Early Intervention and the Role of Pediatricians

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Abstract

Growing evidence supports the efficacious nature of early intervention (EI) services to children with developmental delays and their families. Pediatricians can play a crucial role in identifying developmental delays and referring families to EI services provided by each state, under Part C of the Individuals with Disabilities Education Act (IDEA). The goals of this article are to educate pediatricians about the benefits of EI services and resources available within their state to help facilitate family involvement in EI. By being involved in the EI process, pediatricians can work as partners with parents and multidisciplinary teams to provide seamless coordinated care to children and their families.

Objectives

After completing this article, readers should be able to:

1. Discuss the efficacy of early intervention for children and parents.
2. Identify the current status of early intervention in any given state in the United States.
3. Understand the role pediatricians play in developmental surveillance, screening, and the early intervention system for children from birth to age 3 years.

Introduction

Several articles have documented the fluid interplay between nature and nurture, noting that the stimulation and teaching one receives as a young child is imperative given the neurobiological effect of neurotransmitter changes, synaptic pruning, and gene activation implicated in early learning. (1) As such, early identification of developmental delay and institution of early intervention (EI) services are crucial.

Pediatricians play an important role in identification of developmental delay and referral to EI programs. However, there is a discrepancy between the number of pediatricians providing developmental surveillance and screening during health maintenance visits (80%) and the number of pediatricians referring children who are at risk or showing signs of delay to EI programs (61%). (2) Some possible reasons for this difference may be that pediatricians are not aware of the eligibility criteria associated with EI in their state or are not familiar with the benefits of EI programs. Thus, the primary objectives of this article are to (1) provide a historical background of EI, (2) educate pediatricians about the efficacy of EI for children and parents, (3) explain the current status of EI, and (4) highlight the important role pediatricians play in developmental surveillance, screening, and the EI system for children from birth to age 3 years.

History of EI

The roots of EI can be traced back to 1975 with the passage of the Education for All Handicapped Act (Public Law 94-142), which established the right to a free and appropriate public education for all children ages 5 to 18 years, even if a child had a disability. (3) This legislation (1) mandated that children receive individualized education plans (IEPs) based on nondiscriminatory assessments, (2) specified parent involvement in the development of IEPs, (3) explained the

Abbreviations

IDEA: Individuals with Disabilities Education Act
EI: early intervention

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principles of due process for children and parents, and (4) specified that IEPs occur in the least restrictive environment. (3)

In 1986, the Education for All Handicapped Children Act was amended to include Public Law 99-457 (Education of the Handicapped Act Amendments). (4) Public Law 99-457 supported the development of EI programs for infants and toddlers with disabilities or delayed development. (4)(5) Rather than waiting until children were school-aged to receive services, Public Law 99-457 identified the importance of serving children as early as possible and enabled children birth to age 3 years to receive services immediately after the identification of developmental delay or an established medical condition that had a high probability of resulting in a developmental delay. (4) The Education of the Handicapped Act Amendments were significant for providing comprehensive services to not only infants and toddlers but also families. More specifically, Public Law 99-457 emphasized the importance of providing services to families as a way to facilitate parents' effectiveness in caring for the special needs of their children. (5)

Public Law 99-457 has been amended several times after the initial 1986 changes. In 1990, the Education for All Handicapped Children Act was changed to the Individuals with Disabilities Education Act (IDEA). (6) Current guidelines for EI services for children birth to age 3 years are listed under Part C of IDEA (formerly Part H). Part C provides general parameters in defining eligibility criteria but offers state discretion in setting criteria and defining developmental delays. States also have discretion in serving at-risk children (eg, low birth weight). In 1997, further changes to Part C encouraged states that do not serve at-risk populations to track and monitor these children so that they may be referred to EI services later if necessary. (4) In 2004, additional changes to Part C of the IDEA amendments permitted states to choose whether families would like their children to continue EI services from ages 3 to 5 years until they become eligible for an IEP in kindergarten. Under the current policy, states are also required to refer all children involved in substantiated cases of neglect or abuse, children affected by substance abuse or exposed to family violence, and children who are homeless to EI. (4)(5) As the history of EI services continue to evolve, it will be important for families, pediatricians, and educators to remain well-informed about current EI policies to ensure children and families receive the best possible care.

Overview of EI

EI is a general term for services that aim to reduce potential adverse effects and enhance development for infants and toddlers. (7) Children may qualify for EI services if they have a documented developmental delay or a diagnosed condition that results in a high probability of developmental delay, as defined by the state. (6) Although states have discretion in setting eligibility criteria and defining developmental delays, there are guidelines that are uniform across states.

Regardless of the state in which one lives, a child's health care clinician should make an EI referral as soon as a concern for delay is identified. The EI program then contacts the family and conducts a multidisciplinary eligibility evaluation that includes determining the status of the child's cognitive, physical (including vision and hearing), communication, social or emotional, and adaptive development. If the child is eligible, the EI program has 45 days from referral to develop an individualized family service plan (IFSP). (8)

The IFSP provides a documented plan of services that addresses both child and family needs. The IFSP specifically includes the frequency, intensity, and length of services, as well as the types of services the child will receive. (8) In developing the IFSP, parents are given the opportunity to express their concerns and priorities for care, and members of the multidisciplinary team explain the types of services available given the unique strengths and needs of the child and the family. (9) Possible services include speech, physical, and occupational therapies; special instruction; psychological services; parent education; counseling; social work; medical services for diagnostic or evaluation purposes; and assistive technology devices and services. (10) As services are individualized to meet unique child and family needs, 2 children of the same age, delay, and diagnosis may receive different services (Table 1).

All eligible families are assigned a service coordinator to help facilitate EI services. (10)(11) Service coordinators function as the main contact person for families and help set up appointments for services and provide resources to the family. In some states, the professionals who provide direct services to families act as service coordinators. In other states, service coordinators are assigned to work closely with the professionals who provide therapy for eligible families but do not provide direct services themselves. (10)(11)

By law, EI services included in the IFSP are required to begin within 30 days of the date of the parent's signature on the plan. (8) A multidisciplinary team reviews the IFSP with the family every 6 months to determine

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Table 1. Early Intervention Vignettes

Child 1	Cara is 10 months old and has trisomy 21. She is hypotonic and has a 35% delay in her gross motor skills. Cara is an only child, and her mother is a former special education teacher who has quit her job to be a stay-at-home mom. Cara's mother is very comfortable fostering gross motor skills but needs some general guidance. Cara's individualized family service plan includes one monthly 60-minute physical therapy session at home during which the physical therapist and mother review Cara's progress and the physical therapist discusses and demonstrates exercises and activities for the mother to work on with Cara for the following month.
Child 2	Sandy is 10 months old and has trisomy 21. She is hypotonic and has a 35% delay in her gross motor skills. Sandy is an only child who resides with her grandmother, who is her legal guardian and works full time. During the day, Sandy attends a local Early Head Start program. Sandy's individualized family service plan includes weekly 30-minute physical therapy sessions at her Early Head Start program. During her therapy session, the physical therapist does exercises and activities with Sandy in the classroom. The therapist briefly talks with Sandy's teacher to discuss strategies and activities that can be integrated into Sandy's daily routine at school and the therapist leaves a progress note for Sandy's grandmother in the backpack. Once a month, Sandy's grandmother leaves work early to participate in the physical therapy session.

whether child and family needs are being met; depending on evaluations from the family and service providers, the IFSP may be revised. (11) The IFSP is rewritten annually, and modifications are made as appropriate.

Children eligible because of delay and/or atypical development (as determined by clinical opinion) may receive EI services as long as the delay or atypical development persists. If concerns resolve, the service coordinator and other EI personnel help the child and family transition out of EI and into community resources as appropriate. If concerns persist past age 3 years, the service coordinator will transition the child and family to community resources and/or Part B of IDEA, which focuses on school-based services through an IEP. (3) In some states (eg, Maryland), parents of children found eligible to receive Part B services, which covers special education and related services that enable a child to participate in a general education curriculum to the maximum extent possible, have the choice of staying on an extended IFSP or transitioning to an IEP. A flowchart depicting the EI process is presented in the Figure.

Efficacy of EI for Children and Parents

A thorough review of the literature on the efficacy of EI has consistently revealed several short- and long-term positive influences on the developmental outcomes of children with established disabilities, those at risk, and their families. (11)(12)(13)(14)(15)(16)(17)(18)(19)(20)(21)(22)(23) In particular, participating in EI has been linked to improved cognitive (eg, academic achievement and IQ) and social-emotional (eg, social skills) development for young children. (14)(15)(16)(17) Such findings have been validated across diverse samples, such as low-birth-weight, preterm infants and children with Down syndrome, as well as programs offering different intensity of services. (18)(19)(20)(21)

Longitudinal studies also reveal the lasting benefits of EI. (11)(16)(19)(21)(22)(23) For example, a 20-year follow-up study monitoring low-income children with delays revealed that children who received intervention services through preschool displayed greater academic achievement, lower rates of grade retention, and decreased referral for special education services compared with low-income children with delays who did not receive intervention services. (23) Such positive long-term outcomes, in combination with literature that supports short-term benefits, confirm a consistent pattern of effectiveness for children participating in EI programs. (15)

EI tends to be more effective for children with milder disabilities than children with severe disabilities. (11)(12)(13)(14)(15)(16)(17)(18)(19)(20)(21)(22) For children with milder disabilities, receiving services may help prevent developmental concerns from becoming more serious problems later. Specifically, EI services may help these children overcome minor delays and foster typical development. For children with more serious disabilities, on the other hand, delays may be irreversible. Instead of trying to reduce delays, services for these children may strive to keep delays from worsening. (7) Despite these differences, there is no evidence to suggest that EI cannot have a positive effect on children with more severe delays. (6)

EI programs are designed to help not only children but also parents. In fact, EI programs that emphasize the overall well-being of the family tend to have the

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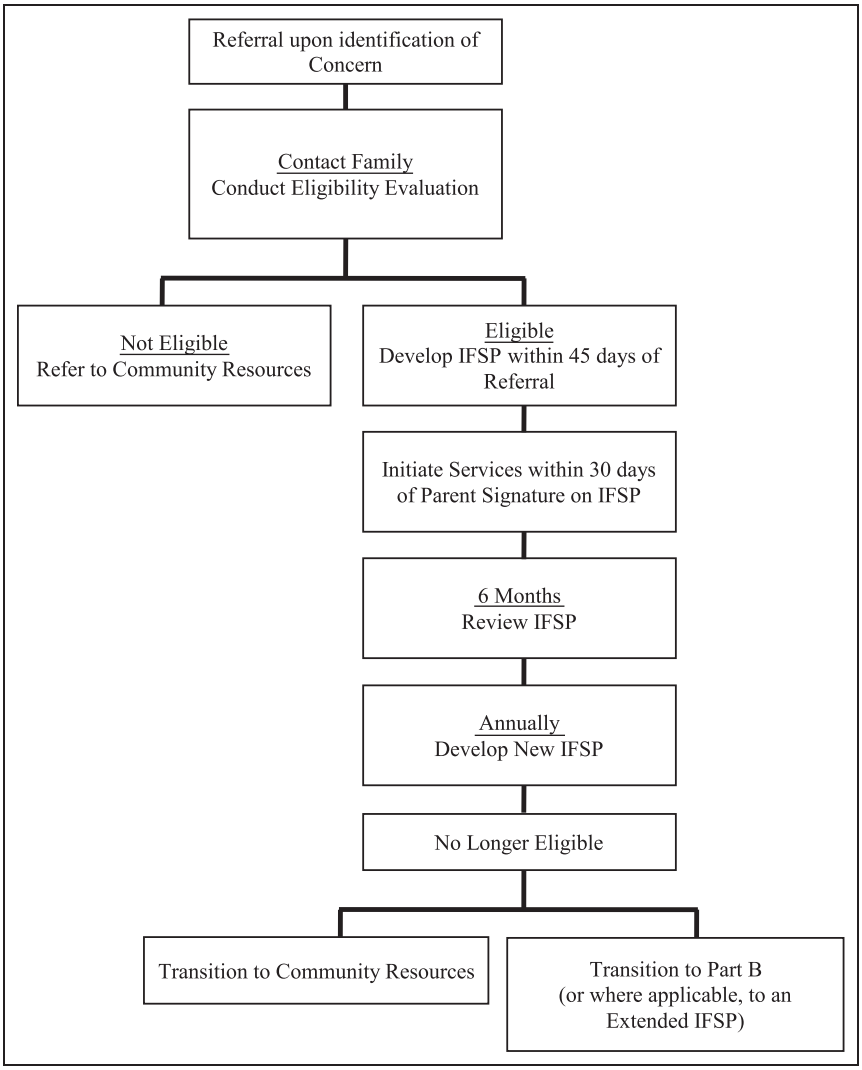

Figure. The early intervention process.

greatest efficacy for children and parents. (12)(13)(14)(15) When EI programs were first developed, many services were child centered. (24) The initial rationale was that families enrolled in EI because their children were in need. Consequently, services were aimed at improving children's outcomes by providing direct care to children with established disabilities or those at risk. (24) Over time, research and theory have found that children's development is not independent of their environment. (25)(26) Parents and family context also play a central role in their children's development. Because of the widespread acceptance of a more ecologic approach, most interventions have moved toward family-centered care. (6)

Family-centered services aim to involve parents in the EI system, provide parents with information pertinent to their child's condition, encourage parent involvement in the instruction of their child, enhance the well-being of parents and other family members, and assist parents in obtaining and using resources that are not directly associated with EI. The overall idea is that supporting parents will reduce their stress and enhance their caregiving ability. (5) Supplementing supportive services with instructional materials about their children's development is also intended to improve parenting behavior by increasing parents' knowledge about developmentally appropriate activities for their children. (23) Providing resources that address the needs of families are thought to enhance parents' effectiveness in caring for their children. Evidence suggests that programs designed to emphasize and support the strengths of families rather than focusing on children alone is more beneficial in facilitating child development. (6)

Current Status of EI

All states currently offer EI services under Part C of IDEA. Each state has specific eligibility criteria, establishes a fee structure, and names the program. (27)(28)

Great variability exists regarding the extent of delay required to constitute receipt of EI services. Requirements range from any delay (Hawaii, Nebraska, and Vermont) to a 50% delay in 1 domain (Alaska, Arizona, and Missouri). In addition, great variability exists regarding how states define developmental delay. Twenty-four of the states use percent delay (1 – mental age/chronological age × 100 = percent delay) alone to define developmental delay, 12 use percent delay and SD information in their eligibility criteria, 11 use SD alone, and 1 uses a combination of SD and percentile; the remaining states use any delay. The most common definition for a minimum delay in 1 developmental domain is 25%, which is used within

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the definitions of 16 states (31%); the second most common is 2 SDs below the mean, which is used within the definitions of 12 states (24%).

Variability is also found regarding lead agency, program name, and fee structure. There are 23 different lead agencies; the 2 most common are education (N=11) and health (N=9) departments. There are a total of 26 different program names; the most common is EI (N=17). Thirteen states provide services at no cost to families and do not bill private insurance; all other states charge a family participation fee and/or bill private insurance.

Role of Pediatricians

EI has proven over time to be an efficacious and beneficial system to children with developmental delays and their families. (11)(12)(13)(14)(15)(16)(17)(18)(19)(20)(21)(22)(23) Despite evidence demonstrating efficacy of EI, these programs remain vulnerable to cuts from federal and state funding. In 2002, the Centers for Disease Control's Task Force on Community Preventative Services recommended health care provider endorsement of participation in publicly funded childhood development programs as part of routine health maintenance. The American Academy of Pediatrics has also recommended that pediatricians participate in obtaining universal access to early childhood care and education. (25) Thus, it is important for health care providers to defend and improve the existence of these programs.

Pediatricians play an important role in the identification of developmental delays and have several responsibilities to ensure the successful receipt of EI services. (26) Once screened and identified as a child who may benefit from EI, it is important for pediatricians to be knowledgeable about the referral process specific to their state, especially given inconsistent and often confusing eligibility criteria, fee structures, and program names. The American Academy of Pediatrics has also issued a policy statement recommending developmental surveillance at every health maintenance visit; developmental screening with a standardized instrument at the 9-, 18-, and 30- (or 24-) month visits; and screening for autism at 18 and 24 months of age. This policy also discusses the responsibility of the pediatrician as outlined in Title V of the Social Security Act and the IDEA of 2004 to provide not only early identification but also intervention for detected developmental delays. (2)

Learning about EI may be particularly important because parents rely heavily on pediatricians for information and advice. (29) Pediatricians should be aware of their state's definition of developmental delay and the fee structure for EI (Table 2). Pediatricians who familiarize themselves with EI can take a proactive role in promptly referring children for services, arranging for diagnostic evaluations as appropriate, and informing families about the benefits of EI programs. (30)

Pediatricians have the unique opportunity to be a member of, or consultant to, the EI multidisciplinary evaluation team. In addition, if pediatricians are unable to directly participate, providing availability through e-mail or conference call is recommended and may be beneficial. (27) More specifically, by being involved in the EI process, pediatricians can work as partners with parents and the multidisciplinary team to provide seamless coordinated care.

During the evaluation process, pediatricians should provide counsel and advice to families, including informing them of their rights. (27) Ongoing guidance regarding their child's progress, future management options, and selection of evidence-based and best practices is also critical to successful EI enrollment. (26) In addition to informing parents about EI services, encouraging parent participation may be a fundamental role of pediatricians. By building a strong relationship, parents may be more likely to bring their children to appointments and bear the responsibility of following through with treatment plans. Furthermore, involving parents purposefully and meaningfully within the EI process, while providing them with options regarding their type and degrees of involvement, may lead to greater overall success of the services. (31)

Lastly, providing a medical home, promoting continuity of care that aims to diminish the rate of secondary disabilities, and collaborating closely with assessment and IFSP teams are integral to the comprehensive care of a child with special needs. (26)(27) This includes the pediatrician as the main coordinator of medical services dictated in the IFSP, access to diagnostic evaluations, and proper medical subspecialty referrals. (26)(27) As pediatricians become more involved in the EI process, it will help to improve the existence of the programs as they stand currently.

Unfortunately, barriers to pediatricians educating themselves and being proactive in the EI process exist. Some have suggested that inadequate developmental screening is responsible. For example, a recent study found that nearly two-thirds of pediatricians thought that an established medical diagnosis was important in the decision to refer to EI. (32) Another barrier is parental report of miscommunication with their pediatrician and poor understanding of the EI referral process.

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Table 2. **Individual State Data (Accurate as of August 2013)**

State	Agency	Program Name	Minimum Delay[1]	Fee Structure[2]
Alabama	Rehabilitation Services	Alabama's EI System	25%	BPI-NCF[3]
Alaska	Health and Social Services	Infant Learning Program	50%	FPF[4] and/or BPI-FC[5]
Arizona	Department of Economic Security	Arizona EI Program	50%	FPF
Arkansas	Department of Human Services	First Connections	25%	BPI-NCF
California	Developmental Services	Early Start	< 24 months: 33% in 1 domain; ≥24 months: 50% in 1 domain or 33% in ≥2 domains	FPF and BPI-FC
Colorado	Human Services	EI Colorado	25% or 1.5 SDs	BPI-NCF
Connecticut	Developmental Services	Birth to 3 years	2 SDs in 1 domain or 1.5 SDs in ≥2 domains	FPF and/or BPI-NCF[6]
D.C.	Education	DC EI	50% in 1 domain, 25% in ≥2 domains	NCF[7]
Delaware	Health and Social Services	Child Developmental Watch	25%	BPI-FC or FPF[8]
Florida	Health	Early Steps	2 SDs in 1 domain or 1.5 SDs in ≥2 domains	BPI-NCF
Georgia	Department of Public Health	Babies Can't Wait	2 SDs in 1 domain or 1.5 SDs in ≥2 domains	FPF and/or BPI-NCF
Hawaii	Health	EI	Any delay	NCF
Idaho	Department of Health and Welfare	Infant Toddler Program	30% or 2 SDs in 1 domain or 30%, 6 months, or 1.5 SDs in ≥2 domains	BPI-NCF
Illinois	Human Services	EI	30%	FPF and/or BPI-NCF
Indiana	Family and Social Services	First Steps	25% in 1 domain or 20% in ≥2 domains	FPF and/OR BPI-FC
Iowa	Education	Early ACCESS	25%	NCF
Kansas	Health and Environment	Kansas Infant-Toddler Services—Tiny K	25% in 1 domain or 20% in ≥2 domains	NCF (local programs have option to BPI-NCF)
Kentucky	Department for Public Health	First Steps	2 SDs in 1 domain or 1.5 SDs in ≥2 domains	FPF and/or BPI-FC
Louisiana	Health and Hospitals	Early Steps	1.5 SDs in 2 domains	FPF[9]
Maine	Education	Child Development Services	2 SDs in 1 domain or 1.5 SDs in ≥2 domains	FPF and/or BPI-NCF
Maryland	Education	Infants and Toddlers Program	25%	NCF
Massachusetts	Public Health	EI	30% or 1.5 SDs	BPI-NCF
Michigan	Education	Early On	<2 months: any delay, >2 months: 20% or 1 SD	NCF
Minnesota	Education	Infant Toddler Intervention	1.5 SDs	NCF

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Table 2. (Continued)

State	Agency	Program Name	Minimum Delay[1]	Fee Structure[2]
Mississippi	Department of Health	First Steps EI Program	33% in 1 domain or 25% in ≥2 domains	BPI-NCF
Missouri	Education	First Steps	50%	FPF and/or BPI-NCF
Montana	Public and Human Services	EI	50% in 1 domain or 25% in ≥2 domains	BPI-NCF
Nebraska	Education and the Department of Health and Human Services	Early Development Network	Any delay	NCF
Nevada	Health and Human Services	EI	50% in 1 domain or 25% in ≥2 domains	BPI-NCF
New Hampshire	Health and Human Services	Family Centered Early Supports and Services	33%	BPI-NCF[2]
New Jersey	Health	EI	2 SDs in 1 domain or 1.5 SDs in ≥2 domains	FPF[10]
New Mexico	Health	Family Infant Toddler Program	25%	BPI-NCF
New York	Health	EI	33%, 2 SDs, or 12 months in 1 domain or 25% or 1.5 SDs in ≥2 domains (exception: 2-SD delay in communication)	BPI-NCF[11]
North Carolina	Health and Human Services	North Carolina Infant-Toddler Program	30% or 2 SDs in 1 domain or 25% or 1.5 SDs in ≥2 domains	FPF &t/or BPI-FC
North Dakota	Human Services	EI	50% in 1 domain or 25% in ≥2 domains	NCF
Ohio	Health	Help Me Grow	25% or 1.5 SDs	NCF
Oklahoma	Education	Sooner Start	50% or 2 SDs in 1 domain or 25% or 1.5 SDs in ≥2 domains	NCF
Oregon	Education	EI	2 SDs in 1 domain or 1.5 SDs in ≥2 domains	NCF
Pennsylvania	Public Welfare[12]	EI	25% or 1.5 SD	NCF
Rhode Island	Executive Office of Health and Human Services	EI	2 SDs in 1 domain or 1.5 SDs in ≥2 domains	BPI- NCF
South Carolina	Office of School Readiness	Baby Net	40% in 1 domain or 25% in ≥2 domains	BPI-NCF
South Dakota	Education	Birth to 3 Program	1.5 SDs	BPI-NCF[5]
Tennessee	Education	EI	40% in 1 domain or 25% in ≥2 domains	BPI-NCF

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Table 2. (Continued)

State	Agency	Program Name	Minimum Delay[1]	Fee Structure[2]
Texas	Assistive and Rehabilitative Services	EI	25%	FPF
Utah	Health	Baby Watch	1.5 SDs or <7th percentile	FPF
Vermont	Agency of Human Services and Department of Education	Children's Integrated Services/EI	Any delay	BPI-FC[13]
Virginia	Department of Behavioral Health and Developmental Sciences	Infant and Toddler Connection of Virginia	25%	FPF and/or BPI-FC
Washington	Department of Early Learning	Early Support for Infants and Toddlers Program	25% or 1.5 SDs	BPI-FC or FPF[14]
West Virginia	Health and Human Resources	WV Birth to 3 Growing Together	Equivalent of 40% in 1 domain, 25% in ≥2 domains	NCF
Wisconsin	Health Services	Birth to 3 Program	25% or 1.3 SDs in 1 domain	FPF
Wyoming	Health	EI and Education Program	25% or 1.5 SDs	BPI-NCF

BPI-FC=bills private insurance—family cost; BPI-NCF=bills private insurance—no cost to family; FPF=family participation fee; EI=early intervention; NCF=no cost to families.
[1]In addition to serving children with the minimum delay defined in this table, states may also serve children with high probability medical conditions, and/or by informed clinical opinion (e.g., atypical development). A few states also serve children with at-risk conditions and several others provide tracking services for at-risk children but do not serve them.
[2]With parent permission, states may also bill public insurance (e.g., medical assistance) with services remaining at no charge to families.
[3]With parent permission, program bills private insurance; family is not responsible for co-payments and/or deductibles.
[4]The program charges a family participation fee based on a sliding scale fee formula; families below a set income are not required to pay the fee.
[5]With parent permission, program bills private insurance; family is responsible for co-payments and/or deductibles.
[6]Obtains family consent to bill self-funded or out-of-state plans. Does not obtain family consent to bill insurance plans that follow state insurance mandates (eg, billing will not affect annual and lifetime limits, copayments and deductibles are covered, premiums will not be increased solely due to child receiving services from ages birth to 3 years). Families with self-funded insurance who decline consent to have their insurance billed are charged an extra monthly fee that represents mean copayments.
[7]Participation at no cost to families; program does not bill private insurance.
[8]Applies FPF only if family declines access to private insurance.
[9]Families pay a share of the cost of the service received based on the sliding scale, but they are not charged a fee for being in the program.
[10]Families may pursue reimbursement of their family cost share from private insurance.
[11]Bills private insurance if the policy is regulated by New York; if the policy is not regulated by New York then private insurance is only billed with parent permission.
[12]Managed by the Bureau of Early Intervention Services within the Office of Child Development and Early Learning.
[13]Financial assistance is available on request with copayments and deductibles.
[14]FPF does not apply to all families. A monthly fee applies only to those families whose child receives services that are subject to family cost participation (primarily occupational therapy, physical therapy, speech therapy, or other medically related early intervention services typically reimbursed by a third party). A monthly fee for services subject to family cost participation is applied under 2 different circumstances: (1) a family does not have public or private insurance or (2) a family declines access to their public or private insurance that helps in paying for services subject to family cost participation.

(33) In addition, lack of time and office staff, inadequate reimbursement, language barriers, lack of confidence in administration, and validity of developmental screening lack of treatment options, poor knowledge of the referral process, and belief that formal developmental screening is not the pediatrician's role may also be barriers for pediatricians in the EI process. (34) Few pediatricians assist in the EI application process primarily because of staff and time limitations and secondarily because of lack of pediatrician knowledge about the process. System or policy changes that would allow time and reimbursement for developmental services provided by the pediatrician or services that harness the resources of the clinic rather than the pediatrician may help limit the aforementioned barriers. (34) Advocating for these changes might be another way for pediatricians to preserve and support the existence of EI.

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Pediatricians who understand the importance of EI, monitor and refer children as necessary, and take an active role as a member of the EI team can help create a standard of care for children with established disabilities, those at risk for developmental delays, and their families. Through ongoing coordinated care with service providers, pediatricians can help recommend services that target specific developmental domains and track progress during health maintenance visits. (30) By collaborating with EI programs and encouraging family involvement, pediatricians can provide optimal care for children and their families.

Conclusion

EI services can improve the outcomes of children with established developmental delays and their families. (11)(12)(13)(14)(15)(16)(17)(18)(19)(20)(21)(22)(23) However, parents who are unaware of these services may be missing opportunities to help their children. Pediatricians can play an essential role in connecting families to EI services within their community, but first they must educate themselves. Becoming familiar with the eligibility criteria associated with EI in their state, pediatricians can encourage family participation and collaborate with EI programs to foster seamless coordinated care for children and their parents.

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Parent Resources From the AAP at HealthyChildren.org

- English: http://www.healthychildren.org/English/health-issues/conditions/developmental-disabilities/Pages/Early-Intervention.aspx
- Spanish: http://www.healthychildren.org/spanish/health-issues/conditions/developmental-disabilities/paginas/early-intervention.aspx
- English: http://www.healthychildren.org/English/news/Pages/Early-Detection-Diagnosis-of-Motor-Delays-is-Key-According-to-New-AAP-Report.aspx
- English: http://www.healthychildren.org/English/ages-stages/toddler/Pages/Assessing-Developmental-Delays.aspx
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