PolicyLab
CENTER TO BRIDGE RESEARCH, PRACTICE & POLICY

EVIDENCE TO ACTION NO. 1 | FALL 2009

Securing Child Safety, Well-being, and Permanency Through Placement Stability in Foster Care

Kathleen Noonan, David Rubin, Robin Mekonnen, Sarah Zlotnik, and Amanda O'Reilly

EXECUTIVE SUMMARY

Placement instability is harming children in foster care. Nationally, two-thirds of children who are in foster care for more than a year experience three or more placements. While placement stability is often considered a well-being issue, it also raises safety concerns, especially in the context of rapid placement moves. Aside from the problems experienced before entering out-of-home care, placement instability increases the risk of poor health, educational, and social-emotional outcomes. The recently enacted *Fostering Connections to Success and Increasing Adoptions Act* requires states to enhance efforts to find permanent homes for children and ensure fewer disruptions in medical care and schooling. States will not be able to meet the stability requirements stipulated in *Fostering Connections* and secure better outcomes for children unless policies and practices to promote placement stability are strengthened.

This Evidence to Action brief reports Year 1 findings from the Children's Stability and Well-Being Study (CSAW) at PolicyLab. CSAW is tracking, in partnership with the City of Philadelphia, 450 children in the Philadelphia child welfare system to identify intervention opportunities that may improve placement stability and thereby improve outcomes for children.

Evidence to date suggests that state and federal administrators involved in child welfare need to take the following actions to meet the requirements of *Fostering Connections*:

EVIDENCE	ACTION
Children in kinship placements demonstrate greater placement stability than those in non-relative foster care.	States must require aggressive identification of kinship resources at the outset of the child welfare system's involvement with a family.
Placement stability for children in non-relative foster care may be influenced by the number of children living in the foster home.	States should lower the limit on the number of unrelated children allowed to live in a single foster home, especially in cases of children who have experienced multiple placements.
Behavioral health resources currently available to help kinship and foster parents mitigate child behavioral problems are limited.	States should invest in evidence-based therapeutic parenting interventions at the community level that support parents and foster parents to reduce out-of-home placements and placement disruptions. State Medicaid plans should be amended to allow for the financing of therapeutic parenting interventions and the staff training necessary to implement these interventions effectively.
Timeliness of placement stability is not being measured and rapid placement moves are being undercounted.	Federal guidance is needed to create uniform placement stability measures that capture the timeliness of placement and are better linked to permanency.

The Children's Hospital of Philadelphia® RESEARCH INSTITUTE
PolicyLab

INTRODUCTION

Placement instability is hurting children in foster care. According to national estimates, almost two-thirds of children who are in foster care for more than a year experience three or more placements.[1] Numerous studies have shown an association between frequent placement disruptions and adverse child outcomes,[2-4] including poor academic performance,[5] school truancy, and social or emotional adjustment difficulties such as aggression, withdrawal, and poor social interaction with peers and teachers.[6] Emerging research has shown that a child's risk of these negative outcomes increases following multiple placement disruptions regardless of the child's history of maltreatment or prior behavioral problems.[3,7]

Despite this evidence, there has been limited intervention by child welfare systems to reduce placement instability as a mechanism for improving outcomes for children. One reason is placement instability is often dismissed as a consequence of the behavioral problems children have upon entering care. According to this view, the needs of children with behavioral problems surpass the ability of child welfare systems to achieve stable placement settings for them. In 2007, PolicyLab researchers published new evidence from a study of the National Survey of Child and Adolescent Well-Being (NSCAW) that debunked this common misconception about placement instability.[7]

The NSCAW study summarized the placement histories of more than 1,300 children with an emphasis on the timeliness of achieving placement stability after entering care, and not just on the number of placements per child. Building on prior work from Sigrid James and colleagues in San Diego, PolicyLab researchers studied three categories of placement stability over the first 18 months of a child's placement in out-of-home care: *early stability*, where a child achieves a stable placement within 45 days of entering care; *later stability*, where a child achieves a stable placement beyond 45 days but within nine months of entering care; and *instability*, where a child does not achieve a stable placement.[8] The researchers also categorized children into three risk groups, from the lowest risk children, who tended to be younger and to lack baseline behavioral problems, to the highest risk children, who tended to be older and to have many baseline behavioral problems and extended child welfare histories. The study found that, while higher risk children did experience more instability than lower risk children, instability alone increased behavioral problems among lower risk children by more than 50 percent. Furthermore, across all levels of risk, regardless of a child's prior behavioral problems, age, or child welfare history, children with instability consistently had more behavioral problems, while those who achieved stability within 45 days of entry into care consistently had fewer behavioral problems.[7]

The recently enacted *Fostering Connections to Success and Increasing Adoptions Act* (P.L. 110-351) explicitly recognizes the importance of placement stability to children's safety and well-being by promoting permanent families for children and requiring greater accountability to prevent discontinuity in schooling and the receipt of medical care. *Fostering Connections* reflects the reality that, despite efforts to improve permanency for children since the *Adoption and Safe Families Act* (P.L. 105-89) of 1997, nearly half of the 510,000 children in foster care today have been there for more than 18 months.[9] Multiple changes in placement continue to be a problem for these children.

This **Evidence to Action** brief presents the findings of the first year of the Children's Stability and Well-Being Study (CSAW) conducted by PolicyLab at The Children's Hospital of Philadelphia in partnership with the City of Philadelphia. CSAW is a longitudinal evaluation of 450 children in the Philadelphia child welfare system to identify intervention opportunities to improve outcomes for children and their families. Although this brief discusses data collected in Philadelphia, its recommendations are relevant to child welfare systems throughout the country.

EVIDENCE TO ACTION FINDINGS

In 2006, CSAW began enrolling children aged three to eight years who were entering the Philadelphia child welfare system in a longitudinal evaluation of their first 18 months in foster care. To track placement stability, researchers interview caregivers and caseworkers each time a child changes placements. CSAW tracks the number of moves, the timeliness of stability, and the child's behavior. The following section highlights the Year 1 findings of CSAW and their potential policy implications based on data collected through December 2008. At that time, 383 children were enrolled in the study, of whom 285 had been enrolled at least one year and 155 for the full 18-month observation period. Complete findings from the study will be available in 2011.

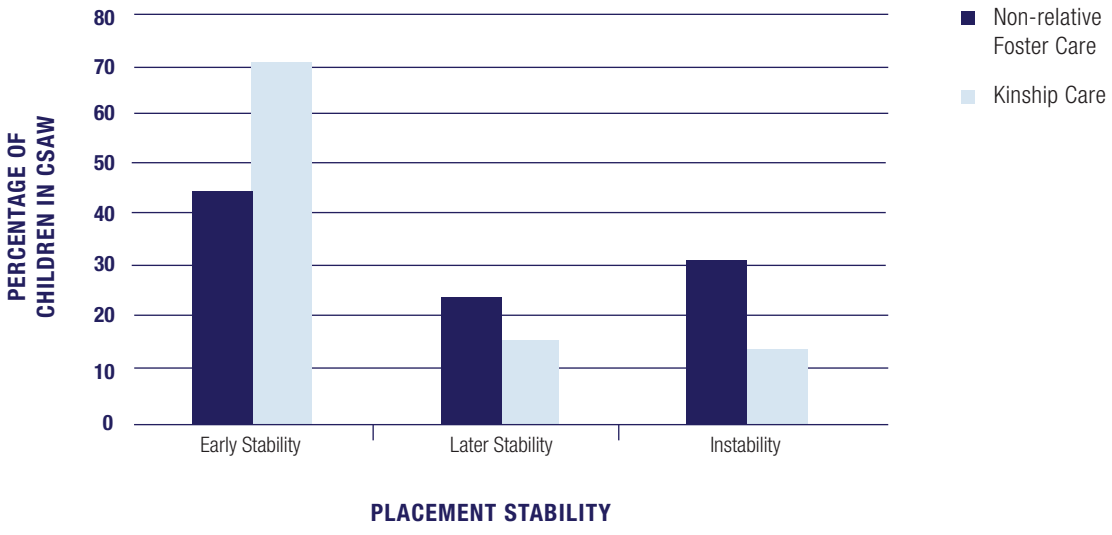
1 EVIDENCE: Children in kinship placements demonstrate greater placement stability than those in non-relative foster care.

Children in kinship placements in Philadelphia exhibited early placement stability 57 percent more often as those in non-relative foster care one year into placement (Figure 1). Fewer than 15 percent of children who entered kinship care became unstable compared to more than 30 percent of children who entered non-relative foster care. These findings are consistent with national data, which demonstrate that children formally placed with relatives experience much lower rates of placement disruption than those placed in non-relative foster homes.[10-13]

ACTION: States must require aggressive identification of kinship resources at the outset of the child welfare system's involvement with a family.

The tremendous difference in placement stability between children in kinship care and those in non-relative foster care underscores the need to support aggressive efforts to locate potential kinship caregivers, a commitment federally embraced in *Fostering Connections*, which requires that all kinship resources be notified within 30 days of placement. This standard should be considered the floor of acceptable practice. States should require identification of kinship resources at the outset of a family's involvement with the child welfare system, even before removing a child from the home. These efforts should continue beyond 30 days where warranted and include practices and policies that identify the extended family members of fathers as well as mothers.

FIGURE 1: The influence of the type of foster care setting on early placement stability for children in CSAW one year after placement (n = 285)



2 EVIDENCE: Placement stability for children in non-relative foster care may be influenced by the number of children living in the foster home.

CSAW identified that one of the most salient differences between non-relative foster and kinship homes was the number of children residing in a home (Figure 2). Individual non-relative foster homes typically had a higher number of children in foster care living in the home than kinship homes. One in five non-relative foster homes in the CSAW Year 1 cohort had four or more children in foster care living in the home, compared with only one in eight kinship homes.

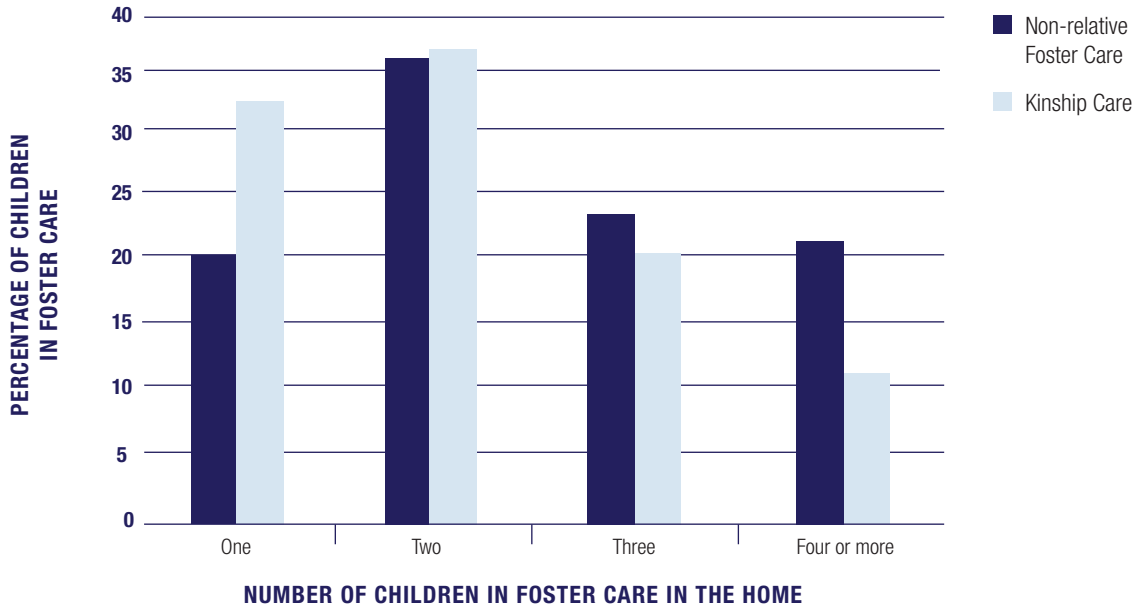
Furthermore, looking at the placement stability of the 132 children living in non-relative foster care who completed the first year of the study, CSAW found that those living in homes with three or more children in foster care were twice as likely to experience instability as those living in homes with only one child in foster care (Figure 3).

ACTION: States should lower the limit on the number of unrelated children allowed to live in a single foster home, especially in cases of children who have experienced multiple placements.

A review of national literature suggests that at a time when child welfare systems are moving away from the use of congregate care,[14] overcrowding in foster homes remains a persistent problem in many regions.[15-17] This is critical since the greater the number of children there are in a home, the greater the risk that a child's placement in that home will be disrupted.[18] CSAW data show that having three or more children in non-relative foster care living in the home increases a child's risk of instability.

States set the legal limit on the number of children allowed to live in a single foster home. All state guidelines allow for three or more unrelated foster children in a home.[19] While it is recognized that states are under tremendous pressure to find and retain appropriate foster homes, the ultimate concern is that crowding in foster homes limits the time and energy any one caregiver can invest in the safety and well-being of a foster child. Having multiple children in a foster home lowers the threshold of disruptive behaviors a caregiver can tolerate from a single child before requesting his or her removal. In Philadelphia, the city's Department of Human Services believes that recent improvements in front-end services as well as improved performance management will help address this issue.

FIGURE 2: The number of children in foster care living in the home by type of foster care setting for children in CSAW at first placement (n = 383)



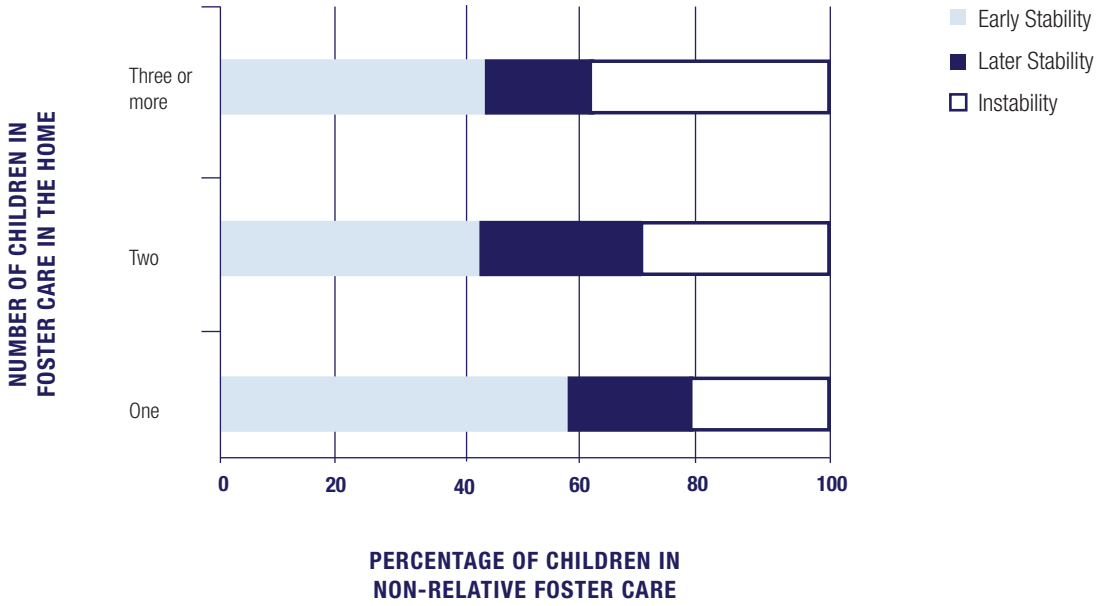
3 EVIDENCE: Behavioral health resources currently available to help kinship and foster parents mitigate child behavioral problems are limited.

Children in foster care have significant unmet mental health needs. CSAW data reveal that nearly a third of children entering their first placement have behavioral problems, as measured by the Child Behavior Checklist (CBCL) completed during each child's enrollment in the study. The city's behavioral health screening measures failed to identify nearly half of children with a clinical CBCL score at the time of their entry into care, and nearly half of families caring for a child with a clinical level CBCL score reported inadequate access to behavioral health services. National data suggest that although 40 to 80 percent of children have significant behavioral problems at the time of entry into care,[20-22] only half receive behavioral health services.[23] Other evidence demonstrates that children in foster care often have limited access to quality behavioral health services and that these services and child welfare services are poorly integrated.[24]

This lack of sufficient behavioral health resources is a concern, especially given that behavioral problems are a primary cause of placement instability.[3, 7] In CSAW, families and agency leaders reported limited options for preventing placement disruptions. While foster parents must attend training as a requirement for licensure, most training lacks specific skills components related to working with children with behavioral problems.[25, 26] Consequently, children with behavioral problems remain undertreated in non-relative foster care and kinship settings, often facing lengthy waiting lists for clinical support and step-ups to treatment-level foster homes. Additionally, emerging evidence suggests that children in foster care are being exposed to increasing numbers and types of medications, particularly in combination, despite the fact that evidence to support these treatments remains suspect.[27] The clear need for behavioral health services and the lack of sufficient interventions has driven policy conversations about alternative treatment models that will better serve children in foster care.[28]

ACTION: States should invest in evidence-based therapeutic parenting interventions at the community level that support parents and foster parents to reduce out-of-home placements and placement disruptions.

FIGURE 3: The influence of the number of children in foster care living in a home on placement stability for children in CSAW with non-relative foster care as a first placement (n = 132)



Therapeutic parenting interventions that address the behavioral health needs of children are key to improving their outcomes in foster care. Decades of research have identified several promising interventions for children who experience maltreatment.[29, 30] Despite strong empirical evidence, however, most models have not been widely adopted at the community level. For example, while child welfare systems mandate foster parent training, only limited evidence supports the effectiveness of the training models most widely used.[26]

Two promising evidence-based models being implemented by some child welfare systems are Multidimensional Treatment Foster Care (MTFC) and Parent-Child Interaction Therapy (PCIT). MTFC is a rigorously tested program shown to be a cost-effective and efficacious intervention for children with behavioral problems.[18] With MTFC, foster parents receive extensive support and real-time skills training at home with the child. Similarly promising are therapeutic parenting models that strengthen caregiver-child attachment and train caregivers in positive discipline strategies, like PCIT, currently being used in child welfare systems in Oklahoma and California. Using weekly caregiver-child therapy sessions to reinforce strength-based behaviors, PCIT has more than thirty years of evidence that demonstrates its ability to reduce externalizing behavior[31] and improve caregivers' skills and attitudes.[32] While these models have great potential to improve child outcomes their successful implementation necessitates the provider community has the capacity and the skill base to effectively deliver these services.

ACTION: State Medicaid plans should be amended to allow for the financing of therapeutic parenting interventions and the staff training necessary to implement these interventions effectively.

While a growing body of research supports the adoption of evidence-based therapeutic parenting models, difficulty in obtaining reimbursement presents a significant barrier to providing these services. Although most children in foster care automatically qualify for health insurance through Medicaid, Medicaid often mandates that children meet minimum criteria for a Diagnostic and Statistical Manual (DSM-IV-TR) Axis I diagnosis to receive services, and the types of services they receive are tied to individual therapeutic sessions with the child or family. This can present a barrier to accessing services, since providers are often hesitant to diagnose young children because DSM-IV-TR criteria are considered less reliable the younger the child. Medicaid also restricts the number of sessions and range of billable services available to eligible children, and may not support training components for models built around family or group sessions with caseworkers or caregivers.[33]

Based on the high prevalence of mental health problems and extensive history of trauma experienced by children in foster care, it is clear that there needs to be greater flexibility in how Medicaid funds are used to support therapeutic parenting models and how other sources of funding through child welfare systems can be blended to support such interventions. More flexible funding schemes through Early Periodic Screening, Diagnosis, and Treatment; Social Security Act, Title IV-E; or special waivers will be needed to improve access to evidence-based therapeutic parenting models, like PCIT, that support both the child and the caregiver.

4 EVIDENCE: Timeliness of placement stability is not being measured and placement moves are being undercounted.

CSAW measures placement stability not only by the number of times a child moves, but also by the timeliness to which a child achieves stability. To optimize the capture of placement stability data, CSAW tracks placement changes among children on a weekly basis. In December 2008, Philadelphia child welfare leadership asked CSAW to conduct an audit of Philadelphia's placement tracking system, which uses administrative billing claims data, to assess the completeness of the city's data and the potential application of the CSAW placement stability measures using the city's data. The audit examined placement moves for the 155 children enrolled in CSAW for a full 18 months and revealed 65 percent agreement between the number of moves recorded by CSAW and the city. In most of the 35 percent of cases in which CSAW and city data did not match, the city had under-recorded periods of rapid placement changes for children. In contrast, when CSAW compared its data with Philadelphia data

related to timeliness of stability (i.e., early stability, later stability, and instability), there was 85 percent agreement between the data sets.

ACTION: Federal guidance is needed to create uniform placement stability measures that capture the timeliness of placement and are better linked to permanency.

Placement stability is measured inconsistently across child welfare systems.[34] At the national level, placement stability is reported by the Adoption and Foster Care Analysis and Reporting System (AFCARS), which tracks the percentage of children in foster care who experience three or more placements. However, the range of definitions states use to monitor placement changes compromises the ability to compare child welfare systems using AFCARS data.[35] In a survey of all 50 states, definitions of placement varied by the length and type of placement setting. For instance, some states count changes in placement from foster care to hospitals or juvenile justice facilities, while other states do not. Moreover, some states count a placement disruption every time a child changes homes; other states only count a placement disruption if a child changes foster care agencies, regardless of the number of homes the child has lived in within that agency. Variation in counting standards limits the validity of comparative analyses of child welfare systems.[36]

Most states continue to struggle to meet the substantial conformity rating for placement stability during Child and Family Service Reviews.[1] New insights from current research on placement stability suggest that now is the opportune time to develop uniform measurement standards across states and cities and to consider other measures that capture the construct of timeliness of placement and better link it to permanency. Evidence from CSAW suggests that measuring placement stability as both the number of times a child moves and the timeliness to stability can be achieved using existing data systems. At the same time, state and local child welfare systems need to identify strategies to ensure that moves for children who rapidly change placements are accurately recorded.

Finally, it is essential that child welfare systems capture the reasons for placement moves in a more standardized way. Administrators need to understand reasons for placement moves not only from the perspective of caseworkers, but also from those of children, parents, and caregivers. This means developing a better understanding of why foster parents "hit a wall" with certain children as well as why (and how) children vote with their feet when a placement is not working for them. While CSAW has not yet analyzed its data on reasons for placement disruptions, early reviews suggest that systems are struggling to maintain reliable data on the issue. Identifying mutually exclusive categories of reasons that children move and parsing out the largest category of "administrative moves" reported in prior analyses would represent significant progress toward this goal.[37]

CONCLUSION

Numerous studies show that when children in foster care experience early placement stability, they achieve better outcomes. With the nationwide implementation of *Fostering Connections* underway, policymakers and child welfare administrators must reassess which policy priorities will improve child safety, well-being, and permanency. In conjunction with national data, PolicyLab findings highlight the importance of placing children with kinship caregivers, reducing the number of children placed in non-relative foster homes, increasing the funding for and access to therapeutic parenting interventions, and creating a uniform placement stability measure as critical ways to meet these aims. Although PolicyLab's strategies and recommendations are not exhaustive, they highlight an evidence-driven approach to improving outcomes for children.

REFERENCES

1. Children's Bureau of the US Department of Health and Human Services. Child welfare outcomes 2002-2005: Report to Congress. Washington, DC.
2. Rubin D, O'Reilly A, Luan X, Localio A. Placement stability and early behavioral outcomes for children in out-of-home care. In: Haskins R, Wulczyn F, Webb M, eds. *Practical Knowledge for Child Welfare Practitioners: Findings from the National Survey of Child and Adolescent Well-being*. Washington, DC: Brookings Institute; 2007.
3. Newton RR, Litrownik AJ, Landsverk JA. Children and youth in foster care: Distangling the relationship between problem behaviors and number of placements. *Child Abuse & Neglect*. 2000;24:1363-74.
4. DiGiuseppe D, Christakis D. Continuity of care for children in foster care. *Pediatrics*. 2003;111:e208-e13.
5. Smithgall C, Gladden R, Howard E, George R, Courtney M. Educational experiences of children in out of home care. Chicago, IL: Chapin Hall Center for Children at the University of Chicago; 2004.
6. Courtney M, Dworsky A, Rutgh G, Keller TE, Havlicek J, Bost N. Evaluation of the adult functioning of former foster youth: Outcomes at age 19. Chicago, IL: Chapin Hall Center for Children at the University of Chicago; 2005.
7. Rubin D, O'Reilly A, Luan X, Localio A. The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics*. 2007;119:336-44.
8. James S, Landsverk JA, Slymen DJ. Placement movement in out-of-home care: Patterns and predictors. *Children and Youth Services Review*. 2004;26:185-206.
9. US Department of Health and Human Services. The AFCARS report: Preliminary FY 2006 estimates as of January 2008. Washington, DC; 2008.
10. Rubin D, Downes K, O'Reilly A, Mekonnen R, Luan X, Localio R. Impact of kinship care on behavioral well-being for children in out-of-home care. *Archives of Pediatric and Adolescent Medicine*. 2008;162:550-6.
11. Webster D, Barth RP, Needell B. Placement stability for children in out-of-home care: A longitudinal analysis. *Child Welfare*. 2000;79:614-32.
12. Testa M. Kinship care and permanency. *Journal of Social Services Research*. 2001;28:25-43.
13. Beeman SK, Kim H, Bullerdick SK. Factors affecting placement of children in kinship and nonkinship foster care. *Children and Youth Services Review*. 2000;22:37-54.
14. Noonan K, Menashi D. Rightsizing congregate care in child welfare: A summary of the Annie E. Casey Foundation's strategic consulting work with four jurisdictions. Baltimore, MD: Annie E. Casey Foundation; In Press.
15. US Government Accountability Office. District of Columbia: Federal funds for foster care improvements used to implement new programs, but challenges remain. Washington, DC: US-GAO; July 2005. Report No.: GAO-05-787.
16. Bush J, Reiger J. The family foster home over/under capacity report: August 2002. Florida: Florida Department of Children and Families; 2003.
17. Roper T. Creating foster care capacity for abused and neglected children. Austin, TX: Center for Public Policy Priorities; 2008.
18. Chamberlain P, Mihalic S. Multidimensional treatment foster care. In: Elliot DS, ed. *Book 8: Blueprints for Violence Prevention Series*. Boulder, CO: Institute of Behavioral Science, University of Colorado; 1998.
19. National Resource Center for Family-Centered Practice and Permanency Planning. Limitations of number of children in a foster home. New York, NY: Hunter College School of Social Work; 2007.
20. Farmer EMZ, Burns BJ, Chapman MV, Phillips SD, Angold A, Costello EJ. Use of mental health services by youth in contact with social services. *Social Service Review*. 2001;75:605-24.
21. Landsverk JA, Garland AF, Leslie LK. *Mental Health Services for Children Reported to Child Protective Services*. Thousand Oaks: Sage Publications; 2002.
22. Taussig HN. Risk behaviors in maltreated youth placed in foster care: A longitudinal study of protective and vulnerability factors. *Child Abuse & Neglect*. 2002;26:1179-99.
23. Rubin D, Alessandrini E, Feudtner C, Mandell D, Localio A, Hadley T. Placement stability and mental health costs for children in foster care. *Pediatrics*. 2004;113:1336-41.
24. Burns BJ, Phillips SD, Wagner RH, et al. Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2004;43:960-70.
25. Barth R, Landsverk J, Chamberlain P, et al. Parent training in child welfare services: Planning for a more evidence-based approach to serving biological parents. *Research on Social Work Practice*. 2005;15:353-71.
26. Price J, Chamberlain P, Landsverk J, Reid J, Leve L, Laurent H. Effects of a foster parent training intervention on placement changes of children in foster care. *Child Maltreatment*. 2008;13:64-75.
27. Zito J, Safer D, Sai D, et al. Psychotropic medication patterns among youth in foster care. *Pediatrics*. 2008;121:e157-e63.
28. Mekonnen R, Noonan K, Rubin D. Achieving better health care outcomes for children in foster care. *Pediatric Clinics of North America*. 2009;56:405-15.

29. Chaffin M, Silovsky J, Funderburk B, et al. Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*. 2004;72:500-10.

30. Chadwick Center on Children and Families. Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices. San Diego, CA; 2004.

31. Gallagher N. Effects of parent-child interaction therapy on young children with disruptive behavior disorders. *Bridges: Practice-Based Research Syntheses*. 2003;1:1-17.

32. Hembree-Kigin T, McNeil C. *Parent-Child Interaction Therapy*. New York, NY: Plenum Publishing Corporation; 1995.

33. Kerker B, Dore M. Mental health needs and treatment of foster youth: Barriers and opportunities. *American Journal of Orthopsychiartry*. 2006;76:138-47.

34. Woodruff K. Placement change definitions implementation guide. Arlington, VA: Child Welfare League of America; 2006.

35. Unrau YA. Research on placement moves: Seeking the perspective of foster children. *Children and Youth Services Review*. 2007;29:122-37.

36. National Working Group to Improve Child Welfare Data. Placement stability measure and diverse out-of-home care populations. Arlington, VA: Child Welfare League of America; 2002.

37. James S. Why do foster care placements disrupt? An investigation of reasons for placement change in foster care. *Social Service Review*. 2004;78:601-27.

THE AUTHORS

KATHLEEN NOONAN, J.D., is managing director and policy director of PolicyLab at The Children's Hospital of Philadelphia Research Institute.

DAVID RUBIN, M.D., M.S.C.E., is senior co-director of PolicyLab at The Children's Hospital of Philadelphia Research Institute, an associate professor of pediatrics at the University of Pennsylvania School of Medicine, and an attending physician at The Children's Hospital of Philadelphia.

ROBIN MEKONNEN, M.S.W., is project director of the Children's Stability and Well-Being Study at The Children's Hospital of Philadelphia Research Institute.

SARAH ZLOTNIK, M.S.W., M.S.P.H., is a research associate with PolicyLab at The Children's Hospital of Philadelphia Research Institute.

AMANDA O'REILLY, M.P.H., is a senior research associate with PolicyLab at The Children's Hospital of Philadelphia Research Institute and scientific director of the Children's Stability and Well-Being Study.

PolicyLab scientific co-directors Chris Feudtner, M.D., Ph.D., M.P.H., and Cynthia Mollen, M.D., M.S.C.E., reviewed and approved this brief. PolicyLab research associate Jane Kavanagh provided editorial support and programmer/analyst Vera Huang, M.S., provided database management.

PolicyLab thanks our partners the City of Philadelphia's Department of Human Services and Department of Behavioral Health and the Commonwealth of Pennsylvania's Department of Public Welfare. Additionally, PolicyLab thanks our early readers of this brief for their comments and advice.

Research for this project is supported with funds from The Children's Hospital of Philadelphia, the Stoneleigh Center, the Annie E. Casey Foundation, the William Penn Foundation, and the Pew Charitable Trusts.

PolicyLab
CENTER TO BRIDGE RESEARCH, PRACTICE & POLICY

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

PolicyLab develops evidence-based solutions for the most challenging health-related issues affecting children. We partner with numerous stakeholders in traditional healthcare and other community locations to identify the programs, practices, and policies that support the best outcomes for children and their families. PolicyLab disseminates its findings beyond research and academic communities as part of its commitment to transform evidence to action.

NOTES

PolicyLab Evidence to Action briefs highlight PolicyLab research areas in the context of local and national policy issues to advance child health and well-being.

www.research.chop.edu/policylab

PolicyLab
The Children's Hospital of Philadelphia
34th Street and Civic Center Boulevard
CHOP North, Room 1528
Philadelphia, PA 19104
Phone: 267-426-5300
Fax: 267-426-0380
PolicyLab@email.chop.edu

The Children's Hospital of Philadelphia® RESEARCH INSTITUTE
PolicyLab