

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

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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](http://www.rsoi.org)

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# 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.

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# 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

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# 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 12<sup>th</sup> 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.

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# CHAPTER 1

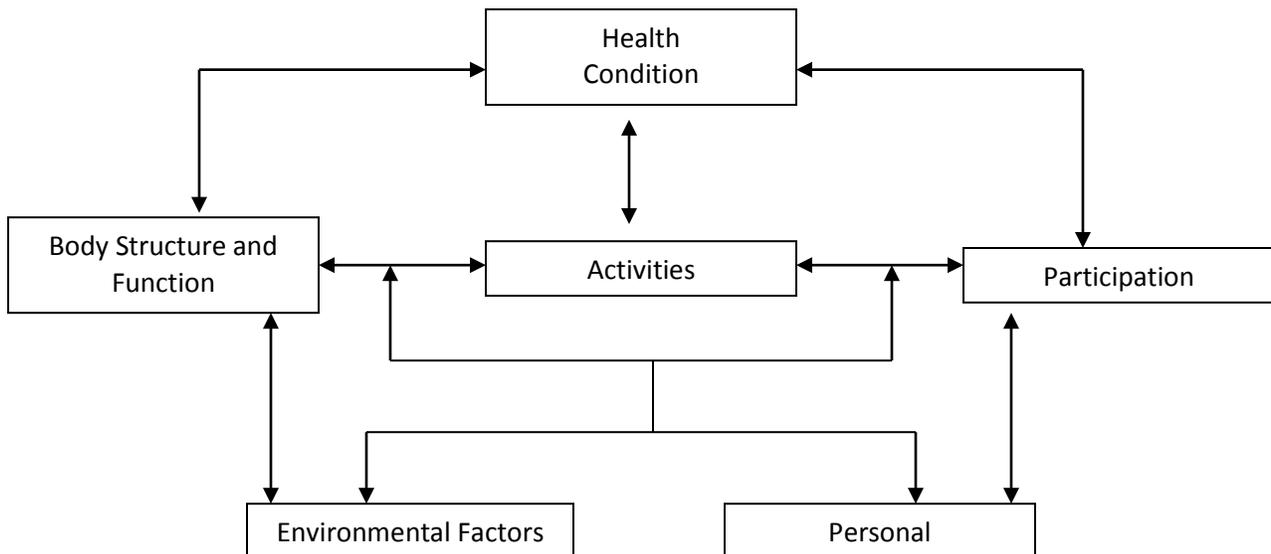
## A Theoretical Framework for Therapy Services under IDEA 2004

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**

	<b>Part C – Early Intervention</b>	<b>Part B – Special Education</b>
<b>Goals</b>	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.
<b>Age</b>	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.
<b>Service Coordination</b>	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.
<b>Services</b>	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.
<b>Delivery of Services</b>	Requires services and supports to be provided in “natural environments.”	Requires special education and related services to be provided in the “least restrictive environment.”
<b>Recipient of OT/PT Services</b>	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.
<b>Assessment Disputes</b>	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)
<b>Dispute Resolution</b>	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.
<b>Procedural Safeguards</b>	Procedural safeguards include: <ul style="list-style-type: none"> <li>♦ prior written notice of meetings, etc.</li> <li>♦ confidentiality of information</li> <li>♦ right to decline some services or supports without jeopardizing others</li> <li>♦ transition planning</li> <li>♦ right to examine agency records related to the child and obtain copies at reasonable cost</li> <li>♦ written consent before assessment or initiation of each service and supports</li> <li>♦ right to have outside evaluation obtained at parent expense be considered by IFSP team and included in child’s records.</li> </ul>	Procedural safeguards include: <ul style="list-style-type: none"> <li>♦ prior written notice of meetings, etc.</li> <li>♦ confidentiality of information</li> <li>♦ right to examine school district records related to child and obtain copies at reasonable cost</li> <li>♦ written consent required before initial assessment and provision of special education</li> <li>♦ special education services provided according to the IFSP/IEP to ensure FAPE</li> <li>♦ extended school year services if child requires them</li> <li>♦ transition planning</li> <li>♦ right to have outside evaluations obtained at parent expense considered by IEP team and included in child’s record.</li> </ul>

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.

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## 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](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.

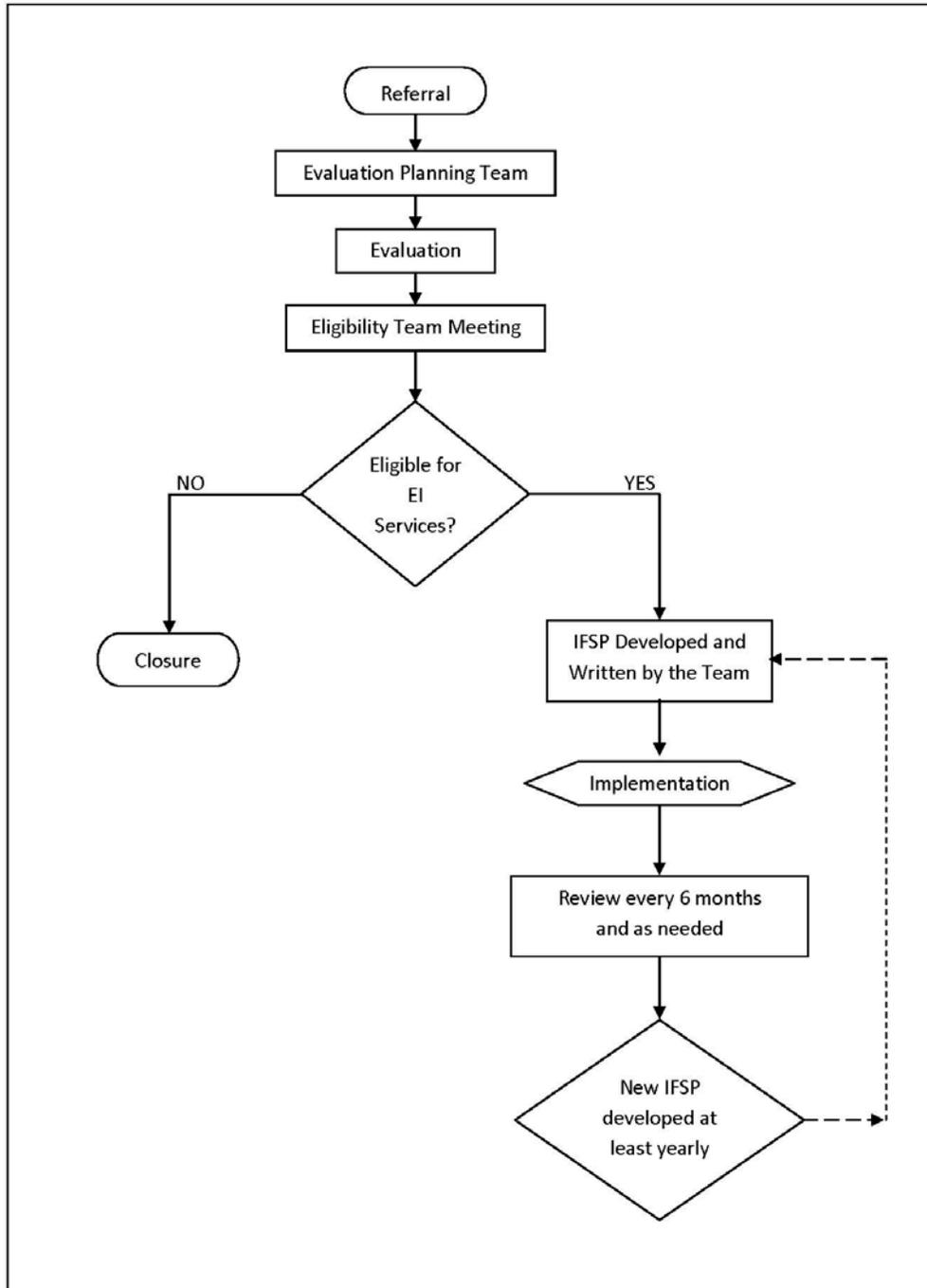
In general the evaluation team must:

- ♦ 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.

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## 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 **specialty 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 specialty 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](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.

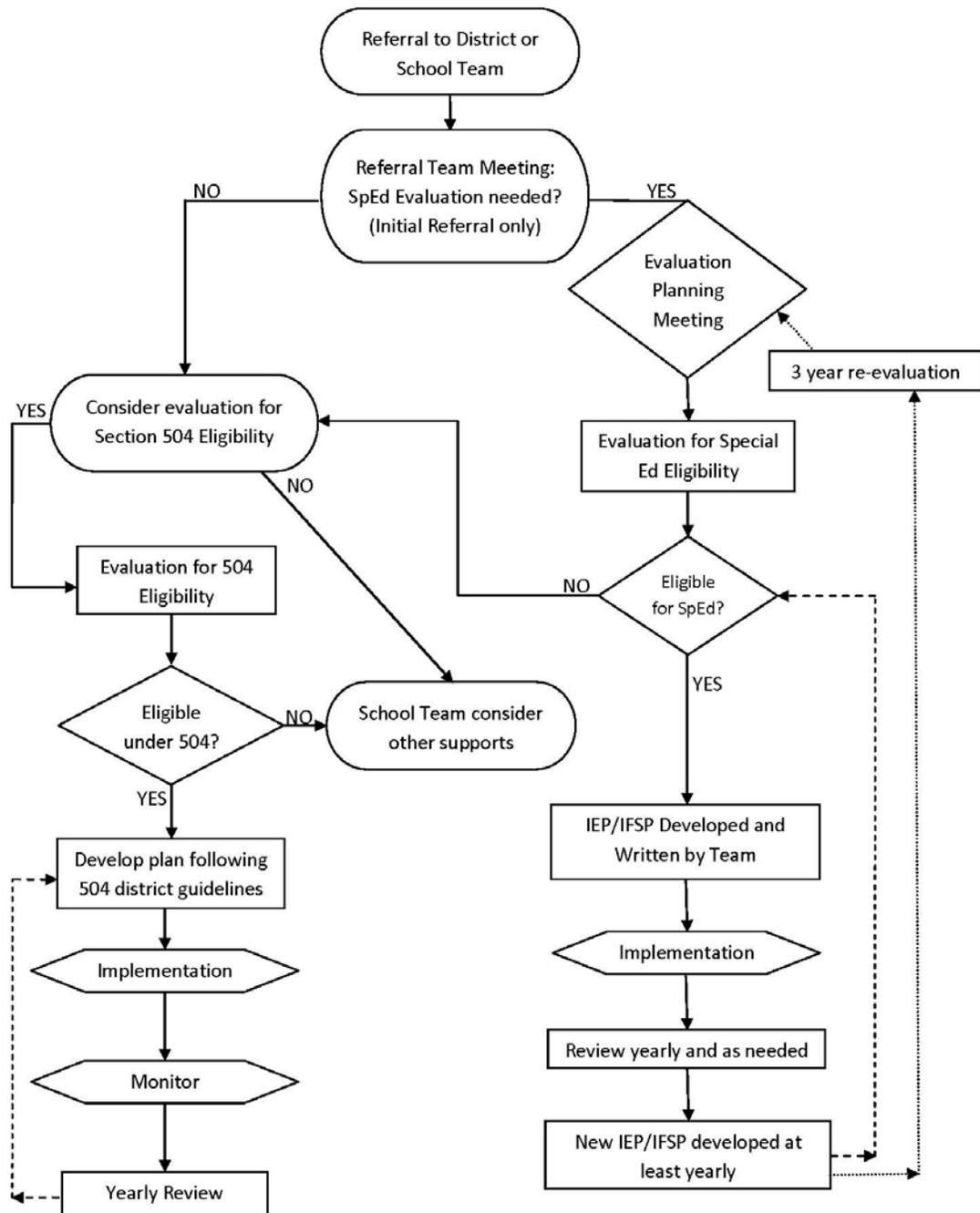
The wording of Section 504 is not as specific about procedures and timelines as is IDEA 2004, but the process for identifying and implementing a plan under Section 504 is roughly parallel to special education procedures. The school district is responsible by law for evaluation, provision of appropriate 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
<b>Who is served by PT/OT?</b>	
<p>Children who qualify for special education services and who require OT/PT:</p> <ul style="list-style-type: none"> <li><b>EI</b> – 0 to 3 years</li> <li><b>ECSE</b> – 3 to 5 years</li> <li><b>School Age</b> – 5 to 21 years</li> <li><b>Transitional</b> – 18-21 years</li> </ul> <p>Students qualifying under Section 504.</p>	<p>All ages without distinction, diagnoses within scope of practice.</p>
<b>Who is not served by PT/OT?</b>	
<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 <b>not</b> a criteria for service.</p>	<p>Resource limited per insurance, private pay, or Medicaid/Medicare.</p>
<b>What is the focus of service?</b>	
<p><b>EI / ECSE</b> – 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><b>School Age</b> – access to instruction and school related activities; designed to meet special needs of students.</p> <p><b>Transition</b> – preparation for living, working and learning in post-school environments.</p>	<p><b>Physical therapy</b> 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 <b>occupational therapist</b> 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>
<b>Where are services provided?</b>	
<ul style="list-style-type: none"> <li><b>EI</b> – Natural environment</li> <li><b>ECSE</b> – Natural environment, preschool</li> <li><b>School Age</b> – School setting</li> <li><b>Transition</b> – School or community setting</li> </ul>	<p>Hospital, out-patient clinic, home, work, nursing facilities, community</p>

EDUCATIONAL SETTING	NON-EDUCATIONAL SETTING
<b>What is the process for entering the system?</b>	
<b>EI</b> - multiple referral options <b>ECSE</b> - multiple referral options <b>School age</b> - request of parent, referred by school staff, other referral source	Physician referral/self-referral-direct access
<b>What is the evaluation process?</b>	
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
<b>What is the plan of care?</b>	
<b>EI</b> - IFSP <b>ECSE</b> - IFSP <b>School age</b> - IEP <b>Transition</b> – IEP with transition goals and services	OT/PT Plan of care
<b>What is the plan of care development process?</b>	
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.
<b>How is the plan of care/service evaluated?</b>	
<b>EI/ECSE</b> - review of IFSP performance data <b>School age/Transition</b> - IEP student progress reports	Periodic reassessments as required by state practice acts
<b>How are modifications to the plan of care made?</b>	
IFSP/IEP team convenes to make changes to IFSP/IEP	In collaboration with patient, family, and health team
<b>How is the plan of care documented?</b>	
<b>EI/ECS</b> - IFSP <b>School age/Transition</b> - IEP	Progress notes in the patient record
<b>How is service documented?</b>	
Contact notes, progress notes	Progress notes in the patient record
<b>What types of services are delivered?</b>	
Hands-on Services, Direct Consultation, and, in-service training to school staff	Wide range of services may be provided
<b>Who may provide follow up implementation of plan of care?</b>	
<b>EI</b> - family, licensed professionals <b>ECSE</b> - licensed professionals, EAs <b>School age/Transition</b> - licensed professionals, EAs	PT, PTA OT, OTA
<b>What Federal and State Statutes and Rules regulate PT/OT practice?</b>	
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
<b>When regulations are in conflict, which set of regulations take precedence?</b>	
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](http://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](http://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"> <li>• Co-teaching</li> <li>• Professional in-service training</li> <li>• Collaborative consultation</li> <li>• Participating in pre-referral interventions</li> <li>• Recommending program evaluation</li> <li>• Assisting in the development of school policies and procedures</li> <li>• Drafting district OT/PT guidelines</li> <li>• OT/PT supervision and mentoring</li> </ul>	<ul style="list-style-type: none"> <li>• Observing and evaluating within the context of the education environment routine</li> <li>• Trial of modifications or equipment</li> <li>• Training new motor skills</li> <li>• Evaluation and training activities of daily living</li> <li>• Access to sports and extracurricular activities</li> <li>• Pre-referral screenings</li> </ul>	<ul style="list-style-type: none"> <li>• Liaison with medical community</li> <li>• Report writing</li> <li>• Travel time</li> <li>• Fabricating equipment or materials</li> <li>• Attending IEP meetings</li> <li>• Progress monitoring</li> <li>• Communicating with community OTs and PTs</li> </ul>

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](http://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](http://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
<b>Overview</b>	<ul style="list-style-type: none"> <li>• Federal law</li> <li>• Protects privacy of students' educational records</li> </ul>	<ul style="list-style-type: none"> <li>• Federal law</li> <li>• Improves the efficiency and effectiveness of health care system</li> <li>• National standards and requirements for electronic health care transmissions</li> <li>• Protects the privacy and security of personally identifiable health information</li> </ul>
<b>Applies to</b>	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)
<b>Does not apply to</b>	Any educational institution that does not receive funds from the U.S. Department of Education (most private and religious schools)	Non-medical records
<b>Release of records by an agency</b>	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
<b>What's covered</b>	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
<b>More information</b>	<a href="http://www.ed.gov/policy/gen/guid/fpco/index.html">www.ed.gov/policy/gen/guid/fpco/index.html</a>	<a href="http://www.hhs.gov/ocr/hipaa/">www.hhs.gov/ocr/hipaa/</a>
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.

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## **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](http://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](http://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](http://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](http://www.otao.com) or the Oregon Physical Therapy Association website at [www.opta.org](http://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](http://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.

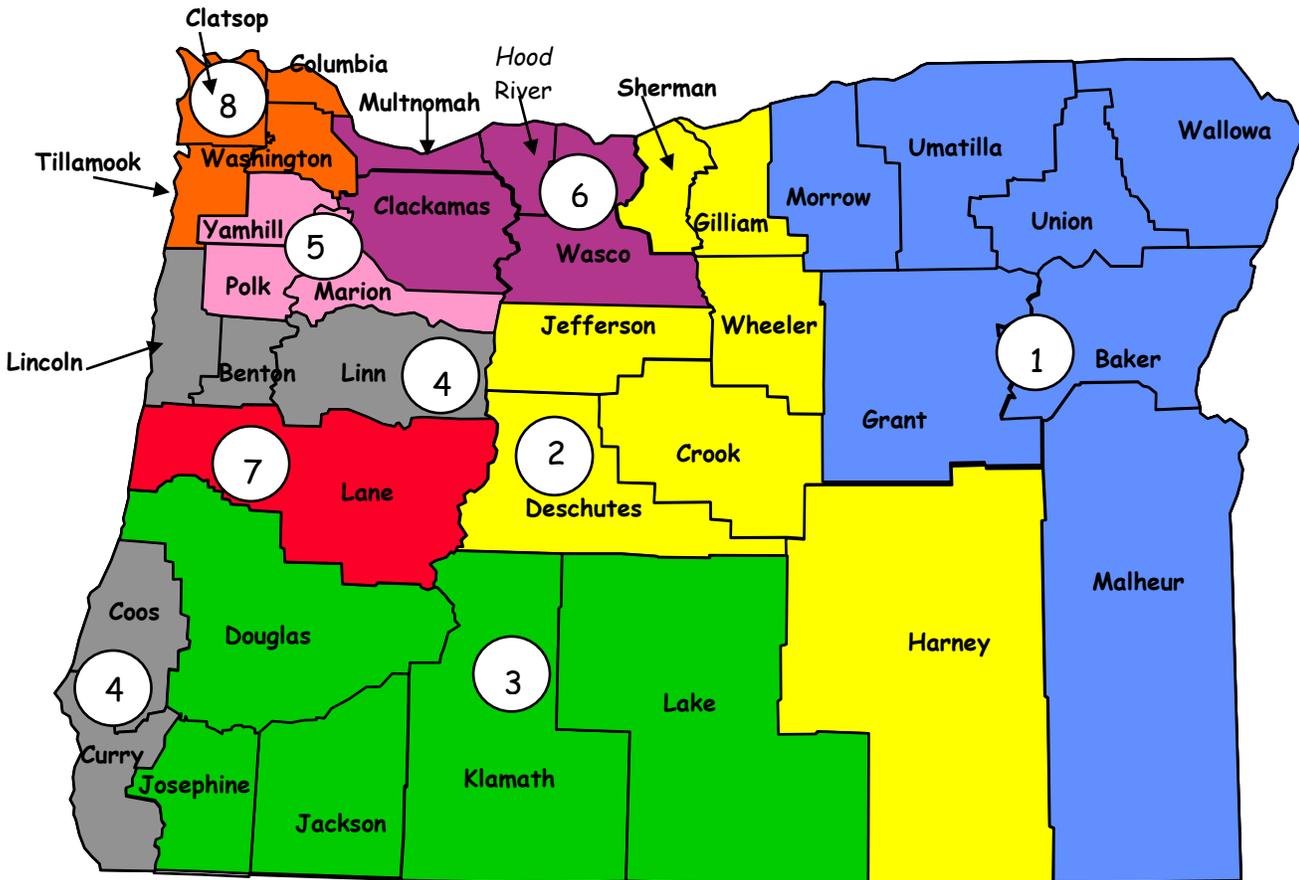
In referring a child to the regional program, the district or early intervention/early childhood special education program must provide the regional coordinator with the following information:

- (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](mailto:mary.apple@imesd.k12.or.us)  
[tonya.smith@imesd.k12.or.us](mailto:tonya.smith@imesd.k12.or.us)

**Region 5: Willamette Regional Program**  
 Linda Felber  
 503-540-4487  
[linda.felber@wesd.org](mailto:linda.felber@wesd.org)

**Region 2: Central Oregon Regional Program**  
 Sandy Bishop  
 541-693-5707  
[sandy.bishop@hdesd.org](mailto:sandy.bishop@hdesd.org)

**Region 6: Columbia Regional Program**  
 Lisa McConachie  
 503-916-5570 x78334  
[lmconac@pps.net](mailto:lmconac@pps.net)

**Region 3: Southern Oregon Regional Program**  
 Agnes Lee-Wolfe  
 541-776-8555  
[agnes\\_wolfe@soesd.k12.or.us](mailto:agnes_wolfe@soesd.k12.or.us)

**Region 7: Lane Regional Program**  
 Sue Mathisen  
 541-461-8374  
[smathisen@lesd.k12.or.us](mailto:smathisen@lesd.k12.or.us)

**Region 4: Cascade Regional Program**  
 Diana Allen  
 541-812-2770  
[diana.allen@lblesd.k12.or.us](mailto:diana.allen@lblesd.k12.or.us)

**Region 8: Northwest Regional Program**  
 George Winterscheid  
 503-614-1351  
[georgew@nwresd.k12.or.us](mailto: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](mailto:sharla.jones@osd.k12.or.us)

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# 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)

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# OREGON ORTHOPEDIC IMPAIRMENT NEEDS ASSESSMENT (OREGON OINA)

Previously known as the OREST which was used for Regional OI eligibility. This tool is for OI assessment purposes, particularly for children who have significant motor impairments. This assessment is NOT for Regional eligibility.

## 2016 Revision Editors

•

*Connie Hector, PT, MSEd  
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*

---

*Distributed by*

•

*Regional and Statewide Services for Students with Orthopedic Impairments  
Douglas ESD • 1871 NE Stephens, Roseburg, Oregon  
(541) 440-4791*

*This document may be downloaded from:*

[www.rsoi.org](http://www.rsoi.org)

## 2006 Revision Editors

•

*Gayl Bowser, MS, Ed.*

*Diana Roberts, M.Ed.*

*Regional and Statewide Services for Students with  
Orthopedic Impairments*

•

*Carol Andersen*

*Coordinator of Health Services*

*Willamette ESD*

•

*D. Jay Gense, Ed.S.*

*Director, Regional Programs*

*Oregon Department of Education*

•

*Oregon Department of Education's  
Orthopedically Impaired Working Group*

## PREFACE

The Oregon Orthopedic Impairment Needs Assessment (OINA) was revised to help guide therapists when determining issues that limit participation by students with orthopedic impairments. This is a revision of the Oregon Regional Eligibility Screening Tool (OREST) which was previously used to determine Regional Orthopedic Impairment (OI) Eligibility. All students in Oregon with an OI eligibility are eligible to receive services through Regional Low Incidence Programs thus eliminating the need for the OREST.

The revision and renaming of this tool was done to keep this assessment which is unique given the categories it covers including gross motor, fine motor, functional ability, relative weight, pain, degenerative condition, oral coordination and communication.

The original work the OINA is based on is entitled Pediatric Screening: A Tool for Occupational and Physical Therapists. It was developed by Doris Taylor, Mary Christopher, Shari Freshman, and Irene McEwen, therapists in the Seattle Public Schools. The original tool was helpful to school districts in Washington in determining the level of service delivery deemed appropriate for specific children with orthopedic impairments, regardless of severity. In 1988, Penny Reed, Nancy Cicirello and Sandy Hall along with numerous Oregon physical and occupational therapists extensively modified the original screening tool, eliminating some items and adding new areas in order to use it for Regional OI eligibility purposes.

Currently all children with an orthopedic impairment eligibility are covered under Regional Services if needed for the purposes of access to trial of equipment and some consultative services for access, safety and participation.

The Oregon Department of Education thanks all the Oregon therapists and educators who have participated in the development, testing and revisions of this needs assessment. Special thanks are extended to the members of the Professional Learning Team for Students with Orthopedic Impairments of Oregon's Regional Program Services and their continued support of the students they serve in Oregon.

## QUESTIONS REGARDING REGIONAL SERVICES AND ADMINISTRATION OF THE OINA

The Oregon Department of Education administers eight Regional Programs across the state, each serving an identified geographic area, as identified on page 9. Questions about the OINA can be directed to the program serving children with orthopedic impairments within any of the respective Regional Programs to clarify services in their region.



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## ABOUT THE OINA

The 1985 legislature directed funding, available through Oregon Regional Programs, to support children with severe orthopedic impairments who need special education and related services. These Regional Program services are delivered in collaboration with local school districts and Early Intervention/Early Childhood Special Education Programs (EI/ECSE). There are eight Regional Programs in Oregon. Each program provides services to children who are determined to have an orthopedic impairment as determined by the OI Eligibility and the IEP/IFSP Team. A map of the Regional Programs service areas, and contact information, is included on page 9.

The Oregon Orthopedic Impairment Needs Assessment (OINA) was developed to assist therapists in determining issues that limit participation in home and school life for children with neuromuscular conditions that may lead to an eligibility under the category of orthopedic impairment. This assessment may be listed on the OI Eligibility form as a non-standardized assessment when considering the need for special education services. Occupational and physical therapists are the only professionals in the school qualified to evaluate the quality of movement and function of children with neuromuscular conditions that lead to eligibility under the educational classification of orthopedic impairment. The speech/language pathologist serving the child should be consulted about items on the OINA relating to communication and oral motor function.

## REGIONAL SERVICES FOR STUDENTS WITH OI ELIGIBILITY

In order to be eligible for Regional Program services, a child must have a referral to Regional Programs and can be served by equipment loans for trial purposes and consultation that is child specific. All other related services for students with an OI Eligibility are the responsibility of the Local Educational Agency or Early Intervention Program.

The OINA is a needs assessment to help identify issues that limit the child's participation in school and life activities. Information from the OINA is used when considering eligibility and services necessary for access, safety and participation of the child. The use of this tool for evaluation purposes is up to the physical therapist and/or occupational therapist depending on the needs and information needed to assist the IFSP or IEP team when determining OI Eligibility. The OINA is a useful assessment for students with significant physical and medical issues.

Decisions about the level of service needed or whether a student receives therapy at all must be made by the IEP/IFSP team. The *Occupational and Physical Therapy Service Needs Checklist* for *Ages 3 - 21* and for *Early Intervention Ages Birth – 2 years* may be used as a guide to help the IEP/IFSP team in making decisions about services. The checklists may be accessed by contacting the respective Regional Programs, or through the office of the Regional and Statewide Services for Students with Orthopedic Impairments.

IDEA 2004 specifies that a reevaluation for school eligibility\* shall occur:

- not more frequently than once a year, unless the parent and the local educational agency agree otherwise;
- at least once every 3 years, unless the parent and the local educational agency agree a reevaluation is unnecessary.

\*Note: The reevaluation for school eligibility is not the same as the state licensing board dictates for physical and occupational therapists. All physical and occupational therapists must follow their practice guidelines set by their state licensing boards in Oregon. Example: Physical therapists working in the educational setting are required to perform a reassessment at least every 60 school days if the student is being treated in an educational setting or at least every visit if the student is seen less frequently. Stat. Auth: ORS 688.160

All reevaluations for students suspected of any disability, including the need to identify the orthopedic impairment, must conform to provisions established in IDEA 2004 [Sec. 614 (a)(2)].

When considering the student's functioning level at the 3-year reevaluation period, the team should review existing information including a medical statement, any current medical reports, standardized assessments and non-standardized assessments which may include the physical therapist evaluation and occupational therapist evaluation. The OINA is another assessment that can be considered depending on the needs of the child and the professional opinion of the occupational and/or physical therapist on the evaluation team.

All children who have an OI Eligibility may receive services through Regional Programs. This includes trial of equipment and child specific consultation. All other related services are the responsibility of the local educational agency. For additional information regarding Regional Program services and eligibility, therapists may contact the Regional Manager in their area or the office of Regional & Statewide Services for Students with Orthopedic Impairments.



## OREGON'S REGIONAL PROGRAMS AND STATEWIDE CONTACT INFORMATION



**Region 1: Eastern Oregon Regional Program**

Umatilla-Morrow ESD  
541-276-6616

**Region 5: Willamette Regional Program**

Willamette ESD  
503-588-5330

**Region 2: Central Oregon Regional Program**

High Desert ESD  
541-693-5700

**Region 6: Columbia Regional Program**

Portland Public Schools  
503-916-5570

**Region 3: Southern Oregon Regional Program**

Southern Oregon ESD  
541-776-8555

**Region 7: Lane Regional Program**

Lane ESD  
541-461-8264

**Region 4: Cascade Regional Program**

Lincoln-Benton-Linn ESD  
541-812-2600

**Region 8: Northwest Regional Program**

Northwest Regional ESD  
503-614-1428

Additional Contacts:  
Oregon Department of Education  
Office of Student Learning and Partnerships  
503-378-3600

Regional and Statewide Services for Students  
with Orthopedic Impairments (RSOI),  
Douglas ESD, 541-440-4791

## INSTRUCTIONS FOR SCORING THE OINA

The OINA specifically addresses eligibility criteria for Orthopedic Impairment. Its purpose is not to determine the level of service needed or to determine whether a student receives therapy at all. Those decisions must be made by the IEP/IFSP team.

There are six Sections (A-F) in the OINA. Each Section has a number of items with corresponding descriptions of severity level.

*NOTE:* In screening the student with global developmental delay, Section A is extremely important. If the student has normal or low tone and does not rate moderate or severe in reflex activity, it is likely that the orthopedic component of the disability is not severe. Either stop at this point or proceed carefully with the rest of the screening, determining with each item whether the lack of performance is due to developmental delay or true orthopedic involvement.

Score each item as defined in the manual, pages 13 - 27. The score number is to the left of each description (N/A or 0, 1, 2, 3). The descriptions are meant to give a general picture of the child's function. The OINA does not describe every possible characteristic. Try to select the category that best describes the child being screened. If you are having difficulty choosing between two numbers, select the higher number for the individual item (i.e., the child's ability falls between a 2 and a 3, choose 3 for the score.)

Total the numbers in each block within each designated section.

Divide the total within each Section by the number of items as indicated on the score sheet. If N/A is used, reduce the divisor appropriately.

In the fine motor section, children with hemiplegia are scored by adding the scores of the involved side with the noninvolved side then dividing by the appropriate denominator, (e.g., one hand with normal function is scored N/A, the involved side receives an appropriate score — the denominator is 1).

Degenerative Conditions (E5) include diagnoses such as Muscular Dystrophy, Mitochondrial Disorders, Neurofibromatosis or other disorders that lead to progressive loss of function over time. Cerebral Palsy, Osteogenesis Imperfecta, Arthrogryposis, Spina Bifida, etc., would not be included because, although students may lose function, these conditions are not progressive in nature.

When computing the average for a block, do not "ROUND UP" scores to the next higher number. You have already chosen the more "severe" number on individual items. Rounding up at this point produces an artificially high score.

Record the number of sections with an average of 3 in the appropriate space in the box.  
Record the number of sections with an average of 2 in the appropriate space in the box.

*NOTE:* In Section D, E, and F, many items may be scored as N/A, depending upon the diagnosis. A score of N/A is neutral and will not affect the child's eligibility.

## OVERVIEW OF OINA SCORING CRITERIA

The following descriptions are meant to give a general picture of the child's function and may not include an exact description of the specific child that you are evaluating. Select the category that best describes the student being seen. In general, the numbers represent the following considerations:

1. The child performs with a diminished quality of movement.
2. The child performs with a significant amount of difficulty.
3. The child is unable to perform or requires a great deal of assistance to accomplish the task, activity, or movement.

Assess the child in the customary educational environment.

Assess the child while he/she is not using adaptive equipment (e.g. hand splints, AFO's, walkers) unless otherwise stated. Use the comment section on the score sheet to clarify all scores.

For items that include wording about developmental age in the scoring criteria (e.g., Item B7, Standing), the child's cognitive level should be considered. For those items where developmental age is not mentioned in the scoring criteria, cognitive level should not be considered. If developmental age is not mentioned, the child should be scored in comparison to typically-developing, same-aged peers.

## DETERMINING THAT A STUDENT HAS A SEVERE ORTHOPEDIC IMPAIRMENT

The OINA is a tool that can be selected when a child has a significant disability making testing difficult. The items in the needs assessment can assist when looking at OI eligibility and planning services necessary for safety, access and participation.

### For Early Intervention:

Established eligibility for Early Intervention Services as a child with an orthopedic impairment.

and

Diagnosis from a medical provider of an orthopedic impairment.

and one of the following conditions:

The child exhibits a developmental delay of three standard deviations or more below the mean in motor (gross or fine motor) development. \*

or

The child exhibits a developmental delay of two standard deviations below the mean in motor (gross or fine motor) development and one other area.

\* *If you are using an evaluation instrument which does not give scores as low as three standard deviations below the mean, report the actual score the child receives and note that if the test gave lower standard deviation scores the child would have scored lower. Do not use formulas to expand the standard deviation calculations.*

### For Early Childhood Special Education (age 3 to school age):

Eligibility for Early Childhood Special Education as a child with an orthopedic impairment.

### For School Aged:

Eligibility for Special Education as a student with an orthopedic impairment and a rating of "severe"\* on the OINA to help determine eligibility and service needs.

\* The OINA is a tool to help assess students with severe orthopedic impairments

For a student to be considered to have a severe orthopedic impairment they must have:

Two or more sections with an average score of 3,

or

Three or more sections with an average score of 2 or more.

# Oregon Orthopedic Impairment Needs Assessment (OINA)

## Section A. NEUROMUSCULAR

NOTE: In this section a score of N/A is not acceptable. A score of "0" is purposefully used for normal tone and reflex activity.

A1. Muscle Tone or Muscle Strength	
0 Normal	
1 Mildly atypical:	Presence of mild hypertonus, hypotonus or muscle weakness which affects function but does not greatly influence it.
2 Moderately atypical:	Presence of more intense hypertonus, hypotonus or muscle weakness which significantly affects performance of daily activities and which may lead to deformity.
3 Severely atypical:	Extreme hypertonus, hypotonus, muscle weakness, or flaccid state which prevent performance of daily living activities or is at greater risk regarding deformities.

A2. Reflex Activity and/or Abnormal Motor Patterns	
0 Normal	
1 Mildly atypical:	Tendency toward abnormal motor patterns or presence of reflex residuals. Reflex activity does not interfere with ability to move but may affect quality of movement.
2 Moderately atypical:	Influence of primitive or pathological reflexes or abnormal motor patterns which interfere with but do not prevent movement and function; can be partially controlled by inhibition or voluntary control. This may vary with fatigue or illness.
3 Severely atypical:	Reflex activity or primitive patterns dominate motor performance and may prevent voluntary control.

## Section B. GROSS MOTOR DEVELOPMENT

B1. Head Control	
Not applicable:	Gross motor function is within normal limits for chronological age or commensurate with global developmental age.
1 Mildly atypical:	When pulled to sit with support at child's shoulders, child gains control in last 10-15 degrees or has a slight delay in righting. Possible interference with daily activities.
2 Moderately atypical:	When pulled to sit with support at child's shoulders, obvious head lag but can recover. Is functional although has obvious deficiency in control which interferes with daily activities. Lack of control may be risk factor in transfers and transportation.
3 Severely atypical:	Little or no voluntary control when head is unsupported (may maintain for 1-3 seconds). Head usually poorly aligned. Lack of head control presents risk for injury in transfers and transportation.

B2. Rolling	
Not applicable:	Gross motor function is within normal limits for chronological age or commensurate with global developmental age.
1 Mildly atypical:	Rolls three feet on level surfaces. May lack rotation.
2 Moderately atypical:	Uses abnormal muscle tone and patterns to roll (i.e., increased flexion of hips, increased extension of legs, increased flexion of arms and pulling down of shoulders, retraction of head and neck). Flaccid lower extremities that follow upper body and arms.
3 Severely atypical:	Unable to roll due to physical limitation. Requires physical assistance.

B3. Creeping (all fours)	
Not applicable:	Gross motor function is within normal limits for chronological age or commensurate with global developmental age
1 Mildly atypical:	Widely abducted legs, sagging trunk and hyperextension of elbow joints or increased hip and knee flexion.
2 Moderately atypical:	Limited reciprocal movement. More weight on one side. Limited hip extension or influence of abnormal patterns of movement (internal rotation plus extension of legs and arms). Bunny hopping. Incomplete hip extension due to muscle weakness.
3 Severely atypical:	Commando crawling with one or both arms or unable to crawl.

B4. Sitting	
Not applicable:	Gross motor function is within normal limits for chronological age or commensurate with global developmental age.
1 Mildly atypical:	Can maintain balance fairly well but may use one hand for support in a variety of sitting positions. Back generally rounded. Lack of trunk rotation. Functionally independent.
2 Moderately atypical:	Can maintain a variety of sitting positions briefly when placed. Frequently relies upon hand support. Limited balance or only uses W-sitting position.
3 Severely atypical:	Cannot maintain sitting positions. Not functional. Requires external support.

B5. Kneeling	
Not applicable:	Gross motor function is within normal limits for chronological age or commensurate with global developmental age.
1 Mildly atypical:	Assumes position independently. Wide base. Wobbly. Tendency toward flexion or hyperextension of hips.
2 Moderately atypical:	Can attain position independently using supports. Cannot maintain upright position without supports. Cannot free hands for functional activities.
3 Severely atypical:	Needs physical assistance from a person to assume or maintain position; extreme flexor pull at hips. Great difficulty keeping trunk extended and maintaining balance.

B6. Half-Kneel	
Not applicable:	Gross motor function is within normal limits for chronological age or commensurate with global developmental age.
1 Mildly atypical:	Wide base. Unsteady balance. Hand on knee for stability.
2 Moderately atypical:	Uses hands to assume position. May include internal rotation and adduction of forward leg or hip sag on weight bearing leg. Much more difficult on one side than the other. Sustains only a few seconds without support.
3 Severely atypical:	Needs a physical assist to assume and maintain position. Abnormal tone or muscle control prevents.

B7. Stand	
Not applicable:	Gross motor function is within normal limits for chronological age or commensurate with global developmental age.
1 Mildly atypical:	Wide-based and unsteady but can independently stand still for at least one minute. Assumes position independently. Hyperextension of knees.
2 Moderately atypical:	Unable to independently stand still for one minute. Uses abnormal tone for stability. Can assume independently but may have difficulties on some surfaces. Lack of symmetrical weight bearing.
3 Severely atypical:	Needs physical assistance from a person to assume or maintain. May require stationary object such as table or couch to lean against.

B8. Functional Gait	
Not applicable:	Gross motor development is within normal limits for chronological age or commensurate with global developmental age.
1 Mildly atypical:	Able to ambulate on relatively level ground, stairs, or ramp independently or with appropriate rail but has some difficulty on uneven ground. Shuffles feet and trips over things.
2 Moderately atypical:	Falls frequently; unstable but ambulates independently. May be an “at home” but not a “community” ambulator. Requires great effort to walk.
3 Severely atypical:	Needs total assistance due to physical involvement; cannot walk. May use wheelchair.

## Section C. FINE MOTOR DEVELOPMENT

NOTE: When assessing fine motor development, the child should be seated and/or positioned in a manner consistent with the way in which he/she usually performs the task in the educational setting. For items 1 and 2 both hands are scored independently and the scores are averaged.

C1. Hand Grasp and Release	
Not applicable:	Child's grasp and release abilities are commensurate with global developmental age.
1 Mildly atypical:	Some difficulty with grading movement of hand opening. Some difficulty actively functioning against resistance. Takes slightly longer than normal to achieve task.
2 Moderately atypical:	May use abnormal movement patterns to achieve task. Takes considerably longer than normal to achieve task. Some difficulty in active function against gravity. May have decreased endurance.
3 Severely atypical:	Is unable to grasp when presented with object or when able to grasp, effort and time element make it nonfunctional. Releases involuntarily or cannot release on command. Muscle strength grade is poor or less. Includes total amputation.

C2. Reach	
Not applicable:	Child's reach ability is commensurate with global developmental age.
1 Mildly atypical:	Able to reach object easily. There may be slight inaccuracies.
2 Moderately atypical:	Ability or accuracy of reach is limited by lack of shoulder and elbow mobility, stability, strength and/or upper extremity length. May compensate with abnormal movement patterns.
3 Severely atypical:	Ability or accuracy of reach is severely limited by lack of shoulder and elbow mobility, stability, strength and/or upper extremity length. Abnormal movement patterns prevent purposeful reach.

C3. Object Manipulation	
Not applicable:	Child's ability to manipulate objects is commensurate with global developmental age.
1 Mildly atypical:	Able to manipulate and transfer objects. May take slightly longer than normal to achieve tasks. Some difficulty manipulating small objects.
2 Moderately atypical:	Limited variety of object manipulation skills or types of objects child is able to manipulate. Effort and time involved limit function.
3 Severely atypical:	Unable to manipulate objects. May need adaptive devices to accomplish tasks.

C4. Bilateral Hand Use	
Not applicable:	Child's ability to use hands bilaterally is commensurate with global developmental age.
1 Mildly atypical:	Able to use both hands to manipulate objects; associated reactions or weakness may be present but do not interfere with child's ability to do task. Crosses midline.
2 Moderately atypical:	Abnormal movements, or weakness interfere with ability to do task; assisting hand may remain fisted but is used to stabilize object. Bilateral forearm supination is difficult. Difficulty crossing midline.
3 Severely atypical:	Assisting hand is fisted and is not used to stabilize object; arm may often be in abnormal position, either flexed or extended; unable to use as an assisting hand due to flail or missing extremity, or deformities. Does not cross midline.

C5. Functional Handwriting	
Not applicable:	Writing ability of student is commensurate with global developmental age.
1 Mildly atypical:	Able to hold pencil or crayon and form shapes or letters consistent with developmental level with slight difficulty. Expected to do assigned writing in classroom with minimal modifications. Takes slightly longer than normal to achieve task.
2 Moderately atypical:	Due to motor involvement student is able to do limited writing such as tracing or indicate answers with underline, circle, X or other mark, but requires considerably longer to achieve task. Adaptations to writing environment may be necessary. May also need alternative means of written communication.
3 Severely atypical:	Because of severely limited fine motor skills, student is unable to do any functional pencil activities. Writing environment must be modified completely. An alternative means of written communication is necessary

## Section D. ORAL MOTOR

D1. Oral Coordination/Feeding	
Not applicable:	Normal or may exhibit immature oral motor patterns that are consistent with global delay.
1 Mildly atypical:	Some abnormality observable but not significantly interfering with feeding or breathing (e.g., mouth consistently opened, some drooling, mouth breathing). Poor feeding techniques or lack of experience, but shows little evidence of pathology.
2 Moderately atypical:	Lack of oral coordination interferes with feeding or breathing (e.g., difficulty with eating due to tongue thrust, lack of mouth closure). Requires proper positioning and intermittent use of physical prompts to inhibit abnormal patterns when eating. May require safe feeding protocol or special diet.
3 Severely atypical:	Feeding or breathing very difficult due to severe reflex activity, tongue thrust, or other aspects of abnormal postural tone and alignment or coordination; requires assistance. External oral control necessary to feed child. Safe feeding protocol/special diet required.

D2. Oral Coordination/Communication	
Not applicable:	Verbal communication is commensurate with developmental level.
1 Mildly atypical:	Oral motor limitation minimally impacts ability to communicate effectively in the community. May take slightly longer to communicate needs or require alternative forms of communication in specific environments..
2 Moderately atypical:	Oral motor function significantly limits verbal communication. Speech understood by primary caretakers but not by peers and other persons. Needs alternative forms of communication in conjunction with verbal speech.
3 Severely atypical:	Unable to express self verbally in a manner commensurate with intellectual functioning due to oral motor limitations. Unable to impact environment without alternative forms of communication.

## Section E. FUNCTIONAL ABILITIES

E1. Transferring	
Not applicable:	Requires no transfer training or skill not expected given level of disability, chronological or developmental age.
1 Mildly atypical:	Can function independently with adaptive equipment.
2 Moderately atypical	Limitations of balance, range of motion, stability and/or strength interfere with performance; generally requires supervision and/or assistance. Requires adaptive equipment. May not be able to repeat transfers throughout day due to time requirements or lack of endurance.
3 Severely atypical:	Limitations of balance, range of motion, stability and/or strength prevent performance. Always requires total assistance from others.

E2. Mobility with Equipment	
Not applicable:	Requires no mobility equipment or use of mobility equipment not expected due to chronological or developmental age.
1 Mildly atypical:	Can manage on various terrains, curbs, stairs, etc., but may need some supervision or special planning. Speed is slower than that of peers.
2 Moderately atypical:	Can manage on level ground independently but requires some assistance and/or supervision in other areas. Child's speed with aided mobility is too slow to keep up with peers.
3 Severely atypical:	Not independent in use of equipment. Requires total assistance; nonfunctional mobility.

E3. Activities of Daily Living	
Not applicable:	Student's ability to perform activities of daily living is commensurate with global developmental age.
1 Mildly atypical:	Limited fine motor control. May need minor adaptations for independence in self-feeding, dressing, grooming, hygiene, and/or written work.
2 Moderately atypical:	Limitations in range of motion, muscle strength, balance and/or sensation which interfere with independence in activities of daily living. Balance limited because constant use of hand is required for support. Requires adaptive equipment or extended time to complete task. May require some assistance and/or supervision.
3 Severely atypical:	Limitations of range of motion, muscle strength/tone and/or balance prevents independent performance. Total assistance is required for activities of daily living.

E4. Structural Deformity	
Not applicable:	No structural deformity.
1 Mildly atypical:	At risk for deformity because of movement patterns, posture, inconsistent asymmetry or pain. Slight interference with function. Asymmetry with little likelihood of deformity or loss of function. Deformity present but stabilized. Absence of limbs; functions independently with or without a prosthesis.
2 Moderately atypical:	Significant interference with function. Consistent asymmetry or pain or has amputation and is learning to use a prosthesis. May need adaptive equipment.
3 Severely atypical:	Prevents function; health threatening deformity affecting breathing, swallowing, and/or other internal organs; deformity is fixed. Requires extensive adaptive equipment and/or prosthetic planning.

E5. Degenerative Condition*	
Not applicable:	Child does not have a degenerative condition.
1 Mildly atypical:	Child has a degenerative condition and has lost ability to keep up with classroom peers in terms of time completion for many functional activities.
2 Moderately atypical:	Child has a degenerative condition and has lost motor function such that she/he needs moderate accommodations with assistance from another individual for functional participation and/or assistance provided through equipment adaptations/modifications.
3 Severely atypical:	Child has a degenerative condition and has lost significant motor function. Child is totally dependant for participation in and set up for the majority of learning activities.

\*Degenerative Conditions (E5) include diagnoses such as Muscular Dystrophy, Mitochondrial Disorders, Neurofibromatosis or other disorders that lead to progressive loss of function over time. Cerebral Palsy, Osteogenesis Imperfecta, Arthrogryposis, Spina Bifida, etc., would not be included because, although students may lose function, these conditions are not progressive in nature.

## Section F. MISCELLANEOUS

F1. Concern for Skin Breakdown	
Not applicable:	No concern regarding skin breakdown.
1 Mildly atypical:	Physical condition and/or activity could lead to skin damage but none currently exists. Student wears well-fitting splints and/or braces. Uses appropriate adaptive equipment.
2 Moderately atypical:	Physical condition or activity will lead to skin damage without awareness and specific care. Poorly fitting appliances, poor circulation evident or decreased sensation.
3 Severely atypical:	Some breakdown already present or recent history of breakdown.

F2. Bowel and Bladder Control	
Not applicable:	Normal or not expected due to developmental or chronological age.
1 Mildly atypical:	Questionable control. Indicates awareness of being wet or soiled.
2 Moderately atypical:	Partial incontinence. Some awareness of having voided. At risk for urinary infections.
3 Severely atypical:	Full incontinence. No awareness of having voided. Has frequent urinary infections.

F3. Bowel and Bladder Management (With Equipment As Need)	
Not applicable:	Is independent or self-management is not appropriate for student's present chronological or developmental age.
1 Mildly atypical:	Is independent in toileting skills but may require supervision and some verbal cues. May need more time to complete.
2 Moderately atypical:	Needs assistance with bowel and bladder management or is learning management program.
3 Severely atypical:	Is not participating in or is incapable of self-management due to physical impairment. Requires total assistance.

F4. Weight in Relation to Functional Ability	
Not applicable:	Weight is within normal limits and is not cause for concern.
1 Mildly atypical:	Condition warrants monitoring of body weight in relation to ability to function.
2 Moderately atypical:	Moderately overweight, underweight or at risk for being impaired by weight. Weight interferes with participation and/or health.
3 Severely atypical:	Severely overweight or underweight. Weight is of significant concern as it prevents participation.

F5. Pain	
Not applicable:	No pain related to the disability or no sensation.
1 Mildly atypical:	Experiences occasional pain related to disability, but it generally does not interfere with physical or mental performance.
2 Moderately atypical:	Experiences pain that may sometimes interfere with physical and/or mental performance.
3 Severely atypical:	Experiences frequent pain that consistently interferes with physical and/or mental performance.



## OREGON ORTHOPEDIC IMPAIRMENT NEEDS ASSESSMENT

Student's Name: \_\_\_\_\_ Region \_\_\_\_\_ County \_\_\_\_\_ Date \_\_\_\_\_

Diagnosis: \_\_\_\_\_

DOB \_\_\_\_\_ CA \_\_\_\_\_ School \_\_\_\_\_ Total number with average of 3= \_\_\_\_\_

PT Evaluator \_\_\_\_\_ Total number with average of 2= \_\_\_\_\_

OT Evaluator \_\_\_\_\_

SLP Evaluator \_\_\_\_\_

A. NEUROMUSCULAR	Score	Comments
1. Muscle Tone Strength		
2. Reflex Activity and/or Abnormal Motor Pattern		
TOTAL GROUP A		÷ 2 =

D. ORAL MOTOR	Score	Comments
1. Oral Coordination		
2. Communication		
TOTAL GROUP D		÷ 2 =

B. GROSS MOTOR	Score	Comments
1. Head Control		
2. Rolling		
3. Creeping		
4. Sitting		
5. Kneeling		
6. Half-Kneel		
7. Stand		
8. Functional Gait		
TOTAL GROUP B		÷ 8 =

E. FUNCTIONAL ABILITY	Score	Comments
1. Transferring		
2. Mobility with Equipment		
3. Activities of Daily Living		
4. Structural Deformity		
5. Degenerative Condition		
TOTAL GROUP E		÷ 5 =

C. FINE MOTOR	Score		Comments
	L	R	
1. Grasp and Release			
2. Reach			
3. Object Manipulation			
4. Bilateral Hand Use			
5. Functional Writing			
TOTAL GROUP C			÷ 5 =

F. MISCELLANEOUS	Score	Comments
1. Concern for Skin Breakdown		
2. Bowel/Bladder Control		
3. Bowel/Bladder Management		
4. Relative Weight		
5. Pain		
TOTAL GROUP F		÷ 5 =

KEY: n/a = not applicable, 0= normal, 1= mildly atypical/minimal limitation,  
2= moderately atypical/moderate limitation, 3=severely atypical/severe limitation

A student with an orthopedic impairment must have two or more sections with an average score of 3, or three or more sections with an average score of 2 or more is considered to have a severe orthopedic impairment.

Page 1 of 1



# **APPENDIX B**

## **Physical and Occupational Therapy under IDEA in Oregon**

### **Laws Relating to Therapy in Educational Settings**

Oregon Administrative Rules

Oregon Revised Statutes

IDEA 2004

Section 504

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## Appendix B: Regulations Relating to Therapy in Educational Settings in Oregon

Note: This is a listing of the laws and regulations referenced in this manual. This is not an exhaustive list of all regulations relating to special education and related services. To access the regulations listed below, and all regulations regarding occupational and physical therapy practice under IDEA, please refer to the following websites:

### Oregon Administrative Rules (OAR):

General Search:

[http://arcweb.sos.state.or.us/rules/OARS\\_100/OAR\\_166/166\\_tofc.html](http://arcweb.sos.state.or.us/rules/OARS_100/OAR_166/166_tofc.html)

Specific OAR Search:

[http://arcsearch.sos.state.or.us/search?site=archives&client=archives&output=xml\\_no\\_dtd&proxystylesheet=archives&proxycustom=%3CHOME/%3E&ie=&oe=&lr=&restrict=AdministrativeRules](http://arcsearch.sos.state.or.us/search?site=archives&client=archives&output=xml_no_dtd&proxystylesheet=archives&proxycustom=%3CHOME/%3E&ie=&oe=&lr=&restrict=AdministrativeRules)

Oregon Revised Statutes (ORS): <http://www.leg.state.or.us/ors/>

Federal Register (CFR): <http://idea.ed.gov/download/finalregulations.pdf>

### Oregon Administrative Rules:

[http://arcweb.sos.state.or.us/rules/OARS\\_100/OAR\\_166/166\\_tofc.html](http://arcweb.sos.state.or.us/rules/OARS_100/OAR_166/166_tofc.html)

#### Division 400: Educational Service Districts, School Districts, and Individual School Records

OAR 166-400-0060 Student Education Records

#### Division 10: Implementation and Administration of the Occupational Therapy Practice Act

OAR 339-010-0005 Definitions

OAR 339-010-0010 Recognition of Education Programs

OAR 339-010-0015 License Examinations Approved by the Board

OAR 339-010-0016 CE Requirements for Applicants for Licensure

OAR 339-010-0020 Unprofessional Conduct

OAR 339-010-0021 Imposition of Civil Penalties

OAR 339-010-0022 Aggravation and Mitigation

OAR 339-010-0023 License Renewals

OAR 339-010-0030 Supervised Field Work

OAR 339-010-0035 Statement of Supervision for Occupational Therapy Assistant

OAR 339-010-0040 Limited Permit

OAR 339-010-0050 Occupational Therapy Services for Children and Youth in Education and Early Childhood Programs regulated by federal laws

OAR 339-010-0055 Occupational Therapy Aides Tasks

**OAR Division 15: Special Education**

OAR 581-015-2000	Definitions
OAR 581-015-2030	Procedures for Complaints as Required by IDEA Regulations
OAR 581-015-2095	Exceptions to Consent
OAR 581-015-2100	Responsibility for Evaluation and Eligibility Determination
OAR 581-015-2105	Evaluation and Reevaluation Requirements
OAR 581-015-2115	Evaluation Planning
OAR 581-015-2120	Determination of Eligibility
OAR 581-015-2125	Interpretation of Evaluation Data
OAR 581-015-2130	Autism Spectrum Disorder
OAR 581-015-2160	Orthopedic Impairment
OAR 581-015-2165	Other Health Impairment
OAR 581-015-2175	Traumatic Brain Injury
OAR 581-015-2210	IEP Team
OAR 581-015-2225	Review and Revision of IEPs
OAR 581-015-2230	Transfer Students
OAR 581-015-2335	Mediation
OAR 581-015-2540	Definitions for Regional Programs
OAR 581-015-2545	Administration of Regional Programs
OAR 581-015-2550	Eligibility for Regional Services
OAR 581-015-2555	Referral for Regional Services
OAR 581-015-2560	Individualized Educational Program/Individualized Family Service Plan
OAR 581-015-2565	Regional Program Services
OAR 581-015-2700	Definitions – EI/ECSE Program

OAR 581-015-2730	Parent Consent for EI
OAR 581-015-2735	Parent Consent for ECSE
OAR 581-015-2775	EI Evaluation
OAR 581-015-2780	EI Eligibility
OAR 581-015-2795	ECSE Eligibility
OAR 581-015-2805	EI and ECSE Transition
OAR 581-015-2810	IFSP Meeting Procedures and Timelines
OAR 581-015-2825	Participants for IFSP Team Meetings and Reviews
OAR 581-015-2840	Service Coordination
OAR 581-015-2885	Preschool Children with Disabilities Covered by Public Insurance
OAR 581-015-2900	Personnel Standards
OAR 581-015-2905	Authorization of Early Childhood Specialist

**DIVISION 10: Licensed Physical Therapists and Licensed Physical Therapist Assistants**

OAR 848-010-0010	Approval of Schools of Physical Therapy
OAR 848-010-0015	Examinations
OAR 848-010-0020	Endorsement of Out-of-State Physical Therapists and Physical Therapist Assistants
OAR 848-010-0022	Endorsement of Out-of-State Foreign Educated Physical Therapists
OAR 848-010-0026	Temporary Permits
OAR 848-010-0033	Yearly Renewal of License Required
OAR 848-010-0035	Renewal of Lapsed Licenses
OAR 848-010-0044	Grounds for Refusal to License an Applicant

**Division 15: Physical Therapist Assistants**

OAR 848-015-0010	Definitions
OAR 848-015-0020	Scope of Practice
OAR 848-015-0030	Prohibited Acts

**Division 35: Continuing Education**

OAR 848-035-0010	Purpose
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- OAR 848-035-0015 Definitions
- OAR 848-035-0020 Required Hours and Period for Completion
- OAR 848-035-0030 Course Requirements and Restrictions
- OAR 848-035-0035 Pain Management Course Requirement for Physical Therapists
- OAR 848-035-0040 Documentation of Continuing Education Credits

**Division 40: Minimum Standards for Physical Therapy Practice and Records**

- OAR 848-040-0100 Definitions
- OAR 848-040-0105 General Standards for Practice
- OAR 848-040-0110 General Standards for Record Keeping
- OAR 848-040-0117 Standards For Authorization To Provide Physical Therapy Services
- OAR 848-040-0120 Standards For Record Of Authorization
- OAR 848-040-0125 Standards For Initiation Of Physical Therapy
- OAR 848-040-0130 Standards For The Documentation Of An Initial Evaluation
- OAR 848-040-0135 Standards For The Plan of Care
- OAR 848-040-0140 Standards For The Documentation Of The Plan Of Care
- OAR 848-040-0145 Standards For Providing Treatment
- OAR 848-040-0147 Standards for Treatment by a Student PT or Student PTA
- OAR 848-040-0150 Standards For The Documentation of Treatment Provided
- OAR 848-040-0155 Standards For Performing The Required Reassessment
- OAR 848-040-0160 Standards For The Documentation Of The Required Reassessment
- OAR 848-040-0165 Standards For Discharging A Patient From Therapy
- OAR 848-040-0170 Standards For Discharge Records
- OAR 848-040-0175 Standards for Screening Services

**Oregon Revised Statutes:** <http://www.leg.state.or.us/ors/>

- ORS 342.850 Teacher evaluation; personnel file content; rules.
- ORS 675.210 through 675.340 Occupational Therapists

ORS 688.010 through 688.201 Physical Therapists

**Federal Register:**

**IDEA 2004:** 38 CFR Part 300, Special Education <http://idea.ed.gov/download/finalregulations.pdf>

**Section 504:** 34 CFR Part 104, Subpart D, Preschool, Elementary and Secondary Education:

<http://www2.ed.gov/policy/rights/reg/ocr/edlite-34cfr104.html#D>

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# **APPENDIX C**

## **Physical and Occupational Therapy under IDEA in Oregon**

### **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 (21 pages)

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## Commonly Used Special Education Acronyms

AAC	Augmentative and Alternative Communication
ADA	Americans with Disabilities Act
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
APE	Adapted Physical Education
ARC	Previously known as Association for Retarded Citizens and now the initials are the name of organization
ASHA	American Speech-Language-Hearing Association
AT	Assistive Technology
AYP	Adequate Yearly Progress
BD	Behavior Disorder
BIP	Behavioral Intervention Plan
CDRC	Child Development and Rehabilitation Center
CDS	Child Development Specialist
CEC	Council for Exceptional Children
CMHP	Community Mental Health Program
COSA	Confederation of Oregon Schools Administrators
COTA	Certified Occupational Therapy Assistant
CP	Cerebral Palsy
DD	Developmental Disability or Developmentally Delayed
DEC	Division of Early Childhood (A subdivision of CEC)
DHH	Deaf and Hard of Hearing
DHS	Department of Human Services
DSM-IV	Diagnostic and Statistical Manual IV
ECSE	Early Childhood Special Education
ED	Emotionally Disturbed
EH	Emotionally Handicapped
EHA	Education of the Handicapped Act
EI	Early Intervention
EI/ECSE	Early Intervention/Early Childhood Special Education
ELL	English Language Learner
ERC	Education Resource Center
ESD	Education Service District
ESL	English as a Second Language
ESY	Extended School Year
EYS	Extended Year Services (EI only)
FAPE	Free Appropriate Public Education
FTE	Full-time Equivalent

FBA	Functional Behavior Assessment
FERPA	Family Education Rights and Privacy Act
HS	Head Start
HIPAA	Health Insurance Portability Accountability Act
ICC	Interagency Coordinating Council IDEA
Act	Individuals with Disabilities Education
IEP	IEE Independent Educational Evaluation
IFSP	Individualized Education Program or Plan
IQ	Individualized Family Services Plan
	Intelligence Quotient
LD	Learning Disabled
LEA	Local Education Agency, usually the local school district
LEP	Limited English Proficiency
LPTA	Licensed Physical Therapy Assistant
LRE	Least Restrictive Environment
MA	Mental Age
NICHCY	National Information Center for Handicapped Children and Youth
NCLB	No Child Left Behind
OAR	Oregon Administrative Rules
OCR	Office for Civil Rights
ODE	Oregon Department of Education
OGPL	Oregon Games for the Physically Limited
OHI	Other Health Impaired
OHSU	Oregon Health Sciences University
OI	Orthopedic Impairment
O&M	Orientation and Mobility
OMAP	Oregon Medical Assistance Program
ORPTI	Oregon Parent Training and Information Center
ORS	Oregon Revised Statutes
OSB	Oregon School for the Blind
OSD	Oregon School for the Deaf
OSEP	Office of Special Education Programs
OSERS	Office of Special Education and Rehabilitative Services
OSHA	Oregon Speech-Language and Hearing Association
OT	Occupational Therapy/Therapist
OVSA	Oregon Very Special Arts Program
P&A	Protection and Advocacy
Part B	Special Education—School-Aged Children
Part C	Special Education—Birth–Two Years Old
PDD	Pervasive Development Disorders

PT	Physical Therapy/Therapist
SEA	State Education Agency
SILP	Semi-Independent Living Program
SLD	Specific Learning Disability
SLP	Speech Language Pathologist
SSI	Supplemental Security Income
TAG	Talented and Gifted
TBI	Traumatic Brain Injury
TSPC	Teachers Standards and Practices Commission
UCP	United Cerebral Palsy
VI	Visually Impaired
VR	Vocational Rehabilitation
WAC	Work Activity Center
YTP	Youth Transition Program

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## **Glossary of Special Education Terms**

**Abduction** (away from midline): Movement away from the midline of the body or a body part, as in raising the arms to the side and away from the body, spreading the legs, or spreading the fingers or toes.

**Abnormal patterns of movement:** Forms of movement which are associated with brain damage and which are not observable at any stage of a normal full-term infant's motor development.

**Adaptive equipment:** Devices used to position or to teach special skills.

**Adduction** (to the midline): Movement to the midline of the body or body part or the anatomical position of closing the fingers or toes or bringing the arms close to the trunk.

**Ambulation:** Walking.

**Antigravity posture:** A position, such as sitting or standing, which requires that the child be able to support himself against the force of gravity.

**Aspiration:** Inhalation of foreign substances (such as fluid or dust) into the lungs.

**Asymmetry:** One side of the body different from the other.

**Ataxic:** One type of classification of cerebral palsy where balance and fine motor functions such as coordination are impaired.

**Athetoid movement** (or athetosis): Uncontrolled and continuous movement associated with cerebral palsy (and other movement disorders) where involuntary writhing movements occur, particularly in the hands and feet.

**Atrophy:** Wasting of the muscles, typically from disuse.

**Automatic movement:** A type of movement which is performed without thinking or conscious control and which aligns body parts or restores and maintains balance.

**Bolster:** A long, narrow, rounded pillow or cushion. A pillow rolled over and tied makes a good bolster. Ideal size is 6-12 inches in diameter.

**Cerebral palsy:** A disorder of posture and movement which results from damage to the brain and which produces atypical postural tone and unusual ways of moving.

**Chorea:** Involuntary jerky movements.

**Clonus:** A repetitive tremor of spastic muscles after those muscles have been stretched or after pressure (such as in weight bearing).

**Co-contraction:** Contraction of muscle groups on both sides of the body part (trunk, legs, arms) which enable the child to assume and maintain antigravity postures, such as sitting or standing.

**Compensatory movement:** An atypical movement pattern used to compensate for the inability to perform a normal movement; may produce abnormal muscle tone.

**Consistency** (of muscle) – The softness or firmness of the muscle tissue when you press it with your fingers or thumb.

**Contracture:** Permanent shortening of muscles or tendons which produces limited range of motion at the involved joints.

**Corner chair:** A piece of adaptive equipment that can be used to seat the child and is shaped in a 90° angle.

**Crawl:** Movement forward, with child's stomach on floor. Child moves legs in alternate way (moves one, then the other).

**Creep:** Movement forward on hands and knees, stomach up, in quadruped. Child moves one hand and opposite knee, then other hand and opposite knee, and so on.

**Cruise:** To walk sideways holding onto furniture or other supports. Example: child walks around coffee table and couch, stepping sideways and hanging on to furniture.

**Deformity:** Permanent change in the joints of the body which can only be altered through surgical intervention and which results from imbalance in muscle action (as in cerebral palsy or meningomyelocele).

**Depression** (lowering): Movement that produces a lowering of a particular area; the opposite of *elevation*. The movement most typically occurs to return the elevated part to the anatomical position (returning the scapula to normal alignment) or can occur as an isolated movement as in mandibular (or jaw) depression, which opens the jaw.

**Diplegia:** A type of cerebral palsy where the muscles in the legs are more involved than those in the arms.

**Dislocation** (of a joint): Complete separation or displacement of the bones that form a joint. In hip dislocation, the hip bone (femur) is pulled out of its socket (acetabulum) in the pelvis.

**Distal:** Farthest from the body trunk, toward the hands and feet.

**Elevation** (raising): Movement that produces a raising of a particular area such as scapular elevation or raising (shrugging) the shoulders or mandibular elevation (closing the jaw). The term *elevation* is always used in combination with the name of the bone being moved (scapular) or, more generally, the body area being moved (shoulder elevation or jaw elevation).

**Elongation** (muscle elongation): Increase in the length of the muscle.

**Equilibrium reactions:** Automatic patterns of body movements that enable restoration and maintenance of balance against gravity.

**Extension** (straightening): Movement that causes an increase in the angle between two adjoining bones, such as straightening the knee or elbow.

**Extremity:** A body limb, such as the arm (upper extremity) or leg (lower extremity).

**Facilitation:** Techniques that make it possible to move; physical techniques where guidance is specifically provided at key points (shoulders, head, hips/pelvis) to normalize tone and promote more normal forms of movement.

**Fine motor:** Small muscle movements; use of hands and fingers.

**Fixate:** To look at or stare at; to focus eyes on something.

**Flaccid:** Lacking force; weakness (as in muscles).

**Flexion** (bending): Movement that decreases the angle between two adjoining parts, such as bending the elbow to bring the forearm toward the upper arm.

**Floppy:** Hypotonic, or with low muscle tone.

**Fluctuating tone:** Changing from one degree of tension to another (i.e., from low to high tone).

**Form:** Way in which the various parts of a movement pattern are arranged in skill sequences (i.e., walking and crawling are two different forms of mobility).

**Gesture:** A physical movement or motion (e.g., child raises hands to be picked up, mother moves her hand toward her to motion for the child to come to her).

**Gross motor:** Large muscle movements like walking, sitting, crawling.

**Habit** (habitual pattern): Compensatory patterns of movement that have been strengthened through nonsystematic (intermittent) reinforcement and practice.

**Handling techniques:** Methods of holding or moving children with motor delay.

**Head control:** Ability to bring head in a straight, upright position when tilted in any direction. Mouth should be in a horizontal (lateral) position, parallel to floor.

**Hemiplegia:** A type of cerebral palsy where half of the body (arm, leg, and trunk on same side) is primarily involved.

**High tone:** Hypertonia or increased tone.

**Hydrocephalus:** Accumulation of spinal fluid in the brain which results in an abnormally large head.

**Hyperextensibility:** Extreme flexibility of joints due to loose or lax ligaments; “double-jointedness”; a characteristic of many children with hypotonia or athetoid cerebral palsy.

**Hyperextension:** Movement that increases the angle between two adjoining parts *past* a straight position (180°).

**Hypertonia:** Increased tension in the muscles that results in limited range of motion of the joints.

**Hypotonia:** Decreased tension in the muscles that results in excessive range of motion and inability to move against gravity.

**Inhibition:** Physical guidance techniques provided at postural proximal key points (shoulders, head, hips/pelvis) to decrease tone and eliminate atypical patterns of movement.

**Insult:** Injury.

**Involuntary movements:** Accidental or unintentional movements that are not performed by choice.

**Joint:** The place where two or more bones of the skeleton are joined. In the hip joint, the hip bone (femur) is joined to the pelvis and held in place by ligaments.

**Joint compression:** A therapy technique in which pressure is applied to bring the joint spaces closer together. Joint compression down through the shoulders and into the pelvis brings the vertebrae (bones that form the spine) closer together. Also known as *joint approximation*.

**Key points of control:** The parts of the body nearest the center of the body; the head, neck, shoulder girdle, and hips. These key points are used in handling and positioning the child with motor delay.

**Ligament:** A thick band of tissue that connects bone to bone to help form the joint.

**Low tone:** A term often used in place of hypotonia to indicate decreased tension in the muscles.

**Manipulation:** Use of the hands and fingers in relation to objects, including such actions as holding, pointing, pounding, releasing.

**Meningomyelocele:** Developmental disability present at birth in which there is an opening in the spine through which part of the spinal cord and its covering protrude.

**Midline:** The middle of the body from top to bottom; an imaginary line drawn from the top middle of the head, over the nose, and down the middle of the body.

**Mobility:** Capability to move or to be moved (i.e., movement of a body muscle or body part or movement of the whole body from one place to another).

**Movement patterns:** Organization of components of muscle action required to produce various forms of total movement that result in a change of position of the body as a whole or of an extremity (arms or legs).

**Muscle strength:** Amount of power of the muscle fibers in relation to contraction of the muscles under varying conditions of resistance; typically rated as good, poor, fair, trace.

**Muscle weakness:** Decreased power of the muscle fibers in relation to various conditions of gravity and with ratings of fair or trace.

**Myelomeningocele:** Same as meningomyelocele.

**Neurodevelopmental treatment (NDT):** A form of treatment of children and adults with disturbances in posture and movement that relies on facilitation and inhibition techniques used when handling and when teaching movement skills.

**Normalized tone:** Postural (muscle) tone that has been made more normal through use of procedures to alter tone.

**Occupational therapist:** Professional trained to work with fine motor activities, self-help skills, visual-motor activities, and activities of daily living.

**Occupational therapy:** A method of treatment that helps the individual function as normally as possible. With children, occupational therapy typically emphasizes the improvement of movement in play and daily living.

**Oral-motor coordination:** Interaction of the muscles of the neck, lips, tongue, cheeks, and jaw to produce smooth movement in eating and phonation.

**Orthopedic conditions/problems:** Specific problems that involve the bones, joints, and muscles of the body and that include deformities such as scoliosis (spine), hip/shoulder dislocations, or muscle contractures.

**Patterns of movement:** The combination of various muscle contractions in order to move a body part in space or to accomplish a particular objective.

**Physical guidance:** A training (or teaching) procedure in which the required movement is produced by physical manipulation by another person.

**Physical therapist:** Professional trained to work with gross motor activities, mobility, and ambulation.

**Physical therapy:** A method of treatment that helps the individual perform movement as normally as possible.

**Pivot:** The first way that an infant moves when in prone (on the stomach); by shifting weight on the arms, the infant moves in a semicircle on her stomach.

**Positioning:** Ways of placing an individual that will help to normalize postural tone and facilitate normal patterns of movement; may involve the use of adaptive equipment.

**Postural fixation:** Co-contraction of specific muscle groups to provide a stable base for movement that can result in normal stability or compensatory stability with atypical postural tone.

**Postural tone:** The degree of tension in the muscles with the body at rest and when actively moving; the degree of tension in the muscles with the body at rest and under various conditions of environmental stimulation.

**Primitive patterns/movements:** Patterns of movement that are present in motor development of a normal full-term infant but prolonged past the typical time of disappearance or integration in the child with motor delay.

**Pronation:** Movement that rotates the forearm so that the palms are down; the opposite of supination. Pronation is the downward rotation of the forearm.

**Prone board:** A piece of adaptive equipment on which the child is placed in a supportive standing position with support provided on the frontal surface of the body (i.e., prone stander).

**Proprioceptive:** Relating to sensations produced in the joint spaces and muscle tendons of the body.

**Quadriplegia:** Involving all four body segments (i.e., arms and legs), as well as the trunk.

**Quadruped:** The hands-and-knees position, as used in creeping on all-fours.

**Range of motion:** The amount of motion present in each joint of the body under conditions of passive movement of the body part (passive ROM) or of active movement produced by the individual (active ROM).

**Reflex:** Stereotypic posture or movement that occurs in response to specific stimuli and is outside of conscious control.

**Regurgitation:** The return of partially digested food to the mouth from the stomach.

**Resistance:** A force to hinder or prevent movement; a therapy technique used to increase muscle tone or muscle strength.

**Respiration:** Breathing; the process by which an organism supplies its cells with oxygen and relieves them of carbon dioxide.

**Respiration/phonation:** Coordination of the respiratory mechanism and oral-motor coordination to produce speech sounds.

**Respiratory distress syndrome:** Lung condition found in premature babies due to immature lung development which requires ventilation to enable the baby to breathe.

**Retrolental fibroplasia:** Visual disorder of particular risk to premature infants.

**Righting reactions:** Subconsciously controlled movements that right the body in space and/or the body parts in relation to each other (e.g., head righting, body righting).

**Rigid:** A condition of increased postural tone (hypertonus) that prevents any movement at all and in which the individual's body is very stiff and difficult to move by another person.

**Rotation:** Movement of the head, trunk, or limb about its axis.

**Side-lying:** A position in which the individual is placed on a supporting surface on either the right or left side.

**Spasticity:** Increased muscle tone (associated with presence of stretch reflex) or stiffness; hypertonia.

**Stability:** The contraction of muscles to hold the body against gravity and/or to hold the joints in place to allow movements at other joints.

**Startle reflex:** Jerking movements of the body or blinking of the eyes as a result of a loud sound or sudden movement at other joints.

**Stiff:** Used to describe spasticity or increased postural tone (hypertonus), which relates to the difficulty in moving the body as a whole or any body part.

**Subluxation:** An incomplete or partial dislocation of a joint.

**Supination:** Movement of the forearm such that the palm is facing up.

**Tactile defensiveness:** Extreme sensitivity to touch.

**Tightness (muscle tightness):** Decreased elasticity in a muscle or group of muscles which produces limited range of active movement but which can be stretched to full length passively.

**Transporter chair:** A piece of adaptive seating equipment that can be used as a car seat to transport a child safely.

**Trunk:** The body, not including the head, the arms and the legs.

**Trunk control:** Ability to bring the body into a straight, upright position when tilted in any direction.

**Vestibular:** Relating to sensations produced in the semicircular canals of the ear, which affect balance and posture.

**Voluntary movements:** Movements produced under the conscious control of the individual.

**Wedge:** A piece of adaptive equipment, like a pillow, that is used to help position the individual in proper body alignment.

**Weight-shifting:** Shifting weight off one body part to another. In order to pivot in prone, for example, the infant must shift weight off of one arm (or elbow) and then move that arm while bearing weight on the opposite arm. Weight-shifting in standing allows the child to cruise around furniture and later to walk.

*The Clinical Connection*, Spring, 1988.

## **Contributing to the Development of the IEP Selected Guidance for OTs and PTs**

*Note: The following excerpts have been taken from guidance offered by the Oregon Department of Education (ODE) regarding the creation of Individualize Educational Programs (IEP). The full text of this guidance, along with the IEP forms themselves, can be found on the ODE website at <http://www.ode.state.or.us/search/page/?id=1163>.*

### **The Present Levels of Academic Achievement and Functional Performance**

The Present Levels of Academic Achievement and Functional Performance (*Present Levels*) information serves as a foundation for the development of the IEP. The Present Levels statement(s) provide a clear picture of the student's strengths and needs, as determined through evaluation. These statements guide the Team in identifying all services necessary to address the student's educational needs related to their disability (ies). These statements should be written in language that is easily understood by all IEP Team members.

The *Present Levels* statement(s) must identify how the student's disability affects the student's involvement and progress in the general education curriculum, defined as the curriculum that is the same as for nondisabled students. Present level statements should be based on student data which reflect current academic achievement and functional performance. A clear linkage should be evident between the needs identified by the data in the *Present Levels* statements, the annual goal statement(s), and all other services identified in the IEP.

In developing the Present Levels of Academic Achievement and Functional Performance Statement, the IEP Team must include specific information addressing:

- The present level of academic performance, including the student's most recent performance on State or district-wide assessments;
- The present level of developmental and functional performance; and,
- How the student's disability affects involvement and progress in the general education curriculum.

### **Measurable Annual Goals, including academic and functional goals**

*NOTE: Two goal page options are available for IEP team use. The first page option allows the team to document the development of measurable annual goals for the student. The second page option allows the team to document the development of both measurable annual goals and measurable short term objectives for the student. The IEP team must develop both measurable annual goals and measurable short-term objectives for students taking alternate assessments based on alternate achievement standards. The team will determine which page(s) to use based on whether the student will be taking alternate assessment aligned to alternate achievement standards in the*

*area of specially designed instruction being considered. It may be necessary for the IEP team to use both pages, if the student will be taking alternate assessment aligned to alternate achievement standards in certain academic areas, but not in all.*

Annual goals are statements, written in measurable terms that describe what the student can reasonably accomplish in a 12-month period. There should be a direct relationship between the goal statements and the student's present levels of educational performance.

- Each goal must include:
  - **Criteria:** How will the skill be demonstrated by the student to be considered successful; and,
  - **Evaluation Procedures:** How the student's performance will be evaluated.
- Identify the Measurable Annual Goals, including academic and functional goals. These goals and objectives must relate to:
  - Meeting the student's needs that result from the disability;
  - Meeting the student's needs to enable involvement in and progress in the general education curriculum; and,
  - Meeting other educational needs that result from the disability.
- Identify the criteria and evaluation procedures for each annual goal.

## **Short-term objectives**

The IEP must include measurable short-term objectives for students taking alternate assessments based on alternate achievement standards. IEPs *may* include measurable short-term objectives for all other students.

Write short-term objectives for the student. Short-term objectives are intermediate performance steps that will enable parents, students and teachers to gage, at intermediate times during the year, how well the student is progressing toward the annual goals by either:

- Breaking down the skills described in the goal into discrete components; or
- Describing the amount of progress the student is expected to make within specified segments of the year.

## **How will progress be reported to parents**

The IEP must include a description of how the child's progress toward meeting the annual goals will be measured and when periodic reports on the progress the child is making toward meeting the annual goals (such as through the use of quarterly or other periodic reports, concurrent with the issuance of report cards) will be provided. Progress toward *each* annual goal will be measured through the identified criteria and evaluation measures established for each goal.

- Identify how progress will be reported to parents (e.g. “written report” or “with regular report card”).
- Identify the dates or time period (e.g. “quarterly”) that the reports will be provided.

Space is provided for noting the student’s “Progress toward Goal.” This can be used to indicate how the student is progressing on the goal at the review date.

## Service Summary

The Service Summary documents the IEP Team’s decisions regarding necessary services for the student. These services must be based on peer-reviewed research, to the extent practicable. Sec. 614(d) (1) (a) (i) (IV) (new).

- Indicate the services that will be provided to the student or on behalf of the child to allow the child to:
  - Advance appropriately toward attaining the annual goals;
  - Be involved in and make progress in the general education curriculum;
  - To participate in extracurricular and other nonacademic activities; and
  - Be educated and participate with other children with disabilities and nondisabled children to the maximum extent appropriate.
- Identify the student’s specially-designed instruction, related services, accommodations, and supplementary aids and services. (If necessary, use a second page to document additional services.)
- Indicate the anticipated amount/frequency, location (e.g., general education class, resource room, self-contained class, work-site, etc.), starting and ending dates for services (month, day, AND year), and provider for:
  - Each area of specially designed instruction (e.g., reading, math, physical education, vocational, travel training);
  - Any related services to be provided (related services are those services necessary to allow a student to benefit from specially designed instruction);
  - Accommodations, and/or Supplementary Aids & Services to be provided to the student;
  - Supports for school personnel (e.g., specified training to be provided to a teacher) provided on behalf of the student.

The amount/frequency of any service should **NOT** be identified as a “range” (e.g. “30-60 minutes/week”) or as an unspecified period of time (e.g. “as needed”, “if appropriate”). The amount/frequency of each service cannot be established based on convenience of school personnel, or because of shortages of personnel or uncertainty regarding staff availability.

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Student's Name:

Date: \_\_\_\_\_

School District: \_\_\_\_\_

**Service Summary (this section may be continued on additional page(s), if necessary)**

Specially Designed Instruction	Anticipated Amount/Frequency	Anticipated Location	Starting Date	Ending Date	Provider e.g. LEA, ESD, Regional
Instruction of individual goals is listed in this section. (See pages 49 - 50)	_____	_____	_____	_____	_____
Related Services	Anticipated Amount/Frequency	Anticipated Location	Starting Date	Ending Date	Provider
This section is often used to list therapy services which take place directly with the student. (Pages 49 - 50)	_____	_____	_____	_____	_____
Supplementary Aids/Services; Modifications; Accommodations	Anticipated Amount/Frequency	Anticipated Location	Starting Date	Ending Date	Provider
Indirect services, special equipment, assistive technology, or other such supports to the student are typically documented here. (Pages 46-47, 49-50)	_____	_____	_____	_____	_____
Supports for School Personnel	Anticipated Amount/Frequency	Anticipated Location	Starting Date	Ending Date	Provider
Consultation and training may be documented in this section. (Pages 46-47, 49-50)	_____	_____	_____	_____	_____

**Nonparticipation Justification**

Does the student need to be removed from participating with nondisabled students in the regular classroom, extracurricular, or nonacademic activities for the provision of special education services, related services, or supplementary aids and services?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, document the amount/ extent of the removal: \_\_\_\_\_

If yes, provide explanation justifying the removal:

**Extended School Year (ESY) Services**

ESY services will be provided for this student:

\_\_\_Yes: ESY services to be provided are described on Services Summary Page \_\_\_No \_\_\_To be considered: Will meet to consider ESY by \_\_\_(date)

### Individualized Family Service Plan (IFSP)

**Child's Name** \_\_\_\_\_ **Gender** \_\_\_\_\_ **Birthdate** \_\_\_\_\_ **Student Identification #:** \_\_\_\_\_  
**Parent(s)/Guardian** \_\_\_\_\_ **Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**Service Coordinator** \_\_\_\_\_ **Resident School District** \_\_\_\_\_

IFSP Date	
Eligibility Date	
Review Date(s)	
Annual Review Date	

EI/ECSE Services	Method	How Often?	Location	Who will do this?	Who will pay?	Start Date	Stop Date
Therapy services from the EI/ECSE program are listed in this section. (See page 49)							
Other (non EI/ECSE) Services Therapy services from sources other than the EI/ECSE program are listed in this section. (See page 49)							

Are **EI** services in the child's natural environment? \_\_\_\_\_ If not, please explain why EI services could not be achieved in the natural environment: \_\_\_\_\_

---

How many hours **per week** does the child attend an early childhood program (group child care, Head Start, community preschool, reverse mainstream classroom; **see early childhood program definitions in the IFSP instructions**): \_\_\_\_\_ How many hours **per week** will ECSE services **not be** provided with typical peers in an early childhood program: \_\_\_\_\_ If ECSE services **will not be** provided with typical peers in an early childhood program, explain the reason(s) for not providing services with typical peers: \_\_\_\_\_

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**Parents or any IFSP member may request an IFSP meeting at anytime, regardless of when the most recent IFSP occurred.**

Parents will be informed of the child's progress toward annual goals. Review Schedule:  Six month and annual review  Other review schedule: \_\_\_\_\_  
 How will progress be reported to parents?

**Services, Continued**

Child's Name: \_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

EI/ECSE Services	Method	How Often?	Location	Who will do this?	Who will pay?	Start Date	Stop Date
<b>Other (non EI/ECSE) Services</b>							

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**Parents or any IFSP member may request an IFSP meeting at anytime, regardless of when the most recent IFSP occurred.**

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## Information Resources for OTs and PTs in Schools

### **Council of Administrators of Special Education (CASE)**

<http://casecec.org>

Fort Valley State University  
1005 State University Drive  
Fort Valley, GA 31030

Office: 478-333-6892  
Fax: 478-333-2453  
Email: [lpurcell@casecec.org](mailto:lpurcell@casecec.org)

Council of Administrators of Special Education, Inc. (CASE) (2006) *Section 504 and the ADA Promoting Student Access: A Resource Guide for Educators*, Third Edition, ISBN #0-865585-343-1

**Oregon Department of Education** Web site: <http://www.ode.state.or.us>

### **Oregon Occupational Therapy Licensing Board**

<http://www.oregon.gov/OTLB/Pages/index.aspx>

Nancy Schuberg, Contact: [Nancy.Schuberg@state.or.us](mailto:Nancy.Schuberg@state.or.us)  
800 NE Oregon Street, Suite #407  
Portland, OR 97232

Phone: 971-673-0198  
Fax: 971-673-0226

### **Oregon Physical Therapist Licensing Board**

<http://www.oregon.gov/PTBrd/index.shtml>

Contact at: [Physical.Therapy@state.or.us](mailto:Physical.Therapy@state.or.us)  
800 NE Oregon Street, Suite #407  
Portland, OR 97232

Phone: 971-673-0198  
Fax: 971-673-0226

### **Regional and Statewide Services for Students with Orthopedic Impairments (RSOI)**

[www.rsoi.org](http://www.rsoi.org)

Nancy Lawson, Coordinator:  
[Nancy.Lawson@douglasesd.k12.or.us](mailto:Nancy.Lawson@douglasesd.k12.or.us) Douglas ESD  
1871 NE Stephens St  
Roseburg, OR 97470  
Phone: (503) 440-4791

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## Recommended Reading

Chiarello L, & Effgen S. K. (2006). *Updated competencies for physical therapists working in early intervention*. Pediatric Physical Therapy, Vol. 18, No. 2, pp. 148-67.

Effgen, S. K., Chiarello, L., & Milbourne, S. (Winter 2007). *Updated Competencies for Physical Therapists Working in Schools*. Pediatric Physical Therapy, Vol. 19, No. 4, pp. 266-274.

*Early Intervention Services: Natural Learning Environments*. Fact Sheet. Section on Pediatrics, American Physical Therapy Association. (2008).  
[www.pediatricapta.org/](http://www.pediatricapta.org/)

*Providing PT in the School Systems Under IDEA*. Brochure. Section on Pediatrics, American Physical Therapy Association. (2008).  
[www.pediatricapta.org/](http://www.pediatricapta.org/)

“Early Intervention: Physical Therapy Under IDEA,” Brochure. Section on Pediatrics, American Physical Therapy Association. (2004).  
[www.pediatricapta.org/](http://www.pediatricapta.org/)

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## **Commonly Used Standardized Assessments for Children with Orthopedic Impairments**

Below is a description of commonly used assessments for the evaluation and eligibility of children with orthopedic impairments. This was compiled by the Professional Learning Team for Orthopedic Impairment. This list is followed by a more comprehensive list of assessment tools. When making a student eligible under the category of orthopedic impairment, both standardized motor assessments and non-standardized assessments are used in addition to a medical statement and educational reports to support the child's development and education. For additional training or information regarding eligibility or testing required for OI eligibility, contact Regional & Statewide Services for Students with Orthopedic Impairments or the Oregon Department of Education.

### **Alberta Infant Motor Scale (AIMS) Birth – 18 months**

This standardized assessment is a valid measure of motor development for infants at risk for motor delay. The AIMS was developed to assist physical therapists and occupational therapists measure motor development in infants at high risk of motor delay. The AIMS focuses on attainment of motor milestones as well as the components needed to attain these milestones (for e.g. posture, weight-bearing, anti-gravity movements) and can be used to assess infants from birth until the attainment of independent walking. A 59-item, observational assessment requiring minimal handling and 20 – 30 minutes administration time, the AIMS assesses infant movement in four positions: Prone, supine, sitting and standing.

### **Peabody Developmental Motor Scales, Second Edition (PDMS-2) Birth – 5 years**

The PDMS-2 is used to assess motor skills in children birth through 5 years and takes approximately 45 – 60 minutes to administer. The assessment is composed of six subtests that measure interrelated motor abilities that develop in early life. Subtests include:

- Reflexes: This 8-item subtest measures a child's ability to automatically react to environmental events. Because reflexes typically become integrated by the time a child is 12 months old, this subtest is given to children birth through 11 months.
- Stationary: This 30-item subtest measures a child's ability to sustain control of his or her body within its center of gravity and retain equilibrium.
- Locomotion: This 89-item subtest measures a child's ability to move from one place to another. The actions measured include crawling, walking, running, hopping, and jumping forward.
- Object Manipulation: This 24-item subtest measures a child's ability to manipulate balls. Examples of the actions measured include catching, throwing, and kicking. Because these skills are not apparent until a child has reached the age of 11 months, this subtest is only given to children ages 12 months and older.
- Grasping: This 26-item subtest measures a child's ability to use his or her hands. It begins with the ability to hold an object with one hand and progresses up to actions involving the controlled use of the fingers of both hands.

- Visual-Motor Integration: This 72-item subtest measures a child's ability to use his or her visual perceptual skills to perform complex eye-hand coordination tasks such as reaching and grasping for an object, building with blocks, and copying designs.

### **School Function Assessment (SFA) (Grades K – 6)**

This standardized tool is used to measure a student's performance of functional tasks that support his or her participation in the academic and social aspects of an elementary school program (grades K-6). It was designed to facilitate collaborative program planning for students with a variety of disabling conditions. The SFA is criterion referenced rather than norm referenced. The scales enable you to measure the student's functional performance relative to the overall continuum of function. In addition, criterion cut-off scores are provided that can be used to establish that the student is performing below grade expectations, as needed to determine eligibility for special education services.

### **Pediatric Evaluation of Disability Inventory (PEDI) 6 months to 7.5 years\***

The PEDI is designed for use with young children with a variety of disabling conditions. The authors were interested in designing an instrument that would take into account the alternative methods that children use with *physical* disabilities to accomplish functional tasks. The item selection is deliberately skewed toward the lower end of the functional skills continuum.

The PEDI has been standardized on a normative sample for non-disabled children from 0.5 to 7.5 years. \*However, the PEDI can be used for children older than 7.5 years if the functional development is considerably delayed. Normative standard scores are not available for this older group, however, scaled scores indicate functional ability in the areas of self-care, mobility and social function can be obtained. Functional outcomes measure and emphasize mastery of functional skills and independence not normality.

### **Pediatric Evaluation of Disability Inventory Computer Adaptive Test (PEDI-CAT) Birth – 20 years**

The Pedi-Cat is a standardized test from birth to age 20 years. The Pedi-Cat measures function in four domains. (1) Daily Activities (2) Mobility (3) Social/Cognitive, and (4) Responsibility. The normative scores are presented as T-scores in which the mean for the age group is 50, with a standard deviation of 10

- The Daily Activities Domain measures the ability of a child to carry out daily living skills such as eating, dressing, grooming, and home tasks as appropriate for age level. These activities require coordination and discrete movements of the hands and arms to complete activities.
- The Mobility Domain measures the child's ability to move in different environments such as in home or in the community. Items range from foundational motor skills of rolling over and sitting unsupported to more advanced skills of jumping, running, playing, and carrying heavy objects. The use of mobility equipment such as a wheelchair or walking device is also included.

- The Social/Cognitive Domain measures the child's ability to interact with others in a community and participate in one's family and culture. This domain includes skills needed to function safely for effective social exchange. Items address communication, interaction, safety, behavior, play, attention and problem solving.
- The Responsibility Domain requires children to use several functional skills in combination to carry out life tasks including transition to adulthood to independent living. Items use several functional skills such as health management, literacy, citizenship, safety, community mobility, fixing a meal, planning and following a weekly schedule. For this reason, this is a more difficult domain and is recommended for age 3 years to age 20 years

### **Beery-Buktenica Developmental Test of Visual-Motor Integration, 6<sup>th</sup> Edition (Beery VMI)**

#### **Ages 2 – 99 years 11 months**

The Beery-Buktenica Developmental Test of Visual-Motor Integration, for ages 2 through 100, is a developmental sequence of geometric forms to be copied with paper and pencil. The Beery VMI is designed to assess the extent to which individuals can integrate their visual and motor abilities (eye - hand coordination). Two optional standardized tests, The Beery VMI Visual Perception test and the Beery VMI Motor Coordination test, are also available for those who wish to statistically compare an individual's Beery VMI results with relatively pure visual and motor performance data.

### **Bruininks-Oseretsky Test of Motor Proficiency 2<sup>nd</sup> edition ( BOT-2) Ages 4 – 21 years**

The Bruininks-Oseretsky Test of Motor Proficiency 2<sup>nd</sup> edition ( BOT-2) is a standardized assessment that measures fine and gross motor control skills for children ages 4 through 21. The Composite Standard scores in the average category extend from 41-59 with a mean of 50 and a standard deviation of 10.

**Fine Motor Control** encompasses motor skills involving control and coordination of the distal musculature of the hands and fingers. The composite score is based on sum scaled scores from Fine Motor Precision, subtest 1 and Fine Motor Integration, subtest 2.

**Manual Coordination** encompasses control and coordination of the arms and hands especially for object manipulation. The composite score is based on sum scaled scores from Manual Dexterity, subtest 3 and Upper Limb Coordination, subtest 7.

**Body Coordination** encompasses control and coordination of the large musculature used in maintaining posture and balance. The composite score is based on sum scaled scores from Bilateral Coordination, subtest 4 and Balance, subtest 5.

**Strength and Agility** encompasses aspects of fitness and coordination involved in casual play, competitive sports, and other physical activity. The composite score is based on sum scaled scores from Running Speed and Agility, subtest 6 and Strength, subtest 8.

## Section on Pediatrics

# List of Assessment Tools Used in Pediatric Physical Therapy

Created by the Practice Committee 05/04

Last revised 06/05

This list of assessment and evaluation tools and measures is NOT exhaustive. The Practice Committee has attempted to compile a list of the tools that are most commonly used by pediatric physical therapists. There are many other tools, as well as many Web sites, with additional information. This list should serve as a starting point for anyone seeking information on assessment and evaluation tools and measures. The Practice Committee suggests the following Web site as one source of additional information: <http://nieer.org/assessment/>. If you have additional tools or measures that you believe should be added to this list, please complete the form at the end of this document and submit it to the Section on Pediatrics at [cindysliwa@apta.org](mailto:cindysliwa@apta.org).

### Assessment Tools

#### *ABILITIES INDEX*

Author: Simeonsson, R. J., Bailey, D., Smith, T., Buyssee, V. (1995).

Publisher: Young children with disabilities: Functional assessment by teachers. *Journal of Developmental Physical Disabilities*, 7, 267-284.

Purpose: Documents the nature and extent of the functional characteristics of childhood disability. Has potential to identify discrete profiles of functional characteristics

Age Range: 36-69 months

Areas Tested: Index of 9 domains: audition, behavior, intelligence, limbs, intentional communication, tonicity, integrity of health, eyes, and structure.

#### *AGES & STAGES QUESTIONNAIRES (ASQ) – Second Edition*

Authors: Diane Bricker, Jane Squires, & Linda Mounts

Publisher: Paul H. Brookes Publishing Co., PO Box 10624, Baltimore, MD 21285-0624

Purpose: To determine the developmental level of a child through parent report

Age Range: Four to sixty months (4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60)

Areas Tested: 19 questionnaires each containing thirty items covering five areas of development: -Communication  
Gross motor, Fine motor, Problem solving, Personal-social

#### *AGES & STAGES QUESTIONNAIRES: Social Emotional (ASQ:SE)*

Authors: Jane Squires, Diane Bricker, and Elizabeth Twombly

Purpose: To help identify young children at risk for social emotional difficulties.

Age Range: six to sixty months (6, 12, 18, 24, 30, 36, 48, and 60)

Area Tested: Social and emotional behavior

#### *ALBERTA INFANT MOTOR SCALE (AIMS)*

Author: Martha C. Piper and Johanna Darrah

Publisher: WB Saunders Co., The Curtis Center, Independence Mall West, Philadelphia, PA 19106

Purpose: To identify infants and toddlers with gross motor delay and to evaluate gross motor skill maturation over time

Age Range: Birth – 18 months

Areas Tested: Fifty-eight gross motor skill items divided among four positions: prone, supine, sitting, standing

Each item observed for the components of: weight bearing, posture, and anti-gravity movement

#### *ASSESSMENT, EVALUATION, AND PROGRAMMING SYSTEM FOR INFANTS AND CHILDREN (AEPS)*

Volume 1: Measurement for Birth to Three Years

Author: Diane Bricker

Publisher: Paul H. Brookes Publishing Co., PO Box 10624, Baltimore, MD 21285-0624

Purpose: To determine level of skill attainment, assist in the development of programmatic outcomes, goals and objectives, and monitor progress toward attainment of outcomes over time  
Age Range: Developmental skill range from one to 36 months of age  
Areas Tested: Two hundred twenty-eight items divided among six domains which are further divided into strands: Fine motor: reach, grasp, release, functional use; Gross motor: movement in prone and supine, balance in sitting, standing and walking, and play; Adaptive: feeding, hygiene, undressing; Cognitive: sensory causality, problem-solving, pre-academic interaction with objects; Social: interaction with adults, peers, and environment; Communication: pre-linguistic, expressive, receptive  
Each strand is further divided into goals and objectives. Goals and objectives are assessed and are arranged hierarchically

*BATTELLE DEVELOPMENTAL INVENTORY (BDI)*

Authors: Newborg J, Stock JR, Wnek L., Guidubaldi J, Svinicki J.  
Publisher: Riverside Publishing Co., 8420 Bryn Mawr Avenue, Chicago, IL 60631  
Purpose: Judgment or performance based measure administered through structured format, interviews with caregivers or naturalistic observations. Norm referenced  
Age Range: Birth to 8 years  
Areas Tested: GM, FM personal-social, language and cognitive skills,

*BAYLEY INFANT NEURODEVELOPMENTAL SCREENER (BINS)*

Author: Glen P. Aylward  
Publisher: Psychological Corporation, 19500 Bulverde Rd., San Antonio, TX 78259  
Purpose: To identify infants who are at risk for delays or neurological impairments  
Age Range: Three to twenty-four months  
Areas Tested: Seventy-two items divided among six age sets (3, 6, 9, 12, 18, 24 months) each containing 11-13 items. Items are categorized into four "conceptual areas of ability": Basic neurological functions/intactness: tone, reflexes, and abnormal signs: Receptive functions: visual, auditory, verbal: Expressive functions: gross motor, fine motor, vocalizations: Cognitive processes; memory, problem solving, object permanence, attention

*BAYLEY SCALES OF INFANT DEVELOPMENT-II*

Author: Nancy Bayley  
Publisher: Psychological Corporation, 19500 Bulverde Rd., San Antonio, TX 78259  
Purpose: To identify developmental delay and to monitor a child's developmental progress  
Age Range: One to 42 months  
Areas Tested: Consists of three scales: Mental: cognition, object permanence, memory, manipulation, problem solving, verbal communication, and comprehension; Motor: gross and fine motor development/ skill acquisition;  
Behavior: qualitative aspects of child's behavior during administration of mental and motor scale

*BERG BALANCE TEST*

Authors:  
Purpose: Measures balance during movement activities  
Age Range: 5 years and older  
Areas Tested: 14 items including common movement activities such as picking an object up from the floor, walking and turning

*BRIGANCE INVENTORY OF EARLY DEVELOPMENT, REVISED EDITION (BDIED-R)*

Author : Albert Brigance  
Publisher: Curriculum Associates, 5 Esquire Road, North Billerica, MA 01862-2589  
Purpose: Commonly used assessment in early intervention and preschool programs to determine developmental delay in several domains and for program planning.  
Age Range: Birth-7 years  
Areas Tested: Criterion-referenced test of: psychomotor, self-help, speech and language, general knowledge and comprehension, early academic skills and social-emotional development.

*BRUININKS-OSERETSKY TEST OF MOTOR PROFICIENCY (BOTMP)*

Author: Robert Bruininks, ----Oseretsky

Publisher: American Guidance Service, Publisher's Bldg., PO Box 99, Circle Pines, MN 55014-1796  
Purpose: Developmental motor skills  
Age Range: 4.5 –14.5 years  
Areas Tested: Balance, strength, coordination, running speed and agility, upper limb coordination (ball skills), dexterity, fine motor control, visual-motor

*CANADIAN OCCUPATIONAL PERFORMANCE MEASURE*

Author: Mary Law, Sue Baptiste, Anne Carswell, Mary Ann McCall, Helene Polatajko, & Nancy Pollock  
Publisher: CTC Building, Suite 3400, 1125 Colonel By Drive, Ottawa, Ontario K1S 5R1  
Purpose: To detect changes in parent or child's self-perception of performance over time.  
Age Range: Any  
Areas Tested: Satisfaction and disability rating of daily activities and routines, which are, identified by the child and family as important part of daily life

*THE CAPUTE SCALES: CAT/CLAMS*

Author: Arnold J. Capute  
Purpose: To quantify delay in language and problem solving  
Age Range: One to 36 months  
Areas Tested: Cognitive Adaptive Test (CAT): visual-motor skills, problem solving  
Clinical Linguistic and Auditory Milestone Scale (CLAMS): receptive and expressive language

*CHILD HEALTH AND ILLNESS PROFILE- ADOLESCENT EDITION (CHIP-AE)*

Author : B. Starfield, B., Berger, M., Ensminger, M., A. Riley, A., Ryan, S., Green, B., et al.  
Publisher: (1993). Pediatrics, 91, 430-435.  
Purpose: Detects differences in health status among children with chronic illness.  
Age Range: 11- 17 years  
Areas Tested: Self-administered questionnaire of health assessment. Domains covered: comfort, satisfaction with health, risk, disorder, achievement of social expectations and resilience

*CHILD HEALTH QUESTIONNAIRE (CHQ)*

Author: Jeanne Landgraf, Linda Abetz, John Ware  
Publisher: Quality Metric Inc., 640 George Washington Hwy., Suite 201, Lincoln, RI 02865  
Purpose: Measures physical and psychosocial health concepts  
Age Range: 2 months – 17 years  
Areas Tested: Judgment based quality of life instrument, completed by parent or child.

*CHILD HEALTH ASSESSMENT QUESTIONNAIRE (CHAQ)*

Author: Len  
Purpose: Judgment based quality of life measure; developed primarily for children with arthritis but has been used for children with other physical disabilities  
Age Range: Any age  
Areas Tested: Performance of activities of daily living and assistance required.

*THE CAROLINA CURRICULUM FOR INFANTS AND TODDLERS WITH SPECIAL NEEDS, SECOND EDITION (CCITSN)*

Authors: Nancy M. Johnson-Martin, Kenneth G. Jens, Susan M. Attermeier, and Bonnie J. Hacker  
Publisher: Paul H. Brookes Publishing Co., PO Box 10624, Baltimore, MD 21285-0624  
Purpose: Curriculum based assessment used to determine approximate developmental level of children and programming strategies  
Age Range: Birth to twenty-four month developmental range  
Areas Tested: Three hundred fifty-nine items and curricula content covering twenty-six areas of development (sequences) divided among five developmental domains: -Cognition-Communication-Social/adaptation-Fine motor-Gross motor

*CAROLINA CURRICULUM FOR PRESCHOOLERS WITH SPECIAL NEEDS (CCPSN)*

Authors: Nancy M. Johnson-Martin, Susan M. Attermeier, Kenneth Jens, and Bonnie Hacker

Publisher: Paul H. Brookes Publishing Co., PO Box 10624, Baltimore, MD 21285-0624  
Purpose: Curriculum based assessment used to determine approximate developmental level of children and programming strategies  
Age Range: Two and five years developmentally  
Areas Tested: Five hundred and eighteen items and curriculum content covering twenty-five sequences divided among five domains of development: - Cognition- Communication- Social Adaptation- Fine Motor- Gross Motor

*CLINICAL OBSERVATIONS OF MOTOR AND POSTURAL SKILLS 2ND EDITION (COMPS)*

Author : Brenda Wilson, Nancy Pollack, Bonnie Kaplan, & Mary Law  
Publisher: Therapro, 225 Arlington Street, Framingham, MA 01702-8723  
Purpose: Screens for subtle motor coordination problems.  
Age Range: 5-9 years screening  
Areas Tested: Tests subtle motor coordination during slow movements, arm rotation, finger-nose touching, prone extension posture, prone extension posture, asymmetrical tonic neck reflex, and supine flexion posture.

*DEGANI-BERK TEST OF SENSORY INTEGRATION (TSI)*

Author : Georgia Degani & Ronald Berk  
Publisher: Western Psychological Services, 12031 Wilshire Blvd., Los Angeles, CA 90025  
Purpose: Screens for sensory integration dysfunction in preschoolers.  
Age Range: 3-5 years  
Areas Tested: Criterion-referenced test of postural control, bilateral motor integration and reflex integration.

*DENVER DEVELOPMENTAL SCREENING TEST-II*

Author: William K. Frankenburg, Josiah Dodds, Phillip Archer, Beverly Bresnick, Patrick Maschka, Norman Edelman, and Howard Shapiro  
Publisher: Denver Developmental Materials, Inc., PO Box 6919, Denver, CO 80206-0919  
Purpose: to detect potential developmental problems in young children and monitor children at-risk for developmental problems  
Age Range: One week to six years, six months of age  
Areas Tested: One hundred twenty-five items divided among four areas of function: Personal-social: behavior, caring for self: Fine motor-adaptive: eye-hand coordination, manipulation of small objects, problem solving Language: hearing, speaking, and understanding: Gross motor: sitting, walking, and jumping. Also, five subjective "Test Behavior" items assessing overall test behavior.

*DEVELOPMENTAL HAND DYSFUNCTION 2ND EDITION*

Author : Rhonda Erhardt  
Publisher: Therapy Skill Builders, 19500 Bulverde Rd., San Antonio, TX 78259-3701  
Purpose: Used to determine delay or dysfunction in prehension skills, but without standardized scores. Useful tool in intervention planning.  
Age Range: Birth-15 months  
Areas Tested: Criterion-referenced assessment of prehension including positional-reflexive, cognitively directed movement and prewriting skills.

*DEVELOPMENTAL OBSERVATION CHECKLIST SYSTEM (DOCS)*

Author: Wayne P. Hresko, Shirley Miguel, Rita Sherbenou, & Steve Burton  
Publisher: PRO ED, Inc., 8700 Shoal Creek Blvd., Austin, TX 78757-6897  
Purpose: Provides general developmental assessment.  
Age Range: Birth – 6 years  
Areas Tested: Norm-referenced checklist covering language, motor, social and cognitive development. Also includes adjustment behavior and parent stress and support.

*DEVELOPMENTAL PROGRAMMING FOR INFANTS AND YOUNG CHILDREN - REVISED (DPIYC)*

Author: D. Sue Schafer, Martha S. Moersch, and Diane B. D'Eugenio  
Publisher: University of Michigan Press, 389 Green Street, Ann Arbor, MI 48104  
Purpose: To describe the developmental status of a child with a disability and assist with program planning and implementation

Age Range: Early Intervention Developmental Profile (EIDP): 0-36 months  
Areas Tested: The EIDP has 299 items divided into six areas of development  
Cognition-Gross Motor- Fine Motor- Language-Social-emotional-Self-care

*DEVELOPMENTAL TEST OF VISUAL-MOTOR INTEGRATION – FOURTH EDITION (VMI-4)*

Author : Keith Beery

Publisher: PRO-ED, Inc., 8700 Shoal Creek Blvd., Austin, TX 78757

Purpose: Easy test to determine problems in visual-motor integration important in writing and reading.

Age Range: 3-8 years (short form), 3-18 years (long form)

Areas Tested: Norm-referenced test of visual perception, motor coordination, and integration.

*DEVELOPMENTAL TEST OF VISUAL PERCEPTION – 2ND EDITION (DTVP-2)*

Author : Donald Hammil, Nils Person, & Judith Voress

Publisher: Assists in distinguishing between problems in visual perception verses visual-motor problems.

Purpose: PRO-ED, Inc., 8700 Shoal Creek Blvd., Austin, TX 78757

Age Range: 4-10 years

Areas Tested: Norm-referenced test of form consistency, figure ground, position in space and spatial relation.

*DEVEREUX EARLY CHILDHOOD ASSESSMENT PROGRAM (DECA)*

Author: P. A. LeBuffe, & J. A. Naglieri

Age Range: Ages 2-5 years

Purpose: To measure resilience in preschool children. Resilience is defined as the ability to recover from or adjust to misfortune or change.

Areas Tested: The tool therefore addresses the child's social emotional development

*EARLY INTERVENTION DEVELOPMENTAL PROFILE (EDP)*

Authors: Schafer SD, Moersch MS

Purpose: Developmental screening tool

Age Range: Birth – 3

Areas Tested: Cognition, gross motor, language, perceptual / fine motor, self-care, social/emotional

*ENERGY EXPENDITURE INDEX (EEI)*

Authors: Rose

Purpose: Measure of endurance

Age Range: 3 years and older

Areas Tested: Calculation of heart rate, distance walked and time, Working HR – Resting Heart Rate/ Speed

*ERHARDT DEVELOPMENTAL PREHENSION ASSESSMENT (EDPA) - Second Edition*

Author: Rhonda P. Erhardt

Purpose: To describe the quality of both right and left arm and hand prehension patterns for treatment planning

Age Range: Birth - 15 months

Areas Tested: Three hundred forty-one items divided into three sections: 1. Positional-reflexive: involuntary arm-hand patterns; 2. Cognitively directed: voluntary movements of approach, grasp, manipulation, and release  
3. Pre-writing skills: pencil grasp and drawing

*FACES PAIN SCALE*

Author : Bieri, D., Reeve, R., Addicoat, L. & Ziegler, J.

Publisher: (1990). The Faces Pain Scale for the self-assessment of the severity of pain experienced by children. Pain, 41, 139-150.

Purpose: Measures self reporting of pain intensity, although probably a better measure of child's emotional distress.

Age Range: 6-8 years

Areas Tested: Pain intensity rating scale using pictures of faces

*FIRSTSTEP: SCREENING TEST FOR EVALUATING PRESCHOOLERS (FirstSTEP™)*

Author : Lucy Jane Miller

Publisher: The Psychological Corporation, 19500 Bulverde Road, San Antonio, TX 78259

Purpose: Determine delay in all developmental areas.

Age Range: 2.9 years –6.2 years

Areas Tested: Norm-referenced screening test of cognition, communication, motor, social-emotional, and adaptive behavior.

#### *FUNCTIONAL OUTCOMES ASSESSMENT GRID (FOAG)*

Author: Phillipa H. Campbell

Purpose: To assist team in developing and implementing functional outcomes for children with disabilities

Age Range: No specific age range. Individualized based on desired outcomes thus age is not a factor

Areas Tested: Six functional outcome areas associated with four disability categories (physical, sensory, special health care needs, and other): Caring for self, Communication, Learning and problem solving, Mobility, Play and leisure skills, Socialization. Performance areas delineated within each outcome area. Performance areas: posture and alignment against gravity, movement patterns, movement of body in space, secondary physical disabilities. Performance areas are further divided into performance components with items such as weight shifting, muscle tone, oral-motor control, transitional movements and movement patterns, etc.

#### *FUNCTIONAL INDEPENDENCE MEASURE FOR CHILDREN (WeeFIM)*

Authors: Carl Granger, Susan Braun, Kim Griswood, Nancy Heyer, Margaret McCabe, Michael Msau, and Byron Hamilton

Publisher: Uniform Data System for Medical Rehabilitation, State Univ. of New York, Research Foundation, 82 Farbert Hall SUNY South Campus, Buffalo, NY 14214

Purpose: To determine the severity of a child's disability, the measurement of caregiver assistance needed in the Performance of functional activities, and outcomes of rehabilitation

Age Range: Children without disabilities: 6 months to 8 years; Children with developmental disabilities: 6 months to 12 years; Children with developmental disabilities and mental ages less than 7 years

Areas Tested: Eighteen items grouped into two major categories of function, motor, and cognition that are divided into six domains divided into sub domains: Motor, Self-care: eating, grooming, bathing, dressing, toileting, Sphincter control: bladder and bowel management, Transfers: chair, wheelchair, toilet, tub, and shower, Locomotion: wheelchair/crawl, stairs, Cognitive -Communication: comprehension, expression, Social cognition: social interaction, problem solving, and memory.

#### *FUNCTIONAL INDEPENDENCE MEASURE (FIM)*

Authors: Dodds, Heinemann

Purpose: Measures mobility in the home and community environment & ability to perform ADLs

Age Range: 7 years through adulthood

Areas Tested: Performance in self-care, sphincter control, transfers, locomotion, communication and social cognition

#### *FUNCTIONAL REACH TEST (FRT)*

Authors:

Purpose: Measure of anticipatory standing balance when reaching

Age Range: 4 years and older

Areas Tested: Measurement of the distance that the child can reach forward from a stationary standing position

#### *REVISED GESELL AND AMATRUDA DEVELOPMENTAL AND NEUROLOGIC EXAMINATION*

Author: H. Knobloch, F. Stevens, A.F. Malone (1987)

Purpose: It is a norm-referenced test identifying minor deviations in the areas of development and it is used to determine developmental status.

Age Range: 4 weeks to 36 months

Areas Tested: 5 areas of development-gross motor-fine motor-language-personal/social-adaptive

#### *GROSS MOTOR FUNCTION MEASURE (GMFM)*

Authors: Dianne Russell, Peter Rosenbaum, Carolyn Gowland, Susan Hardy, Mary Lane, Nancy Plews, Heather McGavin, David Cadman, and Sheila Jarvis

Publisher: Clinics in Developmental Medicine, No. 159, London, England: Mac Keith Press

Purpose: To evaluate change in gross motor function in children with cerebral palsy, describe a child's current level of motor function, and determine treatment goals

Age Range: No specific age range is recommended by the authors; however, the test has been validated on children between 5 months and 16 years. Seems best suited for children two to five years  
Areas Tested: Eighty-eight items of gross motor function divided into five dimensions: -Lying and rolling-Sitting Crawling and kneeling-Standing-Walking, running, and jumping. Items were selected to represent those typically performed by children by age five

*HEALTH UTILITIES INDEX – MARK 3 (HUI-3)*

Author: William Furlong

Purpose: Measures children's functional health status; can compute cardinal utility value to represent Health Related Quality of Life

Age Range: Any age

Areas Tested: Questionnaire completed by caregiver in eight domains: Ambulation, Dexterity, Speech, Vision, Hearing, Cognition, Emotion, and Pain

*INSIDE THE HAWAII EARLY LEARNING PROFILE (Inside-HELP)*

Author: Stephanie Parks

Publisher: VORT Corporation, PO Box 6032, Palo Alto, CA 94306

Purpose: To provide definitions and guidelines for administration and scoring of skills and serve as a reference for all the HELP curriculum and assessment materials

Age Range: Birth to 36 months

Areas Tested: Six hundred eighty-five skills divided among 40 developmentally sequenced conceptual strands covering seven domains-Regulatory/sensory organization: sensory processing. Cognition: symbolic play, imitation, sound awareness, spatial relationships, concepts, discrimination. Language: receptive, expressive. Gross motor: weight bearing, mobility and transitional movements, reflexes and reactions, advanced postural control.

Fine motor: visual tracking, grasp, reach, voluntary release, midline skills, spatial perception, manipulative prehension.

Social- emotional: attachment/separation, development of self, emotional expression, learning rules, social interactions. Self- help: oral motor development, dressing, independent feeding, sleep patterns, grooming and hygiene, toileting, household independence

*HOME OBSERVATION FOR MEASUREMENT OF THE ENVIRONMENT (HOME)*

Author: Bettye M. Caldwell and Robert H. Bradley

Purpose: A screening tool to identify the quality and quantity of social, emotional and cognitive supports available to the child in the home environment

Age Range: Infant and toddlers version birth to three

Areas Tested; Infant and toddlers version: forty-five items clustered into six subscales: Parental responsiveness, acceptance of child-Organization of the environment-Play materials-Parental involvement with the child. Variety of stimulation.

*INFANT TODDLER DEVELOPMENTAL ASSESSMENT (IDA)-PROVENCE PROFILE*

Author: Sally Provence, Joanna Erikson, Susan Vater, and Saro Palmeri

Purpose: To determine a performance age range and a descriptive summary of a child's developmental competencies

Age Range: Birth - 3 years

Areas Tested: Six phase process of evaluation with phase four a developmental assessment (Provence Profile).

Assessment items are grouped by age sets and the number of items varies at each age set and within each domain

Phase One: Referral and Pre-interview Data Gathering. Phase Two: Initial Parent Interview. Phase Three: Health Review. Phase Four -The Provence Profile: Developmental Observation and Assessment: Eight developmental domains divided between two categories: -Motor, Language, and Cognitive / Adaptive Competencies-Gross Motor-Fine Motor-Relationship to Inanimate Objects-Language/Communication-Self - Help-Feelings, Social Adaptation, and Personality Traits- Relationship to Persons-Emotions & Feeling States-Coping Behavior. Phase Five: Integration and Synthesis. Phase Six: Share Findings, Completion, and Report

*INFANT DEVELOPMENTAL SCREENING SCALE (IDSS)*

Author: W. Jane Proctor

Purpose: To assess developmental status of newborns

Age Range: Normal and at-risk infants between 38-42 weeks gestational age; can also be used sequentially on infants from 32 to 40 weeks gestational age.

Areas Tested: Twenty-four items divided into two groups-Behavioral: habituation, attention/interaction, motor responses, physiological system, abnormal posture or movements-Reflexes: rooting, suck, hand grasp, toe grasp, Babinski, ankle clonus, positive support, walk, placing, crawl, ATNR, Moro

*INFANT MOTOR SCREEN (IMS)*

Author: Robert E. Nickel

Purpose: To determine the neuromotor status of infants prematurely born

Age Range: Four to 16 months corrected age

Areas Tested: Twenty-five items adapted from the Milani-Comparetti and the Movement Assessment of Infants  
Muscle tone-Primitive reflexes-Automatic responses-Symmetry

*INFANT NEUROLOGICAL INTERNATIONAL BATTERY (INFANIB)*

Authors: Patricia H. Ellison

Publisher: Therapy Skill Builders, 19500 Bulverde Rd., San Antonio, TX 78259-3701

Purpose: To distinguish infants with normal neuromotor function from those with abnormal findings and to predict need for follow-up treatment

Age Range: One to eighteen month old at risk infants and toddlers, especially those born premature

Areas Tested: Twenty items divided into five content domains: -Spasticity: TLR, ATNR, hands open/closed  
Vestibular function: parachute, body rotative.-Head and trunk control: pull to sit, body derotative, sitting, prone posture.  
-French angles: scarf sign, heel-to-ear, popliteal angle, and hip abduction. -Legs: foot grasp, positive support reaction, dorsiflexion

*INFANT/TODDLER SYMPTOM CHECKLIST: A Screening Tool for Parents (ITS)*

Author: Georgia A. DeGangi, Susan Poisson, Ruth Z. Sickel, and Andrea Santman Wiener

Purpose: To identify infants at risk for sensory integrative disorders, attentional deficits, and emotional or behavioral problems

Age Range: 7 - 30 months

Areas Tested: Five age specific checklists (7-9, 10-12, 13-18, 19-24, 25-30) containing information on nine domains.  
Self-regulation: fussy-difficult behaviors such as crying, difficulty with transitions- sleep patterns: difficulty falling asleep, attention:, difficulty initiating and shifting attention-eating, feeding dressing or bathing: gagging, vomiting, food preferences, behavior problems during feeding-dressing, bathing, touch: tactile hypersensitivities, intolerance in being confined-movement: activity level, motor planning difficulties, balance, postural insecurity listening, language and sound: hyposensitivity to sound, language problems-looking and sight: sensitivity to light, visual distractibility-attachment/emotional functioning: gaze aversion, mood deregulation, flat affect, separation problems. There is also a general screening version.

*LEG LENGTH DISCREPANCY TAPE MEASURE*

Authors: Staheli

Purpose: Measure of leg length

Age Range: Any age

Areas Tested: Tape measurement from ASIS to medial malleoli

*MANUAL MUSCLE TEST (MMT)*

Purpose: Measure of muscle strength

Age Range: 4-5 years and older

Areas Tested: Contraction of muscles and if strong enough, application of manual resistance to the muscle contractions; Strength judged on ordinal scale

*MILANI-COMPARETTI MOTOR DEVELOPMENT SCREENING TEST, Third Edition (MC)*

Author: A. Milani-Comparetti and E.A. Gidoni, Wayne Stuber, Project Director for revised edition

Publisher: Meyer Children's Rehabilitation Institute, University of Nebraska Medical Center, 444 South 44<sup>th</sup> Street, Omaha, NE 68131-3795

Purpose: To identify motor dysfunction in infants by systematically examining the integration of primitive reflexes and the emergence of volitional movement against gravity

Age Range: Birth to two years

Areas Tested: Twenty-seven items divided into two groups: Spontaneous motor behaviors: locomotion, sitting, standing; Evoked responses: equilibrium reactions, protective extension reactions, righting reactions, primitive reflexes.

*MILLER ASSESSMENT OF PRESCHOOLERS (MAP)*

Author : Lucy Jane Miller

Publisher: The Foundation for Knowledge in Development, 1855 West Union Avenue, Suite B-8, Englewood, CO 80110

Purpose: Determination of preschoolers, without major problems, who are at risk for preacademic problems.

Age Range: 2 years, 9 months-5 years, 8 months

Areas Tested: Norm-referenced test of sensory and motor foundations and coordination, verbal and nonverbal cognitive skills and complex tasks.

*MEADE MOVEMENT CHECKLIST (MMCL)*

Author: Vicki Meade

Purpose: To screen infants for neuromotor delays

Age Range: Four to 6 months

Areas Tested: Flexor and extensor control is observed in six positions or transitional movements: - Sitting on lap: awareness to the surroundings-Prone: orientation of infant's body; tolerance of position- Rolling to back position of head, shoulder, pelvis, and hips- Supine: infant's alertness to self and external stimulus- Sitting: position of head, shoulders, pelvis, and hips- Standing: weight bearing through body; tolerance to position-Ventral suspension: lifting of the head and active movement of legs throughout hips/pelvis

*MERRILL-PALMER SCALE-REVISED (2003)*

Publisher: Stoelting Co., 620 Wheat Lane, Wood Dale, IL 60191

Purpose: The new addition of the motor measures makes this a comprehensive assessment that can be used from birth to kindergarten to determine delay or dysfunction and evaluate intervention effectiveness.

Age Range: 2-78 months

Areas Tested: Norm-referenced, standardized measure of cognitive (reasoning, memory, visual, etc.), language and motor (fine and gross), self-help/adaptive and social-emotional development. Patterns of development are assessed. Includes supplemental parent and examiner ratings.

*MODIFIED ASHWORTH SCALE (MAS)*

Authors: Bohannon RW. Smith MB.

Purpose: Measure of resistance to passive movement associated with spasticity

Age Range: 4-5 years and older

Areas Tested: Passive movement of a limb (usually the leg) through range while judging the resistance to the movement; resistance judged on ordinal scale

*MOTOR SKILLS ACQUISITION IN THE FIRST YEAR & CHECKLIST*

Author: Lois Bly

Publisher: Therapy Skill Builders, 19500 Bulverde Rd., San Antonio, TX 78259-3701

Purpose: To monitor motor development and assist in intervention planning for infants with motor delays or dysfunction.

Age Range: Birth –12 months

Areas Tested: Detailed explanation with photographs and checklist of gross motor development and indications of possible disturbances in motor development.

*MOVEMENT ASSESSMENT BATTERY FOR CHILDREN (MOVEMENT ABC)*

Author: Shelia Henderson & David Sugden

Publisher: The Psychological Corporation, 19500 Bulverde Road, San Antonio, TX 78259-7301

Purpose: Identifies impairments in motor function of children with milder movement disorders. Includes qualitative & quantitative information.

Age Range: 4-12 years

Areas Tested: Norm-referenced standardized performance test of manual dexterity, ball skills and static and dynamic balance. Also included is a checklist of daily routine activities, consideration of the context of performance and behavioral attributes.

*MOVEMENT ASSESSMENT OF INFANTS (MAI)*

Author: Lynnette S. Chandler, Mary S. Andrews, and Marcia W. Swanson

Publisher: Infant Movement Research, PO Box 4631, Rolling Bay, WA 98061

Purpose: To identify motor dysfunction in infants, especially those considered at-risk and monitor the effects of physical therapy on infants whose motor behaviors is at or below one year of age

Age Range: Birth to 12 months

Areas Tested: Sixty-five items within four areas of neuromotor functioning: -Muscle tone: anti-gravity postures, resistance to passive stretch, and consistency-Reflexes: relative presence or absence of primitive reflexes- Automatic reactions: righting, equilibrium, and protective-Volitional movement: gross and fine motor behaviors, hearing and vision.

*NATURALISTIC OBSERVATION OF NEWBORN BEHAVIOR (NONB)*

Author: Heidelise Als

Purpose: To develop a profile of the infants' physiological and behavioral responses to environmental demands and care giving.

Age Range: Neonates to four weeks post term

Areas Tested: Ninety-one behaviors based on the conceptual framework underlying the Assessment of Preterm Infant Behavior (APIB) - Autonomic: respiration, color, tremors, and twitch- Visceral: gagging, burp, spit up, and sounds - Motor: tone, posture, gross motor flexion or extension, upper and lower extremity movement State-related (attention related behaviors): eye movement, facial expressions, and gross body movements

*NEONATAL INDIVIDUALIZED DEVELOPMENTAL CARE AND ASSESSMENT PROGRAM (NIDCAP)*

Author: Heidelise Als

Publisher: National NIDCAP Training Center, Enders Pediatric Research Laboratories, The Children's Hospital, 320 Longwood Avenue, Boston, MA 02115

Purpose: Used to determine the infant's physiological and behavioral responses to the environment to assist parents and caregivers.

Training program recommended to become reliable in test administration.

Age Range: Neonates-4 Weeks post-term

Areas Tested: Criterion-referenced assessment of physiological and behavioral responses in the areas of autonomic, motor and attention.

*NEUROLOGICAL ASSESSMENT OF THE PRETERM AND FULL-TERM NEW BORN INFANT(NAPFI)*

Author: Lilly Dubowitz and Victor Dubowitz

Publisher: Cambridge University Press, 40 W. 20<sup>th</sup> Street, New York, NY 10011

Purpose: To document status of the nervous system in infants, document neurological maturation and/or change in infants

Age Range: Full term infants up to the third day of life and preterm infants who are medically stable and can tolerate handling up to term gestation age

Areas Tested: Thirty-three items divided into four categories: Habituation: visual and auditory stimuliD Movement and tone: posture, tone of limbs, trunk and neck, abnormal movementsD Reflexes: tendon reflexes, primitive reflexes, Neurobehavioral characteristics: selected items from *Neonatal Behavioral Assessment Scale*

*NEUROBEHAVIORAL ASSESSMENT OF PRETERM INFANT (NAPI)*

Author: Anneliese Korner and Valerie Thom

Purpose: To assess neurobehavioral status of prematurely born infants, to monitor effects of intervention, and to document individual differences

Age Range: Thirty-two to 37 weeks conceptual age

Areas Tested: Seventy-one items divided into seven clusters: -Motor development and vigor-Scarf sign-Popliteal angle- Alertness and orientation-Irritability-Vigor of cry-Percent sleep

*NEONATAL BEHAVIORAL ASSESSMENT SCALE (NBAS)*

Author: T. Berry Brazelton and J. Kevin Nugent

Publisher: Cambridge University Press, 40 W. 20<sup>th</sup> Street, New York, NY 10011

Purpose: To assess and describe infant's interactions and behaviors within the context of a dynamic relationship with a caregiver. Results provide information regarding infant's ability to handle stressors and self-organize.

Originally designed to study individual differences in neonates that contribute to infant-caregiver interactions and for studying group differences among infants.

Age Range: Full term neonates 37 to 48 weeks post-conceptual age. Supplemental items are provided to test infants born less than 37 weeks

Areas Tested: Twenty-eight behavioral and eighteen elicited items that provide information in five packages:

Habituation: response decrement -Motor-Oral: reflexes of the feet, rooting, sucking, glabella-Truncal: undressing and moderate handling such as pull to sit, grasp-Vestibular: maximal handling and stimulating items

(TNR, Moro) -Social-Interactive: state dependent orientation items. There are also nine supplemental (optional items), five of which were devised by Als and one devised by Horowitz to be used with babies born premature

#### *NEUROLOGICAL EXAM OF THE FULL TERM INFANT*

Author: Heinz Prechtl

Publisher: Cambridge University Press, 40 W. 20<sup>th</sup> Street, New York, NY 10011

Purpose: To diagnose infants with neurological abnormality and predict future neurological problems. A screening test is also available which can be used to determine the need for further testing in low risk infants.

Age Range: Full term and preterm infants 38-42 weeks gestation

Areas Tested: Twelve summary items that include primitive reflexes and responses. Posture: symmetry,

Opisthotonus-Eyes: reaction to light, reflexes-Power and passive movements: tone, range of motion, recall, muscular consistency-Spontaneous and voluntary movements: head control, tremors, clonus-State

#### *NEONATAL NEUROBEHAVIORAL EXAMINATION (NNE)*

Author: Andrew Morgan, Vera Koch, Vicki Lee, and Jean Aldag

Purpose: To determine neurobehavioral status of infants

Age Range: Thirty-two-42 weeks post conceptional age

Areas Tested: Twenty-seven items divided into three sections each having nine items-Tone and motor patterns-

Primitive reflexes-Behavioral responses

#### *NEONATAL ORAL MOTOR ASSESSMENT SCALE (NOMAS)*

Author: Murray A. Braun and Marjorie M. Palmer

Purpose: To screen for oral motor dysfunction in the neonate, distinguish infants with normal sucking from those with disorganization, identify infants with poor feeding abilities, and distinguish inefficient from efficient feeders

Age Range: Neonate to three months of age

Areas Tested: Twenty-six items divided into two categories, jaw movements and tongue movements: -Rate-

Rhythmicity-Consistency of degree of jaw excursion- Direction, range of motion, timing of tongue movement  
Tongue configuration

#### *NINE MINUTE WALK TEST (Screening tool)*

Authors:

Purpose: Endurance

Age Range: 5 years and older

Areas Tested: Distance walked in nine minutes. Subtest from a full fitness battery of the Health-Related Fitness Test.

#### *OBSERVATIONAL GAIT SCALE (OGS)*

Authors: Mackey

Purpose: Structured scale to rate gait parameters from video recordings

Age Range: 6-21 years

Areas Tested: Seven sections rated: Knee mid-stance; Initial foot contact; Foot contact mid-stance; Heel rise; Hind foot; Base of support; Assistive devices

#### *ORAL MOTOR/FEEDING RATING SCALE*

Author: Judy Michaels Jelms

Purpose: To document oral motor/feeding patterns and feeding function

Age Range: One year through adulthood

Areas Tested: Two major areas of oral motor/feeding behavior: Oral motor/feeding patterns lip/cheek movement, tongue movement, jaw movement Related areas of feeding function: self-feeding, adaptive feeding equipment, diet adaptation, position, sensitivity, food retention, swallowing, oral-facial structures

#### *OUCHER SCALE*

Author : Beyer, J.E.

Publisher: (1984). The Oucher: A user manual and technical report. Evanston, IL: The Hospital Play Equipment Co.

Purpose: Measures self reporting of pain intensity

Age Range: 5-12 years

Areas Tested: Pain intensity rating scale using actual pictures

#### *PEDIATRIC QUALITY OF LIFE INVENTORY (PEDS QL)*

Author: James W. Varni

Purpose: To measure health related quality of life

Age Range: 2-18

Areas Tested: The generic core scale consists of 23 items measuring the core dimensions of health from the World Health Organization, physical, emotional, and social functioning, as well as school functioning. The test contains child self-report forms for children 5 and older and parent proxy forms for children 2-18 years of age. Disease-Specific Modules are available for children with asthma, rheumatology, diabetes, cancer, and cardiac conditions.

#### *PEABODY DEVELOPMENTAL MOTOR SCALES SECOND EDITION (PDMS-2)*

Author: M. Rhonda Folio and Rebecca R. Fewell

Publisher: Pro-ed, 8700 Shoal Creek Blvd., Austin, TX 78757-6897

Purpose: To determine level of motor skill acquisition, detect small changes in motor development in children with known motor delays or disabilities, and assist in programming for children with disabilities

Age Range: One through eighty-three months

Areas Tested: Two hundred forty-nine items divided into two scales which are further divided into subtests. Gross Motor Scale: one hundred fifty-one items divided among three subtests:-Reflexes: primitive, automatic reactions-Stationary: static, dynamic--Locomotion: walk, run, jump, hop-Object manipulation: ball handling. Fine Motor Scale: ninety eight items divided among two subtests:Grasping: basic reach, grasp patterns, hand use: -Visual-motor integration: visual perceptual skills paired with motor, eye hand coordination

#### *PEDIATRIC EVALUATION OF DISABILITY INVENTORY (PEDI)*

Authors: Stephen M. Haley, Wendy J. Coster, Larry H. Ludlow, Jane T. Haltiwarger, and Peter J. Andrellas

Publisher: The Psychological Corporation, 19500 Bulverde Road, San Antonio, TX 7825-37019

Purpose: To determine functional capabilities and performance, monitor progress in functional skill performance, and evaluate therapeutic or rehabilitative program outcome in children with disabilities

Age Range: Six months to seven years, six months

Areas Tested: Two hundred seventy-one items divided into three subtests in the Functional Skill Scale:-Self care: eating, grooming, dressing, bathing, toileting-Mobility: transfers, indoors and outdoors mobility-Social function: communication, social interaction, household and community tasks. Also environmental modification and amount of caregiver assistance is systematically recorded in Modification Scale and Caregiver Assistance Scale

#### *PEDIATRIC CLINICAL TEST OF SENSORY INTERACTION FOR BALANCE (P-CTSIB)*

Authors: Crowe, Luyt, Westcott,

Purpose: Measures sensory system effects on stationary standing postural control (balance)

Age Range: 4-10 years

Areas Tested: Six conditions: Standing on floor with eyes open, eyes closed, and with dome (eyes open, but vision stabilized); Standing on foam with eyes open, eyes closed, and with dome (eyes open, but vision stabilized)

#### *POSNA PEDIATRIC MUSCULOSKELETAL FUNCTIONAL HEALTH QUESTIONNAIRE*

Author : Daltroy, L.H., Liang, M.H., Fossel, A.H., & Goldberg, M.J.

Publisher: (1998). Pediatric Outcomes Instrument Development Group.

Pediatric Orthopaedic Society of North America. Journal of Pediatric Orthopedics, 18, 561-571.

Purpose: Used to assess functional health outcomes, generally post orthopedic surgery. Can also examine child-parent agreement.

Age Range: 2-18 years with musculoskeletal disorders

Areas Tested: Scales completed by child and parent to measure upper extremity function, transfers and mobility, physical function and sports, comfort (pain free), happiness and satisfaction, and expectations for treatment.

#### *POSTURE AND FINE MOTOR ASSESSMENT OF INFANTS*

Author: Jane Case-Smith & Rosemarie Bigsby

Publisher: Therapy Skill Builders, 19500 Bulverde Rd., San Antonio, TX 78259-3701 Purpose:

Assists in intervention planning and documenting progress over brief periods of time. Age

Range: 2-12 months

Areas Tested: Fine motor scales addressing infant's reaching and grasping patterns, finger and thumb movements, release and manipulation.

#### *INFANT/TODDLER SENSORY PROFILE*

Author: Winnie Dunn

Publisher: Psychological Corporation, 19500 Bulverde Rd., San Antonio, TX 78259

Purpose: Provides a standard method for measuring an infant's sensory processing with the child's daily life performance.

Age Range: Birth to 36 months

Areas Tested: sensory systems

#### *QUALITY OF WELL-BEING SCALE (QWB)*

Author: R.M. Kaplan, J.W. Bush, C.C. Berry

Publisher: (1976). Health status: types of validity and the index of well-being. Health Services Research, 11, 478-507.

Purpose: Summarizes health across symptoms, problems and functional states.

Age Range: 14 years and older

Areas Tested: Four scales focus on the physical impact of an illness related to symptoms, functions, social and mobility levels.

#### *RILEY INFANT PAIN SCALE*

Author : Schare, J., Joyce, B., Gerkenmeyer, J., & Keck, J.

Publisher: (1996). Comparison of three preverbal scales for postoperative pain assessment in a diverse pediatric sample. Journal of Pain and Symptom Management, 12 (6), 348-359.

Purpose: Indication of pain in infants and pre or non verbal children.

Age Range: Infants & pre or non verbal children

Areas Tested: Behavioral observation as an indication of pain

#### *SCALES OF INDEPENDENT BEHAVIOR-REVISED (SIB-R)*

Authors: Robert H. Bruininks, Richard W. Woodcock, Richard F. Weatherman, and Bradley K. Hill

Publisher: Riverside Publishing Co., 8420 Bryn Mawr Avenue, Chicago, IL 60631

Purpose: To measure functional independence and adaptive functioning in school, home, employment, and community settings

Age Range: Three months - 90+ years

Areas Tested: Adaptive Behavior Full Scale contains two hundred fifty-nine items divided into fourteen subscales which are organized into four clusters: -Motor skills: gross, fine-Social interaction and communication skills: social interaction, language comprehension and expression-Personal living skills: eating and meal preparation, toileting, dressing, personal self-care, domestic skills-Community living skills: time and punctuality, money and value, work skills, home/community orientation-Screening Forms: -Short Form: forty selected items from the 14 subscales-Early Development Form: forty items from developmental areas of Full Scale, for children up to 6 years of age, and individuals with a developmental level below 8 years of age-Problem Behavior Scale: Divided into three broad maladaptive behavior indexes with eight problem behavior areas: Internalized Maladaptive Behavior: hurtful to self, unusual or repetitive habits, withdrawal or inattentive behavior Asocial Maladaptive Behavior: socially offensive behavior, uncooperative behavior Externalized Maladaptive Behavior: hurtful to others, destructive to property, disruptive behavior

*SCHOOL FUNCTION ASSESSMENT (SFA)*

Authors: Coster W, Deeney T, Haltiwanger J, Haley S

Publisher: Psychological Corporation, 19500 Bulverde Rd., San Antonio, TX 78259

Purpose: Measures function in the school environment & can be used to guide program planning

Age Range: Elementary school students

Areas Tested: Three parts: Participation in school activity settings; Task supports; Activity Performance. Includes physical and cognitive/behavioral tasks.

*SENSORY INTEGRATION AND PRAXIS TEST*

Authors: Ayres

Publisher: Western Psychological Services, 12031 Wilshire Blvd., Los Angeles, CA 90025

Purpose: Measures sensory systems contributions to balance and motor coordination

Age Range: 4-8 yrs 11 months

Areas Tested: Numerous tests of postural control, motor coordination & planning, fine and gross motor function, & sensory integration

*TEST OF GROSS MOTOR DEVELOPMENT – 2 (TGMD2)*

Author: Dale Ulrich

Publisher: PRO ED, Inc., 8700 Shoal Creek Blvd., Austin, TX 78757-6897

Purpose: Used to identify children who are significantly behind their peers in gross motor skill development.

Age Range: 3-10 years

Areas Tested: Norm referenced test of 12 gross motor skills involving locomotion and object control

*TEST OF INFANT MOTOR PERFORMANCE (TIMP)*

Authors: S.K. Campbell, G. Kolobe, G. Girolami, E. Osten, and M. Lenke

Publisher: Infant Motor Performance Scales, LLC, 1301 W. Madison St. #526, Chicago, IL 60607-1953

Purpose: To identify infants with deficits in postural control and to document the effects of developmental therapy to improve postural control needed for functional movement in early infancy

Age Range: 32 weeks gestational age through 4 months post-term (or full term to 4 months)

Areas Tested: 27 observed behaviors and 26 elicited behaviors assessing the ability to orient and stabilize the head in space and in response to auditory and visual stimulation in supine, prone, side lying, upright, and during transitions from one position to another, body alignment when the head is manipulated, distal selective control of the fingers, wrists, hands, and ankles, antigravity control of arm and leg movement

*TEST OF VISUAL-MOTOR SKILLS-REVISED (TVMS-R)*

Author: Morrison Gardner

Publisher: Psychological and Educational Publications, Inc., PO Box 520, Hydesville, CA 95547-0520

Purpose: Simple test of visual-motor skills.

Age Range: 3-14 years

Areas Tested: Norm-referenced tests of eye-hand coordination, motor accuracy, motor control, motor coordination, and the child's interpretation.

*TEST FOR HIP JOINT INTEGRITY*

Authors: Staheli

Purpose: Measures hip joint placement to determine likelihood of dislocation

Age Range: Any age

Areas Tested: Manual movement of the hip joint

*TEST OF SENSORY FUNCTION IN INFANTS (TSFI)*

Authors: Georgia DeGangi and Stanley Greenspan

Publisher: Western Psychological Services, 12031 Wilshire Blvd., Los Angeles, CA 90025

Purpose: To determine sensory processing and reactivity in infants as an assist to diagnosing sensory processing dysfunction

Age Range: Four to 18 months

Areas Tested: Twenty-four items divided into five subtests: -Reactivity to tactile deep pressure-Adaptive motor function-Visual-tactile integration-Ocular motor control-Reactivity to vestibular stimulation

#### *TIMED OBSTACLE AMBULATION TEST (TOAT)*

Authors:

Purpose: Measures time and quality of walking at several points when walking through a specified path

Age Range: Any

Areas Tested: Negotiation over different surfaces, picking up an object, stepping up, over, going around, ducking under obstacles.

#### *TIMED UP AND GO (TUG)*

Authors:

Purpose: Measure of anticipatory standing balance & gait control, motor function through a typical activity

Age Range: 4 years and older

Purpose: Measurement of the time it takes to rise from a chair, walk 3 meters, turn around and return to a seated position in the chair.

#### *TODDLER & INFANT MOTOR EVALUATION (TIME)*

Authors: Lucy Jane Miller and Gale H. Roid

Publisher: The Psychological Corporation, 19500 Bulverde Road, San Antonio, TX 7825-37019

Purpose: To identify those children with mild to severe motor problems, identify patterns of movement, evaluate motor development over time, plan intervention, and conduct treatment efficacy research

Age Range: Four months to 3 1/2 years

Areas Tested: Eight subtests: five primary, three optional (clinical)

Primary Subtests- mobility-motor organization-stability-functional performance-social-emotional abilities

Clinical Subtests-quality rating-component analysis-atypical positions

#### *TRANSDISCIPLINARY PLAY-BASED ASSESSMENT- REVISED (TPBA)*

Author: Toni W. Linder

Publisher: Paul H. Brookes Publishing Co., PO Box 10624, Baltimore, MD 21285-0624

Purpose: To identify intervention needs, develop intervention plans and to evaluate progress made by children

Age Range: Six months to six years

Areas Tested: Comprehensive assessment of developmental processes, learning style, and interaction patterns in four developmental areas: -Cognitive-Social-emotional-Communication and language-Sensorimotor

#### *VISUAL ANALOG SCALE*

Author : Shields, B., Cohen, D., Harbeck-Weber, C., Powers, J., & Smith, G.

Publisher: (2003). Pediatric pain measurement using a visual analogue scale. *Clinical Pediatrics*, April.

Purpose: Measures self report of pain intensity

Age Range: 5 years & above, over 11 years

Areas Tested: Pain intensity rating scale using numerical scale on a vertical or horizontal continuum

#### *VULPE ASSESSMENT BATTERY-REVISED (VAB-R)*

Author: Shirley German Vulpe

Publisher: Slosson Educational Publications, Inc., PO Box 280, East Aurora, NY 14052

Purpose: To determine skill performance, strengths and needs, degree of central nervous system functioning, and environmental influence on task performance

Age Range: Children with atypical developmental or functional skills between birth to six years of age

Areas Tested: Thirteen hundred developmental tasks divided into three sections: Assessment of Basic Senses and Function: analysis of sensory-motor abilities such as muscle tone, joint range of motion, coordination, planning

Assessment of Developmental Behavior: sixty skill sequences contained in six domains of behavior: gross motor, fine motor, language, cognitive processing, adaptive behavior, and activities of daily living, Assessment of the

Environment: includes caregiver characteristics and interaction and information regarding the settings such as home, child-care, hospital, Performance Analysis System composed of three sections used to analyze the child's processing related to task performance

#### *YOUTH QUALITY OF LIFE INSTRUMENT-RESEARCH VERSION (YQOL-R)*

Author:

Publisher: The Association for Professionals in Services for Adolescents  
Elsevier Science Ltd. , 360 Park Ave, South, New York, NY 10010-1710  
Purpose: To assess quality of life with an emphasis on aspects of positive health.  
Age Range: 12-18 years with and without disabilities  
Areas Tested: Self-report measure in four domains: sense of self, social relationships, environment and general quality of life.

**Recommendation for Addition to  
Section on Pediatrics List of Assessment Tools  
for Use in Pediatric Physical Therapy**

**Name of Tool:**

**Author(s):**

**Purpose of Tool:**

**Age Range:**

**Areas Tested:**

**Publisher & Date:**

**How to Obtain:**

**In case we have any questions, we would appreciate your name and a way to contact you.**

**Name:**

**Phone/E-Mail:**

Thank you for contributing to the Section on Pediatrics' List of Assessment Tools for Use in Pediatric Physical Therapy!

Please fax this form to: 703/706-8575  
mail to: Section on Pediatrics, 1111 N Fairfax St, Alexandria, VA 22314  
or e-mail to: [cindysliwa@apta.org](mailto:cindysliwa@apta.org)

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