Profiles and Analyses of Child Find, Referral, Early Identification, and Eligibility Practices

Snapshots

Early Intervention and Preschool Special Education Endorsements by the American Academy of Pediatrics

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Abstract

The extent to which IDEA Part C early intervention and Part B (619) preschool special education are endorsed or recommended as needed services for children with disabilities or delays by the American Academy of Pediatrics was examined. Twenty-two policy statements were examined to determine the extent to which policy recommendations implicitly or explicitly endorsed the use of nine different early intervention and preschool special education services or programs. Findings showed that policy statements were more likely to refer to generic services (e.g., early intervention) rather than specific programs (e.g., Part C early intervention). Implications for influencing pediatricians understanding of IDEA are described.

Introduction

The purpose of the study described in this *Snapshots* was to determine the extent to which the American Academy of Pediatrics (AAP or the Academy) endorsed the provision of different Individuals with Disabilities Education Act (IDEA) early intervention and preschool special education services and programs. This was accomplished by examining 22 AAP policy statements that were applicable to young children with disabilities or developmental delays or young children at risk for poor developmental outcomes due to environmental or biological risk factors, or both. The study was conducted as part of research at the Tracking, Referral and Assessment Center for Excellence (TRACE). The major goal of TRACE is to identify and promote the use of evidence-based practices for improving child find, referral, early identification, and eligibility determination of infants, toddlers, and preschool children with disabilities or developmental delays eligible for IDEA Part C early intervention or Part B (619) preschool special education (Dunst & Trivette, 2004; Dunst, Trivette, Appl, & Bagnato, 2004).

Seventy-seven percent of the pediatricians in the United States are members of the American Academy of Pediatrics (Anne Gramiak, AAP, personal communication, April 17, 2006). AAP therefore has the potential for influencing a significant number of pediatricians and their practices. The Academy uses three types of materials to influence pediatricians' knowledge and practices: technical reports, clinical reports, and policy statements. Relevant AAP policy statements constituted the focus of analysis described in this *Snapshots*. Policy statements are "organizational principles to guide and define the child health care system and/or improve the health of all children" (Korioth, 2002, p. 113). The analysis of AAP technical reports and clinical reports are planned for a later time.

AAP policy statements are developed using the same general format. Policy statements are typically developed by a variety of groups: committees, sections, task forces, the AAP Board of Directors, or other AAP entities. According to guidelines of the American Academy of Pediatrics, the development of all policy statements must follow the same procedure (http://www.aap.org). Regardless of who develops a policy statement, the process must include a systematic literature review, an analysis of relevant data, an internal and external peer review process, and be authorized for publication by the AAP Board of Directors.

Policy statements generally include an abstract that summarizes the focus of the policy statement, a background statement that provides the reader with relevant information about the policy topic (including research

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findings if appropriate), and conclude with a recommendation section. This last section is where the policy statement focuses the readers' attention on specific practices the AAP feels are most important for pediatricians to adopt and use. The policy statements reviewed in this study included as few as 4 or 5 recommendations while others included 10 or more recommendations. The recommendation section was the source of information for determining whether the policy prescribed or endorsed the provision of the services and programs that were the focus of this investigation.

The analysis of the AAP policy statements was considered important because the recommendations made to AAP members, and the ways in which the policy recommendations are framed, potentially influence pediatricians' beliefs about and prescriptions of different kinds of medical and nonmedical services, treatments, and interventions. More specifically, we were interested in determining the level of specificity of the policy statement recommendations in terms of both generic (e.g., early intervention) and specific (e.g., IDEA Part C early intervention) recommendations.

Method

Policy Statements

The unit of analysis in this study was the recommendations in 22 policy statements approved and published by the AAP between 1995 and 2003. The entire list of policy statements available on the American Academy of Pediatrics Web page (http://aappolicy.aappublications.org) was first reviewed by two of the study investigators to identify policy statements that were most relevant to young children birth to 5 years of age with disabilities or developmental delays or children at risk for delays. Twenty-five policy statements were identified initially. Three policy statements were subsequently excluded from analysis because, on closer inspection, the age of the children constituting the focus of the policy statements did not include children birth to 5 years of age. Table 1 lists the 22 policy statements that were examined in this study.

The policies constituting the focus of analysis were developed by a variety of AAP committees and groups either alone or jointly. Nine of the 22 policies were developed by the Committee on Children with Disabilities; three were developed by the Committee on Early Childhood, Adoption and Dependent Care; three were developed by the Committee on Genetics; and one policy was developed by the Committee on Pediatric Aids. Two policies were developed jointly by two committees (Committee on Children with Disabilities and Committee on Child Abuse and Neglect; and Committee on Children with Disabilities and Committee on Substance Abuse) and two policies were developed by the Task Force on Newborn and Infant Hearing and the Medical Home Initiatives for Children with Special Needs Project Advisory Committee. Two policy statements were developed by AAP groups other than standing committees.

For purposes of analyses, the policy statements were grouped according to the type of committee that developed the policies: (1) those with a focus on children with developmental disabilities (DD) and (2) those that did not focus specifically on children with disabilities (NonDD). Twelve of the policies were developed solely by or in conjunction with a committee or group whose focus was children with disabilities (e.g., Committee on Children with Disabilities) and 10 policy statements were developed by the Committee on Early Childhood, Adoption, and Dependent Care; Committee on Pediatric Aids; and Committee on Fetus and Newborn.

Procedure

Each policy statement was examined and scored by two raters. The focus of analysis was the recommendation section of each policy statement. The recommendation section was examined to determine the degree of endorsement in terms of nine early intervention and preschool special education services and programs. The services and programs included physical therapy, occupational therapy, speech therapy, behavioral or mental health interventions, early intervention, early childhood special education, IDEA Part C Infant/Toddler Program, IDEA Part B (619) Preschool Special Education, and the Individuals with Disabilities Education Act (IDEA).

Each type of service and program was rated using a 7-point endorsement scale. (See Appendix for a copy of the scale.) The scale ratings were: 1 = Policy recommendation opposes endorsement of the service/program, 3 = Policy recommendations neither implicitly or explicitly endorse nor recommend the provision of the service or program, 5 = Policy recommendations implicitly but not explicitly endorse the provision of the service or program, and 7 = Policy recommendations explicitly endorse the provision of the service or program. Interrater reliability was calculated between two raters using a within 1 point match on the 7-point scale. The mean interrater reliability was 96% agreement ranging from 75% to 100% agreement.

Data Analysis

The endorsement ratings were analyzed in a number of ways. First, the extent to which each of the services and programs were endorsed for all 22 policy statements combined was examined by calculating for each service and program the percentage of policy statements that were rated as not indicated (1-3), implicit endorsement (4-5) or explicit endorsement (6-7) of the services and programs. Second, the degree of endorsement was com-

Table 1
List of American Academy of Pediatrics Policy Statements Reviewed

Role of the Pediatrician in Family-Centered Early Intervention Services
Education of Children with Human Immunodeficiency Virus Infection
Developmental Issues for Young Children in Foster Care
The Pediatrician's Rose in Family Support Programs
Apnea, Sudden Infant Death Syndrome, and Home Monitoring
General Principals in the Care of Children and Adolescents with Genetic Disorders and Other Chronic Health Conditions
Hospital Discharge of the High-Risk Neonate—Proposed Guidelines
The Pediatrician's Role in Development and Implementation of an Individual Education Play (IEP) and/or an Individual Family Service Plan (IFSP)
The Role of the Pediatrician in Prescribing Therapy Services for Children with Motor Disabilities
Guidelines for Home Care of Infants, Children, and Adolescents with Chronic Disease
Health Supervision for Children with Fragile X Syndrome
The Pediatrician's Role in the Diagnosis and Management of Autistic Spectrum Disorder in Children
Assessment of Maltreatment of Children with Disabilities
Care Coordination: Integrating Health and Related systems of Care for Children with Special Health Care Needs
Developmental Surveillance and Screening of Infants and Young Children
Fetal Alcohol Syndrome and Alcohol-Related Neurodevelopmental Disorders
Health Supervision for Children with Down Syndrome
Health Care Supervision for Children with Williams Syndrome
Newborn and Infant Hearing Loss: Detection and Intervention
Provision of Educationally-Related Services for Children and Adolescents with Chronic Diseases and Disabling Conditions
The Medical Home

pared for policy statements developed by committees with a focus on children with developmental disabilities (DD committees) and committees with a more general focus on children (NonDD committees). Third, Cohen's *d* effect sizes were computed to determine the magnitude of the difference in the level of endorsement of the NonDD and DD committees.

Results

Table 2 shows the degree of endorsement for each of the nine early intervention and preschool special education services and programs for all 22 policy statements combined. No type of service program was explicitly en-

Table 2
Percentage of Policy Statement Services and Practices Receiving Different Endorsement Ratings

	Percentages		
Services/Practices	**Neither Implicit nor Explicit Endorsement**	**Implicit Endorsement**	**Explicit Endorsement**
Physical Therapy	41	54	5
Occupational Therapy	41	54	5
Speech/Language Therapy	41	50	9
Behavioral/Mental Health Interventions	63	23	14
Early Intervention	9	50	41
Part C Infant/Toddler Program	82	18	0
Early Childhood Special Education	27	55	18
Part B (619) Preschool Special Education	91	9	0
Individuals with Disabilities Education Act (IDEA)	59	27	14

dorsed in the largest majority of policy statements. Only one type of service or program (early intervention) was explicitly endorsed in more than a third of the 22 policy statements.

At least half of the policy statements implicitly or explicitly endorsed five services or programs (physical therapy, occupational therapy, speech/language therapy, early intervention, and early childhood special education). Of special note is the fact that IDEA Part C early intervention and IDEA Part B (619) preschool special education are not mentioned implicitly or explicitly in the largest majority of policy statements. This suggests, as we discuss later, that the terms early intervention and special education as used in the policy statements do not necessarily mean IDEA Part C or Part B (619) services or programs.

Table 3 shows the mean endorsement ratings for the policy statements prepared by AAP developmental disability (DD) and nondevelopmental disability (NonDD) committees. The four types of therapies (physical, occupational, speech, and behavioral) were more likely to be endorsed in policy statements prepared by AAP DD committees. The same was the case for early childhood special education. In contrast, IDEA (Individuals with Disabilities Education Act) and IDEA Part C early intervention were more likely to be endorsed in policy statements prepared by AAP NonDD committees.

The extent to which the DD and NonDD committee-developed policy statements varied in terms of the degree of specificity of the type of early intervention or preschool special education endorsed in the policy recommendations is shown in Figure 1. Two patterns of findings are clearly discernable. First, neither implicit nor explicit endorsement of IDEA Part C early intervention and IDEA Part B (619) preschool special education were found in the largest majority of policy statements. Second, both implicit and explicit endorsement of generic nonspecified early intervention (and to a lesser degree early childhood special education) were found in many policy statements.

Discussion

Findings presented in this *Snapshots* indicate that AAP policy statements applicable to infants, toddlers, and preschoolers potentially eligible for Part C early intervention or Part B (619) preschool special education do not generally include recommendations that either implicitly or explicitly endorse either IDEA service or program. There is, however, considerably more endorsement of generic types of services and programs, including physical, occupational, and speech therapy; early intervention; and special education.

The analysis of the AAP policy statements were done, in part, because there was some indication that when physicians use the term *early intervention* or *preschool special education*, they do not necessarily mean just the IDEA varieties or those services or programs. As part of conversations with physicians about TRACE and close examination of available documents (e.g., American Academy of Pediatrics, 2003; Rothschild, 2002; Teplin & Escolar, 2000), it was surmised that physicians may be using the terms early intervention and preschool special education in a very broad sense to mean treatments provided to infants, toddlers, and preschoolers by qualified professionals and not necessarily Part C or Part B (619) program personnel. Results from the analyses described in this paper suggest that this may indeed be the case.

Results presented in this paper have at least one im-

Table 3

Means, Standard Deviations, and Effect Sizes for the Comparisons of the DD Committee and NonDD Committee Recommendations

	NonDD Comittee (N = 10)		DD Committee (N = 12)		
Services/Practices	**Mean**	**SD**	**Mean**	**SD**	**Cohen's *d***
Physical Therapy	3.50	0.71	4.42	1.00	1.04
Occupational Therapy	3.50	0.71	4.42	1.00	1.04
Speech/Language Therapy	3.50	0.71	4.50	1.09	1.07
Behavioral/Mental Health Interventions	3.70	1.49	4.00	1.13	0.23
Early Intervention	5.30	1.34	5.25	1.42	-0.04
Part C Infant/Toddler Program	3.30	0.37	3.17	0.39	-0.25
Early Childhood Special Education	4.30	1.25	4.67	1.15	0.31
Part B (619) Preschool Special Education	3.10	0.32	3.08	0.29	-0.06
Individuals with Disabilities Education Act (IDEA)	4.90	1.52	3.17	0.39	-1.63

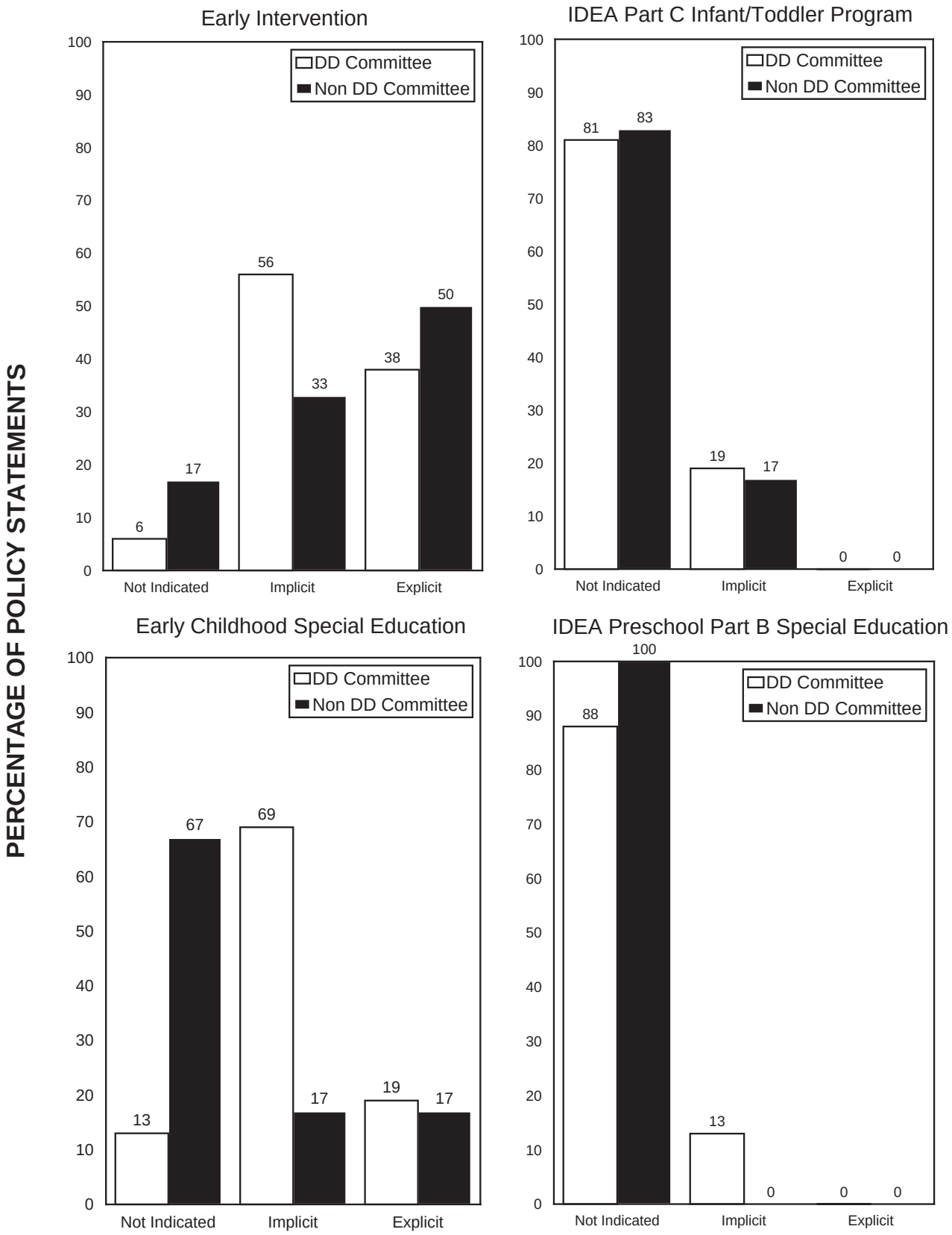

Figure 1 Percentage of policy statements at three endorsement levels by DD and NonDD committees.

plication for improving communications between physicians and early intervention and preschool special education personnel. Most disciplines, including medicine, develop their own terminology that more often than not has discipline-specific meaning. The terms early intervention and, to a lesser degree, preschool special education--if they indeed mean different things to pediatricians and other physicians--suggest that describing Part C and Part B (619) services and programs in language medical professionals understand and use may improve their perceptions and understandings of what a child is likely to receive when they make a referral to a Part C early intervention or Part B (619) preschool special education. A lesson learned from research and practice at TRACE is that the same terminology used by professionals from different disciplines does not necessarily mean the same thing. Even a cursory review of the pediatric literature indicates, for example, that *early intervention* is used in rather diverse ways to describe different kinds of practices (e.g., Harrison & Roush, 1996; Minkovitz et al., 2003; Palti, Zilber, & Kark, 1982; Werner, Joffe, & Graham, 1999). Care is therefore warranted in knowing what early intervention means to medical professionals and how their use of terms influences who, when, and where a referral is made.

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Appendix

AAP Policy Statement Rating Scale

1 = ***The policy recommendation is clearly in opposition to the provision or endorsement of the stated service or practice***. Document provides ***clear***, ***explicit***, and ***discernable evidence*** that the type of service or practice being assessed is discouraged or is not recommended by the Academy.

2 = ***Between a rating of 1 and 3***. Document provides ***implicit evidence*** that the Academy policy statement (guidelines, report) does not endorse or recommend the provision or prescription of the service or practice.

3 = ***The policy recommendation neither implicitly or explicitly endorses nor recommends the provision of the service or practice***. Document provides ***no evidence*** that the Academy policy statement either endorses/recommends or discourages/does not recommend the service or practice. Evidence is ***neutral*** in the sense that it cannot be discerned whether the policy statement is in favor of or opposed to the provision or prescription of the service or practice.

4 = ***Between a rating of 3 or 5***. Document provides a minimal amount of implied evidence that there is a positive tendency toward Academy endorsement of the service or practice, but that endorsement cannot be fully implied using the criterion for a score of five (5).

5 = ***The policy recommendations implicitly but not explicitly endorse the provision of the service or practice***. Document provides clear but ***implied evidence*** that the Academy policy statement (guidelines, report) endorses or recommends the provision of the service or practice. ***Implied*** means the endorsement of the service or practice is suggested or understood to be true, but that endorsement is not explicitly stated.

6 = ***Between a rating of 5 and 7***. Document provides ***some, but minimal, explicit evidence*** that the service or practice is endorsed or recommended by the Academy.

7 = ***The policy recommendation explicitly endorses the provision of the service or practice***. Document provides ***clear and discernable explicit evidence*** that the service or practice is endorsed or recommended by the Academy. ***Explicit*** means that the ***exact service or practice term*** is stated, or a variation of the term is stated, or otherwise is distinctly expressed, leaving nothing implied regarding endorsement of the service or practice.