

## Evaluations and Assessments

### Introduction

In order to plan and implement appropriate supports and services for children and their families, evaluations and assessments must be conducted. The provision of evaluations and assessments must be an on-going process that is clearly linked with intervention. Evaluations and assessments are conducted to:

- assess the current developmental status of the child, including the child's unique strengths and needs;
- address concerns expressed by the family and others;
- identify the priorities and resources of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their child;
- assist, as appropriate, in determining eligibility for the Infant-Toddler Program, and later for the Preschool Program;
- serve as the basis for the development of appropriate interventions in the Individualized Family Service Plan, and
- follow the child's developmental progress during early intervention and provide information for transitioning to other programs at age three.

The Children's Developmental Services Agency is accountable for the quality of all evaluations and assessments. Aspects of quality include evaluator qualifications, thoroughness of evaluation, use of recommended practices, responsiveness to the family, comprehensiveness of written information, and timeliness.

Evaluators should encourage parent participation during evaluations and assessments within the constraints of the testing protocol. Dialogue with the parent and other caregivers is encouraged to ensure that the performance of the child is typical of the child's everyday behavior.

An initial evaluation must be conducted as part of enrollment in the Infant-Toddler Program. Specific requirements related to this initial Infant-Toddler Program evaluation are described following the Introduction in this Policy Bulletin. Also, addressed in this Policy Bulletin are additional evaluations and on-going assessment, evaluation reports, and related requirements associated with all evaluations.

Federal Infant-Toddler Program regulations use the term "multidisciplinary" when referring to the team approach used when conducting evaluations. North Carolina encourages service providers to use an interdisciplinary or transdisciplinary team approach when providing evaluations and intervention services. Definitions for these terms may be found in the Glossary of this Manual. Additional information about recommended evaluation and assessment practices can be found in the document

*Family-Directed Assessment: Birth to Three – A Guidance Document for Early Intervention Providers in North Carolina.*

### **Initial Infant-Toddler Program Evaluation**

The initial Infant-Toddler Program evaluation must be individualized for each child and family in order to address adequately their unique characteristics, needs, and concerns. For some children, this evaluation only needs to be the minimum required by federal regulations and described in this Policy. For other children, the initial evaluation needs to be a comprehensive, diagnostic work-up. For many children, what is needed falls somewhere between the previous two examples. The Service Coordinator, in his initial discussions with the parent, must identify the family's concerns, need for information, and preferences regarding this evaluation and use this information to assist the Children's Developmental Services Agency in offering the most appropriate evaluation.

The Children's Developmental Services Agency is responsible for assuring that the initial Infant-Toddler Program evaluation is completed so that a child's Individualized Family Service Plan can be developed within forty-five (45) days from referral to the Infant-Toddler Program. Any delays in meeting the 45-day requirement must be documented in the Service Coordinator's record on the child. A copy of any notes documenting delay in meeting this requirement must be filed in the Children's Developmental Services Agency's record on the child at the time of the notation.

The Children's Developmental Services Agency may do all or part of the evaluation or the entire evaluation may be done by another provider. For example, an enrolled Infant-Toddler Program service provider might assess all of the child's developmental areas except physical development, which could be assessed by the physical therapist from the Children's Developmental Services Agency, and the medical information could be obtained from the child's own pediatrician.

### **Components of the Initial Evaluation**

#### **For the Family**

A family-directed assessment of the family's concerns, priorities, and resources related to enhancing their child's development should be completed. Completion of this assessment is the responsibility of the Service Coordinator unless arrangements are made for it to be completed by another professional. The parent should be informed that this assessment is not meant to be intrusive, but rather to help professionals more effectively assist the family in designing a program that will build upon and reinforce the family's strengths and resources in meeting his child's needs. Information acquired from the "Welcome to My World" part of the *North Carolina Infant-Toddler Program/Preschool Program Referral Form* can provide initial insight into the family's concerns, priorities and resources. Additional family assessment tools may be used as appropriate, but the assessment must incorporate personal interviews with the family. Completion of the relevant section of the *North Carolina Infant-Toddler Program Individualized Family Service Plan* form may serve as written documentation of this assessment. The process for gathering this family information is not necessarily a formalized process, but may be information gathered in discussion with the family during initial contacts. Areas to address include:

- concerns - circumstances or areas which worry, distress or create difficulties for families that are related to their child or the family's ability to support their child's development. Problems and areas that do not fulfill family members' dreams or expectations are concerns. The needs a family expresses, the challenges they confront, and their interests in "things being better or different" also comprise a family's concerns.
- priorities - concerns that the family decides should be addressed first; a family's agenda and choices for how early intervention will be integrated into family life.
- resources - the people, skills and capacities, relationships and concrete assets that a family has or has access to that support, nurture, and sustain family members or the family as a whole. Resources may include health care providers, community resources, other family members, and friends. Qualities and characteristics of family members and formal and informal supports that help a family meet its needs and accomplish its goals are also resources.

This assessment is voluntary on the part of the family, but is strongly recommended. The parent must be informed that it is at his discretion what information he shares and what he wants included as part of evaluation and intervention planning. The parent must be informed that, with his permission, this information will be shared with persons planning the child's initial evaluation and with the Individualized Family Service Plan team. The parent must be informed that his choosing not to participate in this family-directed assessment may limit the team's ability to fully address the family's concerns, but in no way jeopardizes the child's and family's participation in the Infant-Toddler Program. In the event the parent declines to share his concerns, priorities, and resources, or shares them, but prefers that they not be included in the Individualized Family Service Plan, the Service Coordinator must note this in the relevant section of the *North Carolina Infant-Toddler Program Individualized Family Service Plan*.

### **For the Child**

In planning for the child's initial evaluation, the Service Coordinator must:

- provide information to the parent regarding the general purpose, process, and options regarding this evaluation;
- discuss with the parent the appropriate persons (e.g., professionals, family members, other caregivers) to be involved in the evaluation based on the child's developmental issues and the family's concerns, priorities, and resources;
- discuss the options and considerations for setting, time, location of the evaluation, including identification of the child's and family's everyday routines, activities and natural settings so that the evaluation will incorporate observation of the child during these times and in these locations;
- gather information to individualize the evaluation process by asking questions, such as how would the parent and other family members like to participate in the evaluation, what should

the evaluation team know before evaluating the child, are there favorite toys or other suggestions that would help the child to be more comfortable, etc.;

- discuss if there are any developmental issues that may affect the evaluation or any adaptations that may need to be made, and
- identify any potential barriers to the family participating in the evaluation (e.g., transportation, childcare, work-related issues, language barriers) and assist the parent in resolving these issues.

The specific number and types of disciplines involved in the initial Infant-Toddler Program evaluation is variable and is based on the particular needs and characteristics of the child and concerns expressed by the family. However, it must involve at least two persons, each representing a different discipline or profession and who differ from each other in job classification or clinical perspective. These persons must have evaluated or examined the child and written the evaluation reports. As a means of integrating the results and recommendations in preparation for intervention planning, they must talk directly with each other or with the Service Coordinator, who will be facilitating the Individualized Family Service Plan team. The Service Coordinator cannot count as one of the two disciplines unless he conducted a portion of the child's initial evaluation. The medical provider may only be counted as one of the two required disciplines if he actually saw the child and generated the written report and he actively participates in a discussion with the other evaluation provider or with the Service Coordinator to integrate results and recommendations.

More than one procedure or assessment tool must be used. An initial evaluation must provide an integrated assessment that identifies the child's present level of development and unique strengths and needs in the following areas:

1. Cognitive development.
2. Physical development, including gross and fine motor function, vision, and hearing.
3. Communication development.
4. Social-emotional development.
5. Adaptive development.

In addition, the initial evaluation must include a medical component, which provides a medical perspective of the child's development and need for intervention and includes a review of pertinent records related to the child's current health status and medical history. Growth and nutrition should be addressed as appropriate. The medical component can be completed by a physician, a physician extender, or a nurse who has successfully completed the "Child Health Training Program for Registered Nurses" taught under Division of Public Health guidelines.

The initial evaluation can involve the use of previously conducted developmental evaluations if the evaluation was conducted within the past six months and its information is readily available and complete. Health and medical information included as part of the medical component for children thirty months and younger also must be within the past six months. This is a reasonable expectation for children who are receiving well child care visits with their primary care physician based on the recommended frequency of the American Academy of Pediatrics, which is by one month, at two months,

four months, six months, nine months, twelve months, fifteen months, eighteen months, twenty-four months, and three years. The allowable timeframe for children over the age of thirty months may exceed six months but must not exceed one year. The medical staff of the Children's Developmental Services Agency or the Service Coordinator should discuss, as appropriate, the importance of regularly scheduled well child care with the parent and assist him in establishing a medical home where a primary care physician can provide on-going, preventive health care and coordinate the child's health care needs.

The evaluation of the developmental areas (cognitive, motor, communication, social-emotional, and adaptive) may be completed through the use of standardized instruments and procedures, the application of a developmental profile, and other procedures, such as clinical observation, appropriate to the needs of the child. Screening instruments cannot be used because they are not appropriate for diagnosing conditions or determining eligibility.

Observation must be a part of every child's initial Infant-Toddler Program evaluation and should include:

- observation of the child in situations related to the family's concerns;
- systematic observation of functional abilities in the child's daily routine or natural setting;
- observation of parent-child interaction, and
- evaluation of the child's play, with both familiar and novel toys.

Methods to assess vision and hearing function must be age and developmentally appropriate and must be approved by the Children's Developmental Services Agency. Results of newborn hearing screenings are a valuable source of information for determining hearing function, unless there is concern that the child's hearing ability has changed (e.g., otitis media, progressive hearing loss). Staff from the Governor Morehead Preschool Program and the Early Intervention Program for Children Who are Deaf or Hard of Hearing are valuable resources in the evaluation of children with vision or hearing concerns.

### **Additional Evaluations and On-going Assessments**

During the course of intervention, service providers or the parent may identify the need for additional evaluations. Service Coordinators are responsible for arranging for these evaluations and then calling together the Individualized Family Service Plan team to review the results and incorporate recommendations into the Individualized Family Service Plan, as appropriate. Although the initial Infant-Toddler Program evaluation must involve two or more disciplines, subsequent evaluations do not. The Infant-Toddler Program does not require re-evaluations on any standard schedule, but must arrange for them as the need arises. As the child approaches age three, there may be a need for an evaluation as part of the transition process from the Infant-Toddler Program.

Intervention planning by the Individualized Family Service Plan team must include discussions related to the inclusion of on-going assessments by service providers as a means for monitoring the child's developmental progression and skills acquisition.

## Evaluation Reports

Each evaluator must share in a written format the results of the evaluation conducted. This information may be written in the form of an individual report that would include at a minimum: reason for evaluation; areas or domains evaluated; procedures used; evaluation results including strengths and needs; clinical observations; and recommendations for intervention. The written information of a single evaluator may be combined with the results of other evaluators in the form of a summary or integrated report that would contain all of the above. The use of a summary or integrated reporting format is preferred, when possible, in that it provides for the family and others a clear, concise, integrated picture of the child's development and need for intervention.

Evaluation reports, whether written individually by evaluators or collectively in an integrated, summary report, are more comprehensive than what is required for the Child Assessment section of the Individualized Family Service Plan. Evaluation reports should contain thorough details about the reason for evaluation, clinical observations, and recommendations for intervention. Some of these details may not be desired by the family or appropriate for inclusion in the Individualized Family Service Plan but are needed for a complete evaluation report. Evaluation information appropriate for the Child Assessment section of the Individualized Family Service Plan is to be transferred from evaluation reports to the Individualized Family Service Plan rather than attaching entire evaluation reports.

Evaluation reports should be of sufficient detail to allow the Individualized Family Service Plan team to use the information contained in the report to develop outcomes and select appropriate intervention strategies. Evaluators should describe the child's functional status, identify strengths and needs, and recommend areas for intervention, (e.g., sitting, using words, interacting with peers, responding to caregivers, strengthening muscle tone). Evaluators should avoid recommending in their evaluation reports specific services, programs, providers, methods, settings, type of provider, or frequency and intensity (e.g., Briar Creek Developmental Center, Mary Smith, occupational therapy, twice a week for an hour at the medical clinic) as these will be determined by the Individualized Family Service Plan team after outcomes are developed. Evaluators need to offer parents as many options as possible for addressing the child's needs, including directing the family to both formal and informal supports.

Evaluation reports must be written so that the parent and non-clinicians can understand the findings and recommendations. Reports must be free of technical jargon, easy to understand, and sensitive to the family. If it is necessary to include discipline-specific terminology, then these expressions must be explained.

## Sharing Evaluation Results with Parents

The results of evaluations and assessments must be shared and interpreted with the parent as quickly as possible following the evaluation or assessment in language understandable to the parent. The sharing of the results may happen in a variety of ways depending on the circumstances of when and where the evaluation takes place, who is present during the evaluation, the timelines under which the evaluation is taking place, etc. In some situations, the Service Coordinator may be the most appropriate person to share the results, or one or more of the evaluation providers might best conduct this activity. Individual evaluation providers might share and interpret results at the conclusion of their evaluation sessions with the child rather than scheduling a separate interpretive or parent conference. Since an evaluation provider

is a required participant at initial and annual Individualized Family Service Plan meetings, the results of an evaluation or assessment might best be shared as part of this meeting instead of as a separate activity. If a staffing is held by a group of evaluation providers separate from an Individualized Family Service Plan meeting, the parent must be a participant in the staffing.

### Related Requirements

1. The parent must receive Written Prior Notice and provide Written Parental Consent before evaluations and assessments of the child are conducted (other than assessments related to the on-going provision of therapy, educational services, etc.). Providing Written Prior Notice and obtaining Written Parental Consent for evaluations and assessments are the responsibility of the Service Coordinator. *(For additional information, see Policy Bulletin #13 - Written Prior Notice and Policy Bulletin #12 - Written Parental Consent.)*
2. The time and location of evaluations should be convenient for the family to the extent possible and conducive to obtaining the most representative assessment of the child's developmental functioning.
3. Family members must be an integral part of the evaluation process through planning, information sharing, etc. If a surrogate parent has been appointed, then that person must be included in the evaluation process.
4. All evaluation procedures must be administered in the native language or other mode of communication of the child and family. In addition, all evaluation procedures and materials must be culturally appropriate. *(For additional information, see Policy Bulletin #14 - Native Language/Mode of Communication.)*
5. Evaluation results must be shared in the parent's native language or mode of communication. At a minimum, a summary of the results of the evaluation must be translated. If it is clearly not feasible to have written information translated, particularly in a timely manner, providers must work diligently to secure someone to translate the information orally. *(For additional information, see Policy Bulletin #14 - Native Language/Mode of Communication.)*
6. Staff from either the Governor Morehead Preschool Program or the Early Intervention Program for Children who are Deaf or Hard of Hearing must be involved in evaluation planning and providing evaluations, as appropriate, when a child is known to have a problem with vision or hearing.
7. Specific fee and transportation policies related to evaluations must be explained to the family. *(For additional information, see Policy Bulletin #23 - Fees, Reimbursement, and Billing and Policy Bulletin #30 - Transportation and Respite.)*
8. Evaluations must be conducted by persons qualified to do so. These professionals must be trained in the basic principles of evaluation, including appropriate administration, scoring, and interpretation of results for young children. The Children's Developmental Services Agency is

- responsible for ensuring that evaluators are qualified and that evaluation methods and instruments used are appropriate.
9. Evaluators must administer the latest, most up-to-date version of the test when a standardized evaluation tool is used.
  10. All evaluation and eligibility information for children under age three should be viewed holistically. For very young children, developmental domains often are not clearly detectable. Therefore, for children under age three, parental report, informed clinical opinion, and other qualitative and quantitative information are all essential components to the evaluation of individual children. Quantitative scores can be useful but are not a necessary outcome of evaluation unless this is an objective of the evaluation or scores are needed or desired by the family or referral source. Qualitative statements of a young child's development often are more helpful to intervention planning. *(For additional information about informed clinical opinion, see Policy Bulletin #20 - Eligibility Determination.)*
  11. The practice of adjusting for prematurity, when conducting developmental assessments with children who are born prematurely, is used to compare the child with his age peers and to provide better information for developmental programming. When evaluating infants and young children up to 24 months of age, the evaluator should follow the instructions on the evaluation tool regarding adjusting for prematurity when scoring and interpreting the results. In the absence of such instructions, it is the recommendation of the Infant-Toddler Program that the child's age be adjusted for prematurity by computing a gestational age by subtracting the length of prematurity from the chronological age. However, the practice of adjusting for prematurity does not replace the need for professionals to use clinical opinion when interpreting the assessment results to the family and developing Individualized Family Service Plan outcomes. Likewise, the Children's Developmental Services Agency must use clinical opinion when determining eligibility for the Infant-Toddler Program. Therefore, the absence of a qualifying delay when the adjusted age is used should not, in and of itself, be used to deny eligibility for the Infant-Toddler Program.
  12. The Children's Developmental Services Agency must work with hospitals to ensure appropriate and timely evaluations of children in Neonatal Intensive Care Units for eligibility determination and intervention planning. Most developmental evaluations and protocols used in community settings were not standardized on the population of infants served by Neonatal Intensive Care Units and are not appropriate to determine developmental levels for these children. It is important that other procedures including neurobehavioral assessments, observational tools, and informed clinical opinion be used when evaluating these children. Areas assessed may include behavioral indicators of the baby's physiological functioning, motor development, maturation, and function within different states of consciousness; development and robustness of attention; development and effectiveness of self-regulation, and response to handling. Individuals performing evaluations of children in this hospital setting should review the medical chart to gather information on the medical history, diagnosis, and health status of the newborn. Evaluators need to be familiar with the developmental needs of these newborns and their rapidly changing medical status and behavior. Evaluators may contact the Children's Developmental Services Agency for suggested evaluation tools and protocols.

13. The parent and the surrogate parent, if one has been appointed, must be fully informed of all evaluation results and copies of all reports must be made available to them upon request.
14. The Infant-Toddler Program is not responsible for costs the parent incurs in seeking a second opinion regarding evaluation or assessment findings. However, if the parent obtains an evaluation or assessment at his own expense, the Individualized Family Service Plan team must take into consideration the information provided.
15. The Individual Child Complaint Resolution process described in this Manual is to be followed if a parent disputes the administration or results of a particular evaluation. (*For additional information, see Policy Bulletin #18 - Complaint Resolution-Individual Child.*)