



Question: Can we use the physician as the second discipline in the Part C required multidisciplinary evaluation/assessment? We would only use physicians as the second discipline when we have determined through conversation and observation that there is not a concern or delay that is significant enough to warrant further assessment through criterion-referenced or standardized measurement tools. The physician's contribution to the evaluation/assessment would be "informed clinical opinion." Is this practice acceptable?

Response: Federal Part C regulations and Virginia Part C Policies and Procedures require that *the evaluation and assessment of a child include the following:*

1. *A review of pertinent records less than six months old related to the child's current health status and medical history (34 CFR 303.322(c)(3)(i));*
2. *An evaluation of the child's level of functioning or a review of existing evaluation data less than six months old in each of the following developmental areas (34 CFR 303.322(c)(3)(ii)):*
 - *Cognitive;*
 - *Physical, including fine motor, gross motor, vision and hearing;*
 - *Communication;*
 - *Social or emotional development;* and
 - *Adaptive development.*
3. *An assessment of the unique strengths and needs of the child in terms of each of the developmental areas above (34 CFR 303.322(c)(3)(iii))*

In addition *the evaluation and assessment of a child are based on informed clinical opinion (34 CFR 303.322(c)(2)).* A note under VI.A.1.g(3) in Virginia's Part C Policies and Procedures goes on to explain that:

"Informed clinical opinion" makes use of qualitative and quantitative information to assist in forming an eligibility determination regarding difficult-to-measure aspects of current developmental status and the potential need for early intervention. Use of informed clinical opinion as a separate basis for establishing eligibility helps assure that children needing early intervention

services will be appropriately identified at the earliest possible age. Evaluators may use any or all of the following to reach an informed clinical opinion about the development of a particular child: clinical interviews with the parent(s), evaluation of the child at play, observation of parent-child interaction, information from teachers or child care providers, and neurodevelopmental or other physical examinations.

While the intentions to avoid duplication of evaluation/assessment and to include the physician in the evaluation/assessment process are appropriate, the practices outlined in the question do not meet Part C requirements for the following reasons:

- Children receiving an initial Part C evaluation/assessment must be evaluated in all areas of development. There is no provision in Part C that allows for a less rigorous level of evaluation/assessment in areas of development where there are no concerns at the time of referral. While screening or initial observation may suggest that there are no delays in a certain area(s) of development, the purpose of the evaluation/assessment are to determine specifically the child's level of functioning in each area of development as well as the child's unique strengths and needs in each developmental domain. A more specific understanding, based on evaluation/assessment, of the child's strengths in areas of development where there are no concerns may well assist in determining intervention strategies, supports and services that will most effectively address areas of delay.
- The note (above) from Virginia's Part C Policies and Procedures states that informed clinical opinion assists in forming an eligibility decision regarding difficult-to-measure aspects of current developmental status. Since the practice outlined in the question proposes that physicians would only be used to assess areas in which there was no developmental concern,

that would suggest these are not difficult-to-measure aspects of development and there would be no apparent reason why traditional evaluation/assessment tools could not be used. Whereas physicians may use developmental screening tools and procedures in their practices (in accordance with recommendations from the American Academy of Pediatrics), most do not routinely employ methods of looking at development that rise to the level of evaluation/assessment.

- Informed clinical opinion must be based on an appropriate method of evaluation/assessment. Informed clinical opinion is not an evaluation/assessment method in and of itself, rather it is the outcome of synthesizing the evaluation/assessment information (based on an assessment tool, observation, interview, etc.) with the professional's expertise and experience to determine the child's developmental status and eligibility for Part C services. Professionals must be familiar with the particular child, knowledgeable about the expected sequence of development across all domains and understand the broad range of individual variations that may be expected of peers who are developing typically in order to competently use informed clinical opinion. The evaluation/assessment method used (e.g., assessment tool, observation, clinical interviews, etc.) and the results of that method(s) that support the informed clinical opinion must be documented.

While the practices suggested in the question do not meet Part C requirements, there are appropriate ways to include physicians in the local Part C system, including the following:

- Conducting developmental screening;
- Making referrals to the local Part C system;
- Diagnosing conditions with a high probability of resulting in developmental delay;
- Conducting vision and/or hearing screening that may address components of the Part C Hearing/Vision Screening tool that must be completed as part of each child's initial evaluation/assessment;

- Providing records that document the child's current health status and medical history;
- Providing screening and other information from the child's medical records to help the local Part C system determine the most appropriate evaluation/assessment team members and tools/methods; and
- Providing medical counsel and advice to parents and evaluation/assessment and IFSP teams.

These roles are discussed in The American Academy of Pediatrics (AAP) Policy Statement entitled The Pediatrician's Role in Development and Implementation of an Individual Education Plan (IEP) and/or an Individual Family Service Plan (IFSP) [*Pediatrics*, 1999, 104: 124-127], which was reaffirmed by the AAP in January 2006 and is available at www.aap.org.

The Part C Office, in partnership with a stakeholder work group, will be developing a technical assistance document related to considerations in Part C evaluation and assessment, and informed clinical opinion is one topic that will be addressed in more detail within that document.