

Informed Clinical Opinion

Anne Lucas and Evelyn Shaw
NECTAC Notes # 28 August 2012

This paper is an update of NECTAC Notes No. 10 (May 2002) by Jo Shackelford.

The term “informed clinical opinion” appears in the regulatory requirements for the implementation of Part C of the Individual with Disabilities Education Act (IDEA) as an integral part of an eligibility determination (See Appendix). It must be included in evaluation and assessment procedures, since it is a necessary safeguard against eligibility determination based upon isolated information or test scores alone. Since the term carries different meanings for individuals and agencies, it is important to clarify the meaning and use of “informed clinical opinion” in the context of Part C. This document uses a question-and-answer format to address three key issues:

- What does informed clinical opinion mean in the context of Part C?
- How does informed clinical opinion affect the determination of eligibility?
- Why is it necessary to document informed clinical opinion?

What Does Informed Clinical Opinion Mean in the Context of Part C?

Informed clinical opinion is used by early intervention professionals in the evaluation and assessment process in order to make a recommendation as to initial and continuing eligibility for services under Part C and as a basis for planning services to meet child and family needs. Informed clinical opinion makes use of qualitative and quantitative information to assist in forming a determination regarding difficult-to-measure aspects of current developmental status and the potential need for early intervention. For example, a physical therapist must make judgments about muscle tone abnormality based on the therapist’s training and experience with other children. Likewise, a psychologist may note in observing a child playing that she performs tasks in adaptive ways not permitted during the administration of a standardized cognitive assessment. Another example includes an early interventionist observing a child occasionally engaging in self-stimulating behaviors (i.e., rocking, hand waving) when playing with toys leading to a conclusion that child is exhibiting atypical development or that the child may have early signs of a diagnosed condition or developmental delay. Finally, an occupational therapist may observe a premature infant having oral sensitivity to the bottle and other objects.



The knowledge and skill of the early intervention multidisciplinary evaluation team, including information obtained from the parents, constitute the basic foundation for the process of becoming “informed” about a child’s developmental status within a socially valid context. In essence, they seek to answer the question, “What are the child’s abilities and needs within his/her natural environment?” Thus, appropriate training, previous experience with evaluation and assessment, sensitivity to cultural needs, and the ability to elicit and include family perceptions are all important elements of informed clinical opinion.

The individuals and agencies responsible for implementing Part C need to consider who might have an informed clinical opinion, what these people might have an informed clinical opinion about, and how their informed clinical opinion can be integrated into the process of evaluation and assessment. In the context of Part C, these questions should be considered at both the individual early intervention professional level and at the team level.

[How Does Informed Clinical Opinion Affect the Determination of Eligibility?](#)

Informed clinical opinion should be considered at both the individual and team levels.

[Individual Team Member Level](#)

The individual early intervention professional uses both qualitative and quantitative information to shape an informed clinical opinion about a child’s development and need for early intervention services. To do so, the professional must have knowledge of the multiple domains of development characteristic of infants and toddlers; the expected sequence of development; and the broad range of

individual variations that may be seen in appropriately developing infants and toddlers. In order to reach an informed clinical opinion about the development of a particular infant or toddler, multiple procedures and sources of information must be used, including the following:

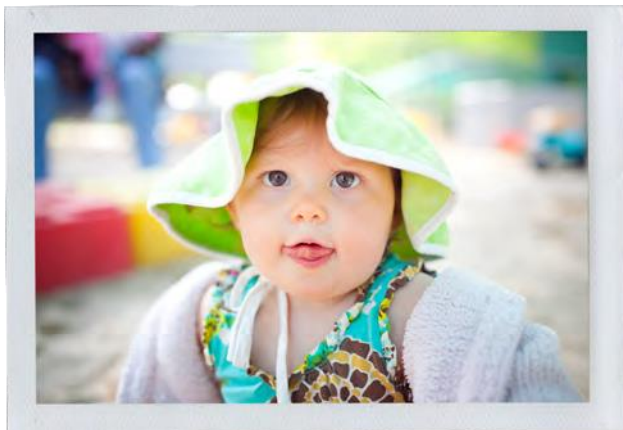
- review of a child’s developmental history;
- interviews with parents (including taking the child’s history);
- observation of the child at play and in various settings;
- observation of parent-child interaction;
- information gathered from family members, other care-givers, medical providers, social workers, and educators;
- review of medical, educational, or other records;
- neurodevelopmental or other physical examinations;
- use of an evaluation instrument; and
- identification of a child’s level of functioning (and needs) in each developmental area.

Information derived from these methods and additional psychometric and diagnostic data are synthesized to become the “informed clinical opinion” of an individual. The informed clinical opinion should reflect a meaningful assessment of the individual child’s development and family resources, priorities, and concerns, and suggest areas that may require further evaluation and/or assessment.

[Team Level](#)

The team, which includes family members, then synthesizes and interprets all available information, both qualitative and quantitative, about a child and family offered by the team participants. This opportunity to integrate observations, impressions, and evaluation

findings of the individuals facilitate a “whole child” approach to evaluation and assessment that goes beyond a reporting of test scores. In this way, the functional impact and the implications of noted delays or differences in development can be discussed and considered by the team in determining eligibility and developing the Individualized Family Service Plan (IFSP). Knowledge about available services is useful in formulating the IFSP but should not limit the recommendations made by the team.



Why Is It Necessary to Document Informed Clinical Opinion?

Appropriate documentation of the sources and use of informed clinical opinion is important for two reasons.

First, documentation provides a baseline against which to measure the progress and changing needs of the child and family over time. The initial recommendations of the team reflect the needs of the child and family at a specific point in time. In Part C, assessment and subsequent eligibility determination is an ongoing process that may require modifications in the IFSP. The perceptions and impressions of individual early intervention professionals may change over time. Documentation of the individual and

team findings can facilitate transition when families move, change service providers, or enter additional or new service delivery systems.

Secondly, documentation of the sources and use of informed clinical opinion also can provide information to assure that procedural safeguards were provided in the evaluation and assessment process and the determination of eligibility. This documentation should be maintained by a designated person, such as the interim or permanently assigned early intervention service coordinator and the parent.

Examples of information to document:

- Providing information about who was involved in the team and in gathering information;
- Describing the procedures used and in which settings;
- Summarizing the information and describing the functioning of the child in each developmental area; and
- Stating the decision of the team and rationale for concluding that the child is eligible.

Thus, the regulations regarding informed clinical opinion are intended to accomplish the following:

- ensure a dynamic assessment approach;
- support and encourage the acquisition and interpretation of multiple sources of information as part of the evaluation and assessment process; and
- permit greater compatibility between a child and family’s needs and the provision of services.

References

Early Intervention Program for Infants and Toddlers With Disabilities Rule of 2011, 34 C.F.R. §303 (2011).

Shackelford, J. (2002). Informed clinical opinion (NECTAC Notes No. 10). Chapel Hill: The University of North Carolina, FPG Child Development Institute, National Early Childhood Technical Assistance Center.

Resources

Bagnato, S.J. (2006). Formalizing informed clinical opinion assessment procedures is more likely to yield accurate results. *Endpoints*, 2(3). Retrieved from: http://tracecenter.info/endpoints/endpoints_vol2_no3.pdf

Bagnato, S.J. & McKeating-Esterle, E. (2010). Authentic and evidence-based instruments for informed clinical opinion. *Valid Use of Clinical Judgment (Informed Opinion) for Early Intervention Eligibility Session 3: NECTAC Webinar Series on Early Identification and Part C Eligibility*. Retrieved from: <http://www.nectac.org/~calls/2010/earlypartc/earlypartc.asp#session3>

Bagnato, S.J., McKeating-Esterle, E., Fevola, A.F., & Bortolamasi, P. (2008). Valid use of clinical judgment (informed opinion) for early intervention eligibility: Evidence-base and practice characteristics. *Infants and Young Children*, 21(2), 334-349.

Dunst, C. (May 10, 2010). Streamlining Eligibility Decisions for Part C Early Intervention. NECTAC webinar series on Early Identification & Part C Eligibility. Retrieved from: <http://www.nectac.org/~calls/2010/earlypartc/earlypartc.asp#session4>

About the authors:

Anne Lucas has worked in early intervention for 34 years as an occupational therapist, program administrator, consultant, Virginia State Part C Coordinator and technical assistance provider.

Evelyn Shaw has 32 years of experience in research, demonstration, and TA in autism and early childhood special education.

Photos: Alex Lazara

Please Cite as:

Lucas, A. & Shaw, E. (2012). *Informed Clinical Opinion (NECTAC Notes no. 28)*. Chapel Hill: The University of North Carolina, FPG Child Development Institute, National Early Childhood Technical Assistance Center website: <http://www.nectac.org/~pdfs/pubs/nnotes28.pdf>

The National Early Childhood Technical Assistance Center (NECTAC) is supported by cooperative agreement H326H060005 with the Office of Special Education Programs (OSEP), U.S. Department of Education (ED). NECTAC is a part of OSEP's Technical Assistance and Dissemination (TA&D) Network. Grantees undertaking projects under government sponsorship are encouraged to express their judgment in professional and technical matters. Opinions expressed do not necessarily represent the Department of Education's position or policy.

Project Officer: Julia Martin Eile

Project Director: Lynne Kahn



UNC

FPG CHILD DEVELOPMENT INSTITUTE

NECTAC is a program of the FPG Child Development Institute at the University of North Carolina at Chapel Hill.

303.24 Multidisciplinary.

Multidisciplinary means the involvement of two or more separate disciplines or professions and with respect to—

(a) Evaluation of the child in § 303.113 and § 303.321(a)(1)(i) and assessments of the child and family in § 303.321(a)(1)(ii), may include one individual who is qualified in more than one discipline or profession; and

(b) The IFSP Team in § 303.340 must include the involvement of the parent and two or more individuals from separate disciplines or professions and one of these individuals must be the service coordinator (consistent with § 303.343(a)(1)(iv)).

(Authority: 20 U.S.C. 1221e-3, 1435(a)(3), 1436(a)(1), 1436(a)(3))

303.111 State definition of developmental delay.

Each system must include the State’s rigorous definition of developmental delay, consistent with §§ 303.10 and 303.203(c), that will be used by the State in carrying out programs under part C of the Act in order to appropriately identify infants and toddlers with disabilities who are in need of services under part C of the Act. The definition must—

(a) Describe, for each of the areas listed in § 303.21(a)(1), the evaluation and assessment procedures, consistent with § 303.321, that will be used to measure a child’s development; and

(b) Specify the level of developmental delay in functioning or other comparable criteria that constitute a developmental delay in one or more of the developmental areas identified in § 303.21(a)(1).

(Approved by Office of Management and Budget under control number 1820-0550)

(Authority: 20 U.S.C. 1435(a)(1))

303.113 Evaluation, assessment, and nondiscriminatory procedures.

(a) Subject to paragraph (b) of this section, each system must ensure the performance of—

(1) A timely, comprehensive, multidisciplinary evaluation of the functioning of each infant or toddler with a disability in the State; and

(2) A family-directed identification of the needs of the family of the infant or toddler to assist appropriately in the development of the infant or toddler. (b) The evaluation and family directed identification required in paragraph (a) of this section must meet the requirements of § 303.321.

(Authority: 20 U.S.C. 1435(a)(3))

303.321 Evaluation of the child and assessment of the child and family.

(a) General. (1) The lead agency must ensure that, subject to obtaining parental consent in accordance with § 303.420(a)(2), each child under the age of three who is referred for evaluation or early intervention services under this part and suspected of having a disability, receives—

(i) A timely, comprehensive, multidisciplinary evaluation of the child in accordance with paragraph (b) of this section unless eligibility is established under paragraph (a)(3)(i) of this section; and

(ii) If the child is determined eligible as an infant or toddler with a disability as defined in § 303.21-

(A) A multidisciplinary assessment of the unique strengths and needs of that infant or toddler and the identification of services appropriate to meet those needs;

(B) A family-directed assessment of the resources, priorities, and concerns of the family and the identification of the supports and services necessary to enhance the family's capacity to meet the developmental needs of that infant or toddler. The assessments of the child and family are described in paragraph (c) of this section and these assessments may occur simultaneously with the evaluation, provided that the requirements of paragraph (b) of this section are met.

(2) As used in this part—

(i) Evaluation means the procedures used by qualified personnel to determine a child's initial and continuing eligibility under this part, consistent with the definition of infant or toddler with a disability in § 303.21. An initial evaluation refers to the child's evaluation to determine his or her initial eligibility under this part;

(ii) Assessment means the ongoing procedures used by qualified personnel to identify the child's unique strengths and needs and the early intervention services appropriate to meet those needs throughout the period of the child's eligibility under this part and includes the assessment of the child, consistent with paragraph (c)(1) of this section and the assessment of the child's family, consistent with paragraph (c)(2) of this section; and

(iii) Initial assessment refers to the assessment of the child and the family assessment conducted prior to the child's first IFSP meeting.

(3)(i) A child's medical and other records may be used to establish eligibility (without conducting an evaluation of the child) under this part if those records indicate that the child's level of functioning in one or more of the developmental areas identified in § 303.21(a)(1) constitutes a developmental delay or that the child otherwise meets the criteria for an infant or toddler with a

disability under § 303.21. If the child's part C eligibility is established under this paragraph, the lead agency or EIS provider must conduct assessments of the child

and family in accordance with paragraph (c) of this section.

(ii) Qualified personnel must use informed clinical opinion when conducting an evaluation and assessment of the child. In addition, the lead agency must ensure that informed clinical opinion may be used as an independent basis to establish a child's eligibility under this part even when other instruments do not establish eligibility; however, in no event may informed clinical opinion be used to negate the results of evaluation instruments used to establish eligibility under paragraph (b) of this section.

(4) All evaluations and assessments of the child and family must be conducted by qualified personnel, in a nondiscriminatory manner, and selected and administered so as not to be racially or culturally discriminatory.

(5) Unless clearly not feasible to do so, all evaluations and assessments of a child must be conducted in the native language of the child, in accordance with the definition of native language in § 303.25.

(6) Unless clearly not feasible to do so, family assessments must be conducted in the native language of the family members being assessed, in accordance with the definition of native language in § 303.25.

(b) Procedures for evaluation of the child. In conducting an evaluation, no single procedure may be used as the sole criterion for determining a child's eligibility under this part. Procedures must include—

(1) Administering an evaluation instrument;

(2) Taking the child's history (including interviewing the parent);

(3) Identifying the child's level of functioning in each of the developmental areas in § 303.21(a)(1);

(4) Gathering information from other sources such as family members, other care-givers, medical providers, social workers, and educators, if necessary, to understand the full scope of the child's unique strengths and needs; and

(5) Reviewing medical, educational, or other records.

(c) Procedures for assessment of the child and family.

(1) An assessment of each infant or toddler with a disability must be conducted by qualified personnel in order to identify the child's unique strengths and needs and the early intervention services appropriate to meet those needs. The assessment of the child must include the following—

(i) A review of the results of the evaluation conducted under paragraph (b) of this section;

(ii) Personal observations of the child; and

(iii) The identification of the child's needs in each of the developmental areas in § 303.21(a)(1).

(2) A family-directed assessment must be conducted by qualified personnel in order to identify the family's resources, priorities, and concerns and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the family's infant or toddler with a disability. The family-directed assessment must—

(i) Be voluntary on the part of each family member participating in the assessment;

(ii) Be based on information obtained through an assessment tool and also through an interview with those family members who elect to participate in the assessment; and

(iii) Include the family's description of its resources, priorities, and concerns related to enhancing the child's development.

(Authority: 20 U.S.C. 1435(a)(3), 1435(a)(5), 1436(a)(1)–(2))

303.409 Fees for records.

(a) Each participating agency may charge a fee for copies of records that are made for parents under this part if the fee does not effectively prevent the parents from exercising their right to inspect and review those records, except as provided in paragraph (c) of this section.

(b) A participating agency may not charge a fee to search for or to retrieve information under this part.

(c) A participating agency must provide at no cost to parents, a copy of each evaluation, assessment of the child, family assessment, and IFSP as soon as possible after each IFSP meeting.

(Authority: 20 U.S.C. 1417(c), 1432(4)(B), 1439(a)(2), 1439(a)(4), 1442)

Ohio Revised Code: 5123-10-02 (15)

“Informed clinical opinion” means the process used by qualified personnel in the evaluation and assessment process to make a recommendation as to initial and continuing eligibility for services under part C and as a basis for planning services to meet child and family needs. Informed clinical opinion makes use of qualitative and quantitative information to assist in forming a determination regarding difficult-to-measure aspects of current developmental status and the potential need for early intervention.

(C)(c)(i) “Eligibility for early intervention services” Children for whom the developmental evaluation tool does not indicate a developmental delay of at least one and one-half standard deviations below the mean in adaptive, cognitive, communication, physical, or social and emotional development, may be made eligible using informed clinical opinion with a written explanation of the sources of information used and how those sources of information support eligibility.