

Physical and Occupational Therapy under IDEA in Oregon: Early Intervention, Early Childhood and School Age Special Education

Amended May 2016

Revised and Edited by the following members of the Oregon Orthopedic Impairments Professional Learning Team of the Oregon Regional Programs System:

*Connie Hector, PT, MEd
Regional and Statewide Services for Students with Orthopedic Impairments*

*Wendy Friedman, LPT
Physical Therapist
4J School District*

*Brad Hendershott
Academic Program Administrator
Columbia Regional Program*

*Patricia Irelan, OTR/L
Occupational Therapist
Northwest Regional ESD*

*Lisa McConachie, Ed.D.
Senior Director
Columbia Regional Program*

*Cynder Lammers-Smith, PT
Physical Therapist
Intermountain ESD*

*Annette Willrett, OTR/L
Occupational Therapist
Southern Oregon ESD*

Julie Clark, Program Assistant

Distributed by

Regional and Statewide Services for Students with Orthopedic Impairments
1871 NE Stephens, Roseburg, Oregon 97470
www.rsoi.org

Physical and Occupational Therapy under IDEA in Oregon may be published in whole or in part without permission. This manual may be accessed online at www.rsoi.org.

It is the policy of the State Board of Education and a priority of the Oregon Department of Education that there will be no discrimination or harassment on the grounds of race, color, sex, marital status, religion, national origin, age, sexual orientation, or disability in any educational programs, activities or employment. Persons having questions about equal opportunity and nondiscrimination should contact the State Superintendent of Public Instruction at the Oregon Department of Education, 255 Capitol Street NE, Salem, Oregon 97310; phone 503-947-5740; or fax 503-378-4772.

Preface

This manual is written as a guide for provision of occupational and physical therapy (OT and PT) services in educational programs in Oregon. It is intended for therapists who are new to the educational setting, as well as for those who are experienced in the field, but who are sometimes challenged to understand the role that OT and PT play in the broad spectrum of educational programs throughout the state. It is also intended as a resource for supervisors who may not have a background in the field of therapy, but who supervise and evaluate therapists.

This page intentionally left blank.

Acknowledgements

This guide was originally adapted from two manuals published by Project TIES: Therapy in Educational Settings, a three-year, grant-funded project conducted by the University Affiliated Program of the Child Development and Rehabilitation Center at the Oregon Health Sciences University, and the Oregon Department of Education's Regional and Statewide Services for Students with Orthopedic Impairments Program. The goal of the project was to develop training materials for physical therapists and occupational therapists working in educational programs. We are indebted to the original writers of the TIES manuals for their vision, and the high quality and durability of their work. They are Nancy Cicirello, PT, MPH, EdD; Sandra Hall, OTR; Judith Hylton, MS; and Penny Reed, PhD.

When the original TIES manuals were re-examined in 1999, representatives from school programs throughout the state reported that they were still in use after more than ten years. This endorsement of the continued need and the high utility of the original documents led to the decision to update the manuals and combine them into a single guide. The resulting document, published in 2001, retained much of the information found in those original manuals.

This manual continues to guide therapists, educators and administrators in Oregon regarding the practice and services for students from birth to age 21. The manual was revised again in 2011 to include the changes from the 2004 reauthorization of the Individuals with Disabilities Education Improvement Act (herein referred to as IDEA). Due to changes in Regional Programs Services for Students with Low Incidence Disabilities for children with Orthopedic Impairments and new OARs for telepractice, the manual was again revised to help guide practice. Included in the revision was a change to the previous Oregon Regional Eligibility Screening Tool which was renamed the Oregon Orthopedic Impairment Needs Assessment which can be used to assist in eligibility determination for orthopedic impairment. In addition, the new manual includes separate chapters for early intervention, early childhood special education, and school-aged special education, in recognition of the important distinctions among each of those settings.

We are grateful to the members of the statewide OI Professional Learning Team, who collaborated with us to revise and edit this updated edition of the manual. Their partnership and ongoing leadership are vital to the integrity of this work, and to the work of therapists working in educational settings throughout Oregon. We would also like to thank the staff of the Oregon Department of Education's Office of Student Learning and Partnerships for assisting to ensure compliance with IDEA 2004 in this amended edition.

Connie Hector
May, 2016

This page intentionally left blank.

Physical and Occupational Therapy under IDEA in Oregon: Early Intervention, Early Childhood and School Age Special Education

Contents

Preface	iii
Acknowledgements.....	v
Contents.....	vii
Introduction	1
Chapter 1: A Theoretical Framework for Therapy Services under IDEA 2004	3
Chapter 2: Delivery of Therapy Services under IDEA 2004 – EI/ECSE	9
Chapter 3: Delivery of Therapy Services under IDEA 2004 – School Age.....	27
Chapter 4: Modes of Service Delivery under IDEA 2004.....	45
Chapter 5: Documenting Therapy Services under IDEA 2004.....	52
Chapter 6: Supervision, Evaluation, and Mentorship of Therapists Employed by Educational Agencies	58
Chapter 7: Regional Services for Students with Orthopedic Impairment in Oregon	68
Bibliography	72
Appendix Table of Contents	74
Appendix A: Oregon Documents	
Appendix B: Regulations Relating to Therapy in Educational Settings	
Appendix C: Resources	

This page intentionally left blank.

Introduction

The United States Department of Education was established to promote student achievement and prepare for global competitiveness by fostering educational excellence and ensuring equal access. The Department is dedicated to establishing policies on federal financial aid for education, distributing as well as monitoring those funds, focusing national attention on key educational issues and prohibiting discrimination and ensuring equal access to education. To meet these intentions the Department of Education has been given mandates from Congress. The Elementary and Secondary Education Act (ESEA) and the Individuals with Disabilities Education Improvement Act of 2004 (IDEA or IDEA 2004) are but two of the laws which apply to the educational system.

Federal special education law, IDEA 2004, specifically states that educational programs are responsible to provide occupational and physical therapy services to children with disabilities who need them in order to benefit from his/her instructional program. The law indicates that therapy provided in educational settings is designed to enhance the child's ability to participate in the educational process.

The Oregon Administrative Rules (OARs) for the Oregon Department of Education interpret the Oregon Revised Statutes, which include many statutes based on federally enacted laws. The OARs have requirements which each school district or educational agency must follow. However, each district or agency has the latitude to implement the rules as the district or agency determines. The OARs for special education and occupational and physical therapy inform practice in educational environments.

The educational preparation of occupational therapists (OTs) and physical therapists (PTs) strives to prepare graduates for employment in any number of practice environments. As medical professionals, OTs and PTs typically have more familiarity with predominant medical environments such as hospitals and outpatient clinics. Practice in an educational environment, such as a public school, may be given less emphasis in their respective professional educational preparation. Consequently, therapists may experience some confusion regarding their role in the educational programs of children with disabilities within the parameters of IDEA 2004. This manual is a guide for Oregon therapists embarking on provision of therapy services to children under this federally mandated legislation.

It is intended as a guide or reference for therapists who are new to the field of therapy in Kindergarten through 12th grade education, as well as for supervisors of therapists working in educational environments. It discusses the therapist's primary role of providing services that help a child with a disability to benefit from his/her educational program. It contains information about the therapist's role in the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) process, types of services provided by therapists in educational settings, and supervision and evaluation of licensed therapists and licensed or certified therapist assistants. This information should be of help to administrators, teachers, parents and therapists in understanding the unique role and scope of service of therapists working in educational settings.

This page intentionally left blank.

CHAPTER 1

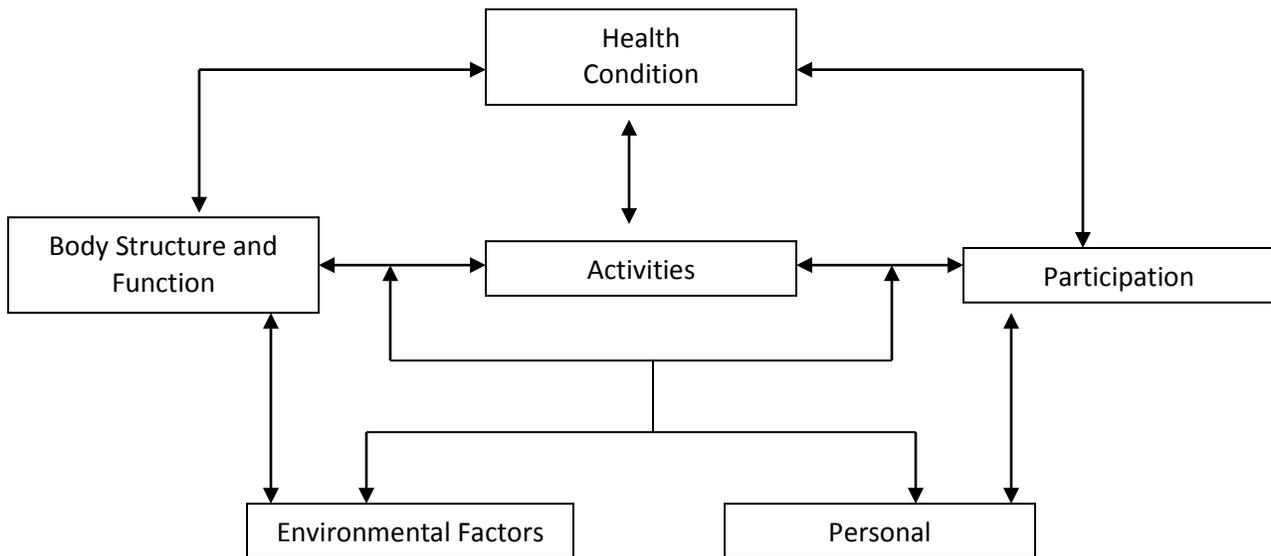
A Theoretical Framework for Therapy Services under IDEA 2004

Prior to 2002, the model for service delivery recommended by the World Health Organization (WHO) and the National Center for Medical Rehabilitation Research (NCMRR) identified five dimensions of disability, known as the "Disablement Model."

This model was primarily a hierarchical model which implied that a change in one level would impact the next level in a somewhat linear relationship. There were several limitations to the model and the result was that in many cases too much emphasis was placed on impairment with the expectation that this would have a positive impact on function. Research in the area of motor learning and motor control did not bear this out.

Since 2002 the American Physical Therapy Association (APTA) and the American Occupational Therapy Association (AOTA) use the WHO's International Classification of Functioning, Disability, and Health (ICF). This framework is used to organize the therapists' examination, evaluation, and intervention process throughout all practice venues and across the lifespan of therapy recipients. An explanation of this classification framework succinctly melds with the intent of the IDEA 2004. The ICF framework (see Figure 1, page 4) reflects an emphasis on an individual's participation in activities germane to his/her current and future roles in a variety of environmental contexts.

The intersection of person, task, and environment (Horak, 1991, and Bradley and Westcott, 2006), with an emphasis on a person's successful participation in a variety of environments, is at the core of the ICF theoretical framework. Inability to carry out activities and participate in life situations such as attending school can be impacted by problems in one's body structure and function. These situations may stem from a health condition or a potential current or future environmental barrier. Physical and occupational therapists, in collaboration with other professionals providing supportive services to students, infants and young children, can use this model to communicate what the recipients of their services need for successful participation in the various activities. Assessments of children within this framework should take a holistic approach to identifying any enabling or restricting factors to the child or student's full participation. This holistic assessment should inform team planning for services. It displaces the traditional deficit model approach to service delivery that perpetuates discipline specific goal writing, and replaces it with student/child/family centered goal development. Long-term outcomes are more easily identified and pursued and therapist advocacy roles are more transparent when utilizing the ICF framework.

Figure 1: The ICF Framework (WHO, 2001)

Elements and definitions of the ICF framework include:

- ♦ **Participation:** Role fulfillment such as functioning as a student in an educational environment.
- ♦ **Activity:** Functional tasks, e.g., writing responses to an exam, attending school plays, playing on the playground, giving a book report, or eating lunch.
- ♦ **Health Condition:** Specific pathology, diagnosis, and prognosis of condition course such as spina bifida, autism, cerebral palsy, or limb deficiency.
- ♦ **Body Structure:** The anatomical parts of the body such as organs, limbs, and their components.
- ♦ **Body Function:** The physiological function of body systems (including psychological functions).
- ♦ **Personal and Environmental Contributing Factors:** External physical factors may include materials, environment, climate, geography, or rural/urban settings. Social factors may include language, relationships, or cultural expectations.

Using the ICF model, physical and occupational therapists' interactions with each child/student encompasses six elements of patient/client management, collectively referred to as Assessment in Education Practice Setting. In chronological order these include:

- ♦ **Examination** is required prior to initial intervention for all students/children. It includes a comprehensive screening and specific testing to determine impairments, activity limitations, and participation restrictions. The three major components of any examination are history, systems review, and tests and measurements.
- ♦ **Evaluation** refers to the clinical judgment made based on the clinical findings and history acquired from the examination in concert with knowledge regarding the specific health condition.

- ♦ PT or OT **Diagnoses** are those labels that can identify the impact of a condition on function at the level of the body system.
 - ♦ **Prognosis** is the determination of predicted optimal level of improvement in function and the amount of time needed to reach that level. In non-school environments this would be the plan of care, in school or early intervention environments this would be the IEP or IFSP document.
 - ♦ **Intervention** is the intended interaction of the therapist with the child/student or other providers/support staff involved with physical management of the child/student. This may include treatment, coordination, communication, documentation, and instruction.
 - ♦ **Outcomes** are the anticipated, projected goals and objectives from the interventions.
- (Adapted from Guide to Physical Therapist Practice, 2001)

Therapy services in educational settings are defined by federal special education law, known as IDEA or the Individuals with Disabilities Education Improvement Act of 2004.

In addition to IDEA there are a number of other federal laws which also impact services to students identified as eligible for special education programs. While essentially different, there are many of overlapping principles and protections.

The World Health Organization's 2001 International Classification of Functioning, Disability, and Health (ICF) may be used to organize the therapists' examination, evaluation, and intervention process throughout all practice venues and across the lifespan of therapy recipients.

Age Categories under IDEA

There are two distinct parts of IDEA 2004: Part B and Part C. Part B describes services for children ages 3 to 21. Part C describes services to children ages birth to 3. In Oregon, the state Department of Education provides early intervention (birth to age 3) and early childhood special education (age 3 to school age) services through contracts with Education Service Districts (ESDs). School Districts provide special education services for children in kindergarten through grade 12.

Student census numbers vary according to population densities; therefore, some school districts form a consortia, called regional programs, that are defined by geographical boundaries for employing therapists who are itinerant across many districts. A few districts contract with therapists from local hospitals.

Special education age groupings parallel the roles and expectations of children at different times of their lives and learning. By the same token, the environments where services are provided are very different.

Early intervention services take place in "natural environments" or other settings as determined by the IFSP team. Natural environments include, but are not limited to, the family home, child care, community setting, etc. Child and family-centered goals are paramount. Early intervention goals focus on the child's developmental needs which are

indistinguishable from educational needs at this age. Gross and fine motor exploration is important as a part of a child's overall development as are the ways in which a child communicates and learns reciprocity. Communication and social skills should be supported in the delivery of OT and PT services.

The early childhood special education setting is determined by the IFSP team and provided in the location(s) that best meet the child's needs. This may be in settings such as a community preschool, the child's home, or an ECSE classroom. Developmental and educational child-centered goals are often one and the same at this age. Some goals may address pre-literacy and pre-numeracy skills but the focus remains on providing what the child needs. The expectation for 3-5 year olds is to develop skills to navigate their daily environments and prepare them for school. Occupational and physical therapy services provide necessary supports to help children meet these expectations.

Recognizing and embracing these age groupings gives additional value to the commonalities of the ICF model and the tenets of IDEA 2004. Personal and environmental contextual considerations encourage therapists to make decisions and provide services appropriate to the child's development. It also facilitates child- and family-centered goals that are not therapy domain-specific. Child/student goals can be more readily written in terms of activity participation and function in the educational environment.

Table 1: Comparison of Part C and Part B of IDEA 2004

	Part C – Early Intervention	Part B – Special Education
Goals	The focus is on supporting the family to meet the developmental needs of their child with a delay or disability.	The focus is on the child and his/her educational needs.
Age	Applies to children from birth to age 3; eligibility determined by medical condition or by significant developmental delay.	Applies to children age 3-21; eligibility determined by specific categories of disability or, for 3 and 4 year-olds, significant developmental delays.
Service Coordination	Each eligible infant or toddler and his/her family must be provided with a service coordinator.	Under special education law, there is no requirement that a service coordinator be designated for a child and his/her family. Service coordination is typically provided by the special education teacher.
Services	Services and supports are documented in an IFSP (Individual Family Service Plan) and may be provided by a variety of agencies.	Special education and related services are documented in an IFSP for children age 3 to 5 and provided by the local EI/ECSE program. For children K to age 21, special education and related services are documented in an IEP (Individualized Education Program) and are the responsibility of the local school district.
Delivery of Services	Requires services and supports to be provided in “natural environments.”	Requires special education and related services to be provided in the “least restrictive environment.”
Recipient of OT/PT Services	Recipients of services and supports are the infant/toddler and/or the child’s family.	Recipients of special education and related services and supports are the child, the education staff and the child’s family.
Assessment Disputes	NA	Parents may obtain an independent educational evaluation (IEE) at school district’s expense if they disagree with the accuracy or appropriateness of the school district’s assessment. Districts may request a due process hearing to prove the accuracy or the appropriateness of its assessment. OAR 581-015-2765 (age 3 to 5); OAR 581-015-2305 (age 5 to 21)
Dispute Resolution	Dispute resolution through the complaint process, mediation or due process hearing; after using these, parents may file a civil court action, but are not entitled to recover their attorney’s fees and costs.	Dispute resolution available through all of the same processes as Part C; attorney’s fees incurred for due process hearing or civil action may be awarded to parents under certain circumstances.
Procedural Safeguards	Procedural safeguards include: <ul style="list-style-type: none"> ♦ prior written notice of meetings, etc. ♦ confidentiality of information ♦ right to decline some services or supports without jeopardizing others ♦ transition planning ♦ right to examine agency records related to the child and obtain copies at reasonable cost ♦ written consent before assessment or initiation of each service and supports ♦ right to have outside evaluation obtained at parent expense be considered by IFSP team and included in child’s records. 	Procedural safeguards include: <ul style="list-style-type: none"> ♦ prior written notice of meetings, etc. ♦ confidentiality of information ♦ right to examine school district records related to child and obtain copies at reasonable cost ♦ written consent required before initial assessment and provision of special education ♦ special education services provided according to the IFSP/IEP to ensure FAPE ♦ extended school year services if child requires them ♦ transition planning ♦ right to have outside evaluations obtained at parent expense considered by IEP team and included in child’s record.

Adapted from: Long, M.J. (Ed.). (1999). *First Steps to Discovery: A Parent Guide to Colorado's Early Childhood Services Under Parts C and B of the Individuals with Disabilities Education Act*. Denver: The Legal Center.

This page intentionally left blank.

CHAPTER 2

Delivery of Therapy Services under IDEA 2004 in Early Intervention and Early Childhood Special Education

This chapter will address the requirements of Part C (birth-age 3) and Part B (ages 3 to 5) in a chronological progression of IDEA 2004 mandated service programs. The process for the school-age population (ages 5 to 21) will be discussed in more depth in Chapter 3.

In Oregon, EI (birth to age 3) and ECSE (ages 3 to 5) programs are managed as one program. In many other states, EI programs for children birth to- age 3 are managed separately from ECSE preschool-based programs for children ages 3-5. Since the programs fall under two parts of IDEA, it can be confusing for therapists who come from other states where the programs are managed by different agencies as separate programs.

Delivery and mode of therapy services for a given child and family are based upon individual needs. Decisions regarding therapy services are made by a team which includes the child's parent(s), teachers, therapists, and others, and are based upon the recommendations of the therapist. For children in EI programs the team develops the Individual Family Service Plan, or IFSP, reflecting the emphasis on service to the child in the context of the family.

For children in early intervention programs, therapists teach and support families and other professionals to encourage the child's success in gaining developmental milestones.

Therapy in EI/ECSE is designed to help children benefit from their specialized program of instruction by focusing on the child's function, level of independence, ability to generalize skills from setting to setting, and transition needs. Activity- and participation-centered therapy strives to provide young children with skills and adaptations which allow them to become as independent as possible in a variety of environments: the home and community, and the preschool and community for older children. An activity- and/or participation-centered basis for therapy provide continuity for children and their families during the anticipated and expected transitions from one educational setting to another.

Occupational and Physical Therapy Services in Early Intervention (EI) Programs (0-3)

Part C of IDEA 2004 defines the responsibilities of early intervention (EI) programs for children from birth to three. Part C requires that OT and PT services be related to the child's development. More intensive OT and PT service may be needed by children from

birth to three than is needed for children age three and older. The rationale is that provision of a higher level of therapy services at a young age could reduce the level of functional limitation and disability the child experiences as he matures. Decisions about early intervention services are made by a team, called the Individualized Family Services Plan (IFSP) team.

For children birth to age 3, services are provided to address the child and family’s needs as documented by goals and objectives on the IFSP. These goals and objectives address all of the child’s areas of delay and the family’s concerns to enhance the child’s development. There are no related services under Part C of IDEA – all services, including OT and PT are considered the same and are designed to help the child meet his/her goals and objectives.

Early intervention programs provide OT and PT services deemed necessary by the IFSP team and are listed on the IFSP. EI programs are required to provide OT and PT services to meet IFSP goals, but are not required to provide the entire spectrum of therapy options. If

An activity- or participation-centered basis for therapy provides continuity for children and their families during the anticipated and expected transitions from one educational setting to another.

additional therapy services are requested beyond those identified by the IFSP team to meet the child’s developmental needs, a referral may be made to the child’s doctor to determine the need for clinic-based services. When this happens, the clinic-based and EI therapists should work collaboratively with the child and family.

Occupational and physical therapists in EI programs address areas such as gross and fine motor development, sensory processing, mobility, or feeding issues that affect function or have the potential to affect function as the child grows. Many children develop motor skills which allow them to function effectively but still show some difference in motor functioning from typically-developing children. When the child’s motor skills are functional and do not pose a future risk of deformity or loss of function, occupational and physical therapy services might not be provided by the EI program.

In the state of Oregon, children with disabilities from birth to three years of age are entitled to receive services designed to meet their developmental needs. These services are provided at no cost to the child’s family. The service coordination role in early intervention programs helps families connect with outside community services which may include additional physical and/or occupational therapy accessed by the family.

Determining Eligibility for Early Intervention

In the state of Oregon, eligibility criteria are established by the Oregon Administrative Rules (OARs) under Section 581, Division 15. For OARs regarding evaluation and minimum criteria for early intervention, early childhood special education, and special education eligibility for all

disabilities, contact the coordinator of your local program or see http://arcweb.sos.state.or.us/rules/OARS_500/OAR_581/581_015.html.

An EI evaluation or reevaluation must:

- (a) *Be conducted by a team representing two or more disciplines or professions, including persons who are knowledgeable about the child;*
- (b) *Assess the child's level of functioning in all the following areas: cognitive development, physical development including vision and hearing, communication development, social or emotional development, and adaptive development;*
- (c) *Be based on informed clinical opinion;*
- (d) *Be completed in time to conduct the initial IFSP meeting within 45 calendar days from the date of referral; and...*

OAR 581-015-2775(6)

In Oregon a child may qualify for services in early intervention by meeting **any** of the following eligibility criteria:

1. **Categorical:** The child meets the minimum criteria for one of the following disability categories: Autism Spectrum Disorder, Deaf Blindness, Hearing Impairment, Orthopedic Impairment, Traumatic Brain Injury or Vision Impairment.
2. **Medical:** The child has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, as documented by a physician licensed by the State Board of Medical Examiners.
3. **Developmental Delay:** Child demonstrates a significant delay of 2 standard deviations below the mean in one area of development or 1.5 standard deviations below the mean in 2 or more areas of development and as a result needs EI services. The evaluation for Developmental Delay must include:
 - a. At least one norm-referenced, standardized test addressing the child's level of functioning in each of the following developmental areas: cognitive; physical (including vision and hearing); communication; social or emotional; and adaptive;
 - b. At least one additional procedure to confirm the child's level of functioning in each area of suspected delay listed in number one above;
 - c. At least one 20-minute observation of the child;
 - d. A review of previous testing, medical data and parent reports; and
 - e. Other evaluative information as necessary to determine eligibility.

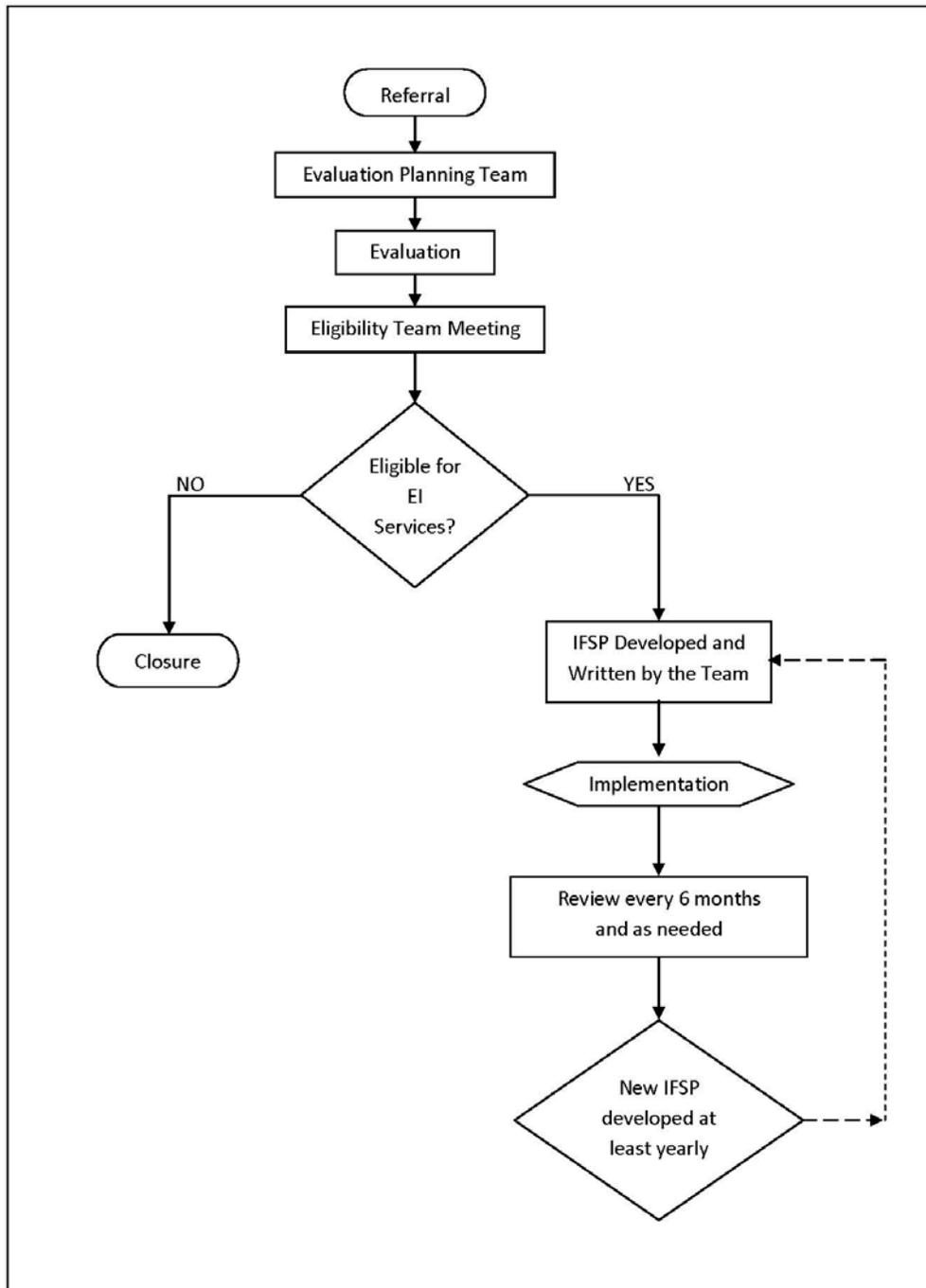
In general the evaluation team must:

- ♦ Use a variety of assessment tools and strategies to gather relevant functional and developmental information about the child, including information provided by the parent that may assist in determining if the child has developmental delay;
- ♦ Not use any single measure or assessment as the sole criterion for determining whether a child is a child with a disability and for determining an appropriate developmental program for the child;

- ♦ Use technically sound and culturally sensitive instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors;
- ♦ Following the evaluation, a written statement of eligibility is completed outlining the tools and strategies used to determine eligibility, the type of eligibility; and agreement or disagreement of parents and team members by signature.

Figure 2, on the following page, represents the eligibility process for the state of Oregon’s early intervention program.

Figure 2: Oregon Early Intervention Process



Role of the OT or PT in Determining Eligibility for EI Programs

In early intervention, the OT and/or PT will most likely be involved in the initial evaluation process to assist in determining a child’s eligibility for EI services. A child being considered for early intervention services will be evaluated in all areas of development. As members of the evaluation team, PTs and OTs may be responsible for evaluation in any developmental area, but are most likely to be involved in the evaluation of adaptive, fine and gross motor areas of development.

When a child age birth to age 3 is suspected of having a developmental disability the child may be referred for an EI program evaluation. If the referral questions or concerns relate to specific sensory-motor skills, or if the team identifies a need for sensory-motor assessment, the evaluation should include assessment by a physical or occupational therapist. The evaluation findings will be used to help decide eligibility for EI services. Once eligibility is determined, the therapist makes recommendations for the type and level of therapy services needed by the child and family.

Formal testing is not required for a child to qualify for EI services under the medical category, however, current assessment information is required for developing the IFSP. Both the PT and OT are required through their state practice regulations to perform a discipline-specific initial evaluation in order to begin services for a child who is brought into the program via a physician’s statement. (For Oregon State OT and PT practice regulations, see the websites of the respective licensing boards listed in Appendix C5.)

IFSP Team Membership in EI Programs

If a determination is made that a child has a developmental disability and needs early intervention, the team develops an Individualized Family Service Plan or IFSP. The plan addresses the identified needs of the child and family. Depending on the individual needs of the child, the specific expertise of a variety of professionals, as members of the IFSP team, may be necessary.

Participants for IFSP Team Meetings and Reviews

- (1) *Each initial and annual IFSP meeting must include the following participants:*
 - (a) *The child's parents;*
 - (b) *The child's EI or ECSE specialist and, as appropriate, persons who will be providing services to the child or family;*
 - (c) *A representative of the contractor or subcontractor who may be another member of the team and who is:*
 - (A) *Qualified to provide or supervise the provision of EI or ECSE services to meet the unique needs of children with disabilities;*
 - (B) *Knowledgeable of typical child development and appropriate activities for infants and young children; and*
 - (C) *Knowledgeable about the availability of resources.*

(d) For a child eligible for EI services, the service coordinator who is responsible for implementation of the IFSP and may be the child's EI specialist;

.....

(f) Family members and/or advocates as requested by the parents;

(g) Other individuals, including related services personnel as appropriate, invited by the parent, primary contractor, or subcontractor who have knowledge or special expertise regarding the child;

(h) An individual, who may be another member of the team who:

(A) Was involved in conducting the evaluation of the child;

(B) Is knowledgeable about the child's disability; and

(C) Can interpret the developmental or instructional implications of the evaluation; and

.....

.....

(4) Each review must include the participants in subsections (1)(a), (b), (d) and, if feasible to do so (f) of this rule. When the review indicates any changes in the IFSP, then the individualized meeting must follow all IFSP procedural requirements.

(5) For the purposes of subsection (1)(h), if such an individual is unable to attend the meeting, arrangements must be made for the person's involvement through other means, including:

(a) Participating in a telephone conference call;

(b) Having a knowledgeable authorized representative attend the meeting; or

(c) Making pertinent records available at the meeting.

OAR 581-015-2825

OTs and PTs fall under (1)(g) and (1)(h) of this rule. One team member may fulfill more than one of the roles listed above if that person meets the criteria for both roles.

Role of the IFSP Team in Early Intervention

The IFSP team process is a means to systematically address the diverse developmental needs of children with disabilities. The primary role of the IFSP team in the EI program is to identify the instruction and services that will help the child to improve his/her skills in all domains of early childhood development, including: adaptive, cognitive, social/emotional, communication, physical/motor (including vision and hearing, and sensory processing). (ORS 343.521) For instance, a child who has an orthopedic impairment, developmental delay, and a speech disorder clearly has multiple needs that require the expertise of people from several disciplines. However, unless these experts work as a team and regularly exchange information, each may see the concerns of their discipline as paramount and de-emphasize concerns in other areas, perhaps to the detriment of the child's progress.

A licensed OT or PT serving the child may be assigned the leadership role as service coordinator on the IFSP team. This arrangement generally identifies the therapist or developmental specialist who has the background to address the child and family issues

and problems as identified by the team in accordance with OARs 581-015-2840 and 581-015-2900(4).

The primary focus of the IFSP team is to ensure that appropriate services are provided and that the child has a reasonable opportunity to benefit from the program. In order to successfully maintain this focus, each team member must be committed to the following principles:

- ♦ Focusing team efforts on addressing the needs of young children by integrating assessment information and developing IFSP goals based on input from all pertinent disciplines;
- ♦ Meeting periodically to exchange information and keep one another informed of changes in the child’s progress;
- ♦ Demonstrating a high level of competence in one’s own discipline so that contributions are valuable;
- ♦ Actively seeking opportunities to advance knowledge in all developmental domains, to provide a well-rounded and holistic approach to the child and to address the families’ priorities;
- ♦ Actively seeking ways to incorporate assessment data and recommendations from all team members into the IFSP;
- ♦ Consciously and continually working to educate one another in addressing the child’s needs by welcoming questions, explaining terms and concepts in everyday language and avoiding discipline-specific jargon.

In Oregon, some early intervention programs choose to use licensed therapists as service coordinators, others do not.

For children birth to age 3, progress toward goals must be reviewed at least every 6 months with the parents (OAR 581-015-2810 (3)). At the 6-month review, the team determines if there is a need to revise the goals or services. At the annual review (every 365 days), the team convenes to review the IFSP and develop new goals and objectives in accordance with OAR 581-015-2810(2). Parents or any member of the IFSP team can request a meeting at any time.

Therapist’s Role on the IFSP Team in Early Intervention Programs

IDEA 2004 mandates that service to children birth to age 3 should be provided in the child’s natural environments. These can be a variety of settings including the child’s home, extended family’s home, community or home based child care, or any other community setting. Clinical and hospital based services are not acceptable locations in which to provide ongoing EI services to children under IDEA 2004.

The therapist’s role in early intervention programs will vary from program to program but may include service coordination, hands-on service, team and/or system supports.

If a child’s primary delay is in the area of motor development, a PT or OT may be assigned as service coordinator, in accordance with OAR 581-015-2900(4). The service coordinator must:

- (a) *Coordinate all services across agency lines by serving as a single point of contact in helping parents obtain the services and assistance they need;*
- (b) *Assist parents of eligible children in gaining access to EI services and other services identified in the IFSP;*
- (c) *Facilitate the timely delivery of available services;*
- (d) *Continuously seek the appropriate services in situations necessary to benefit the development of each child being served for the duration of the child's eligibility;*
- (e) *Coordinate the performance of evaluation and assessments;*
- (f) *Facilitate and participate in the development, review, and evaluation of IFSPs;*
- (g) *Assist families in identifying available service providers;*
- (h) *Coordinate and monitor the delivery of available services;*
- (i) *Inform families of the availability of advocacy services;*
- (j) *Coordinate with medical and health providers; and*
- (k) *Facilitate the development of a transition plan to ECSE services or other early childhood service, if appropriate.*

OAR 581-015-2840(3)

Service delivery may take many forms depending on the program and parent priorities. There are several models of service delivery that are supported by current research. The following three examples often are used together to provide services to a family:

Routines-based intervention employs a strategy where the family’s routines are identified and interventions are designed to fit within those routines. The expectation is that the interventions will be employed at a higher frequency because they are part of the daily routines of the family. These interventions are generally designed to improve the child’s participation in routine activity and to provide opportunities for the child to practice new skills throughout the day.

A “coaching model” for service delivery is used by many therapists. This model focuses on teaching the parent(s) to provide instruction and support to the child as needed. With this strategy parents are taught to identify problems and, in collaboration with the therapist, a variety of solutions may be identified. Solutions are designed to facilitate the child’s ability to actively participate in those daily activities. This model is a very interactive model for therapist, parent, and child, working together to identify problems and solutions for optimal participation of the child.

Some programs in the state of Oregon work under a collaborative team model. In this model, one team member is identified as the primary provider and oversees all areas of development with guidance and assistance from team members as needed. This puts the OT and PT in a very different role, and requires that therapists update skills and knowledge in all developmental domains, while being certain to stay within their scope of practice. Team members should always be available for assistance with this model. Therapists, especially new graduates, should rely on their team members’ expertise to

supplement their knowledge and skills in areas of development not usually addressed in entry level programs.

For a comprehensive list of competencies for physical therapists in early intervention see Chiarello & Effgen, 2006, on the recommended reading list in Appendix C6.

Role of the Occupational and Physical Therapist in Transition to ECSE

Occupational and physical therapists providing services to children in EI should be active participants in the transition process from EI to ECSE. Service levels and priorities may change during the transition and therapists should adjust goals and objectives to mirror these changes.

For EI students transitioning to ECSE, OAR 581-015-2805(1)(a) states, “Before a child reaches the age of eligibility for ECSE, the school district must **obtain parental consent for initial evaluation under 581-015-2735, and conduct an initial evaluation...**”

ECSE Eligibility:

- (1) *Upon completing the administration of tests and other evaluation materials, the designated referral and evaluation agency must determine, through a team, whether a child is eligible for ECSE services by following the procedures in this rule.*
- (2) *The team must include the parents, in accordance with OAR 581-015-2750, and two or more professionals, at least one of whom is knowledgeable and experienced in the evaluation and education of children with the suspected disability. The team may be the child's IFSP team.*
- (3) *In determining eligibility for a child suspected of having a specific learning disability, the team must also include:*
 - (a) *The child's preschool teacher or, if the child does not have a preschool teacher, a preschool teacher qualified to teach a child of his or her age; and*
 - (b) *A person qualified to conduct individual diagnostic examinations of children, such as a psychologist, speech-language pathologist, or other qualified personnel.*
- (4) *To be eligible for ECSE services, the child must meet the following minimum criteria:*
 - (a) *Categorical. The child meets the minimum criteria for one of the disability categories in OAR 581-015-2130 through 581-015-2180; or*
 - (b) *Developmental delay.*
 - (A) *The child has a developmental delay of 1.5 standard deviations or more below the mean in two or more of the developmental areas listed under OAR 581-015-2780(3)(c);*
 - (B) *The child's disability has an adverse impact on the child's developmental progress; and*
 - (C) *The child needs ECSE services.*
- (5) *The team must prepare an evaluation report and a written statement of eligibility.*
 - (a) *The evaluation report(s) must describe and explain the results of the evaluation*

conducted.

- (b) The written statement of eligibility must include:*
 - (A) A list of the evaluation data considered in determining the child's eligibility;*
 - (B) A determination of whether the child meets the minimum criteria for ECSE as described in (4) of this part;*
- (c) A determination of whether the primary basis for the suspected disability is:*
 - (A) Lack of instruction in reading or math; or*
 - (B) Limited English proficiency.*
- (d) A determination of whether the child's disability has an adverse impact on the child's developmental progress;*
- (e) A determination of whether, as a result of the disability the child needs ECSE services; and*
- (f) The signature of each member of the team indicating agreement or disagreement with the eligibility determination.*
- (6) When determining eligibility for a child suspected of having a specific learning disability, the team must prepare a written report following the procedures in OAR 581-015-2170.*
- (7) The team may not determine that a child is eligible for ECSE services if:*
 - (a) The determinant factor for that eligibility determination is:*
 - (A) Lack of appropriate instruction in reading (including the essential components of reading) or math; or*
 - (B) Limited English proficiency; and*
 - (b) The child does not otherwise meet the eligibility criteria under this rule.*
- (8) For a child who may have disabilities in more than one category, the team need only qualify the child for ECSE services under one disability category, however:*
 - (a) The child shall be evaluated in all areas of suspected disability; and*
 - (b) The child's IFSP shall address all of the child's special education needs.*
- (9) The team must give the parents a copy of the eligibility statement and evaluation report.*
- (10) The contractor or subcontractor must notify the child's resident school district upon determination of eligibility for ECSE services.*

OAR 581-015-2795

With the approval of the child's family and in accordance with OAR 581-015-2810, a transition meeting to establish a transition plan must be held at least 90 calendar days, and at the discretion of the parties, up to nine months, before the child's third birthday and must include:

1. Discussions with and training of parents regarding future services, placements and other matters related to the child's transition;
2. Procedures to prepare the child for changes in service delivery, including steps to help the child adjust to and function in a new setting or, if appropriate, steps to exit from the program;
3. A review of the child's program options for the period from the child's third birthday through the remainder of the school year.

In addition, for children eligible for ECSE services, the team must initiate and conduct an IFSP meeting on or before the child's third birthday to:

1. Develop an IFSP,
2. Determine placement, and
3. Obtain parent consent for initial placement in special education.

This is the initial consent for placement in special education for school-age students.

Occupational and Physical Therapy Services in Early Childhood Special Education (ECSE) Programs

For children ages 3 to 5, under Part B of IDEA, services are provided to address the child's IFSP goals and objectives. These goals and objectives address all of the child's areas of delay. Related services such as OT and PT are provided to assist the child in meeting their goals and objectives and to access the general curriculum or typical age-appropriate activities.

Determining Eligibility in Early Childhood Special Education

For children who have not received EI services, a parent or public agency may request an initial evaluation to determine if a child qualifies for ECSE services. In accordance with OAR 581-015-2790(6), and OAR 581-015-2795, a child may qualify for services in ECSE by meeting the minimum criteria for one or more of the following disability categories: Autism Spectrum Disorder, Communication Disorder, Deaf Blindness, Emotional Disturbance, Hearing Impairment, Intellectual Disability, Orthopedic Impairment, Other Health Impairment, Specific Learning Disability, Traumatic Brain Injury, Vision Impairment, or Developmental Delay.

In general the evaluation team must:

- ♦ Use a variety of assessment tools and strategies to gather relevant functional and developmental information about the child, including information provided by the parent that may assist in determining if the child has developmental delay;
- ♦ Not use any single measure or assessment as the sole criterion for determining whether a child is a child with a disability and for determining an appropriate developmental program for the child;
- ♦ Use technically sound and culturally sensitive instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors;
- ♦ Following the evaluation, a written statement of eligibility is completed outlining the tools and strategies used to determine eligibility, the type of eligibility; and agreement or disagreement of parents and team members by signature.

OAR 581-015-2795

Role of the OT or PT in Determining Eligibility for ECSE Programs

Therapists may be a part of the evaluation team for ECSE when there is a concern in the areas of gross, fine or adaptive motor development or if there are concerns in sensory motor processing. In EI, the team must evaluate the child in all areas, **regardless of concerns**, while for ECSE the team is required to evaluate the developmental areas in which there is **an identified concern**. In all cases, the evaluation must be sufficiently comprehensive to identify all of the child’s EI/ECSE and related services needs, even those needs which are not commonly linked to the disability category. (OAR 581-015-2790(9)(e))

IFSP Team Membership in ECSE

If a determination is made that a child has a disability and needs special education and related services, the team must develop an IFSP. The plan should address the identified needs of the child for specially designed instruction, related services, supplemental aids and services and support for school personnel. (Refer to pages 27 and 28 for definitions.) Depending on the individual needs of the student, the specific expertise of a variety of professionals, as members of the IFSP team, may be necessary. The following regulation specifies those who, at a minimum, comprise the IFSP team:

Participants for IFSP Team Meetings and Reviews

- (1) *Each initial and annual IFSP meeting must include the following participants:*
 - (a) *The child's parents;*
 - (b) *The child's EI or ECSE specialist and, as appropriate, persons who will be providing services to the child or family;*
 - (c) *A representative of the contractor or subcontractor who may be another member of the team and who is:*
 - (A) *Qualified to provide or supervise the provision of EI or ECSE services to meet the unique needs of children with disabilities;*
 - (B) *Knowledgeable of typical child development and appropriate activities for infants and young children; and*
 - (C) *Knowledgeable about the availability of resources.*
 -
 - (e) *For a child who is eligible for ECSE services, the child's preschool teacher if the child is or may be participating in a regular preschool;*
 - (f) *Family members and/or advocates as requested by the parents;*
 - (g) *Other individuals, including related services personnel as appropriate, invited by the parent, primary contractor, or subcontractor who have knowledge or special expertise regarding the child;*
 - (h) *An individual, who may be another member of the team who:*
 - (A) *Was involved in conducting the evaluation of the child;*
 - (B) *Is knowledgeable about the child's disability; and*

- (C) *Can interpret the developmental or instructional implications of the evaluation; and*
- (i) *A representative of the school district in which the child resides during the year before the child enters school.*
- (2) *The regular preschool teacher must participate, to the extent appropriate, in the development, review and revision of the child's IFSP, including assisting in the determination of:*
 - (a) *Necessary modifications to appropriate preschool activities in the classroom and participation in the preschool environment;*
 - (b) *Supplementary aids and services, program modifications or supports for preschool personnel that will be provided for the child; and*
 - (c) *Appropriate positive behavioral interventions and strategies for the child.*
- (3) *IFSP team attendance for children age 3 and older:*
 - (a) *A member of the IFSP team described in subsection (1)(b) through (1)(e) is not required to attend an IFSP meeting, in whole or in part, if the parent of a child with a disability and the contractor or subcontractor agree in writing that the attendance of the member is not necessary because the member's area of the curriculum or related services is not being modified or discussed at the meeting.*
 - (b) *A member of the IFSP team described in subsection (1)(b) through (1)(e) may be excused from attending an IFSP meeting, in whole or in part, when the meeting involves a modification to or discussion of the member's area of curriculum or related services, if:*
 - (A) *The parent and contractor or subcontractor consent in writing to the excusal; and*
 - (B) *The member submits, in writing to the parent and the IFSP team, input into the development of the IFSP before the meeting.*
- (4) *Each review must include the participants in subsections (1)(a), (b), (d) and, if feasible to do so, (f) of this rule. When the review indicates any changes in the IFSP, then the individualized meeting must follow all IFSP procedural requirements.*
- (5) *For the purposes of subsection (1)(h), if such an individual is unable to attend the meeting, arrangements must be made for the person's involvement through other means, including:*
 - (a) *Participating in a telephone conference call;*
 - (b) *Having a knowledgeable authorized representative attend the meeting; or*
 - (c) *Making pertinent records available at the meeting.*

OAR 581-015-2825

Role of the IFSP Team in ECSE Programs

Once the team has determined that a child meets the eligibility criteria for disability, team members identify the specially designed instruction and related services the child will need to meet their goals. Occupational and physical therapy services are available to *all* children who have an IFSP **and** the team determines that such therapy is needed in order for the child to meet IFSP goals.

The development of an IFSP is a means to systematically address the diverse needs of children with disabilities. The primary role of the IFSP team is to identify the instruction and services that will help the child to benefit from his/her educational program. For instance, a child who has an orthopedic impairment, developmental delay, and a speech disorder clearly has a multiplicity of needs that require the expertise of people from many disciplines. However, unless these experts work as a team and regularly exchange information, they may each see the concerns of their discipline as paramount and de-emphasize concerns in other areas, perhaps to the detriment of the child's progress.

It is common for the child's special education teacher to be assigned the leadership role as service coordinator on the IFSP team. This arrangement capitalizes on their greater familiarity with the child and the educational environment in which the child functions, and increases the possibility that IFSP objectives will be well-integrated into the child's routine. The primary focus of the IFSP team is to ensure that appropriate services are provided and that the child has a reasonable opportunity to benefit from IFSP services. In order to successfully maintain this focus, each team member must be committed to the team functions previously listed on page 16.

The OARs for EI/ECSE services allow for licensed therapists or other related service providers to assume the role of service coordinator in EI and ECSE programs (OAR 581-015-2900 and 581-015-2905). In ECSE programs, occupational and physical therapy are related services which support the child in benefitting from specially designed instruction.

No single discipline has all the answers. People from different disciplines who respect one another's judgment, learn from one another, and work together collaboratively are best able to carry out comprehensive and coherent IFSP services. Each team member, including parents, administrators, educators, and related service providers contributes to the decision-making of the team based on her or his knowledge of the child, but decisions are made by the team as a whole, not by any individual member. For example, during the development of the IFSP, the team may look to the speech-language pathologist to help the child develop functional communication needed for other learning. The speech-language pathologist, in turn, may rely on the physical and occupational therapists to determine effective positioning, to increase breath control, or to facilitate the student's handling of learning materials.

Role of the Occupational and Physical Therapist on the IFSP Team in the ECSE Program

As a member of an eligible child's IFSP team, the therapist makes the recommendation for services using data from screenings and evaluations. The IFSP team determines the services which are written into the IFSP and carried out by the assigned therapist. Services may be documented as combined team goals, specific motor or other goals, or as modifications and supports to the child's program. A reference entitled, "IEP Guidance for OTs and PTs," may be found in Appendix C3. An occupational or physical therapist may

contribute to the child’s program by delivering hands-on service, consulting with school staff, coordinating with medical professionals, training and monitoring others who conduct sensory-motor activities, and/or participating in the team process. In order to include therapy on the IFSP, the therapist and the other members of the IFSP team must agree that therapy is needed for the child to benefit from their program. Programs which employ OTs and PTs should adopt guidelines for making decisions related to therapy needs.

Role of the Occupational and Physical Therapist in Transition to Kindergarten

Before a child reaches the age of eligibility for public school, the ECSE program and the school district must hold a meeting to determine the steps to support the transition from ECSE to public or other educational settings and to develop an Individualized Education Program (IEP) that will be in effect at the beginning of the following school year.

If the child is receiving services under a categorical eligibility the district can, but is not required to, conduct a reevaluation to determine the need to continue services. A reevaluation is not required until the third year of eligibility, or if a member of the team has questions about the child’s eligibility. In Oregon, Developmental Delay is not a category for school age eligibility. If the child has been previously eligible as Developmentally Delayed, the district must consider if a disability under OAR 581-015-2130 through -2180 is suspected, and, if so, conduct a reevaluation and determine eligibility for school age special education services under a categorical disability.

If a reevaluation is required in order to establish the need for school-age services, it may be conducted by either the ECSE team or the school-based team. It is most effective to work collaboratively in order to develop the most comprehensive picture of the child and his/her needs in the transition to school-age services.

Collaboration with clinical- or hospital-based services for children in EI or ECSE programs

Communication between EI/ECSE therapists and clinic- or hospital-based therapists is important for optimal coordination of services to children. Sharing information between community and hospital environments promotes a collaborative model of services important for consistent and effective outcomes. Coordination is especially critical for children who are receiving services in multiple environments. Written parent consent is required prior to collaboration between the district/program and the medical provider(s).

For example, it may be beneficial for the EI/ECSE therapist to communicate with the clinic-based therapist to review equipment needs, general goals and directions. The EI/ECSE therapist may consult with hospital staff prior to or during a child’s hospitalization

(typically for surgery) to coordinate the services and/or supports the student will require during and after their hospital stay. For example, the EI/ECSE therapist may need to inform hospital staff about how a child who is nonvocal uses augmentative communication strategies to communicate their needs. Other examples may include working with staff to arrange for the loan, purchase, or fabrication of special equipment for the child to use during the recovery period and to develop a plan for the child's transition from hospital to home and/or preschool.

This page intentionally left blank.

CHAPTER 3

Delivery of Therapy Services under IDEA 2004 – School-Age Special Education

Occupational and Physical Therapy Services in School Age Programs for Children Aged 5 - 21

Therapy services provided to children at school age focus on the skills a child needs to access and participate in the educational environment. Although Part B of IDEA 2004 defines the responsibilities of school age programs for children from 3 to 21, in this section we are referring to school age children, ages 5 and older. The local school district is responsible for determining whether a child qualifies as a “child with a disability. . . [who] needs special education and related services” (IDEA 602(3)(A)(ii). Under Part B (ages 5 -21), a student with a disability might be eligible for IDEA 2004 services under any of eleven disability areas as follows:

(4) “children with disabilities” or “students with disabilities” means children or students who require special education because of: autism; communication disorders; deaf/blindness; emotional disturbances; hearing impairments, including deafness; intellectual disability; orthopedic impairments; other health impairments; specific learning disabilities; traumatic brain injuries; or visual impairments, including blindness.
OAR 581-015-2000

The purpose of special education is to enable students with disabilities to access and benefit from the general education curriculum through **specially designed instruction and related services**. For children with disabilities academic, social or other skill deficits may be remediated through specially designed instruction geared to the unique instructional needs of the child. Special education is instruction which is tailored to the individual needs of a child with a disability. Special Education is defined as follows:

(33) “Special education” means specially designed instruction that is provided at no cost to parents to meet the unique needs of a child with a disability “Special education” includes instruction that:

- (a) May be conducted in the classroom, the home, a hospital, an institution, a special school or another setting; and*
- (b) May involve physical education services, speech language services, transition services or other related services designated by rule to be services to meet the unique needs of a child with a disability.*

OAR 581-015-2000(33)

Supplementary Aids/Services; Modifications; Accommodations are aids, services, and strategies which are designed to augment the child’s ability to access the general education curriculum, including activities, materials, and environment.

Supports to personnel include training or consultation to the child’s teachers and other school staff or members of the IEP team.

Related services are the services which the IEP team determines the child needs in order to access and benefit from **specially designed instruction**. Under IDEA 2004, physical and occupational therapists are listed as related services for school age students receiving special education. Related services are delivered for the purpose of supporting the specially designed instruction, or individual goals, of the student. **Related services** are:

transportation, and such developmental, corrective, and other supportive services... and includes speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic and evaluation purposes...school health services and school nurse services, social work services in schools, and parent counseling and training.
 IDEA 2004, 34 CFR §300.34

Activities of Occupational and Physical Therapy Services in School Age Programs

As a rule, the activities of school OTs and PTs fall into four categories for school-age children: (see Appendix A6, Scope of School Services.)

School therapists evaluate the functional skills of students with disabilities. When the child has functional limitations that significantly affect educational performance, the OT or PT may be called upon to assist in determining service needs. Functional skills may also be evaluated by other educational personnel as part of the child’s educational program.

School therapists address access to education for students with disabilities. Both IDEA 2004 and Section 504 require that school programs provide the same level of access for students with disabilities that is provided to non-disabled students in all services provided by the school. Examples of OT and PT activities in this realm might include modification of positioning equipment, computer adaptations, modification of curricular tasks to account for physical limitations or consulting with district facilities staff about building or playground modifications.

School therapists address safety of students and school staff. Therapists address the safety of students and care givers in several ways. Therapists monitor a student’s

functional skills to make sure that he/she is not participating in activities which are dangerous. They consult regarding equipment used by the student such as walkers, wheelchairs, school chairs and feeding utensils to ensure its appropriateness. Therapists may also check students for the possible development of impairments such as contractures or muscle weakness associated with progressive health conditions that require additional medical attention. Therapists may act as a liaison between the school program and the child's family and medical provider.

In addition, therapists instruct school staff in proper lifting, safe feeding and physical management skills that address the safety of both the student and the school staff. Therapists provide consultation about the unique needs of identified students to risk management personnel who are responsible for developing evacuation plans and other safety procedures, and provide consultation on building accessibility and the provisions of the Americans with Disabilities Act (ADA).

School therapists help teach functional skills associated with success in school. The educational team may determine that some of the goals on the IEP/IFSP should address the learning of new functional skills to support school participation. Occupational and physical therapists may help plan, implement, and monitor instructional programs addressing the development or refinement of fine motor skills, gross motor skills, postural adaptations, or ability to participate in learning activities.

(Adapted from the Scope of School Services, RSOI, January, 2010)

IEP Team Membership

If a determination is made that a child has a disability as defined in IDEA 2004 and needs special education and related services, the team must develop an Individualized Education Program (IEP). The plan should address the identified needs of the child for specially designed instruction, for related services, supplemental aids and services and support for school personnel. Depending on the diverse needs of the student, the specific expertise of a variety of professionals, as members of the IEP team, may be necessary.

IEP Team

(1) School districts must ensure that the IEP Team for each child with a disability includes the following participants:

- (a) One or both of the child's parents, except as provided in OAR 581-015-2195;*
- (b) The child where appropriate;*
- (c) At least one regular education teacher of the child, if the child is or may be participating in the regular education environment, consistent with section (4) of this rule;*
- (d) At least one special education teacher of the child or, if appropriate, at least one special education provider of the child;*
- (e) A representative of the school district, who may also be another member of the team, who is:*

- (A) *Qualified to provide, or supervise the provision of, specially designed instruction;*
- (B) *Knowledgeable about the general education curriculum;*
- (C) *Knowledgeable about district resources; and*
- (D) *Authorized to commit district resources and ensure that services set out in the IEP will be provided.*
- (f) *An individual who can interpret the instructional implications of the evaluation results (who may also be another member of the team);*
- (g) *Other individuals, including related services personnel as appropriate, invited by:*
 - (A) *The parent, whom the parent determines to have knowledge or special expertise regarding the child; or*
 - (B) *The school district, whom the school district determines to have knowledge or special expertise regarding the child; and*
- (h) *Transition services participants, as described in section (2) of this rule.*
- (2) *If a purpose of the meeting will be consideration of the postsecondary goals for the student and the transition services needed to assist the student in reaching those goals:*
 - (a) *The school district must invite the student. If the student does not attend the meeting, the school district must take other steps to ensure that the student's preferences and interests are considered.*
 - (b) *To the extent appropriate, with consent of the parents or adult student, the school district must invite a representative of any participating agency that is likely to be responsible for providing or paying for transition services.*
- (3) *IEP team attendance:*
 - (a) *A member of the IEP team described in subsection (1)(c) through (1)(f) is not required to attend an IEP meeting, in whole or in part, if the parent of a child with a disability and the school district agree in writing that the attendance of the member is not necessary because the member's area of the curriculum or related services is not being modified or discussed at the meeting.*
 - (b) *A member of the IEP team described in subsection (1)(c) through (1)(f) may be excused from attending an IEP meeting, in whole or in part, when the meeting involves a modification to or discussion of the member's area of curriculum or related services, if:*
 - (A) *The parent and school district consent in writing to the excusal; and*
 - (B) *The member submits, in writing to the parent and the IEP team, input into the development of the IEP before the meeting.*
- (4) *The regular education teacher of the child must participate as a member of the IEP team, to the extent appropriate, in the development, review, and revision of the child's IEP, including assisting in the determination of:*
 - (a) *Supplementary aids and services, program modifications and supports for school personnel that will be provided for the child; and*
 - (b) *Appropriate positive behavioral interventions and supports, and other strategies for the child.*

OAR 581-015-2210

OTs and PTs fall under (1)(f) and (1)(g) of this rule. One team member may fulfill more than one of the roles listed above if that person meets the criteria for both roles.

Role of the IEP Team

It is common for a special education teacher to be assigned the leadership role on the IEP team. This arrangement capitalizes on their greater familiarity with the student and the educational environment in which the child functions, and increases the possibility that IEP objectives will be well-integrated into the child's day. The primary focus of the IEP team is to ensure that appropriate educational services are provided and that the child has a reasonable opportunity to benefit from the educational program. As with the IFSP team, each team member must be committed to the elements listed on page 16 in Chapter 2.

Role of the Occupational and Physical Therapist on the IEP Team

Once the team has determined that a child meets the minimum criteria for eligibility, team members identify the specially designed instruction and related services the child will need. Occupational and physical therapy services are available to *all* children, regardless of special education eligibility category, if they have an IEP **and** if the team determines that therapy is needed for the child to meet educational goals. For example, a PT or OT may address endurance issues of a student eligible under Orthopedic Impairment, or sensory diet needs of a student eligible under Autism.

As a member of the team, the therapist can make four primary contributions:

1. *Assessment:* Assessment includes screening, observation, evaluation, and reassessment. The multifaceted therapy assessment process evaluates the student's educationally-related needs. Findings are used to develop the IEP;
2. *Outcome:* Both the IEP and the therapy intervention plan are components of program planning. The IEP contains goals and objectives representing the overall educational needs unique to the child. The therapy intervention plan reflects the specific issues that the treatment activities are addressing;
3. *Intervention:* Intervention includes all activities performed by the therapist to support and implement the IEP goals and objectives and the intervention plan; and,
4. *Management:* The management role involves the varied responsibilities required to plan, develop, implement, and evaluate the therapy program.

(Johnson, 1996)

As a member of an eligible child's educational team, the therapist makes the recommendation for therapy services using data from screenings and evaluations. The therapy services deemed appropriate by the IEP Team are written into the IEP and carried out by the therapist or by school staff who are trained and monitored by the therapist. Services may be documented as combined team goals, specific motor or other goals, or as modifications and supports to the total educational plan. An occupational or physical therapist may contribute to the educational program by delivering direct therapy,

consulting with school staff, coordinating with medical or other community settings, training and monitoring others who conduct sensory-motor activities, and/or participating in the team process. In order to include therapy on the IEP, the therapist and the other members of the IEP team must agree that therapy is needed. Programs which employ OTs and PTs should adopt guidelines for making decisions related to therapy needs.

The ***Occupational and Physical Therapy Service Needs Checklist***, developed by Oregon’s Regional and Statewide Services for Students with Orthopedic Impairments (RSOI), is a tool for therapists to use when making recommendations about the level of therapy needed by an individual child and the amount of service the child should receive. The checklist is also useful for clarifying for parents and other professionals how recommendations have been reached. Two versions of the checklist, one for ages 3-21 and one for use in early intervention, are included in Appendix A1 and A2.

If OT or PT services are included on the IEP (or if therapy services are being considered for the student), the therapist is considered an, “other individual”, who has, “knowledge or special expertise regarding the child,” and may be invited by either the parent or the district, as appropriate.

Other individuals, including related services personnel as appropriate, invited by:

(A) The parent, whom the parent determines to have knowledge or special expertise regarding the child; or

(B) The school district, whom the school district determines to have knowledge or special expertise regarding the child...

OAR 581-015-2210(1)(g)

If the therapist has performed an assessment of the child or has knowledge of the child’s special needs, it is advisable for the therapist to attend the meeting if invited, to participate in the discussion and decision-making about the child’s goals, specially-designed instruction, related services, and placement. If the therapist performed an assessment, the therapist must either attend the meeting or submit a written report of findings and recommendations prior to the meeting (see OAR 581-015-2120(2)(a)).

Related Services under IDEA 2004

Under Part B of IDEA 2004, physical therapists and occupational therapists are considered “related service providers.” For children aged 5 to 21 who require special education, related services support the child’s individualized school program. According to IDEA 2004, “Related services means transportation and such developmental, corrective, and other supportive services...as are required to assist a child with a disability to benefit from special education....”

34 CFR §300.34(a) (2010)

An IEP Team decides which related services a child needs. The IEP team must look carefully at all of the evaluation results, which show the child’s areas of strength and need, and decide upon measurable annual goals that are appropriate for the child. Part of

developing the IEP also includes specifying “the special education and related services, and supplementary aids and services to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided” to enable the child:

- (i) *To advance appropriately toward attaining the annual goals;*
- (ii) *To be involved in, and make progress in, the general education curriculum and to participate in extracurricular and other nonacademic activities; and,*
- (iii) *To be educated and participate with other children with disabilities and nondisabled children.*

34 CFR §300.320(a)(4)

To the greatest extent possible, the IEP team discusses, decides upon, and specifies the related services that a child needs in order to benefit from their educational program. Making decisions about how often a related service will be provided, where and by whom, is also a function of the IEP team.

Pre-Referral Activities

If any student is experiencing difficulties in school, it is the expectation of IDEA 2004 that the professionals responsible for the student’s education take steps to modify the educational program to minimize the difficulties and maximize learning. Attempts to remedy the child’s difficulties must take place prior to referral for special education. In some school districts an OT or a PT may be asked to sit in on meetings where a specific child is discussed in order to share their expertise and perhaps to suggest simple accommodations that may help the child. If these attempts fail to make a positive impact on the child’s progress, and if the child is suspected of having a disability that negatively impacts his/her ability to access education, the school district has a responsibility under IDEA 2004 to refer the child for evaluation to determine whether there is a need for special education services.

Response to Intervention (RTI) practices and activities vary from state to state, but all share the core feature of systematically examining children’s responses to the educational interventions they are receiving.

The concept of Response to Intervention (RTI) is a basic component of accountability in general education. RTI addresses the question, *does the instruction being provided to a student lead to increased learning and appropriate progress for this individual student?* RTI is an approach to remedial intervention. The model may also be used to generate data to inform instruction and as one component in an evaluation to identify students who may require special education and related services.

RTI is based on the following concepts:

- ♦ Meet needs of all students
- ♦ Address the needs of groups or individual students
- ♦ Involve parents in a meaningful way

- ♦ Utilize/implement progressive interventions
- ♦ Focus on improved instruction (goals)
- ♦ Focus on results/accountability (outcomes)
- ♦ Monitor student progress
- ♦ Allocate services through a problem-solving team, merging staff and resources in a collaborative process

Related service providers such as OTs, PTs and others may focus on RTI in the following examples:

- ♦ A social worker implements a class-wide social skills intervention
- ♦ An occupational therapist provides handwriting tips to teachers that can be used with all students
- ♦ A school psychologist monitors classroom academic performance
- ♦ A speech-language pathologist addresses emerging sounds in a small group
- ♦ A physical therapist suggests activities for gross motor groups

Note that RTI activities are not defined by the age of the student, type of learner needs or severity of learning disability. RTI involves using differentiated instructional strategies for all learners, providing all learners with evidence-based interventions, continuously measuring student performance, using scientific, research-based progress monitoring instruments for all learners, and making educational decisions based on a student’s response to interventions.

Within the RTI model, some aspects of a related service provider’s role are the same, such as participation in teams, engaging in problem solving, using evidence-based methods, collecting data, monitoring progress and using data to make decisions. However, some aspects of the therapist’s role could be different. RTI will involve an increased need for flexibility, more collaborative consultation, and planning that is driven by student need. As schools and school districts adopt an RTI approach, motor teams will be challenged to redefine their roles and responsibilities within the new paradigm.

Eligibility Process for School Age Services under IDEA 2004

In addition to defining who is eligible for special education, the law specifies procedures for establishing a special education program. The process provides a means to identify children who qualify for special education and related services, determine his/her needs, and develop a written plan for meeting those needs. Once the plan is developed there is also guidance about how it should be implemented and its effectiveness assessed. Specific steps in the process are described below. Figure 3 on page 38 offers a flow chart of the entire process.

The key steps of the special education eligibility process are:

1. Someone suggests that a child may have a need and that it may be interfering with his/her ability to benefit from the educational program provided to non-disabled children.

2. The child is referred for evaluation by a teacher, parent, or other professional.
3. District designates a team, which includes the parent, to decide if an initial evaluation will be conducted.
4. If the team decides a special education evaluation is appropriate, the district must conduct evaluation planning, and include the parent.
5. The district must describe, in writing, the evaluation procedures.
6. Written permission to complete the special education eligibility evaluation is obtained from the parent or guardian.
7. The child is evaluated by appropriate qualified professionals in all areas related to the suspected disability. The evaluation must be sufficiently comprehensive to identify all of the child's special education and related services needs, whether or not commonly linked to the disability.
8. The eligibility team, which includes the parent, reviews the evaluation data and determines whether the child is eligible for special education and related services. Eligibility determination is made by reviewing state criteria for eligibility.
9. An initial evaluation must be completed within 60 school days from written parent consent to the date of the meeting to consider eligibility.
10. If the child is eligible for special education under Oregon state criteria, a team comprised of the child's parents and the professionals who completed the assessment or are knowledgeable about it, meets to develop a written individualized education program (IEP) for meeting the child's educational needs. Afterward, this team also determines educational placement.
11. The IEP is implemented; special education and related services are provided.
12. The IEP is reviewed by the IEP team periodically, but at least once every 365 days, to determine whether the annual goals are being achieved and to revise the IEP in accordance with OAR 581-015-2225(1)(b).
13. Each child eligible for special education and related services is reevaluated at least every three years to consider continuing eligibility and/or the student's educational needs. The reevaluation must be completed within 60 school days from written parent consent (or from the date the evaluation is initiated under OAR 581-015-2095) to the date of the eligibility meeting.

If the referral questions or concerns relate to specific sensory-motor skills, or if the evaluation planning team identifies a need for sensory-motor assessment, the child should be assessed by an OT or PT, who then develops specific recommendations. The evaluation findings will be used to help decide eligibility. When eligibility is determined, the therapist makes recommendations to the IEP team for the type and level of therapy service.

As noted in an earlier chapter, eligibility criteria for students in the state of Oregon are established by the Oregon Administrative Rules (OARs). For OARs regarding evaluation and minimum criteria for special education eligibility for all disabilities, contact the coordinator of your local program or online at:

http://arcweb.sos.state.or.us/rules/OARS_500/OAR_581/581_015.html.

Students Transferring from another District or State

If a student who has an IEP transfers from a school district within Oregon, the new school district must provide services comparable to those described in the child’s IEP from the previous district until the new district either adopts the child’s current IEP from the previous school district, or develops a new IEP for the child. If a student on an IEP transfers from another state, the new school district must provide services comparable to the ones described in the child’s IEP until the new district conducts an initial evaluation (if determined necessary by the district), establishes Oregon eligibility and develops a new IEP (OAR 581-015-2230). Related services providers participate in evaluation of the child and implementation of the IEP as determined by the IEP team.

Services for a transferring student may continue or change, as determined by the IEP team.

Sometimes a student who transfers from another district or state may have related services on his/her IEP that, upon evaluation of the child in the new setting, do not seem appropriate in the judgment of the new IEP team. Alternatively, a member of the IEP team may suggest that a related service be added that has not previously been included on an existing IEP. **IEP team decision-making about type and level of therapy services should be based upon the recommendations of the therapist, with consideration for the educational relevance and educational necessity of the services.** According to state practice regulations, non-therapists should not make recommendations about levels of therapy services.

Occupational and Physical Therapy Services under Section 504 of the Rehabilitation Act

Under Section 504 of the Rehabilitation Act of 1973 (reauthorized in 2009), a person may be eligible for accommodations due to limitations in one or more major life activities. These accommodations may include services provided by a physical or occupational therapist. Section 504 prohibits discrimination against persons with disabilities, including both students and staff members, by school districts receiving federal financial assistance. If a child does not meet eligibility criteria for special education, the results of the eligibility evaluation may be reviewed to determine whether accommodations to the child’s program are required under Section 504. Section 504 defines a person with a disability as one who:

- 1) has any physical or mental impairment which substantially limits major life activities, 2) is treated as having such a limitation, or 3) has a history of such a limitation. Major life activities include such activities as caring for one’s self, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activities also include the operation of major bodily functions,

A list of pediatric evaluations may be found in Appendix C.

including functions of the immune system, normal cell growth, and digestive, bowel, bladder, neurological, brain, musculoskeletal, respiratory, circulatory, endocrine, and reproductive functions. Some students who are not eligible for special education services under IDEA 2004 may still be considered disabled under Section 504. While those children are not in need of special education, they may still need services from a therapist such as an accessibility review or adaptive equipment that supports their participation in general education program or activities.

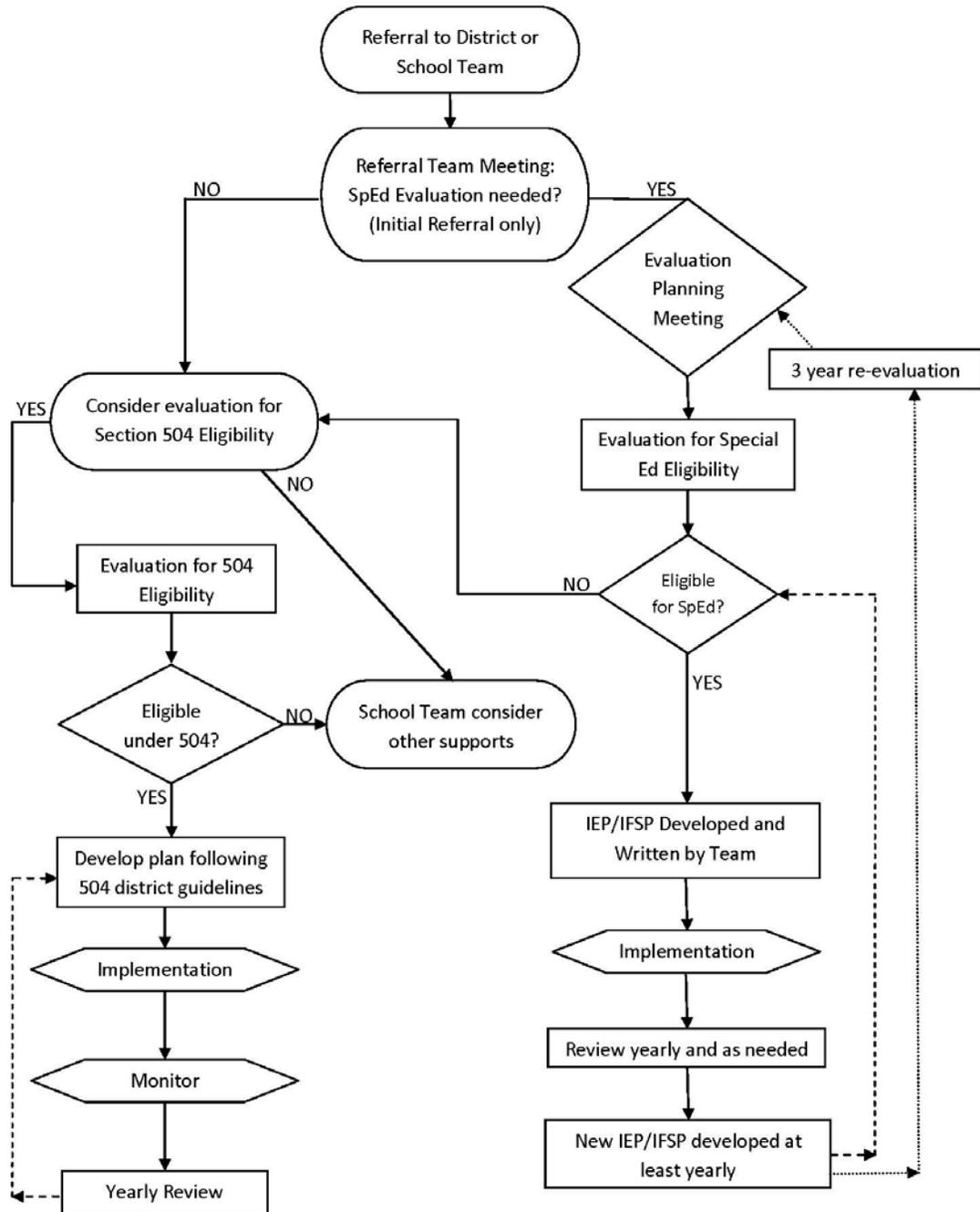
The wording of Section 504 is not as specific about procedures and timelines as is IDEA 2004, but the process for identifying and implementing a plan under Section 504 is roughly parallel to special education procedures. The school district is responsible by law for evaluation, provision of appropriate services, and procedural safeguards. The child's parent must be notified of any actions affecting the identification, evaluation, or placement of the student, and they are entitled to an impartial hearing if they disagree with a district decision. Decisions about Section 504 eligibility and services must be documented in the student's file and reviewed periodically.

If a child is found to be eligible under Section 504, a written accommodation plan must be developed to meet the child's individual educational needs. While this plan may be similar to an IEP document and there is no legally required format, one should not use an IEP form to develop a Section 504 plan. Most school districts have developed a set of forms for use in developing a Section 504 plan. An OT or PT may work with the school to evaluate the sensory-motor needs of the child who is eligible under Section 504, and to help assure safety and access.

While the above guidelines may assist in determining the nature and amount of occupational and physical therapy services provided to children and youth through educational programs, it should be emphasized that both IDEA 2004 and Section 504 require that the unique needs of each child be considered by the child's individual team when identifying the OT and PT services to be provided. Occupational and physical therapists in educational programs act as members of this educational team in determining need for OT and PT services.

Section 504 Example: A teenager returned to school following hospitalization for a traumatic spinal cord injury. School staff met with the student, his family and hospital rehabilitation staff to become acquainted with the student's needs. Based on psycho-educational evaluations, it was determined that the student could be expected to learn at the same rate as he had before the accident, and would not need special education. The student had, however, sustained injuries that significantly impacted his motor skills. The team developed a plan for accommodations and modifications enabling the student to participate in the school program. The team agreed to meet at mid-term to evaluate and modify the plan.

Figure 3: Oregon ECSE/School-Age Special Education and Section 504 Evaluation/Eligibility/IEP-IFSP-Section 504 Plan Development and Implementation Processes



Student Goals

Therapists may help a child/student achieve an educational goal if the expertise of the therapist is needed for skill acquisition. Student goals may be supported or recommended by the therapist, or by a teacher in collaboration with the therapist.

If the IEP team includes the goal on the IEP, instruction may be provided by the therapist or by school staff taught by the therapist. Examples of student motor skills may include teaching of:

- ◆ Independent sitting
- ◆ Independent wheelchair transfers
- ◆ One-handed typing
- ◆ Use of adapted self-feeding equipment

In a *participation approach* to therapy, an adapted splint for handwriting may be used in all of the student's environments: at school, at home or in another setting. Likewise, before transition to middle school, a therapist using a participation approach might help a student to work on operating a combination lock for his locker, dressing down more quickly for gym, and mastering a laptop computer for producing written work.

Examples of student goals with objectives that reflect integration of outcomes recommended by a therapist include;

Goal: Student will sit upright with necessary supports in classroom for 45 minutes.

Goal: Student will use eye contact and eye gaze to communicate with staff.

Goal: Student will independently move to the bathroom and transfer to and from a wheelchair to commode 100% of opportunities.

Goal: Student will independently manipulate adapted clothing for successful voiding 100 % of opportunities.

Goal: Student will use one-handed typing strategies for in-classroom computer keyboard during 75% of written assignments.

Goal: Given set up by an adult or peer helper, student will use adapted self-feeding equipment, 3 to 5 days/week.

Times needed for implementation of each type of therapy service are also listed on the IEP. All times listed are considered together when totaling therapy service time for the child. (Time involving implementation of physical management or motor programs by trained classroom staff are not therapy and do not count as therapy.)

Transition from School to Community Settings

Another area of IEP development in which OTs and PTs will be involved is planning for transition from school to the community. By federal law, secondary transition for a student in special education begins at age 16, however it may begin sooner if the team determines that it is appropriate. The IEP for a student of transition age must include:

- ♦ Appropriate measurable postsecondary goals based upon age-appropriate transition assessments related to training, education, employment, and independent living skills;
- ♦ The course of study needed to assist the child in reaching these goals;
- ♦ Agency participation, if the IEP team determines an agency is likely to be responsible for the transition service (parent consent required); and
- ♦ The anticipated date of graduation and the type of diploma or alternate document the student is anticipated to receive.

Related services may play a part in any of these aspects of a student’s transition plan. The therapist might be responsible for performing a site study of internship locations to determine if there are any accessibility issues and if modifications are necessary. An OT might consult with a student concerning self-care issues and assist in designing any necessary interventions.

Collaboration with Non-Educational Settings

Communication between educational and non-educational therapists is important for optimal coordination of services to children. Sharing information between educational, community, and hospital environments promotes a collaborative model of services important for consistent and effective outcomes. Coordination is especially critical for children who are receiving services in multiple environments. Written parent consent is required prior to any exchange of information with medical providers.

For example, it may be beneficial for the school therapist to communicate with the clinic-based therapist to review equipment needs, general goals and directions. When equipment such as a powered wheelchair is used primarily in school, it makes sense for modifications to be made based on collaborative assessment by the therapist from the educational program, the clinic therapist, the medical equipment specialist, and parents, with input from school staff. The education-based therapist may coordinate with hospital staff prior to or during an inpatient stay (typically for surgery), to plan for the transition back to school. This coordination may involve arranging for a loan or fabrication of special equipment for the child to use at school during the recovery period.

Therapy services conducted in educational environments are different in many respects from therapy conducted in non-educational environments. Therapy services differ in terms of intent, the role of the therapist, the size of the caseload, the types of supports available to the therapist, the demands of the environment, and the activity. It is important to differentiate between the roles of therapists in different environments, since children often receive therapy services from various sources. Coordination and communication between the providers are critical for effective provision of services to children and their families. There can be confusion about the therapist’s role in making the transition between educational and non-educational practice settings. An additional set of laws and regulations need to be considered in educational settings. In an effort to

alleviate potential confusion, Table 2 below presents frequently asked questions about the roles of therapists in educational and non-educational practice settings.

Some children may need occupational and/or physical therapy in a clinical environment, but may not be eligible for those services as part of their educational program. For example, a child with a disability who is recovering from surgery, may be in need of, and receiving therapy in a medical setting, but may not be entitled to receive therapy within the context of the educational program.

Many students who receive therapy through educational programs have a lifelong health condition. Therapy services are provided in the educational environment to help the student to access, and benefit from, his or her program of instruction. Educational goals and functional skills hold a primary position in the provision of therapy in educational settings.

In the state of Oregon, the educationally-based therapist does not need a physician's prescription in order to provide services to a child in the educational program.

Education-based therapists are expected to share their knowledge and skills with others in educational environments by demonstrating and monitoring activities that are therapeutically, as well as educationally, appropriate. IDEA 2004 shapes the role of the therapist in special education. The service models may include individual therapy, therapy provided in small groups, and consultation with others in the school, the community, and the child's home. (See Chapter 4) The therapist may be asked to make suggestions and educate staff in activities that will be conducted by teachers and instructional assistants.

The education-based therapist does not have ready access to physicians and other medical professionals, but may nevertheless be perceived by others in the educational environment as a potential link to the medical community. As such, therapists may be asked for advice on questions outside their scope of practice. In such a case, the therapist may be a source of referral to appropriate medical resources.

For a table comparing frequently asked questions about the contrasting roles of therapy in education and non-educational settings, see the table on the following pages.

Table 2: FAQ’s About Therapy Services in IDEA Environments

EDUCATIONAL SETTING	NON-EDUCATIONAL SETTING
Who is served by PT/OT?	
<p>Children who qualify for special education services and who require OT/PT:</p> <ul style="list-style-type: none"> EI – 0 to 3 years ECSE – 3 to 5 years School Age – 5 to 21 years Transitional – 18-21 years <p>Students qualifying under Section 504.</p>	<p>All ages without distinction, diagnoses within scope of practice.</p>
Who is not served by PT/OT?	
<p>Children with or without disabilities who do not require individual, specially designed instruction , related services or Section 504 accommodations. A medical diagnosis alone is not a criteria for service.</p>	<p>Resource limited per insurance, private pay, or Medicaid/Medicare.</p>
What is the focus of service?	
<p>EI / ECSE – enhance the development of infants and toddlers with disabilities; reduce need for special intervention; maximize independent living; and, enhance the capacity of families to meet the child’s needs.</p> <p>School Age – access to instruction and school related activities; designed to meet special needs of students.</p> <p>Transition – preparation for living, working and learning in post-school environments.</p>	<p>Physical therapy is concerned with identifying and maximizing quality of life and movement potential within the spheres of promotion, prevention, treatment/intervention, habilitation and rehabilitation. This encompasses physical, psychological, emotional, and social well-being. It involves the interaction between physical therapist (PT), patients/clients, other health professionals, families, care givers, and communities in a process where movement potential is assessed and goals are agreed upon, using knowledge and skills unique to PTs.</p> <p>The practice of occupational therapist means the therapeutic use of everyday life activities (i.e., occupations) with individuals or groups for the purpose of facilitating participation in roles and situations in home, school, work place, community, and other settings. OT services are provided for the purpose of promoting health and wellness and are provided to those who have or who are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of occupational performance in a variety of contexts. (<i>Definition of occupational therapy practice for the AOTA Model Practice Act, 2004</i>).</p>
Where are services provided?	
<ul style="list-style-type: none"> EI – Natural environment ECSE – Natural environment, preschool School Age – School setting Transition – School or community setting 	<p>Hospital, out-patient clinic, home, work, nursing facilities, community</p>

EDUCATIONAL SETTING	NON-EDUCATIONAL SETTING
What is the process for entering the system?	
EI - multiple referral options ECSE - multiple referral options School age - request of parent, referred by school staff, other referral source	Physician referral/self-referral-direct access
What is the evaluation process?	
Written parent consent to evaluate is required and information explained to parent. Evaluation is completed within 60 school days, results are shared with the team, and then eligibility is determined.	Every patient is evaluated using a variety of assessment tools and instruments
What is the plan of care?	
EI - IFSP ECSE - IFSP School age - IEP Transition – IEP with transition goals and services	OT/PT Plan of care
What is the plan of care development process?	
Collaboration within the IFSP/IEP team, which determines priority of goals and objectives.	Developed by the therapist in collaboration with the patient, family, and health care team and based on examination findings.
How is the plan of care/service evaluated?	
EI/ECSE - review of IFSP performance data School age/Transition - IEP student progress reports	Periodic reassessments as required by state practice acts
How are modifications to the plan of care made?	
IFSP/IEP team convenes to make changes to IFSP/IEP	In collaboration with patient, family, and health team
How is the plan of care documented?	
EI/ECS - IFSP School age/Transition - IEP	Progress notes in the patient record
How is service documented?	
Contact notes, progress notes	Progress notes in the patient record
What types of services are delivered?	
Hands-on Services, Direct Consultation, and, in-service training to school staff	Wide range of services may be provided
Who may provide follow up implementation of plan of care?	
EI - family, licensed professionals ECSE - licensed professionals, EAs School age/Transition - licensed professionals, EAs	PT, PTA OT, OTA
What Federal and State Statutes and Rules regulate PT/OT practice?	
OT: OAR 339-001-0000 through 339-020-0100 PT: OAR 848-001-0000 through 848-045-0020 ODE: OAR 581-015-2100 & 2105 IDEA 2004: 34 CFR Part 300 and 301 Section 504: 34 CFR Part 104	OT: OAR 339-001-0000 through 339-020-0100 PT: OAR 848-001-0000 through 848-045-0020 OT: ORS 675.210 through 675.340 PT: ORS 688.010 through 688.201
When regulations are in conflict, which set of regulations take precedence?	
Most restrictive regulation (IDEA and state regulations)	State practice acts and HIPAA apply

School therapy is limited in IDEA 2004 and Section 504 to assuring that students have access to their education and are able to learn unique skills related to their disability. Some children with disabilities are independent and able to participate in the general education environment without therapy services to provide modifications or accommodations. These students do not receive school therapy services even though they have a documented disability. Chapter 4 contains a more in-depth discussion of services provided under Section 504.

CHAPTER 4

Modes of Service Delivery under IDEA 2004

Under IDEA 2004, school districts are required to provide related services to students who have a special education eligibility that impacts their ability to benefit from their general educational program and who have a documented need for the service. IDEA 2004 identifies physical therapy and occupational therapy as two of the related services that may be provided for children Birth to age 21. The purpose of a related service is to assist a child with a disability to benefit from his or her special education program, and achieve the goals identified for the child. In other words, from age 3-21, therapy is designed to enhance the child’s ability to participate in the educational process.

In special education programs, students receive occupational therapy and physical therapy service so that they can attend and participate in school. **If the purpose of a therapy service is to help the student to accomplish IEP goals, participate in the general education curriculum, or participate in extracurricular activities, the therapy is considered *educationally relevant and educationally necessary* and should be included in the student’s IEP if agreed to by the IEP team.**

The goal and intent of the IEP team process is to provide a decision by “working together for a common end using three basic approaches – consulting, coaching, and teaming.” IEP teams are collaborative teams. A collaborative team is “a group of people with a common goal and shared belief system who work with parity and distributed functions in a collaborative teaming process.” In education the collaborative team is “an interactive team process that focuses student, family, education, and related service partners on enhancing the academic achievement and functional performance of all students in school” (Hanft, 2008).

Providers of physical and occupational therapy must be licensed by their respective state boards. Licensed occupational therapists and physical therapists should be aware of the Oregon OT Practice Act (OAR 339-010-0005 through OAR 339-010-0055 and the PT Practice Act (OAR 848-010-0010 through OAR 848-010-0044). When in doubt about their responsibility under the law, the therapist should follow the most restrictive binding regulation. Therapists should refer to these OARs regularly for updated information.

Decisions about services provided to a child must be made by the team on a case-by-case

OT Licensing Board:

www.oregon.gov/OTLB/index.shtml

OT Practice Act:

OAR 339-010-0005 through OAR 339-010-0055

PT Licensing Board:

www.oregon.gov/PTBrd/index.shtml

PT Practice Act:

OAR 848-010-0010 through OAR 848-010-0044

basis. When it is determined through evaluation that a child is eligible for special education and needs physical or occupational therapy services, the child's IEP or IFSP should reflect those services. During the development of the plan for therapy services, the team needs to determine the appropriate service delivery mode, the location of the services, and the individuals to be involved in the services. All services listed as provided by OT/OTA and PT/LPTA must be provided by a licensed occupational therapist, physical therapist, or therapy assistant licensed by the OT/PT Licensing Board. Therapy services under IDEA involve a range of activities in addition to direct intervention with the child. There are three major modes of service delivery: consultative, direct, and indirect. Similar to home health practice environments, a non-clinic-based setting, OTs and PTs serving in the educational environment are generally required to be itinerant. This fact, along with the classification of OT and PT as a related service, means that the bulk of therapy service will be consultative. Keeping this in mind, the consultative mode of service delivery will be discussed first.

Consultation:

In a consultative model the therapist plans physical management activities and training programs that are implemented by another person such as the child's teacher, parents or an instructional assistant. Those people are trained and monitored by the therapist. The

therapist maintains regular contact to update programs and oversee how the program is implemented. Consultative service delivery will often take one of two forms:

Consultation: Team support and when appropriate, hands-on interaction with the child.

Direct Services: Hands-on support.

Indirect Service: Team and systems support.

- ♦ **Consultation with direct child contact** is a service whose overall objective is integration of a program or activity that will continue in the absence of the therapist. In this approach to service delivery the majority of a child's progress will occur through practice with school staff or parents as trained facilitators. The role of the therapist is to train the facilitator, monitor the program and make adjustments as appropriate. This approach includes direct contact with the child for the purpose of demonstration, monitoring progress, and assessment.
- ♦ **Consultation as support for school personnel** is a service where direct contact with the child is minimal. This service is focused towards the teacher and classroom assistants. Programs implemented by school personnel are monitored through observation of the child and/or school staff interview. As a therapist develops familiarity with school staff and the student, this becomes an increasingly appropriate method of service delivery.

Direct Services:

In a direct service model, the therapist is the primary service provider. Direct service may be provided individually or in groups. The objective of this service model is to help the

child make changes primarily through direct interaction. Direct service is minimal in educational programs.

Indirect Services:

Indirect services are all therapy services that are provided by the therapist on behalf of the child or school staff. Indirect services could include phone calls, report writing, equipment management, funding approvals, etc. Another form of indirect service is adaptation of equipment, materials, and environments so that the child can be more functional in the educational setting. This service is often provided along with consultative and direct service, however in some instances could be the only therapy service provided. Therapists should consider recording indirect service on the IEP separately from direct or consultative services if this is a significant component of service for the child.

One way to help the team determine the appropriate type and amount of service for each student was developed by a task force of the Vermont Department of Education (Vermont Department of Education, 2001). This planning system is called “only-as-special-as-necessary.” When teams use the *only-as-special-as-necessary* approach to therapy, they work to identify and draw upon natural supports, including those currently existing and available to students without disabilities (e.g., teachers, peers, and student study teams). In cases where more specialized services are necessary, ongoing data are collected on the impact of the services. The *only-as-special-as-necessary* approach requires that the team continually explores ways that students with disabilities can receive needed therapy supports in the most natural ways possible. *Only-as-special-as-necessary* does not necessarily mean “less is always best” or “only a little is plenty.” When used as intended, the *only-as-special as-necessary* approach results in students receiving all needed services in the most natural way that can be achieved in the environment.

Regardless of the approach employed to determine the type and level of related services, IDEA 2004 requires that special education services be provided in an environment that is the least restrictive environment appropriate for the child. For children in ECSE and school age programs, services may be provided in a preschool or school classroom, lunchroom, playground or other educational environment. For children in EI programs, the natural environment is most typically at home, where parent(s) or family members can become actively involved. This kind of integrated therapy program in customary and natural environments provides opportunities for the child to practice newly-acquired skills or to try out adapted methods for performing a task in the same environment as his/her non-disabled peers.

The proportion of supports and services provided will change depending on a student’s projected outcomes and progress toward achieving goals. Other variables that affect the proportion of supports and/or services include the knowledge of the team members related to addressing student’s educational needs, the education environments in which students learn and interact with peers and teachers, and the structure, routines, and culture of school activities (Hanft, 2008).

Table 3: Examples of Consultation, Direct and Indirect Therapy Services

Consultation	Direct Services	Indirect Services
<ul style="list-style-type: none"> • Co-teaching • Professional in-service training • Collaborative consultation • Participating in pre-referral interventions • Recommending program evaluation • Assisting in the development of school policies and procedures • Drafting district OT/PT guidelines • OT/PT supervision and mentoring 	<ul style="list-style-type: none"> • Observing and evaluating within the context of the education environment routine • Trial of modifications or equipment • Training new motor skills • Evaluation and training activities of daily living • Access to sports and extracurricular activities • Pre-referral screenings 	<ul style="list-style-type: none"> • Liaison with medical community • Report writing • Travel time • Fabricating equipment or materials • Attending IEP meetings • Progress monitoring • Communicating with community OTs and PTs

Therapy services should be documented on the IFSP or IEP as clearly as possible in order to provide the most accurate picture of the services to be delivered. While some local or Regional programs may have a preference for how therapy services are documented, **there is no single way to correctly document therapy services on the IEP.** In general, direct services to the child may be recorded under Related Services. Equipment to improve the student’s ability to access to the school program may be listed under Modifications and Accommodations/Supplementary Aids and Services. Consultation or training to school staff may be listed under Supports to Personnel. Regardless of the type of services provided, therapy services should be described on the IEP in a way that is specific enough to provide a clear understanding of the IEP team’s intent, while still being general enough to allow the service to be adapted as the student changes or progresses without the need to reconvene the IEP team to modify the document.

For a more in-depth look at documenting therapy services under IDEA, see Chapter 5.

There is no single way to correctly document therapy services on the IEP. When in doubt about how related services should be listed on the IEP, see the *Oregon Standard IEP Guidelines for Completion* on the ODE website at www.ode.state.or.us/search/page/?id=1163.

TELEPRACTICE IN SCHOOL-BASED PRACTICE

Some services by occupational therapy and physical therapy can now be delivered via telepractice or telehealth in Oregon. This adds a new dimension to the practice of both OT and PT which could enhance current service to students and collaboration with school staff, particularly in rural communities and during winter months when travel may be treacherous. Telepractice does not replace the face-to-face evaluation, intervention, education and consultation done in early intervention or school-based practice. It is the responsibility of the therapist to ensure security of information and continued quality of care.

The increased accessibility of therapist consultation can improve access when the expertise is needed in a timely manner and can assist when clarification of key points is necessary for student access, participation and safety. The final decision to use telepractice is up to the licensed therapist since it is a part of their Oregon state licensure and should be noted appropriately in the IFSP or IEP.

Telehealth OARs for Occupational Therapy

339-010-0006

Standards of Practice for Telehealth

- (1) "Telehealth" is defined as the use of interactive audio and video, in real time telecommunication technology or store-and-forward technology, to deliver health care services when the occupational therapist and patient/client are not at the same physical location. Its uses include diagnosis, consultation, treatment, prevention, transfer of health or medical data, and continuing education.
- (2) Telehealth is considered the same as Telepractice for Occupational Therapists working in education settings; and Teletherapy and Telerehab in other settings.
- (3) In order to provide occupational therapy services via telehealth to a patient/client in Oregon, the occupational therapist providing services to a patient/client must have a valid and current license issued by the Oregon OT Licensing Board. Oregon licensed Occupational Therapists using telehealth technology with a patient/client in another state may also be required to be licensed in the state in which the patient/client receives those services and must adhere to those state licensure laws.
- (4) Occupational therapists shall obtain informed consent of the delivery of service via telehealth from the patient/client prior to initiation of occupational therapy services via telehealth and maintain documentation in the patient's or client's health record.
- (5) Occupational therapists shall secure and maintain the confidentiality of medical information of the patient/client as required by HIPAA and state and federal law.
- (6) When providing occupational therapy services via telehealth, an occupational therapist shall determine whether an in-person evaluation is necessary and make every attempt to ensure that a therapist is available if an on-site visit is required.

(a) If it is determined in-person interventions are necessary, every attempt must be made to ensure that an on-site occupational therapist or occupational therapy assistant shall provide the appropriate interventions.

(b) The obligation of the occupational therapist to determine whether an in-person re-evaluation or intervention is necessary continues during the course of treatment.

(7) In making the determination whether an in-person evaluation or intervention are necessary, an occupational therapist shall consider at a minimum:

(a) The complexity of the patient's/client's condition;

(b) His or her own knowledge skills and abilities;

(c) The patient's/client's context and environment;

(d) The nature and complexity of the intervention;

(e) The pragmatic requirements of the practice setting; and

(f) The capacity and quality of the technological interface.

(8) An occupational therapist or occupational therapy assistant providing occupational therapy services via telehealth must:

(a) Exercise the same standard of care when providing occupational therapy services via telehealth as with any other mode of delivery of occupational therapy services;

(b) Provide services consistent the AOTA Code of Ethics and Ethical Standards of Practice; and comply with provisions of the Occupational Therapy Practice Act and its regulations.

(9) Supervision of Occupational Therapy Assistant under 339-010-0035 for routine and general supervision, can be done through telehealth, but cannot be done when close supervision as defined in 339-010-0005 is required. The same considerations in (7)(A) through (F) must be considered in determining whether telehealth should be used.

(10) An Occupational Therapist who is supervising a fieldwork student must follow the ACOTE standards and other accreditation requirements.

(11) Failure to comply with these regulations shall be considered unprofessional conduct under OAR 339-010-0020.

Stat. Auth.: ORS 675.320(8)

Stats. Implemented: ORS 675.320

Hist.: OTLB 2-2014, f. & cert. ef. 11-20-14; OTLB 2-2015, f. & cert. ef. 3-27-15

Telehealth OARs for Physical Therapy

848-040-0180

Standards for Telehealth Services

(1) A Licensee may provide telehealth services to a patient who is domiciled or physically present in the state of Oregon at the time the services are provided. An aide may not provide telehealth services.

(2) Telehealth services provided must conform to the scope and standards of practice and documentation as provided in Oregon Revised Statutes 688.010 through 688.201 and these Division 40 rules. Telehealth services must be at least equivalent to the quality of services delivered in-person.

(3) Prior to the initiation of telehealth services, a Licensee shall obtain the patient's consent to receive the services via telehealth. The consent may be verbal, written, or recorded and must be documented in the patient's permanent record.

(4) When providing telehealth services, a Licensee shall have procedures in place to address remote medical or clinical emergencies at the patient's location.

(5) The application and technology used to provide telehealth services shall meet all standards required by state and federal laws governing the privacy and security of a patient's protected health information.

(6) A Licensee providing telehealth services to a person who is domiciled in another state and physically present in that state at the time the telehealth services are being provided, may be required to be licensed in the state where the services are being rendered.

Stat. Auth.: ORS 688.160(6)(C)

Stats. Implemented: ORS 688.010-688.230

Hist.: PTLB 2-2015, f. 8-27-15, cert. ef. 9-1-15

CHAPTER 5

Documenting Therapy Services under IDEA 2004

Documenting Therapy Services on an IFSP

As with IEPs, therapy services on the IFSP may be listed as supplemental aids and services, adaptations, accommodations or modifications, or support for program personnel. There is not a category entitled “related services” on an IFSP. In addition, direct OT and PT services can be listed under the EI/ECSE services section of the IFSP and may either be provided by the EI/ECSE program or by other agencies. There may be times when the only service required for a child on an IFSP is a therapy service. This is because the goal of early intervention is to help the child to achieve developmental milestones which are, by their nature, motor or speech-language related. As such, those goals fall under the domain of therapy. (See *Scope of School Services*, Appendix A6, and sample IFSP Summary Page, Appendix C4.)

Documenting Services on the IEP

Occupational and physical therapy services may be listed on the Individualized Educational Program (IEP) under four sections entitled related services, supplemental aids and services, modifications and accommodations, and supports for personnel.

Related Services take place with or without the child present. Examples include:

- ♦ Teaching and monitoring of sensory-motor programs
- ♦ Assessment or standardized evaluation
- ♦ Trial of new equipment or adjustment of current equipment
- ♦ Functional assessment in the classroom or other environment
- ♦ Observation of a student on the playground to determine access

Supplemental Aids/Services Activities and things which are necessary to create an environment that supports the student’s progress in the educational program. Examples include:

- ♦ Researching equipment to recommend for purchase
- ♦ Communications with parents or community medical providers
- ♦ Scheduling co-planning and collaboration meetings

Modifications and Accommodations contribute to the child’s ability to participate in the general educational environment or increase independence. The child may or may not be present when these services are provided. Sample activities include:

- ♦ Communicating with community resources
- ♦ Reviewing a student’s file

- ♦ Setting up a data collection system with an Instructional Assistant
- ♦ Consulting with the Adaptive PE teacher
- ♦ Fabricating materials
- ♦ Customizing equipment
- ♦ Assisting a teacher to modify written assignments to accommodate limited endurance

Supports for Personnel help school staff to include children in activities. Again, the child may or may not be present. Supports for personnel may include:

- ♦ Providing inservice training to school staff
- ♦ Attending team meetings
- ♦ Communicating with the teacher via telephone or email
- ♦ Writing reports
- ♦ Consulting with the instructional assistant
- ♦ Discussing transportation for an upcoming field trip with a teacher and/or bus driver

It may be difficult to decide where to list some therapy activities on the IEP/IFSP form. Many therapy activities may be hard to categorize, or may fall under more than one category. What matters most is that all therapy activities are represented on the IEP/IFSP. Sections are provided in order to enhance clarity. What is of primary importance is that the IEP/IFSP presents a clear and understandable picture of the child's school program. Everything on the IEP/IFSP carries equal importance, regardless of where in the document it is recorded. (See Appendix C4, sample IEP Summary Page.)

The Oregon Department of Education provides written guidance on the use of the standard IEP and IFSP forms. Forms with accompanying ODE guidance may be accessed at the following links:

Oregon Standard IEP form and guidelines for use:
www.ode.state.or.us/search/page/?id=1163

IFSP form and guidelines for use:
<http://www.ode.state.or.us/search/page/?=3154>

The Oregon Administrative Rule (OAR 848-040-0160) for physical therapy states the permanent record of each reassessment shall include **at a minimum**:

1. Subjective status of patient;
2. Objective data from tests and measurements conducted;
3. Functional status of patient;
4. Interpretation of above data;
5. Any change in the plan of care; and
6. Any change in physical therapy goals (including patient goals).

The rules also state that a physical therapist shall perform a reassessment for each student at least every 60 school days or at every visit if the student is seen less frequently.

The Oregon Administrative Rule (OAR 339-010-0050 (4)) for Occupational Therapy states documentation must contain the following:

- (a) The occupational therapy practitioner must document evaluation, goals, interventions and outcomes if they are not included in the service plan.
- (b) Documentation should reflect the child's current status, progress towards goals, response to interventions, and strategies that were promising or ineffective.
- (c) The occupational therapist should utilize a method of data collection that allows for concise and accurate recording of intervention and progress.
- (d) The occupational therapy practitioner is responsible for the analysis of data collected to verify progress and the documentation of their own activities to accomplish the goals.

The format for the documentation of student contacts, case notes, etc. is up to the individual therapist. However, best practice should always be followed.

Permission to Share Information

Therapists from different practice environments can work together by exchanging information about the child, equipment options, or additional resources. Signed permission to exchange information between an educational setting and other health providers must always be obtained from the child's parent on an annual basis. Legal requirements about the confidentiality of health care and educational records are legislated under the Health Information Portability & Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA).

Confidentiality is an ethical concern. The fundamental intent is to protect a child's right to privacy by ensuring that matters disclosed to a professional not be relayed to others without informed consent. Neither privacy nor confidentiality, however, is an absolute right, especially in the case of minors. There are fundamental exceptions, some involving ethical considerations and some involving legalities. Therapists in school settings should comply with confidentiality standards required by both **their profession**, and by **school district policy**. Therapists should be aware of the federal and state laws and regulations that address classification, accessibility, review, challenges, amendments, transfer, maintenance, and destruction of student records including:

- ◆ Family Educational Rights and Privacy Act of 1974 (FERPA)
- ◆ FERPA incorporated into IDEA 2004
- ◆ Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Table 4: Major features of FERPA and HIPAA

	FERPA	HIPAA
Overview	<ul style="list-style-type: none"> • Federal law • Protects privacy of students' educational records 	<ul style="list-style-type: none"> • Federal law • Improves the efficiency and effectiveness of health care system • National standards and requirements for electronic health care transmissions • Protects the privacy and security of personally identifiable health information
Applies to	Educational agencies and institutions that receive funds under ANY program administered by the U.S. Department of Education	Health plans, health care clearing houses, and health care providers that transmit health information in electronic form in connection with covered transactions (i.e., hospitals, physicians, dentists, and other practitioners)
Does not apply to	Any educational institution that does not receive funds from the U.S. Department of Education (most private and religious schools)	Non-medical records
Release of records by an agency	Person in the role of parent or, if student is 18 years or older, student or guardian; written consent required	Parent or eligible student (18 years old); written request
What's covered	Educational records – those records directly related to a student, and maintained by an educational agency or institution (i.e., health records, school nurse records, all special education)	Medical records, including names, address, dates directly related to an individual, including birth date, admission date, discharge date, date of death, phone and fax numbers, electronic mail addresses, Social Security numbers, medical record numbers, health plan beneficiary numbers, account number, license plate numbers, full face photographic images and any comparable images, and any other unique identifying number, characteristic, or code
More information	www.ed.gov/policy/gen/guid/fpco/index.html	www.hhs.gov/ocr/hipaa/
Source: Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) And the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to Student Health Records. November 2008.		

In the course of providing assessments and therapy services to students with disabilities, there are occasions when the therapist will need access to the educational records of students. This may be during assessment activities in order to gather and review existing evaluation information, during an IEP meeting when the planning for instruction and related services occurs, or in the school setting when providing services. When a therapist is employed or under contract for services to students with disabilities, this creates a legitimate educational interest and allows each school in the district served by the therapist to allow the therapist access to the educational records of individual students.

Retention of Records

The OARs for Physical Therapy, state, "Patient records shall be kept for a minimum of seven years measured from the date of the most recent entry." (OAR 848-040-0110(15))

For educational programs, OAR 166-400-0060(28)(a) states, “Records documenting speech pathology and physical therapy services: Until student reaches age 21 or 5 years after last seen, whichever is longer”. The Occupational Therapy Practice Act is silent on the issue of records retention. Best practice would suggest that the physical/occupational therapist retain the records as defined in OAR 848-040-0110(15) for seven years from the **date of the last entry in those records**; however, copies of those records housed in the student’s educational record may be destroyed after five years from the date the student was last seen by the therapist.

This page intentionally left blank.

CHAPTER 6

Supervision, Evaluation and Mentorship of Therapists Employed by Educational Agencies

Given the nature of school-based services, and the medically-oriented OT and PT educational programs, the school setting can be a challenging place for therapists to work. Therapists who are new graduates may not be sufficiently prepared to work in this setting and should have formal supervision. Therapists with more experience will often find that, while they are more than capable of managing the therapeutic issues, they are unfamiliar with the terminology, practice issues, IDEA directives and legal requirements of the setting.

Regardless of the therapist's professional background, those who are new to school-based service should have opportunities for mentorship. In the best of circumstances these opportunities will be provided by the district or Education Service District (ESD) that employs the therapist. If not, mentorship should be actively sought out by the incoming therapists. Therapists who work for ESDs will often have opportunities to interact with other therapists who have years of experience and who are available for questions and discussion of issues related to school practice. Since practice does vary between states and even within ESDs or districts, therapists should check with their immediate supervisors and/or district special education directors for clarification of their roles and responsibilities within each setting.

Mentorship by an experienced member of the same discipline (PT or OT) is a valuable adjunct to traditional supervision and allows mentors and mentees to identify the strengths and abilities they bring to the school-based setting and develop new skills and strategies to work in these educational environment settings. A mentor can also help a new employee become familiar with best practice strategies, update knowledge in evidence-based school practice, and become familiar with the milieu of the ESD or districts they serve.

Opportunities for mentorship exist within professional organizations. The American Physical Therapy Association (APTA) and American Occupational Therapy Association (AOTA) both have a school-based special interest group (SIG), or special interest section (SIS), where therapists with years of experience can be contacted for assistance. The APTA school-based SIG is hosted within the section on pediatrics and requires membership to the national organizations. AOTA and OTAOS SIS groups also require membership.

In Oregon there is also a variety of information and opportunity for mentorship through the Regional and Statewide Services for Children with Orthopedic Impairments (RSOI). The RSOI coordinator and staff can provide invaluable assistance and can direct therapists to discipline-specific mentors within the state. The RSOI website offers publications and a

library of books, DVD's and other resources to assist Oregon therapists who are new to school-based services (www.rsoi.org).

Publications and a lending library of books, DVD's and other resources are available from Regional and Statewide Services for Students with Orthopedic Impairments (RSOI) at www.rsoi.org.

Evaluation of Occupational and Physical Therapists in Oregon

Senate Bill 880 (SB 880), approved by the 1997 Oregon Legislature, governs the minimum elements for evaluation of licensed educational staff. Districts are free to develop their own forms and format for evaluation. The provisions of SB 880 require that every teacher receives a performance evaluation based on a job description and written performance standards established by the school district. Many school districts apply this requirement to the evaluation of licensed therapy staff in addition to teachers. Districts have begun to develop performance standards specifically for evaluation of school therapists. Suggested performance standards for educational-based occupational and physical therapists in Oregon may be found in Appendix A7 and A8 and online at www.rsoi.org.

Supervisors in educational programs who evaluate and supervise the work of physical therapists and occupational therapists typically are not therapists themselves. Educational agency therapist supervisors may need more information about the roles and responsibilities of OTs and PTs. Therefore, professional practice may be best assessed by a therapist in the same discipline. Generic work performance skills such as timeliness, efficiency, and/or team responsiveness can be assessed by non-therapist supervisors. If at all possible, districts may consider coordinating with a therapist from their local regional program to establish peer evaluation. If not, someone from a neighboring district may be recruited.

A supervision and evaluation process that is well conceived and well executed can open a mutually-beneficial exchange between the occupational or physical therapist practitioner and the supervisor. A therapist can learn how better to tailor her or his activities to enhance the school program. They can ask specific questions about the performance standards used to evaluate their work, and they may learn about areas in which they may need to develop additional expertise. The supervisor can increase their understanding of therapy as a discipline and the many ways it can serve students with disabilities. They can learn more specifically what the therapist does with a student, and the purposes and benefits of the activities of the therapist. The purpose of the supervision and evaluation process is to benefit both supervisor and employee.

Although evaluation practices vary from district to district, the process mandated by Senate Bill 880 must include the following:

1. An interview before the evaluation to develop performance goals;
2. An evaluation based on written criteria related to the performance goals; and,
3. An interview following the evaluation in which the results of the evaluation are discussed with the employee.

Therapists should receive a written copy of the program's process for employee evaluation. The therapist meets with their supervisor to discuss and agree on performance goals. Performance goals can relate to any of the items in the therapist's job description, performance standards or other goals set by the supervisor. Goals must be reasonable and clearly apply to the job. Examples of goals developed by therapists are shown below.

1. Learn to use two new functional tests to assess students' need for therapy;
2. Develop or organize a set of handouts to help school staff implement motor programs;
3. Develop a data collection system for motor programs which is implemented throughout the school day as part of functional skill sequences;
4. Develop and present an inservice presentation to help school staff understand the role of the physical and occupational therapist in the school; and,
5. Investigate and make recommendations for the use of licensed physical therapist assistants (LPTAs) in school by reading articles or manuals and visiting one or more programs where LPTAs are employed.

Preparing to be Evaluated

Evaluation of a therapist's performance in the educational setting is an interactive exchange in which two professionals play complementary roles. The following tips, used in the private sector and adapted for use in the school setting, may be useful in preparing to be evaluated.

- ♦ Learn what performance standards will be used to evaluate your performance. Get them in writing, preferably in a copy of the same form that will be used during your evaluation;
- ♦ Identify for yourself ways in which you have met the performance standards. Write down examples of your behavior that support your own assessment, or at least say them to yourself so they will be readily available to you during your assessment;
- ♦ During an observation, remember that this is an exchange between two professionals and conduct yourself accordingly. Welcome the supervisor to your working environment. You might suggest a spot where she or he will be comfortable and able to see your work without interfering with it;
- ♦ Before the observation, ask if there is anything in particular your supervisor wants to see or talk about and tell them about any items on your own agenda;
- ♦ Explain what you are doing during the observation, if you can, without interfering with your work. Emphasize how your services contribute to promoting the student's participation in the educational program;
- ♦ Develop performance goals annually with the supervisor to improve your performance. If you need some support to accomplish them, such as additional training, resources, or administrative cooperation, ask the supervisor for assistance in getting it. If necessary, make an appointment for an update on your progress; and,

- ♦ Thank the supervisor for taking the time and interest to give you feedback. Point out what was especially helpful to you. Summarize your newly developed goals and mention any way the supervisor has agreed to help you reach them.

(Reed, et al, 1988)

Peer Review

Typically, school therapists, except those in very large districts, are supervised by school administrators or special education supervisors who are not therapists. One way to ensure that occupational and physical therapists in school programs receive adequate evaluation is to have administrators assess the areas that fall within their realm of expertise, and to invite a therapist consultant to assess the areas that require the expertise of a licensed therapist. Oregon law regarding evaluation of licensed school staff states that “nothing in this subsection is intended to prohibit a district from consulting with any other individuals.” (ORS 342.850(2)(c)) School districts can arrange for therapists from their own or other agencies to serve as consultants as part of the evaluation of educationally-based therapists.

Although supervisors can be expected to be skillful in some of the essential functions of a therapist’s job description, they are unlikely to have the same technical skills for which they hired the therapist. Consequently, the non-therapist supervisor is well qualified to evaluate in areas such as organization, communication, parent and community contact and the maintenance of useful data on student performance. A non-therapist supervisor may wish to utilize collegial observation or the consultation of a therapist from outside the agency for evaluation of specific skills related to the provision of therapy. When this is done, the performance evaluation will be more likely to adequately evaluate the therapist and to provide the therapist with appropriate feedback. A therapist should also feel comfortable in requesting a peer review or collegial observation for evaluation of specific skills related to OT or PT.

Monitoring of Contracted Therapy

Some therapists contract with a district to provide therapy and are not employed directly by the district. As a contractor, a therapist is not required to develop performance goals or to participate in a mandatory evaluation process. However, it is desirable that the contracts include arrangements for a district administrator to provide regular monitoring of the services provided. The district should be furnished with: a) proof that the therapist holds a current Oregon occupational or physical therapy license, and b) assurance of malpractice and/or liability insurance. The contract may be written for a specific number of hours or for specific tasks. For example, a contract that identifies the services to be provided may contain items such as:

“Complete evaluations on all students who have been referred including written reports, by November 25, 2011.”

or

“Instruct classroom staff to carry out physical management recommendations for positioning and handling.”

The details of contracts will vary. If a district is contracting for a very limited amount of time, it must prioritize the services it wants to purchase and the students it wants served. If the district is contracting for full service from a therapist, the therapist should have the flexibility to prioritize and schedule her or his own time but not to set priorities for services provided. That is the role of the IEP team.

When a therapist works for a district under a contract, the district may not provide liability coverage for the therapist. The therapist should insure that they are covered with appropriate liability and malpractice insurance. If the therapist works for a clinic or hospital, they may be covered by its group policy. If in private practice, they will need to obtain their own insurance. A district which contracts with a therapist for services should require proof of liability and malpractice insurance as a condition of the contract.

Supervision of Licensed Therapy Assistants

Licensed occupational therapy assistants (OTAs) must be supervised by an occupational therapist; licensed physical therapist assistants (LPTAs) must be supervised by a physical therapist. Both OTAs and LPTAs provide therapy

Under Oregon law all therapy assistants must have an identified supervising therapist who is legally responsible for intervention done under their direction. Licensed therapy assistants are also legally responsible for the treatment they provide.
OAR 339-010-0035 (OTA) and OAR 848-015-0020 (LPTA)

under the direction of the supervising therapist according to state practice acts. OTAs and PTAs are individuals who have been educated in an accredited program and have a license from the State of Oregon. Therapy assistants, by nature of their education, are expected to be knowledgeable about health-related disabilities and the application of recommended treatment techniques. They are expected to understand the principles that govern normal development and learning. All activities of OTAs and LPTAs must be monitored by a licensed therapist. Therapy services provided by a licensed assistant are counted as therapy hours for both IEP/IFSP and Medicaid billing purposes.

If licensed assistants (LPTAs or OTAs) are employed by the school district, all therapy provided by OTAs and LPTAs must be supervised by the respective supervising therapist. In the case of occupational therapy assistants, Oregon Administrative Rules (OARs) require that before an occupational therapy assistant assists in the practice of occupational therapy, he/she must file with the Occupational Therapy Licensing Board a “current statement of supervision of the licensed occupational therapist who will supervise the occupational therapy assistant.” (OAR 339-010-0035 (2)). While the supervision of LPTAs does not require a formal report to the Physical Therapy Licensing

Board, the licensed assistant must be able to identify, at all times, the supervising physical therapist to whom they are reporting.

While the supervising OT or PT need not observe all of the assistant's activities, they must regularly monitor these activities and be available in person or by phone to the assistant at all times in case of an emergency.

Both the OT and PT OARs indicate that licensed therapists should only assign responsibilities to a therapy assistant that they judge as appropriate and safe for the child and within the ability of the assistant to perform.

By Oregon state law, therapy assistants can provide all aspects of therapy except evaluation and development of a plan of care. The therapist and licensed assistant must develop a plan to follow in the event that the student's status changes rapidly or in an unexpected manner, and the therapist must be available to the licensed assistant to answer questions and to help with problem solving. **Reevaluations must be conducted by the licensed therapist and not by the licensed therapy assistant.** (OAR 339-010-0050)

For the full text of the state of Oregon regulations regarding licensure of occupational and physical therapists, OTAs and PTAs, see the Occupational Therapy Association of Oregon website at www.otao.com or the Oregon Physical Therapy Association website at www.opta.org.

Evaluation of OTAs and PTAs

The supervision of a licensed therapist assistant in the educational setting is a responsibility shared by the department supervisor and the supervising therapist. The specific monitoring activities required of supervising therapists are defined in the OARs for licensing occupational therapists and physical therapists. It is the responsibility of both the educational supervisor and the supervising therapist to know and understand these rules. (OTA: OAR 339-010-0035, LPTA: OAR 848-015-0020)

Since the responsibility for supervision of OTAs and PTAs is jointly held, the department supervisor and the licensed therapist work together during evaluation of OTAs and PTAs. The department supervisor must implement the district's evaluation plan as it applies to the educational aspects of the assistant's performance. They should meet with the therapy assistant to establish performance goals, set up and complete the required observation, evaluate their performance and give them feedback about that performance. Within that process, the therapist who is providing the clinical supervision should be asked to give a written statement about the individual's skills in implementing therapy programs, or any other information a non-therapist administrator could not be expected to judge. This written statement can then be attached to and incorporated into the formal evaluation document.

Assigning Responsibilities to Classroom Assistants

Classroom teachers and classroom assistants lack the medical education to make decisions regarding the provision of therapy services. A teacher, classroom assistant or parent can be instructed by the therapist to perform only specified activities with specified children, such as daily physical management, transfers, positioning, or feeding. These motor activities may not be counted as therapy hours.

A comparison of the performance responsibilities for therapists, therapy assistants, and classroom assistants is shown in Table 5.

Table 5: Comparison of Responsibilities of Therapists, Licensed Therapist Assistants, and Classroom Assistants

Therapist	Licensed Therapist Assistants	Classroom Assistants
Assess student's level of functioning and need for therapy.	Assist in the assessment of student's level of functioning and need for therapy under direction of the therapist.	Provide information to the therapist about the student's function based on observation and classroom performance.
Develop IEP/IFSP goals for a student in the area of physical or occupational therapy and participate in IEP/IFSP meetings with parents.	Assist in the development of an IEP/IFSP for a student in the area of physical or occupational therapy and participate in IEP/IFSP meetings with parents at the direction of the therapist.	Contribute information about educational performance and needs.
Develop and implement therapy programs to support IEP/IFSP goals.	Implement therapy programs to support IEP/IFSP goals and give feedback to therapist on implementation of program.	Implement specific motor programs or activities that are recommended by therapist or therapy assistant.
Design motor programs and teach parents, teachers, classroom, assistants, and other appropriate personnel to implement them.	Teach parents, teachers, classroom assistants, and other appropriate personnel to implement motor programs as prescribed by the therapist.	Implement motor programs and provide performance data to therapist or therapy assistant.
Collect, design, record, and interpret data on results of therapy programs.	Collect, design, record, and interpret data on results of therapy programs.	Collect, record, and report data on motor programs.
Monitor and evaluate therapy programs using observation, data and/or pre-post testing.	Monitor therapy programs using observation, data and/or pre-post testing.	Report student's performance to therapist or therapy assistant.
Manage student behavior during intervention.	Manage student behavior during intervention.	Manage student behavior during intervention.

Therapist	Licensed Therapist Assistants	Classroom Assistants
Work cooperatively and communicate appropriately with teaching and support staff.	Work cooperatively and communicate appropriately with teaching and support staff.	Work cooperatively and communicate appropriately with teaching and support staff.
Develop and adhere to a daily schedule.	Develop and adhere to a daily schedule.	Develop and follow daily schedule as directed by teacher.
Order appropriate materials and equipment; use and maintain them.	Order appropriate materials and equipment; use and maintain them.	Use and maintain selected equipment as directed.
Monitor and report student performance and progress.	Monitor and report student performance and progress.	Monitor and report student performance and progress.
Attend staff meetings and serve on committees.	Attend staff meetings and serve on committees.	Attend staff meetings and serve on committees as directed by teacher.
Complete required reports, IEP/IFSP and other forms promptly and in an acceptable manner.	Complete required reports, IEP/IFSP and other forms promptly and in an acceptable manner.	Complete required reports, IEP/IFSP and other forms promptly and in an acceptable manner.

Determining Work Assignments for Therapists and Therapist Assistants

In determining reasonable work assignments for the itinerant therapist, questions to consider include,

- ♦ Student service needs: *Which of the goals and related service needs of the child has the IEP/IFSP team determined will involve the therapist?*
- ♦ Inservice training, consultation and teaming with school staff: *How do the services to be offered impact the therapist's time in terms of research, materials preparation, implementation time, and follow-up?*
- ♦ Number of school sites and geographic areas: *What is the distance between schools and how much of the therapist's time must be spent in travel between locations on a daily basis? Is there ample time for the therapist to have a duty-free lunch break in addition to travel time between sites? Has time been built into the schedule for building-related activities such as check-in, e-mail and communication with school staff?*
- ♦ Student assessment: *How much time is spent in assessment or evaluation of children not already on the therapist's caseload (i.e., eligibility determination)?*
- ♦ Report writing and meeting times: *How much time should be set aside for regularly scheduled meetings, other meetings, documentation, and paperwork? Are meetings scheduled for times when the therapist will be at the meeting site?*

- ♦ Contact with medical providers: *Given the therapist’s specific caseload, how much time will be spent in communication with medical and other community resources?*
- ♦ Equipment needs and problems: *Is the therapist the designated “troubleshooter” who is responsible when problems with equipment such as wheelchairs and splints must be attended to quickly?*
- ♦ Supervision of therapist assistant: *Is the therapist the designated supervisor for a licensed therapist assistant? How much direct supervision does the assistant require? Has time been allotted for supervision activities for both the therapist and the licensed assistant? and,*
- ♦ Mentoring: *Does the role of the therapist include induction and training activities of new therapy staff who are unfamiliar with IDEA 2004-based service environment and practice? Has the therapist been assigned by supervisors to participate on special committees and/or projects? How much time will be needed?*

The supervisor’s best resources for information concerning delivery of therapy in educational settings are the therapists who work in their programs. State licensing boards and associations are an additional resource. For more information supervisors may contact the RSOI office. Contact information for RSOI, state licensing boards, professional associations and other resources is included in Appendix C5.

Billing Oregon Medicaid for Therapy Services

EI/ECSE programs may bill Medicaid for eligible services. Many school districts in the state of Oregon bill Medicaid for reimbursement for health-related services under the School-Based Health Service Program. Physical therapy and occupational therapy, along with some nursing, speech, transportation, and care assistant services qualify as health-related services which are provided in the educational setting. In those districts that bill Medicaid, therapists are required to document their services to eligible students and report those services to the school district offices for submission for reimbursement. Criteria for documentation are dictated by Medicaid, but methods for reporting are determined on a district-by-district basis. Billing Medicaid for educational therapy services in Oregon does not affect coverage of the child’s therapy treatment in non-educational environments. (OAR 581-015-2885)

Medicaid may reimburse costs for necessary and appropriate health services, on a fee for service basis, provided to Oregon’s Medicaid-eligible children who have disabilities, in accordance with the Individuals with Disabilities Education Act (IDEA 2004). Oregon has actively supported this relationship since 1992.

(Oregon School Based Health Services, acquired from website on September 8, 2008)

Specific information about the Oregon School-Based Health Services program, its limits, and operations can be found at www.oregon.gov/DHS/healthplan/school-based-hs/main.shtml.

While PT and OT services provided in the educational setting are primarily funded by education dollars, the educational program may be partially reimbursed through the Medicaid system for services provided to Medicaid-eligible children.

Billing Oregon Medicaid for needed educational services should never affect which services are provided to a child in an educational setting. IFSP/IEP teams determine what services a child needs to benefit from the educational program. If these services are covered by Medicaid, a school district may request reimbursement for them.

CHAPTER 7

Regional Services for Students with Orthopedic Impairment in Oregon

The Oregon Legislature funds eight Regional Programs that provide services to students with low-incidence and high-needs disabilities. Under the OARs, the Regional Program eligibilities include Hearing Impairment, Vision Impairment, Traumatic Brain Injury, Deaf-Blindness, Autism Spectrum Disorder, and Orthopedic Impairment. A link to the OAR for regional eligibility is included in Appendix B.

The purpose of Regional Programs is to provide specialized expertise to assist the school district to provide for the educational needs of their students with low-incidence conditions. In Oregon, the term, Regional Program, “consultative services funded through the Department, provided on a single or multi-county basis that assist school districts and early intervention/early childhood special education providers in meeting the unique needs of eligible children.” (OAR 581-015-2540(7)) For Regional Programs, “eligible children” means “children with low-incidence, high-need disabilities who need the services of the regional program.” (OAR 581-015-2540 (5))

In the state of Oregon, a child age 3 to 21 with an orthopedic impairment is eligible for Regional services if determined to need trial evaluation of equipment and consultative services to train school staff on child-specific information required to assist in participation, safety or access to their education. Additional OT or PT services on the IEP or IFSP are provided by the local education agency when the IEP/IFSP team decides those services are needed.

In Oregon, children from 0-3 years of age who are found eligible for early intervention may receive services from the Regional Program if they meet the criteria of an orthopedic impairment eligibility and need trial of equipment and consultation to the family or EI staff. All other PT/OT Services are provided by the EI or ECSE Program. (OAR 581-015-2550)

Procedure for Providing Regional Services for Students with Orthopedic Impairments in Oregon

For the district or EI/ECSE program to make a referral for regional services for a student or young child with an orthopedic impairment, the child must first be identified as eligible for special education under the eligibility category of orthopedic impairment by the district or early intervention/early childhood special education eligibility team. Orthopedic impairment is defined in the Oregon Administrative Rules as “a motor disability that adversely affects the child’s educational performance. The term includes

impairments caused by an anomaly, disease or other conditions (e.g., cerebral palsy, spina bifida, muscular dystrophy or traumatic injury).”

OAR 581-015-2000 (4)(g)

To be eligible as a child with an orthopedic impairment, the child must meet all of the following minimum criteria:

- (a) *“The child has a motor impairment that results in deficits in the quality, speed or accuracy of movement. These deficits must be documented by a score of two or more standard deviations below the mean in fine motor skills, gross motor skills, or self-help skills, or functional deficits in at least two of these three motor areas; and*
- (b) *The child’s condition is permanent or is expected to last for more than 60 calendar days.”*

OAR 581-015-2160 (2)(a)(b)

The eligibility team must also determine that:

- (a) *“The child’s disability has an adverse impact on the child’s educational performance; and,*
- (b) *The child needs special education services as a result of the disability.”*

OAR 581-015-2160 (3)(a)(b)

To receive services from a Regional Program for students with Orthopedic Impairment, a child must first be found eligible under the category of orthopedic impairment and require equipment trial and consultation for school access, safety and participation. Any consultation provided is listed under Supports for Personnel on the Service Page of the IEP. Sample Service Pages are included in this manual in Appendix C4. These are only samples to help guide the IEP team document services.

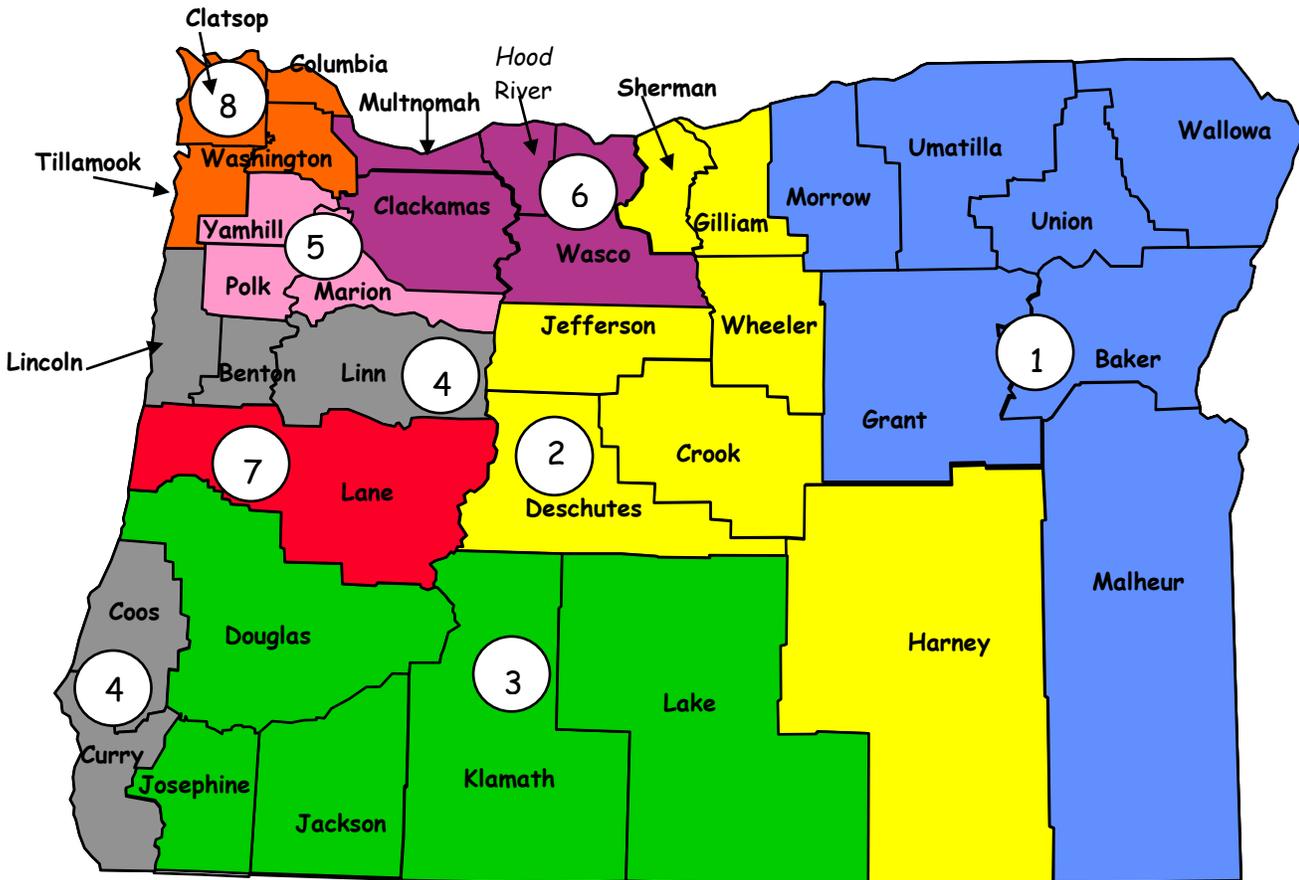
In referring a child to the regional program, the district or early intervention/early childhood special education program must provide the regional coordinator with the following information:

- (1) *A request for regional services;*
- (2) *A statement of a child's eligibility in one of the following categories, if previously determined: autism spectrum disorder; deafblindness, hearing impairment, orthopedic impairment, traumatic brain injury, vision impairment, and;*
- (3) *Additional information as the regional coordinator or other regional program representative may request.*

OAR 581-015-2555

When a child is referred for regional eligibility, the child may receive services from the Regional Program. However, the local education agency retains the primary responsibility for the educational and related services provided to the child (FAPE). If the child is found not to qualify for services from the Regional Program, but needs services under IDEA 2004, or would qualify for therapy services under the Americans with Disabilities Act or Section 504, school districts are still responsible to provide these services. (See Appendix B.)

Oregon Regional Programs Serving Students with Low Incidence Disabilities



Region 1: Eastern Oregon Regional Program
Mary Apple and Tonya Smith
541-966-3129
mary.apple@imesd.k12.or.us
tonya.smith@imesd.k12.or.us

Region 5: Willamette Regional Program
Linda Felber
503-540-4487
linda.felber@wesd.org

Region 2: Central Oregon Regional Program
Sandy Bishop
541-693-5707
sandy.bishop@hdesd.org

Region 6: Columbia Regional Program
Lisa McConachie
503-916-5570 x78334
lmconac@pps.net

Region 3: Southern Oregon Regional Program
Agnes Lee-Wolfe
541-776-8555
agnes_wolfe@soesd.k12.or.us

Region 7: Lane Regional Program
Sue Mathisen
541-461-8374
smathisen@lesd.k12.or.us

Region 4: Cascade Regional Program
Diana Allen
541-812-2770
diana.allen@lblesd.k12.or.us

Region 8: Northwest Regional Program
George Winterscheid
503-614-1351
georgew@nwresd.k12.or.us

Oregon Department of Education
Director of Interagency Education Services
503-947-5786

Oregon Department of Education
Education Specialist
Sharla Jones
503-378-3825
sharla.jones@osd.k12.or.us

This page intentionally left blank.

Bibliography

Bradley & Westcott, (2006). Motor control: Developmental aspects of motor control in skill acquisition. In Campbell, S., Vander Linden, D. & Palisano, R. (Eds.) Physical Therapy for Children, 3rd edition. St. Louis: Saunders, Elsevier, 77– 130.

Campbell, S., ed., 3rd edition, (2006). Physical therapy for children. W.B. Saunders Co., Philadelphia, Pennsylvania.

Coolman, R., Foran, W., & Lee, J. (1998). Oregon guidelines for medically-based outpatient physical therapy and occupational therapy for children with special health needs in the managed care environment. Portland, OR: Oregon Health Sciences University.

Giangreco, Michael F. (1996). Vermont interdependent services team approach: A guide to coordinating educational support services. Baltimore, MD: Paul H. Brookes.

Guide to physical therapist practice, 2nd ed. (2001). Journal of the American Physical Therapy Association, 81(1).

Hanft, B. & Shephert, J. (2008). Collaborating for student success; A guide for school-based occupational therapy. American Occupational Therapy Association.

Horak, F. (1991). Assumptions underlining motor control for neurologic rehabilitation. In Contemporary Management of Motor Problems: Proceedings of the II STEP Conference. Foundation for Physical Therapy, APTA's Neurology Section and Section on Pediatrics, 11-27.

Hylton, J., Reed, P., Hall, S., and Cicirello, N. (1987). The role of the physical therapist and the occupational therapist in the school setting. TIES: Therapy in Educational Settings.

Johnson, J. (1996). School-based occupational therapy. In J. Case-Smith, A.S. Allen and P.N. Pratt (Eds.), Occupational Therapy for Children, 3rd edition. St. Louis, MO: Mosby.

Reed, P., Hylton, J., Cicirello, N., and Hall, S. (1988). A model plan for the supervision and evaluation of therapy services in educational settings. TIES: Therapy in Educational Settings.

Council of Administrators of Special Education, Inc. (2006). Section 504 and the ADA, promoting student access: A resource guide for educators, 2nd edition. CASE.

Vermont Department of Education (2001). Guidelines for making decisions about IEP services. Acquired from <http://www.state.vt.us/educ/Cses/sped/main.htm> on August 20, 2008.

U.S. Department of Health and Human Services. (2008) Joint guidance on the application of the family educational rights and privacy act (FERPA) and the health insurance portability and accountability act of 1996 (HIPAA) to student health records. Retrieved , January 10, 2010, from <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveridentities/hipaaferpajointguide.pdf>

This page intentionally left blank.

APPENDICES

Physical and Occupational Therapy under IDEA in Oregon

Appendix A: Oregon Documents

- A1: Occupational and Physical Therapy Service Needs Checklist for Ages 3 to 21 (4 pages)
- A2: Occupational and Physical Therapy Service Needs Checklist-Early Intervention (4 pages)
- A3: Parent's Guide to PT and OT in Educational Settings (2 pages)
- A4: Español: A Parent's Guide to PT and OT in Educational Settings (2 pages)
- A5: OINA: Oregon Orthopedic Impairment Needs Assessment (31 pages)
- A6: Scope of School Services: Physical and Occupational Therapy (2 pages)
- A7: School-based Occupational Therapists: Recommended Performance Standards (4 pages)
- A8: School-based Physical Therapists: Recommended Performance Standards (4 pages)

Appendix B: Regulations Relating to Therapy in Educational Settings

- Oregon Administrative Rules
- Oregon Revised Statutes
- IDEA 2004
- Section 504

Appendix C: Resources

- C1: Commonly Used Special Education Acronyms (3 pages)
- C2: Glossary of Special Education Terms (8 pages)
- C3: IEP Guidance for OTs and PTs (3 pages)
- C4: IEP and IFSP Summary Pages (3 pages)
- C5: Information Resources (1 page)
- C6: Recommended Reading (1 page)
- C7: Assessment Tools Used in Pediatric Physical Therapy (17 pages)

This page intentionally left blank.

