. Track timeliness, comprehensiveness audit findings, disproportionality, complaints, informal removals, and repeat noncompliance.

4. Reduce cost and capacity barriers to specialized assessment

DC should pursue two connected but distinct capacity strategies: DHCF, DC Health, payers, and provider partners should address coverage and supply for medically necessary clinical and neuropsychological evaluations; OSSE and LEAs should strengthen their capacity to conduct comprehensive educational evaluations across all suspected areas.

- Clarify Medicaid/EPSTD and private-insurance pathways for clinical and neuropsychological assessment
- Identify shortages by evaluation type, age, language, and geography
- Strengthen school access to psychological, educational, speech-language, occupational therapy, behavioral, and developmental assessment expertise
- Avoid making a privately purchased neuropsychological evaluation the de facto gateway to school action

Owner and measures: DHCF/DC Health and payers should lead clinical access; OSSE and LEAs should lead educational capacity. Track wait time, network adequacy, authorization/denial patterns, out-of-pocket cost, appointment completion, school assessment capacity, and equitable access.

5. Require a bridge from evaluation to action

Schools and cross-system teams should translate findings into a time-bound implementation plan that identifies supports, owners, progress measures, and a review date, with family and youth priorities documented.

- Provide a plain-language findings conference
- Track whether agreed recommendations are implemented and adjusted
- Invite family and youth partners to review aggregate findings and improve the process

Owner and measures: LEAs and cross-system teams should implement; OSSE should define minimum expectations. Track implementation rate, time from report to support, progress review, and student and family experience.

Who owns what

AJE can lead agenda-setting, co-design, family and youth accountability, coalition-building, and public advocacy. It cannot substitute for agency authority, LEA compliance, payer administration, or provider capacity. The implementation plan should make that boundary explicit so responsibility does not migrate back to families or to AJE.

Actor	Accountable function	AJE contribution	First concrete output
OSSE	Statewide special-education policy, monitoring, technical assistance, LEA accountability, and public reporting	Frame policy ask; test family usability; monitor implementation	Named convener and baseline evaluation data
DCPS and charter LEAs	Child Find, IDEA/504 evaluation, no-cost assessment, service implementation, and progress monitoring	Document patterns; support families; co-design understandable materials	Local workflow, owner, and corrective-action process
DHCF and managed care organizations	Medicaid benefit clarity, authorization, network adequacy, appeals, and access data	Convene CHAP; surface barriers; translate coverage rules	Benefit map and network/wait-time baseline
DC Health and clinical providers	Screening, clinical assessment, referral quality, provider supply, and accessible care	Connect partners; test warm handoffs; identify community entry points	Referral standard and provider-capacity map
Families and youth	Define usability, burden, trust, priorities, and what meaningful support looks like	Use Parent Ambassadors and compensated youth roles as decision-making infrastructure	Tested pathway and documented revisions
DC Council / Mayor / budget actors	Authorize funding, oversight, legislation, and cross-agency performance expectations where needed	Present evidence, implementation gaps, and a bounded policy request	Commitment to data, pilot authority, or targeted capacity investment

A realistic implementation sequence

Phase	Priority	Lead/partners	Early evidence
0–90 days	Map the current pathway and baseline data; convene family, youth, education, health, payer, and provider partners	OSSE convener; DC Health, DHCF, LEAs, AJE and peer organizations	Named governance; agreed definitions; baseline gaps
3–6 months	Co-design the pathway, minimum handoff protocol, consent language, and pilot measures	Cross-system design team with family/youth decision-making roles	Usability testing; pilot sites; data-sharing review
6–12 months	Pilot in a diverse set of LEAs and clinical/community entry points; provide coaching	Pilot LEAs and provider partners; technical assistance team	Faster handoffs; fewer lost referrals; implementation feedback
12–24 months	Revise, scale, and publish an equity-focused dashboard; invest in capacity where pilots show bottlenecks	OSSE/DHCF/DC Health with Council and budget partners as needed	Improved timeliness, access, implementation, and experience

Risks, blind spots, and safeguards

Over-identification or labeling: Use culturally and linguistically appropriate, multi-method evaluation; center strengths; separate concern from diagnosis.

More referrals without more capacity: Phase implementation, publish wait times, invest in workforce and provider access, and support children during the wait.

Privacy and inappropriate information sharing: Use informed consent, minimum-necessary information, clear roles, and legal review.

Compliance without better outcomes: Measure whether findings lead to supports and progress, not only whether a deadline was met.

Shifting school responsibility to families or healthcare: State plainly that medical and educational pathways inform one another but do not replace an LEA's IDEA or Section 504 duties.

Uneven charter-sector implementation: Use common statewide expectations, LEA-level reporting, technical assistance, and escalation for repeated gaps.

Repackaged exclusion: Track informal removals, shortened days, discretionary discipline codes, and intervention practices so formal reform does not conceal continuing exclusion.

Limited local access data: Begin with a baseline and treat missing data as a policy finding, not permission to overclaim.

What success should look like

- Families can identify the correct pathway and responsible owner without becoming expert navigators
- Children receive timely, comprehensive, culturally and linguistically appropriate evaluations
- Referrals are acknowledged, tracked, and closed rather than handed off into silence
- Support begins during the wait and is adjusted when new information becomes available
- Evaluation findings are translated into implemented supports and monitored progress
- Access, timeliness, experience, and outcomes improve without widening racial, disability, language, income, or sector inequities

A warm handoff, a clear owner, and a closed loop should be features of the system, not favors families must negotiate.

From policy foundation to grant readiness

Evidence verification: Audit every statistic and causal statement in the RWJF concept materials; prioritize primary research and official DC data; correct incomplete or mismatched citations; and label propositions that the future study must test.

Research operationalization: For each research question, specify the population, sample, measure, data source, collection method, analytic approach, responsible partner, community interpretation process, and intended policy use.

Partnership and governance: Document the roles of AJE, Parent Ambassadors, youth, CHAP, Children's National Mental Health CORE, and other partners, including decision authority, compensation, consent, privacy, data ownership, dissemination, and institutional-review responsibilities.

Pilot design: Begin with a feasible combination of a family evaluation-access survey, interviews or focus groups, referral-pathway mapping, payer and provider interviews, and analysis of public DC data. Pilot instruments and recruitment before proposing scale.

Funding package: Translate the verified evidence, pilot protocol, measurement framework, governance plan, partner commitments, timeline, and budget assumptions into a grant-ready package for RWJF or another aligned funder.

Baseline data AJE should request

- Initial evaluation referrals, consent, completion, eligibility, and days elapsed, disaggregated by LEA and legally permissible student groups
- Reason for delay and corrective action, using common categories that distinguish family-related exceptions from system-caused delay
- Assessment domains completed and whether all suspected areas were addressed

- Medicaid and managed-care authorization, denial, appeal, provider-network, appointment, and completion data for relevant diagnostic and neuropsychological codes
- School and clinical workforce capacity by discipline, language, age range, and setting
- Family-reported navigation burden, clarity, respect, consent, out-of-pocket cost, and whether the referral loop closed
- Time from completed evaluation to service, accommodation, instructional change, or other documented action
- Discipline and informal-removal indicators linked only in privacy-protective aggregate analyses; never use individual linkage to presume disability or blame students

Method and limitations

Approach. This consultancy synthesizes peer-reviewed literature, federal and District policy, public administrative reports, AJE’s client questionnaire and RWJF concept materials, instructor feedback, and descriptive Health Policy Camp poll responses. It is a policy analysis and evidence synthesis, not a causal study, insurance-coverage audit, or representative DC needs assessment.

Interpretive limits. Administrative data describe system performance but do not reveal every family’s experience or show that an evaluation delay caused an outcome. The Health Policy Camp barrier poll included 11 respondents and is used only as a relevance check. Public data do not adequately measure private evaluation cost, coverage denial, wait time, referral completion, comprehensiveness, or implementation of recommendations.

Equity lens. Future refinement should explicitly test how recommendations affect families across race, disability, language, income, ward, age, school sector, and insurance status. AJE’s Parent Ambassador Program and CHAP provide existing infrastructure for family

leadership and cross-sector interpretation. A compensated youth advisory role should operate in parallel so that young people with disabilities have defined decision-making authority rather than being represented only through adult proxies.

Recommended decisions for AJE

- Authorize a defined grant-readiness phase built from the existing RWJF concept rather than creating a second research agenda
- Name the internal owner and confirm the decision-making roles of Parent Ambassadors, youth representatives, CHAP, and the research partner
- Select a feasible first pilot that can test access, coordination, cost, eligibility, and capacity without overpromising causal outcomes
- Determine which baseline data can be obtained publicly, which require agency requests or agreements, and which must be collected directly from families, providers, or payers
- Use the policy brief as the DC policy foundation for partner engagement, pilot development, fundraising, and future policy advocacy

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About this brief

This final brief was prepared as an American University EDU 686 Proseminar consultancy product for Advocates for Justice and Education. It provides a DC-focused policy and evidence foundation for advocacy, partnership development, a community-governed pilot, and future grant development. It is intended to inform—but not substitute for—the larger research agenda AJE has already proposed.