# OCCUPATIONAL THERAPY AND PHYSICAL THERAPY IN OKLAHOMA SCHOOLS

# TECHNICAL ASSISTANCE DOCUMENT

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## PROCESS

In 1994, the American Occupational Therapy Association (AOTA) began providing leadership training, focusing on preparing state teams to identify priority needs in the delivery of occupational therapy services and designing strategies to meet these needs. The project, *Promoting Partnerships: Leadership Training for Therapists in Education and Early Intervention* was sponsored by AOTA in collaboration with the National Association of State Directors of Special Education's (NASDSE) Networking System for Training Education Personnel Project (NSTEP), and the Council for Exceptional Children's (CEC) National Institute on Comprehensive System of Personnel Development (CSPD). Participants in the training included occupational therapists practicing in local school systems and early intervention programs, personnel from institutions of higher education (IHE) training programs, and Part B and Part C (formally part H) CSPD Coordinators outlined in the Individuals with Disabilities Education Act (IDEA).

In April 1995, the state of Oklahoma was invited to attend the Promoting Partnerships Leadership Training in Colorado. Sarah Cromwell, OTR/L, Sandra Arnold, PT, MEd, Director of Occupational Therapy and Physical Therapy Programs for the State of Oklahoma, and Cathy Perri, MS, CCC Assistant Director Oklahoma State Department of Education, Special Education Services represented our state as a leadership team. Sarah participated as the clinician, Sandra as the personnel from IHE, and Cathy as the CSPD and Part H representative. The task of the leadership team was to develop for our state (a) a vision statement, (b) problem and corresponding opportunity statements, and (c) goals and objectives pertaining to related service delivery. The Oklahoma leadership team decided that the primary goal was establishment of a related services task force whose mission would be to increase the number of qualified related services personnel providing services to students in Oklahoma.

The leadership team's goal was approved by the Oklahoma State Department of Education, Special Education Services. The leadership team recruited related services task force members from throughout the state and the first Oklahoma related services task force meeting was held in October 1995. The Oklahoma Related Services Task Force prioritized the development of a technical assistance document describing occupational and physical therapy services for school aged children as their initial goal. Using federal statutes and regulations, judicial decisions, Office of Special Education (OSEP) guidance, Oklahoma State Department of Education Special Education Services (OSDE/SES) policies and procedures, and current best practice in pediatric therapy, the task force developed this document. This document was prepared to assist occupational therapists and physical therapists in their understanding of the provisions of the Individuals with Disabilities Education Act (IDEA), the Oklahoma policies and procedures, and contemporary pediatric practice related to students with disabilities in school.

In June 1997, President Clinton signed into law the Amendments to the Individuals with Disabilities Education Act (IDEA). And in 1999, OSEP developed the rules and regulations for the amended IDEA. We encourage all therapists, educational personnel, and families working with students under the IDEA to obtain and read the most current federal regulations from OSEP

for special education, and the *Policies and Procedures for Special Education in Oklahoma* from OSDE/SES. When this document was published, IDEA '97 was the most current federal regulation.

So . . . after several years of heartfelt labor, the Oklahoma Related Services Task Force is pleased to provide the State of Oklahoma with the *Occupational Therapy and Physical Therapy in Oklahoma Schools Technical Assistance Document.* We hope this document provides you with information to improve your service delivery and interaction with the students of Oklahoma who receive related services in schools.

## ACKNOWLEDGMENTS

Many people contributed to this document. I am especially grateful for the work of all the members of the Oklahoma Related Services Task Force, particularly those who 'hung in there' for the ups and downs of the past several years; Letha Bauter, MS, Connie Blanco, OTR, Karen Bryant, PT, Rebecca Renfro-Bush, PT, Jennifer Campbell, OTR/L, BCP, Sarah Cromwell, OTR/L, Antonette Doty, PT, MS, PCS, Beverly Fentress, PT, Leslie Jefferson, OTR/L, MS, Lynn Jeffries, PT, MS, PCS, Irene McEwen, PT, PhD, M'Lisa Shelden, PT, PhD, PCS, Mary Lee Stephens, PT, MS, PCS, and Helena Scott, PT.

Occupational therapy and physical therapy pediatric post professional graduate students and graduates from the Department of Rehabilitation Science at the University of Oklahoma Health Sciences Center also contributed to the document. As part of their requirements for the course Teamwork in the Public Schools, they searched the therapy and special education literature to identify and support recommended practices. Individuals who contributed are: Melanie Anderson, Sherri Cadenhead, Jennifer Campbell, Sarah Cromwell, Rene Daman, Antonette Doty, Kari Fields, Jeff Hammontree, Margo Hayes, Melissa Hughes, Barbara Murphy, Gary Robinson, Mary Ross, Mary Lee Stephens, and Joanne Walkup.

I also would like to express sincere appreciation and thanks to the Oklahoma State Department of Education, Special Education Services (OSDE/SES), Comprehensive System of Personnel Development (CSPD), especially Jodie Williams, Margaret Bergant, and Darla Griffin, for helping the longtime dream of this document become a reality. I am grateful not only for the financial support, but for the collaboration and trust in the development of this project.

## GLOSSARY OF TERMS AND IMPORTANT WEB SITES

AOTA - American Occupational Therapy Association
CEU - continuing education unit
CSPD - Comprehensive System of Personnel Development
COTA- certified occupational therapy assistant
EHCA - Education of all Handicapped Children Act
ESY- extended school year
FAPE - free and appropriate public education
IDEA (IDEA '97) - Individuals with Disabilities Education Act, also entitled the Individuals with Disabilities Education Act Amendments of 1997
IEP - individualized education program
LEA - local education agency
MEETS - multidisciplinary evaluation and eligibility team summary
NCMRR - National Center for Medical Rehabilitation Research
OSDE/SES- Oklahoma State Department of Education, Special Education Services
OSEP - Office of Special Education Programs
OT- occupational therapist
OTR/L - occupational therapist registered, licenced
OTA - occupational therapy assistant
PT - physical therapist
PTA - physical therapist assistant

Oklahoma State Department of Education:
www.sde.state.ok.us

American Occupational Therapy Association:
www.aota.org

American Physical Therapy Association:
www.apta.org

## INTRODUCTION

Both federal and state laws mandate that public schools provide related services when needed by students with disabilities to benefit from special education. Related services include occupational therapy and physical therapy [Individuals with Disabilities Education Act Amendments of 1997 (IDEA)]. Occupational therapy and physical therapy as related services must comply with the IDEA statutes and regulations, and with state legislation and professional standards of practice. All therapists and therap(y)ist assistants working in the school setting must know and understand the mandates of the education related laws and the state's practice acts. Standards and guidelines set forth in the state practice acts for occupational therapy and physical therapy apply to practice in all types of settings, including public schools.

As legislators revise and develop law, the definition of effective and appropriate special education and related services for children with disabilities continues to evolve. Services previously provided in isolated or clinical settings, for example, are more often taking place in the student's natural setting, students with disabilities are increasingly being included with students in the general curriculum, and functional goals and objectives are replacing developmentally based goals and objectives. Current literature related to best practices in school-based service delivery is challenging therapists to provide the most effective and efficient service delivery for students with disabilities. This challenge requires therapists to be knowledgeable in the applicable laws, standards of practice, and current literature related to students with disabilities.

The Oklahoma Related Services Task Force developed the *Occupational Therapy and Physical Therapy in Oklahoma Schools Technical Assistance Document* primarily for occupational therapy and physical therapy professionals in the state of Oklahoma. The document is also meant to be a resource document for special educators, administrators, and family members who have students with disabilities that receive special education and related services. The question and answer format of the document was developed to assist the reader in finding quick answers to frequently asked questions. All of the answers are supported by current laws, research, and recommended best practice.

## OCCUPATIONAL AND PHYSICAL THERAPY SERVICES IN THE SCHOOL SETTING: AN OVERVIEW

The Individuals with Disabilities Education Act (IDEA) codified at 20 U.S.C. 1400-1487 is the single most influential piece of federal legislation associated with the delivery of therapeutic intervention within educational environments. Part B of the statute applies to children ages three through 21 years of age who require specially designed instruction to meet their unique needs. The Code of Federal Regulations 34 (34CFR) Part 300 are regulations for IDEA.

One major purpose of the IDEA is *"to ensure that all children with disabilities have available to them a free and appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for employment and independent living"* [20 USC 1400(d)(1)(a)]. Because occupational therapy and physical therapy practitioners working under the provisions of the IDEA need to know and understand the law and regulations, they are quoted throughout this document.

### What is a related service?

In Section 1401(22) of the IDEA, occupational therapy and physical therapy are listed as related services, which are defined as a supportive service that may be required to assist a child with a disability to benefit from special education. The law states:

> *20 USC 1401(22) Related Services*
> *As used in this part, the term "related services" means transportation and such developmental corrective, and other supportive services (including speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, social work services, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a child with a disability to benefit from special education, and includes the early identification and assessment of disabling conditions in children.*

### What does "required to assist" mean?

Once a student's educational program is developed, the Individualized Education Program (IEP) team is responsible for deciding if the student needs occupational therapy, physical therapy, or another related services to benefit from that program. Refer to the **IEP** chapter in this document for further information related to the IEP team. Although related services may assist a student with a disability, the student's opportunities do not need to be "maximized" through related service delivery. In *Board of Education of the Hendrick Hudson Central School District v. Rowley*, 1981-82 EHLR 553:656 (1982), the U.S. Supreme Court declared that the IDEA requires school districts to provide an "appropriate" education, not the best possible education. Amy Rowley was deaf and doing better than average in general

education classes, with some support services. She might have done even better if she had a sign language interpreter, which her parents requested. The Supreme Court decided that Amy was benefitting from her educational program without an interpreter and that school districts only had to provide a "basic floor of opportunity" consisting of "access to specialized instruction and related services which are individually designed to provide educational benefit to the handicapped child" 1981-82 EHLR at 553:667 (Gorn, 1999).

When occupational therapy and physical therapy services are necessary components of an individualized education program that provides a child with a basic floor of opportunity - access to an equal opportunity that would not otherwise exist without therapy services - and not merely maximization of a child's potential, these services are required to assist the student to benefit from special education. (Gorn, 1999).

**What is "special education?"**

This is an important question because if occupational therapy and physical therapy services are to assist a child to benefit from special education, we need to know what comprises special education. According to 20 USC 1401(25):

> *The term "special education" means specially designed instruction, at no cost to the parents, to meet the unique needs of a child with a disability, including--*
> *(A) Instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings: and*
> *(B) Instruction in physical education.*

Because of its child-specific nature, special education is not more precisely defined. The federal regulations however, further define "specially designed instruction."

> *Specially designed instruction means adapting, as appropriate to the needs of an eligible child under this part, the content, methodology, or delivery of instruction (i) To address the unique needs of the child that result from the child's disability; and (ii) To ensure access of the child to the general curriculum, so that he or she can meet the educational standards within the jurisdiction of the public agency that apply to all children* [34 CFR300.26(a)(3)].

Since the intent of the law was to individualize instruction, special education is not the same instruction for every child nor is it restricted to traditional academic instruction in the classroom. School districts cannot make educational decisions by applying rules or criteria to all children with certain characteristics, nor should all children with disabilities receive only special curriculum and be restricted to segregated classrooms. All children categorized as having multiple disabilities, for example, cannot receive a certain amount or type of special education and related service based on the classification. The IEP team evaluates and considers each child's unique needs in determining the educational program for that child. The IEP team also makes individualized decisions about occupational therapy and physical therapy services required to assist the student to benefit from his special education.

**How are occupational therapy and physical therapy defined in IDEA?**

The IDEA does not actually define occupational therapy or physical therapy. In the federal regulations to the IDEA amendments, occupational therapy means *"services provided by a qualified occupational therapist and includes improving, developing or restoring functions impaired or lost through illness, injury, or deprivation; improving ability to perform tasks for independent functioning if functions are impaired or lost; and preventing through early intervention, initial or further impairment or loss of function"* [34 CFR 300.24(b)(5)].

Physical therapy is defined as *"services provided by a qualified physical therapist"* [34 CFR 300.24(b)(8)]. These definitions support services within the occupational therapy and physical therapy scopes of practice that the IEP team agrees are required to "assist the child with a disability to benefit from special education."

**What are the personnel standards of occupational therapist and physical therapists in the IDEA and in Oklahoma public schools?**

The IDEA states that the personnel shall be appropriately and adequately prepared and trained. *"Standards shall be consistent with any State-approved or State-recognized certification, licensing, registration, or other comparable requirements that apply to the professional discipline in which those personnel are providing special education or related services"* [20 USC 1414(A)(15)].

In the state of Oklahoma, occupational therapists and physical therapists must hold appropriate state licensure from the Oklahoma Board of Medical Licensure and Supervision. A special education certification is not required.

**What is the essence of occupational therapy and physical therapy in the school setting?**

Occupational therapists and physical therapists are required to provide appropriate services based on the educational needs of the student as identified in the IEP. Even though occupational therapists and physical therapists are trained to provide many types of developmental and rehabilitative services, legal mandates require the school-based therapist to deliver only those services that are necessary to assist students to benefit from their educational programs (Rapport, 1995;20 USC 1401(22)). Refer to the **Intervention** chapter for additional information.

**How does the therapist decide if a student is eligible for occupational therapy or physical therapy in school?**

The difference between "eligibility" for school-based therapy and "need" for school-based therapy is important to understand. All students who are eligible for special education and some students with disabilities who are not in special education are “eligible” for occupational therapy and physical therapy. The IDEA does not define an automatic eligibility statement for related services, however if a student is eligible for special education or Section

504 of the Rehabilitation Act of 1973 services (refer to the Section 504 information included within this **Overview** chapter), the IEP team will determine if related services are needed to assist the child to benefit from special education. This may include assisting the child in achieving the educational goals, or assisting the student with access to and participation in the educational environment. Therapists cannot independently determine that a student needs or does not need therapy, nor can any single team member decide independently. The decision for related services is determined by the IEP team and is a team decision.

**Who is eligible for special education and can therapists determine eligibility for special education services?**

Under the IDEA, students are eligible for special education and related services if they are within the age range of three through 21 years, meet the eligibility criteria for one of the categories of disabilities specified in the IDEA (listed below), and require special education and related services because of the disability [20 USC 1401(3)(A)].

School districts may ask therapists to participate in the multidisciplinary evaluation, usually in the area of gross and fine motor development, adaptive behavior, observation in the class, perceptual skills, and student ability in relation to educational needs. The IDEA states that the local education agency (LEA) may not determine whether a child is a child with a disability nor determine an appropriate education program of a student solely on the findings of a single evaluation procedure [20 USC 1414(b)(2)(B)]. Rather, data must come from a *"variety of assessment tools and strategies"* [20 USC 1414(b)(2)(A)]; therefore, therapists are not responsible for determining eligibility for special education but submit relevant information regarding the student to the multidisciplinary evaluation team. See the **Evaluation** chapter for further details.

**What are the categories of disabilities?**

The categories are autism, deaf-blindness, emotional disturbance, hearing impairment including deafness, mental retardation, multiple disabilities, orthopedic impairment, other health impairment, specific learning disability, speech or language impairment, visual impairment including blindness, traumatic brain injury, and for children ages three through nine, at state discretion, the category of developmental delay [20 USC 1401(3)(b)]. In Oklahoma, after July 1, 2000, if a LEA chooses it may use the term developmental delay for children aged three to six, except for those children who are deaf-blind, deaf or hearing impaired, and visually impaired or blind. Effective July 1, 2001, a LEA may choose to use the term developmental delay for children aged three to eight except for those who are deaf-blind, deaf or hearing impaired, and visually impaired or blind.

**Do all children with one or more of these disabilities (including developmental delay) qualify for special education and related services under the IDEA?**

No, if students' disabilities do not adversely affect their educational performance, they do

not require special education and related services, and do not qualify for these services under the IDEA. A child may, however, be eligible for civil rights protections under Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990, to insure access to what is otherwise available to students without disabilities.

**What is Section 504?**

Section 504 of the Rehabilitation Act of 1973, is civil rights legislation aimed at protecting individuals with disabilities. In educational environments this law allows professionals to provide services to students who need them, but who are not eligible for special education under IDEA. Section 504 does not require students to enroll in special education to receive related services. The definition of disability is far broader in Section 504 than under the IDEA, in that the Section 504 legislation does not require a categorical label. Under Section 504, a person has a disability who (a) has a physical or mental impairment that substantially limits one or more major life activities, (b) has a record of having a physical or mental impairment that substantially limits one or more life activities, or (c) is regarded as having such an impairment [34 CFR 104.3(j)(1)]. Students who need physical therapy in school usually meet the first criterion. Major life activities mean *"functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working"* [34 CFR 104.3(j)(2)(ii)]. Children with permanent or temporary disabilities that meet this definition might qualify for accommodations. As an example, a student with an acutely broken arm may need accommodations for performing manual tasks such as writing, self-feeding, or self-care.

**How does Section 504 relate to occupational therapy and physical therapy?**

Some students' limitations in major life activities may require occupational therapy or physical therapy to accommodate the limitations or participate in school activities. If a student with mobility limitations, for example, needed to learn to move from place to place on a new school campus, a student might require the skills of a physical therapist to provide accommodations or modifications. Another student might need to learn to use the bathroom at school and require accommodations from an occupational therapist.

**How are 504 services provided?**

The multidisciplinary evaluation team, through an individualized student evaluation, determines whether the student is disabled within the meaning of Section 504 and if the student requires services to accommodate limitations or participation in school activities. The 504 services must include any “related aids or services,” such as administering medicine or receiving occupational therapy or physical therapy that are necessary to meet the individual student’s needs. Services provided under Section 504 do not require an IEP, but do require an accommodation plan (CASE, 1992). Section 504 does not specify who must set up the accommodation plan, but recommends that a group of persons knowledgeable about the student meet and specify what accommodations/services are necessary.

Section 504 requires periodic reevaluations and a reevaluation is required before a significant change in placement is made. A helpful reference for further information on Section 504 as it relates to school based services is the *Student Access: A Resource Guide for Educators Section 504 of the Rehabilitation Act of 1973* (Council of Administrators of Special Education [CASE], 1992).

**How does the Americans with Disabilities Act affect services for students?**

The Americans with Disabilities Act (ADA) is civil rights legislation that prevents discrimination against people with disabilities. The definition of disability is the same as in Section 504, but the ADA applies to both public and private entities. The Rehabilitation Act applies only to entities that receive federal dollars including school districts.

The ADA affects students primarily when they are outside school, such as riding public transportation, attending child care, receiving training at a job site, and participating in other activities that require *"reasonable accommodation" (" . . . those modifications or adjustments that do not cause undue hardship . . . ")* [29 CFR 1630.2(o)] by transportation, businesses, and other facilities. In general, the term "undue hardship" means

> *... an action requiring significant difficulty or expense. Factors to be considered in determining whether an accommodation would impose an undue hardship on a covered entity include; (i) the nature and cost of the accommodation needed under this Act; (ii) the overall financial resources of the facility or facilities involved in the provision of the reasonable accommodation; the number of persons employed at such facility; the effect on expenses and resources, or the impact otherwise of such accommodation upon the operation of the facility; (iii) the overall financial resources of the covered entity; the overall size of the business of a covered entity with respect to the number of its employees; the number, type, and location of its facilities; and (iv) the type of operation or operations of the covered entity, including the composition, structure, and functions of the workforce of such entity; the geographic separateness, administrative, or fiscal relationship of the facility or facilities in question to the covered entity* [Pub. L. 101-336, 101(10)].

Court cases and legislation are still determining "reasonable" accommodation and "undue" hardship, therefore therapists who work with students in community-based activities should keep abreast of the latest interpretations of the ADA (Rapport, 1995). The ADA also states that private or public child care centers and preschools cannot exclude children with disabilities, neither can they charge families higher rates for their children to attend these programs.

**Why don't therapists use formulae to decide which students need occupational therapy or physical therapy?**

For years, therapists, school administrators, and others have tried to develop simple and "objective" methods to decide which students are "eligible" for therapy in school or to decide

how much of what kind of therapy to provide. Some teams, for example, have attempted discrepancy criteria such that students whose cognitive abilities measure lower than their motor abilities are "ineligible" for occupational therapy. Others have criteria that students must score so many standard deviations below the mean to be "qualify" for physical therapy, or that students over a certain age, students who attend certain schools, or students who have certain diagnoses are "eligible" for only certain types of services (Campbell, 1994).

Criteria or attempts at formulae for determining which students require occupational therapy and physical therapy often end up discriminating against particular groups of students. Every student's program must be considered individually, based on the student's educational goals and short term objectives or benchmarks. Neither the district nor the IEP team should make decisions regarding provision of occupational therapy and physical therapy based on disability category, availability of services (*Policies and Procedures for Special Education in Oklahoma),* or by a student's score on a test. The U.S. Department of Education Office of Special Education Programs (OSEP) has made it clear that any guideline or policy violates IDEA if it categorically denies services or limits an IEP team's ability to made decisions based on assessment of students' individual and unique needs [*Letter to Rainforth*, 17 EHLR 222 (OSEP 1990) in Gorn, 1999; Rainforth, 1991].

**Can educational goals be occupational therapy or physical therapy goals?**

Educational goals are discipline-free; that is, they are the goals that a student's educational team decides are appropriate for the student, given a student's unique needs. Goals are not developed in isolation by a specific discipline (e.g., the occupational therapist or the physical therapist). Educational goals, therefore, are not therapy goals.

> "Although it is not specifically stated in the IDEA, a persuasive case can be made considering the legislation as a whole that the unique educational needs of a child with a disability encompass much more than mastery of academic subjects. Rather, unique educational needs should be broadly construed to include academic, social, health, emotional, physical and vocational needs" (Gorn, 1999, p. 3:15).

If a student has sensory-motor concerns, some of the student's educational goals may relate to sensory-motor skills, such as mobility, self-help, attention, self-regulation, handwriting, or similar skills. Depending on the skills of the child and the expertise of other educational team members, including the student's teacher and other related services providers, the team will develop the IEP educational goals. The team will then determine if there is a need for related services. It would be inappropriate for a therapist to make additional therapy goals for the IEP.

**Why might a student need occupational therapy or physical therapy to assist with access to and participation in the educational environment?**

Some activities that take place during a school day are not directly related to helping students achieve their goals but are required for students to remain in the educational environment and have the opportunity to work toward their goals; for example, teachers must

feed some students, change diapers, catheterize, or transfer to a toilet, other students. Students with severe motor impairments often need to have their position changed throughout the day or they may need some means of mobility to move from place to place.

In a landmark U.S. Supreme Court decision in 1984, *Irving Independent School District v. Tatro* 1983-84 EHLR 555:511 (1984), the court said that a school district was responsible for providing clean intermittent catheterization, which a student with spina bifida needed to attend school. The four-part standard that the Court applied could relate to services that an occupational therapist or a physical therapist might appropriately provide. The standard requires that: 1) the student is eligible for the IDEA; 2) the student must need the service to benefit from special education; 3) the student must need the service during the school day; and 4) the service can be provided by a nonphysician (Gorn, 1999).

The services that students need other people to do for them so they can attend school are not written as goals and objectives for the student to achieve. As described in the **IEP** chapter of this document, the IEP team documents these services on the IEP as services that the student will receive so that the student can have access to and participate in the educational environment. The IEP team may decide that occupational therapy is needed, for example, to identify and acquire appropriate eating utensils for a child and teach classroom personnel how to use the equipment, show a paraprofessional how to diaper a student in the restroom, or teach peers how to adjust a lap board for a student who uses the lap board for writing activities.

**Is there a procedure for giving suggestions to a teacher without having a child go through qualifying for special education services? What can therapists do for children who have poor handwriting, but are not in special education?**

There are no simple answers to these questions. Some school districts support and encourage informal consultation; however, it is often difficult to make meaningful recommendations without a full evaluation of a child. A long term solution for handwriting concerns may be for therapists to provide inservices related to handwriting readiness and mastery to kindergarten and first grade teachers. It is appropriate for therapists to provide inservice training to teachers and school staff on any topic related to occupational therapy or physical therapy.

## References - Overview


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## TEAM DECISION-MAKING

### Who are the members of the team?

In special education there are two teams, the multidisciplinary evaluation team that conducts the individual student evaluation, and the IEP team that collaborate to develop the individualized education program for the student. Members of the multidisciplinary evaluation team may be members of the IEP team. For further information on the members of the multidisciplinary evaluation team refer to the **Evaluation** chapter of this document, and for more information on the members of the IEP team refer to the **IEP** chapter of this document. For purposes related to team decision-making this chapter will refer specifically to the IEP team.

### What is the purpose of the IEP team?

The IEP team, through full and equal participation, develops, implements, and reviews a program of special education, related services, supplementary aids and services, and program modifications or supports for school personnel that will be provided as needed for a student with disabilities.

### How does the team function or operate together?

Before establishing an educational program for a student with a disability, the team must arrive at a common framework from which to work. This framework, or basic structure of common ideas, beliefs, or assumptions about education, students/families, and professionals will be unique to each local school district (Giangreco, 1996). Common ideas to consider when building a framework for the team include an understanding of the laws concerning special education, the local environment and educational philosophy, importance of communication, and the choice or model of team interaction. The goal of building a shared framework is to enhance the problem solving ability and effectiveness of the team.

An example of how a team without a shared framework might encounter difficulties is as follows. A student's teacher may expect the therapist to provide a specific list of motor skills to accomplish. At the same time, the therapist plans to help develop team educational goals and objectives. When the team does not establish a shared framework, decision-making and the implementation of services are more likely to be disjointed and fragmented, and roles and expectations among service providers working with the same child become ambiguous (Giangreco, 1996). The teacher may continue to seek specific motor activities and the therapist may become frustrated by being unable to work in the classroom on educationally related skills. Taking time to establish a common framework may prevent the often expressed "we versus they" dilemma that can result in major time-consuming conflicts. The responsibility of the team is to function as a unit.

**What does 'models of team interaction' mean?**

Models of team interaction are defined by the amount and type of collaboration among team members. Types of team models include multidisciplinary, interdisciplinary, or transdisciplinary. In the multidisciplinary model, professionals perform their duties with minimal interaction of team members. For example, in the multidisciplinary model, a therapist would independently evaluate a student, independently establish goals and objectives/benchmarks for the student, and then independently provide services to the student. In this model, the therapist would not collaborate or share information with other team members.

The interdisciplinary team performs professional tasks relatively independently of each other, but shares information and coordinates efforts toward common goals. In the interdisciplinary model, the therapist may perform the evaluation in isolation or with other team members observing. Team members collaborate with the therapist to develop goals and benchmarks and therapists coordinate service delivery with the team members.

The transdisciplinary team employs a high degree of interaction and coordination in tasks, with shared and overlapping roles. In this type of interaction, the therapist gathers evaluation information from all members of the team. The team decides together upon the goals and benchmarks, and coordinates services and training to encourage shared roles of service delivery using one primary service provider. The manner in which an educational team interacts and functions can influence how occupational therapy and physical therapy services are provided, by affecting the amount of team collaboration.

The IDEA uses the term multidisciplinary. Because multidisciplinary was a statutory term, the term could not be updated; however, a new definition was provided in the Rules and Regulation for PL 99-457: "Multidisciplinary means the involvement of two or more disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment activities and the development of the IFSP" (OSERS, Federal Register, June 22, 1989, p.26313). This definition is consistent with the definition of an interdisciplinary model. In Oklahoma, the SoonerStart Early Intervention Program uses a transdisciplinary approach. Growing infants and toddlers do not develop skills in isolation. That is, motor development affects communication, and cognitive development affects motor development. Therefore, early intervention teams use the transdisciplinary model and select a primary service provider who works with the child and family on all areas of development, with consultation from processionals of other disciplines. School districts should strive to employ, at a minimum, an interdisciplinary approach to team interaction.

**How do teams make decisions?**

Giangreco (1995, 1990) describes three types of decision making options; autocratic, democratic, and consensus. Autocratic decision making leads to individual authority, while democratic decision making promotes that the majority rules (Giangreco, 1995,1990). Consensus decision making, allows all members of the team to make collaborative decisions.

The consensus method enhances the collaborative intent of the IDEA. IEP teams should communicate and work together, rather than following an individual agenda and all team members should accept responsibility for the decisions made in the meeting. Team members listen attentively to others and communicate openly their individual observations, results of evaluations, decisions regarding related services and personal perspectives. Training, education, and support of the team are each member's responsibility. Although the IEP team may obtain consensus, it may not have been the first choice of every team member. Yet, all team members agree to come to consensus. The team does not base decisions on (a) unilateral or independent opinions, (b) discipline-specific goals or objectives (Refer to the **IEP** chapter in this document), (c) availability of services, or (d) category of disability.

**How is disagreement within the team resolved?**

Team consensus enhances services provided to students. If a team member disagrees with a therapist's decision, the occupational therapist and the physical therapist should ask that specific team member to explain the areas of concern. The therapist would then further describe how therapy services will or will not provide support to the student's individualized education program. Following additional dialogue and often developed new collaborative ideas between team members, the team should be able to come to consensus. If a team member is unable to agree with the team consensus, that team member may choose not to sign the IEP. Parents are provided procedural safeguards under the IDEA. If a parent disagrees with an IEP consensus decision, the parent may seek resolution of any disagreements by initiating an impartial due process hearing. Every effort should be made to resolve differences through voluntary mediation or other informal steps without resorting to a due process hearing [34 CFR Appendix A (II.8.) to Part 300]. Refer to the *Policies and Procedures for Special Education in Oklahoma* for additional information on mediation and due process.

**Who determines the Least Restrictive Environment (LRE)?**

As stated in the *Policies and Procedures for Special Education in Oklahoma*, "The purpose of the LRE requirement is to ensure that, to the maximum extent appropriate, children with disabilities receive instruction with children who do not have disabilities." The *Policies and Procedures for Special Education in Oklahoma* also say that the IEP team determines LRE placement based on the child's IEP; therefore, occupational therapists and physical therapists participate in decision making for LRE. Occupational therapists and the physical therapists can facilitate students in LRE to succeed. Therapists have specific skills that can improve the student's quality of experience in the LRE. For example, therapists might provide appropriate positioning for a student to enable that student to sit in the typical 6th grade desk, or adapt a playground swing to enable a student in kindergarten to swing during recess.

**How do teams decide whether an OT or PT would best meet the student's needs?**

Related services (OT and PT) provide services to assist the student to benefit from special education. When deciding which service providers should deliver the services, the service provider with the most appropriate expertise available to assist the student to benefit from special education (IEP goals and objectives/benchmarks) should be chosen. Individual therapists have varying areas of expertise, interests, and limitations. The team decides, using information provided by the related service provider, which individual team member can best assist the needs of the student. As an example, if the team occupational therapist was interested in orientation and mobility and had attended several continuing education courses, and the physical therapist did not have skills in this area, it would be more appropriate for the occupational therapist to provide services in orientation and mobility to a student with these needs rather than the physical therapist. Additionally, if the physical therapist had more expertise, than the occupational therapist, in an area traditionally thought of as an occupational therapy skill area, it again, would be more appropriate for the physical therapist to provide the services for a student with these needs.

**How are decisions regarding frequency of OT and PT services made?**

The IEP team, through consensus, decides the frequency of services. The team cannot establish frequency and type of service provision based on student category nor on availability of services, (see the **Intervention** chapter in this document) rather frequency and duration must reflect the individual student's needs to achieve IEP outcomes and to assist the child to benefit from special education in the least restrictive environment.

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## EVALUATION

The IDEA defines initial evaluation as the procedures used *"to determine whether a child is a child with a disability and to determine the education needs of such a child"* [20 USC 1414(a)(1)(B)]. A full and individual evaluation shall be conducted before a child with a disability receives the initial provisions of special education and related services and the agency proposing to conduct the initial evaluation (and any reevaluations) shall obtain an informed consent from the parent of the child before the evaluation is conducted [20 USC 1414(a)(1)(A),(a)(1)(C)(i),& (c)(3)].

**How does the referral and evaluation process work in Oklahoma?**

The evaluation process begins with the *Review of Existing Data.* This form provides essential information for planning an appropriate evaluation by listing teacher concerns, efforts made to help the student in class, parental concerns, and background information. If it is determined that a multidisciplinary evaluation is necessary, districts must obtain parental consent and therapists must consent to evaluate a student.

When a district refers a student for a multidisciplinary evaluation, the *Multidisciplinary Evaluation and Eligibility Team Summary (MEETS)* is initiated. The plan includes specific referral concerns, suspected disability areas to be assessed, types of tests and evaluation procedures, and personnel involved. In the sections that the therapist addresses (ex. motor, developmental, adaptive behavior, observation in class, vocational, perceptual, and other) it is best for the therapist to write OCCUPATIONAL THERAPY EVALUATION and/or PHYSICAL THERAPY EVALUATION to allow therapists freedom in selecting the evaluation procedure for each student. Parents provide needed and valuable information at this level in the evaluation process.

The *Multidisciplinary Evaluation and Eligibility Team Summary (MEETS)* is completed when the team meets and discusses evaluation results and conclusions. The team must schedule a meeting with the parents within 15 school days of obtaining the necessary evaluation results and data. The IEP team must convene within 30 calendar days after determining a child is eligible for special education and related services. Although it is not mandatory for therapists to attend the MEETS meetings, best practice recommends that therapists attend them, if possible, to facilitate a coordinated evaluation plan and provide a clear interpretation of findings for the parents.

The team conducts a *reevaluation* if conditions warrant a reevaluation, or if the child's parents or teacher request a reevaluation. But the team must conduct a reevaluation at least once every three years [20 USC 1414(a)(2)(A)]. The IEP review addresses the reevaluation and parents should participate in planning the reevaluation as members of the IEP Team. The team reviews existing data and determines what reevaluation data is necessary: the present levels of performance and educational needs of the child; whether the child needs special education and

related services; or to decide whether the child continues to have a disability; whether any additions or modifications are needed to enable the child to meet the measurable annual goals set out in the IEP of the child and to participate, as appropriate, in the general curriculum [34 CFR 300.533]. The team does not have to retest areas ruled out on the initial evaluation unless conditions have changed. Therapists do not have to use the same evaluation methods that were used in the initial evaluation, but they should review the student's IEP goals.

*Independent Education Evaluation*: Parents have the right to an independent evaluation at public expense it they disagree with an evaluation obtained by the local education agency (LEA). An examiner who is not employed by the LEA and meets SDE approved licensure and certification may perform these evaluations. Qualifications of the examiner must meet criteria established by OSDE/SES. Although local therapists at hospitals or private practices may do an independent evaluation, a school-based therapist employed by another district would be the best choice for this type of evaluation. The evaluator should be familiar with the focus of school therapy and its relevance to the educational process and the evaluation should be performed in the school setting.

**What is the responsibility of the occupational therapist and physical therapist in the evaluation to determine if a child has a disability?**

The IDEA states that the determination of whether the child is a child with a disability shall be made by a team of qualified professionals and the parent of the child [20 USC 1414(b)(4)(A)]. Occupational therapists and physical therapists can contribute to evaluations that decide if a student has a disability, as defined under IDEA. In Oklahoma, therapists can help in identifying and documenting a developmental delay - usually in motor-related areas for young children. For older students, occupational therapists and physical therapists may contribute to identifying and documenting a student's disability category. An evaluation of motor functioning by a licensed occupational therapist and physical therapist or both must be included as a component of a comprehensive evaluation when orthopedic impairment is the suspected disability. Evaluations of motor skills may be included in comprehensive evaluations when the suspected disability category is mental retardation, multiple disabilities, or developmental delay. An evaluation of a student's sensorimotor/perceptual abilities may be included when the suspected disability category is autism or traumatic brain injury, and evaluation of motor skills may be necessary for specific health conditions that have motor characteristics for the category of other health impaired. NOTE: In Oklahoma, a physician's prescription in not required for an evaluation by an occupational therapist or a physical therapist. A physician's prescription **is** required for physical therapy intervention.

**What types of evaluations tools are appropriate and are therapists required to use specific tests?**

Many evaluation tools are available to therapists. By using a combination of procedures therapists will perform thorough evaluations to obtain useful information about the student's needs. Neither the IDEA nor the *Policies and Procedures for Special Education in Oklahoma*

require therapists to use specific tests or types of tests. The IDEA gives only general requirements for evaluation, which apply to all evaluation procedures:

> *In conducting the evaluation, the LEA shall (A) use a variety of assessment tools and strategies to gather relevant functional and developmental information, including information provided by the parent, that may assist in determining whether the child is a child with a disability and the content of that child's IEP, including information related to enabling the child to be involved in and progress in the general curriculum or, for preschool children, to participate in appropriate activities; (B) not use any single procedure as the sole criterion for determining whether a child is a child with a disability or determining an appropriate educational program for the child; and (C) use technically sound instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors* [20 USC 1414(b)(2)(A)-(C)].

The IDEA gives additional requirements to the LEA's *" . . . Tests and other evaluation materials used to assess a child are selected and administered so as not to be discriminatory on a racial or cultural basis; and are provided and administered in the child's native language or other mode of communication, unless it is clearly not feasible to do so"* [20 USC 1414(b)(3)(A)(i)-(ii)]. This means that occupational therapists and physical therapists to the best of their ability must ensure that students understand test instructions, and that testing procedures are not culturally or racially biased. A child, for example, who does not walk the circle as specified by the *Peabody Developmental Motor Scales* (Folio & Fewell, 1983) may have adequate motor skill but simply not understand what is expected. Sometimes demonstrations will take care of this problem.

Therapists must also ensure that any standardized tests *"have been validated for the specific purpose for which they are used; are administered by trained and knowledgeable personnel; and are administered in accordance with any instruction provided by the producer of such tests"* [20 USC 1414(b)(3)(B)(i)-(iii)]. Before choosing a tool it is important to consider its purpose, and the reliability, validity and the usefulness of the information it gives to the therapist. Many of the published tests used by occupational therapists and physical therapists were developed for specific purposes and for children within a specific age range. The four main purposes of evaluations are; discriminative, predictive, evaluative, and program planning (Harris & McEwen, 1996; Kishner & Guyatt, 1985).

Discriminative measures discriminate between children who have and do not have a particular characteristic. They are useful in determining student eligibility for programs but are not helpful for program planning or evaluating outcomes. Predictive measures predict the future status or performance of a child. Evaluative measures identify change or lack of change over time and attempt to identify effects of intervention. Program planning measures identify goals and help determine intervention strategies. Therapists should appropriately choose evaluation tools understanding the purpose of the particular measure. In school-based settings, therapists should primarily use program planning measures and evaluative measures for evaluation of a student prior to the IEP. The School Function Assessment (Coster, Deeney, Haltiwanger, &

Haley, 1998), is a good example of a program planning tool that can be used with elementary aged students.

A common misuse of tests is to administer instruments designed for infants and young children, such as the *Bayley Scales of Infant Development* (Bayley, 1993), to older children with severe motor impairments. Information obtained from such misuse of tests serves no valid purpose -- it is not useful to identify children with developmental delays (the delays are obvious), it is not useful for prediction purposes, and it is not useful for program planning or evaluation of outcomes (the test items are not individually meaningful or age appropriate).

The evaluator must administer standardized tests and other tests with instructions as specified by the test manual. Sometimes it is necessary to modify instructions, such as demonstrating test items instead of giving oral instructions to a child with a hearing impairment who does not sign. Evaluators must document if they deviate from the instructions, and they must interpret test results cautiously, considering the alterations in test administration. Best practice does not recommend therapists evaluate using only a norm referenced (standardized) test. Standardized tests will not give a clear picture of the child's performance in different environments at school. Furthermore, neither the IDEA nor the *Policies and Procedures for Special Education in Oklahoma* require therapists to give percentiles or standard deviations on evaluation reports because related services' do not determine eligibility for special education and related services. (One exception is the developmental delay category if the motor areas are the main area of concern for special education.). Observing the student in the school environment is one of the most useful ways to gather information on educational needs. Interviews with parents and teachers also provide a large amount of information in a relatively short amount of time. Table 1 illustrates various evaluation tools.

Table 1
Types of Evaluation Tools

| TYPE OF EVALUATION TOOL | DEFINITION | EXAMPLE & PURPOSE |
|---|---|---|
| TESTING OF NEUROMOTOR BEHAVIORS | Testing of reflexes, stiffness, and responses to movement. Most useful for prediction and diagnosing. Not helpful in treatment planning (Haley, 1994). | Pathologic reflex testing, testing muscle stiffness; Most useful in identifying and classifying disability. |
| NORM REFERENCED DEVELOPMENTAL TESTING | Scales designed to compare the development of children being evaluated to other children of the same age. A norm is the normal or average performance of the population of interest (Palisano, 1994). | Peabody Developmental Motor scales test gross and fine motor skills in the normal developmental sequence. Usually used for identification and determining need for services. May be used for program planning in students with mild delays. |
| CRITERION REFERENCED TESTING | Scales designed to compare the performance of a child with the external criteria for standards for a particular domain (Palisano). *Curriculum Based Assessments* are examples which measure student achievement specific to the content in the school curriculum (Palisano, 1994). | Hawaii Early Learning Profile for Preschoolers, Goal Attainment Scaling, Useful for program planning and evaluating outcomes of test items. |
| MOVEMENT ANALYSIS | A series of methodologies to assess quantity and quality of movement. They focus on movement, not task completion (Haley, 1994). | Gait analysis, evaluating classroom self care tasks. Developing appropriate programming, and evaluating educational outcomes. |
| JUDGMENT BASED ASSESSMENTS | Scales or questionnaires used to collect, structure and quantify the impressions of professional and care giver about a child's performance (Haley,1994) | Pediatric Evaluation of Disability inventory, useful for determining need for services, programming, evaluating educational outcomes. |
| OBSERVATION OF NATURALISTIC MOVEMENT | Observation of movement in the setting in which it naturally occurs with no constraint on physical location or specific activity (Haley,1994). | Useful for all purposes of evaluation. |
| ECOLOGICAL ASSESSMENTS | An ecological assessment is an approach. There are 4 steps:<br>1)Determine domains to be included in the child's program<br>2)Determine environments and subenvironments in which the child functions<br>3)Determine activities the child needs to function in each environment<br>4)Determine the skills the child needs for each activity. (McEwen, 1994). | Useful for all purposes of evaluation. |

** For further information on ecological assessments read:
McEwen, I. R. (1994). Mental retardation. In S .K. Campbell (Ed.), Physical Therapy for Children. Philadelphia, Pa: WB Saunders Co.

**Do therapists have to document students' age-equivalent scores?**

No, the IDEA does not require documentation of a student's "motor age" or age-equivalent in other areas of development, except for eligibility purposes for the category of developmental delay. As discussed in the **IEP** chapter of this document, it is more useful to describe what a student can and cannot do in personally meaningful language (i.e., without jargon and medical terms) than to report age-equivalent scores. This is especially true when students' age-equivalent scores are far below their chronological ages. Knowing that a 6-year-old student has a fine motor age equivalent score of eight months and a gross motor age equivalent score of five months, for example, tells the team nothing that helps to plan an appropriate program for the child.

**Is there a framework or tool available which helps therapists evaluate all areas of the student need?**

A health status or disablement model can provide occupational therapists and physical therapists with a useful framework for organizing both assessments for program planning purposes and evaluation of outcomes. Disablement is a term that "reflects all of the diverse consequences that disease, injury or congenital abnormalities may have on human functioning at many different levels" (Jette, 1994). Several disablement models exist, including the World Health Organization's (WHO) International Classification of Impairment, Disability, and Handicap (1980) and the Nagi scheme (1965). Jette (1994) defines disablement as a global term that reflects all the diverse consequences that disease, injury, or congenital abnormalities may have on human functioning at many different levels. More recently, the National Center for Medical Rehabilitation Research (NCMRR) has developed a five component model based on earlier schemes by Nagi and the WHO. This model is a useful framework for the evaluation of children (McEwen & Shelden, 1995). The five components of the NCMRR framework are Pathophysiology, Impairment, Functional Limitations, Disability and Societal Limitations. An understanding of each dimension can help therapists to plan assessment and intervention, and measure goals and objectives appropriately (McEwen & Shelden, 1995). Table 2 explains the dimensions of the disablement framework.

A comprehensive motor assessment may address all the dimensions of the disablement framework, using multiple procedures, including testing neuromotor behaviors, criterion and norm-referenced testing, and observation in the natural environment.

***Practical application:*** A therapist evaluates the impairments of a six and one-half-year-old child with spastic diplegia by testing reflexes, examining muscle tone and checking range of motion. The therapist then chooses a criterion-referenced test, the Gross Motor Function Measure to examine impairments (weight shift) and functional limitations (inability to rise from the floor or sit unsupported). To gain information on disability, the therapist observes the student in class using an ecological assessment of toileting skills, classroom mobility, and getting a drink of water. The therapist may use judgment-based assessments by interviewing the teacher

to collect information about the student's performance (inability to participate in PE because coach does not feel comfortable with students with disabilities).

Table 2
The National Center for Medical Rehabilitation Research (NCMRR) Classification Schema Applied to a Child with Cerebral Palsy

| |
|---|
| **Pathophysiology:** Interruption of normal developmental and physiological processes. Intervention at this level usually involves physicians and researchers. (McEwen & Shelden, 1995). *A child with cerebral palsy has brain damage or malformation.* |
| **Impairment:** Loss and/or abnormality of cognitive, emotional, physiological, or anatomical structure or function and includes secondary impairments not attributable to the initial pathophysiology. *As a result of pathophysiology, the child with cerebral palsy may have excess muscle contraction, and poor control of posture and balance, with a secondary impairment of range of motion limitations.* |
| **Functional Limitations:** Restriction or lack of ability to perform an action in the manner or range consistent with the purpose of an organ or organ system. *If a child's impairments are of sufficient magnitude, they will result in functional limitations, such as inability to reach, grasp, sit, or walk.* |
| **Disability:** Inability or limitation in performing tasks, activities, and roles to levels expected within physical and social contexts. Functional limitations may or may not lead to disability, or may lead to a disability under some conditions and not others. *A child with cerebral palsy who cannot walk can fulfill expected roles related to mobility by using a wheelchair (not have a disability), but have a disability in other roles such as self care.* |
| **Societal Limitation:** Restriction due to social policy or barriers (structural or attitudinal), which limits fulfillment of roles or denies access to services and opportunities associated with full participation in society. *A child who uses a wheelchair but faces architectural barriers is limited by societal attitudes and actions.* |

Taken from: McEwen, I. R., & Shelden, M.L. (1995). Pediatric therapy in the 1990s: the demise of the educational versus medical dichotomy. Physical and Occupational Therapy in Pediatrics, 15, 33-45.

**What areas should therapists include in evaluation reports?**

Therapists must write evaluation reports that are concise and written in terms that teachers, administrators, and parents easily understand. Evaluation results must explain how motor deficits influence education and give recommendations that are useful to teachers. Though therapists may want to give recommendations, they must be careful not to give specific goals or frequency and duration recommendations in evaluation reports. Therapists should discuss the student's adaptive and motor needs but decisions on service frequency and delivery should be determined at the IEP team meeting.

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## INDIVIDUALIZED EDUCATION PROGRAM (IEP)

### What is an IEP?

Public Law (PL) 94-142, the Education for All Handicapped Children Act (EHCA) of 1975, originally introduced all of the requirements of the Individualized Education Program (IEP). The IEP actually consists of two entities; the IEP meeting and the IEP written document. During the IEP meeting the parents and the school personnel collaborate to develop, review, and revise an educational program for the student (34 CFR 300.340). Those attending the meeting, as well as other individuals prominent in securing the educational program for the student, are considered part of the IEP team.

### How does a student become eligible for an IEP?

If a student is having difficulty progressing in the general curriculum or, for preschool children, participating in appropriate activities, a teacher or other school personnel may, after providing student adaptions or modification, refer the student for a multidiciplinary evaluation. The evaluation and identification process determines student eligibility for special education and related services. After eligibility is determined, an IEP is developed for the student (see the **Evaluation** chapter of this document and the *Policies and Procedures for Special Education in Oklahoma*). The evaluation process encompasses the following components: (a) parental consent, (b) a multidisciplinary evaluation team who evaluates the child in all areas related to the suspected disability, and (c) team decision-making to decide if the child fits the federal category or disability definitions and determines if the child needs special education and related services (see the chapter on **Occupational Therapy and Physical Therapy Services in the School Setting: An Overview** in this document).

### How soon after the evaluation, in which the student is determined eligible for special education, must the IEP be written?

Refer to the *Policies and Procedures for Special Education in Oklahoma* for updated rules and regulations related to time lines. The initial IEP meeting must be conducted within 30-days of a determination that the child needs special education and related services [34 CFR 300.343(b)(2)]. The LEA notifies the parents in writing within adequate time to attend this initial, and all subsequent, IEP meetings. Note, however, that the IDEA has no specific timetable for implementing the IEP that results from the meeting. However, the IEP should be *"implemented as soon as possible following the [IEP] meeting"* [34 CFR 300.342(a)(1)(ii)] and the IEP must be in place before special education and related services can be provided [34 CFR 300.342(a)(1)(i)].

### Who are the members of an IEP team? (OR, Must the occupational therapist and physical therapist be present?)

According to 20 USC 1414(d)(1)(B) and 34 CFR 300.344(a) the IEP team means a group

of individuals composed of:

*i) the parents of a child with a disability;*

*ii) At least one regular education teacher of such a child (if the child is, or may be participating in*

*iii) at least one special education teacher, or where appropriate, at least one special education provider of such child;*

*iv) a representative of the local educational agency who is qualified to provide, or supervise the provision of specially designed instruction to meet the unique needs of children with disabilities, is knowledgeable about the general curriculum, and is knowledgeable about the availability of resources of the local educational agency;*

*v) an individual who can interpret the instructional implications of evaluation results;*

*vi) at the discretion of the parent or the agency, other individuals who have knowledge or special expertise regarding the child, including related services personnel as appropriate; and*

*vii) whenever appropriate, the child with a disability*

**Must occupational therapists and physical therapists attend IEP meetings?**

Occupational therapists and physical therapists are not required to attend IEP meetings, but should make every effort to attend meetings for students who receive therapy services or who might need occupational therapy or physical therapy as a related service. Decisions about students' educational programs, including related services, are made at IEP meetings; therefore, the best time for physical therapists to provide input and hear the input of the rest of the team is during the meeting. As noted above, "*at the discretion of the parent or the agency, other individuals who have knowledge or special expertise regarding the child, including related services personnel as appropriate compose the IEP team*." Further, because IEP goals should be discipline-free and generated by the IEP team, therapists should not submit "OT goals" or "PT goals" before a meeting takes place. The only way a student's need for therapy and goals of therapy can be determined is through the IEP process.

**What do you mean never include occupational therapy or physical therapy goals in an IEP?**

A student's annual goals should be goals that guide the student's educational program. Identifying "physical therapy goals" or "occupational therapy goals" leads to therapy being an isolated service, rather than a related service that directly assists a child to benefit from the educational program. The student's goals should be discipline-free; that is the team decides which goals are most important for the student to accomplish, without regard to the discipline usually associated with them. The IEP team determines the annual goals, through contribution and expertise of all members, and then identifies the people who will help the student achieve the identified goals.

**If therapists do not attend the IEP meeting, should they turn in their annual goals and objectives before the meeting?**

No, therapists should not include "physical therapy goals" nor “occupational therapy goals” in an IEP either prior to or during the IEP meeting. Presenting discipline specific goals negates the contribution of the entire team. Rather, all team members should come prepared, or provide information if unable to attend, to focus on the individualized, unique, educational needs of the student. The purpose of the meeting is to plan, through full and equal team participation, a program of special education and related services, with modifications as needed for the student.

As an example, if a physical therapist noted a decrease in a student's stair climbing skills, the therapist might feel it important to write a student goal related to stair climbing. The consensus of the rest of the team members, the student included, might decide that stair climbing was not an important goal at this time, particularly since the student has no opportunity to climb stairs during the day or at home. Perhaps the team might choose self-feeding as a more meaningful goal. Without a routine opportunity or an incentive to climb stairs it would be difficult for the student to obtain a goal of stair climbing. Though the student is developmentally behind in the skill of stair climbing, stair climbing was not an immediate nor important need for the student. The student, however, will have many opportunities to practice feeding both at school and at home.

During the IEP meeting, the IEP team makes decisions by consensus. It would be acceptable for a therapist, unable to attend the IEP meeting, to provide prior to the IEP meeting, written information and suggestions related to the student. This information might include present levels of educational performance, strengths, weaknesses, and specific skill information from the team occupational therapist or physical therapist related to the student's goals. For more information about the decision-making process refer to the **Team-Decision Making** chapter of this document.

**Where should the team hold the IEP meeting?**

Addressed within the notification of meeting to parents are the mutually agreed upon time and place of the IEP meeting (34 CFR 300.345). Customarily, the team holds the meeting during school hours, where the child attends school, and in a comfortable room that encourages open communication of all team members (Bateman, 1992).

**Is the same written IEP form/document used across states?**

No, individual states and some individual districts have created their own IEP document appropriate for their public agencies, which is inclusive of and adheres to all federal and state legislative guidelines relating to the IEP document. There is no federally mandated format nor requirement for specific length of the document. The Oklahoma State Department of Education, Special Education Services (OSDE/SES) has developed an IEP that is used throughout the state. The instructions, in draft form, for completing this IEP are printed in **Appendix E**. The

OSDE/SES IEP is also printed in the *Policies and Procedures for Special Education in Oklahoma* and can be located on OSDE's web page: www.sde.state.ok.us.

**What are the legal requirements of the IEP?**

The IEP document is a legally bound commitment of resources that addresses the unique needs of the student. According to 20 USC 1414(d)(1)(A), minimally the IEP document must contain the following information:

*(i) a statement of the child's present levels of educational performance, including -*
- *(I) how the child's disability affects the child's involvement and progress in the general curriculum: or*
- *(II) for preschool children, as appropriate, how the disability affects the child's participation in appropriate activities;*

*(ii) a statement of measurable annual goals, including benchmarks or short term objectives, related to-*
- *(I) meeting the child's needs that result from the child's disability to enable the child to be involved in and progress in the general curriculum, 'or for preschool children as appropriate, to participate in appropriate activities' [34 CFR 300.347(a)(20)(i)]; and*
- *(II) meeting each of the child's other educational needs that result from the child's disability;*

*(iii) a statement of 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 for the child -*
- *(I) to advance appropriately toward attaining the annual goals;*
- *(II) to be involved and progress in the general curriculum in accordance with clause (i) and to participate in extracurricular and other nonacademic activities; and*
- *(III) to be educated and participate with other children with disabilities and nondisabled children in the activities described in this paragraph;*

*(iv) an explanation of the extent, if any, to which the child will not participate with nondisabled children in the regular class and in the activities described in clause (iii);*

*(v) (I) a statement of any individual modifications in the administration of State or district wide assessments of student achievement that are needed in order for the child to participate in such assessment; and*
- *(II) if the IEP Team determines that the child will not participate in a particular State or district wide assessment of student achievement (or part of such an assessment), a statement of -*
  - *(aa) why that assessment is not appropriate for the child; and*
  - *(bb) how the child will be assessed;*

*(vi) the projected date for the beginning of the services and modifications described in clause (iii), and the anticipated frequency, location, and duration of those services and modifications;*

*(vii)* *(I)* *beginning at age 14 "or younger, if determined appropriate by the IEP team"[34 CFR 300.347(a)(7)(ii)(B)], and updated annually, a statement of the transition service needs of the child under the applicable components of the child's IEP that focuses on the child's course of study (such as participation in advanced-placement courses or a vocational education program);*

*(II)* *beginning at age 16 (or younger, if determined appropriate by the IEP Team), a statement of needed transition services for the child, including, if appropriate, a statement of the interagency responsibilities or any needed linkages; and*

*(III)* *beginning at least one year* {age 17 in Oklahoma} *before the child reaches the age of majority* {age 18 in Oklahoma} *under State law, a statement that the child has been informed of his or her rights under this title, if any, that will transfer to the child on reaching the age of majority under section 615(m); and*

*(viii)* *a statement of-*

*(I)* *how the child's progress toward the annual goals will be measured: and*

*(II)* *how the child's parents will be regularly informed (by such means as periodic report cards), at least as often as parents are informed of their nondisabled*

*(aa)* *their child's progress toward the annual goals described in clause (ii);and*

*(bb)* *the extent to which that progress is sufficient to enable the child to achieve the goals by the end of the year.*

**Practical application:** Sample IEP statements

*Present level of educational performance*: Kim is functioning academically at her expected grade level (1st grade), and she is motivated and eager to learn. She is unable to manipulate a pencil for writing/class work, but she can hold a crayon and color if it is placed in her hand. Kim can use a mouse to play computer games, and spell her name. Kim is unable to walk, but uses a power wheelchair independently in the classroom and on the school campus. Kim in nonverbal and uses uncommon signs/gestures for communication. Kim is not toilet trained, and cannot independently access the classroom toilet. Kim has frequent urinary tract infections.

*Annual goals and benchmarks*: see section on annual goals within this chapter.

*Supplementary aids and services*: Kim will use a supine stander during math class.
Jordan needs to wear his foot splints during recess and P.E.

**What should annual goals address?**

1) Annual goals should be <u>functional</u>. Functional refers to activities that another person must do for a student if the student cannot do them independently (e.g., getting to class on time, eating lunch independently, playing safely on the playground, writing one's name on class work, deciding which book to read during free reading time) (McEwen, 1992). Functional also means that the student will be active: that is the student will <u>do</u> something (i.e., the student will get his own lunch, the student will do math problems) (Brown, et al., 1979). It is important to differentiate things that people will do for the student, such as acquiring a wheelchair, from things the <u>student will do</u> (McEwen, 1992).

Things that other people do are not written into the IEP as goals. These are written as services to be provided. It also is important to avoid making goals of passive activities the student will do, such as "tolerate" standing or "participate" in a toileting program. Instead, either state the active behavior the student will accomplish or write the passive activity as a service to be provided in another section of the IEP, such as the comments section.

2) Annual goals should be discipline-free. Discipline-free goals are goals that the team decides are the most important for the student to accomplish, without regard to the discipline usually associated with them (Brown, et al., 1979). The goals are the student's goals; they are not classroom goals, occupational therapy goals, physical therapy goals, and so on. In the IEP meeting, all team members decide upon the annual goals together. Each team member contributes to the development of the IEP by providing information from their own points of view and disciplinary perspectives to identify the most important and achievable goals for the student (University of Oklahoma Health Sciences Center, 1995).

3) Annual goals should be chronologically age appropriate. Students should be engaged in activities in which peers of the same age would participate (Brown, et al., 1979). For example, it would be inappropriate for an 8-year-old male with severe cognitive and motor delays to be playing with a baby doll or a busy box on a mat on the floor. If the goals for the student addressed independent play, cause and effect, or both, perhaps a soft baseball or a super hero toy could replace the baby doll and a tape recorder (with the student's favorite songs), radio, or a computer with switch access could replace the busy box. Additionally, most students should be upright, rather than lying on the floor when engaging in school activities. Occupational therapists, physical therapists, and other service providers must be creative to develop age appropriate activities for students, particularly for students with severe disabilities.

4) Annual goals should be meaningful. Meaningful goals are goals that the student, family, and other IEP team members think are particularly important for the student to learn. If goals are meaningful then the student will be self-gratified with goal accomplishment (Brown, et at. , 1979). Self-gratification is a motivator in obtaining specific tasks or goals. A nonmeaningful goal is one that the student and family have no interest in. As an example, the student will stack four square blocks in one minute. A more meaningful goal is the student will put the cups away after snack. In this example, the student puts the cups away by stacking them on the shelf. The student may need to work on the motor skill of stacking, but the skill is embedded in a more functional goal. Putting the cups away at school may be more meaningful for a student if the student has the same responsibilities/chores at home. If the child receives an allowance for putting away cups and dishes at home, then putting away the cups at school may be more meaningful to the student than stacking blocks.

5) Annual goals should include activities that will be frequently used across a variety of environments (Brown, et al., 1979). Frequency provides many opportunities to learn. Students are in school for only a small part of their lives, therefore, educational goals need to address tasks/activities that students will do often on a daily basis, in the future and within a variety of environments. If a physical therapist works with a student to squat, pick up a beanbag, and then stand to throw the beanbag in a bucket, but the student has no opportunities to practice similar activities outside the therapy session, the benefit of the activity is questionable. Similarly, working on a more functional activity, such as getting a drink from a particular drinking fountain, is unlikely to be either important or learned unless the student has many opportunities to drink from similar drinking fountains (McEwen, 1992). Some examples of frequently used activities that students use across a variety of environments include; drinking from a straw, unbuckling a seat belt, transferring to a toilet, using a computer, writing one's name (either with a pencil or with a word processor), and communicating effectively.

6) Annual goals should meet present and/or future needs of the student to benefit from their educational program (Brown, et al., 1979). Many students with disabilities take a long time to learn a few things. For this reason, it is important to select the most important goals and to select goals that will not only meet present needs, but will meet the student's needs in the future. We cannot assume that by working on "prerequisite" skills a student will eventually accomplish skills needed in the future. Examples of goals that probably will not meet future needs are developmental activities that are rarely used by adults, such as walking on a balance beam, using play money, and naming pictures. Some goals that could help to meet future needs include independent mobility, bearing weight to assist with transfers, and learning to use assistive technology devices for functional purposes.

The OSDE/SES, in their IEP instructions, state that annual goals are measurable statements describing how the child's educational needs, resulting from the disability, and needs in the general curriculum can be reasonably met.

**Practical application:** Sample IEP goal and objective/benchmark statements.

I. Jose will get his own lunch and eat with his classmates.
   A. Jose will carry his lunch, using an adapted tray, from the lunch line to the 3rd grade table, each day during lunch time.
   B. Jose will hold and balance his adapted tray, without dropping, in the lunch line each day while reaching for and placing his milk carton and eating utensils on his tray.

I. Jasmine will get to all of her classes on time by independently accessing her school environment.
   A. Using her power wheelchair with assistance for door opening only, Jasmine will get to all of her first floor classrooms within three minutes of the class start time every day.

B. Jasmine will move through the school campus with assistance for door opening only, every day.
C. Jasmine will get from her last period class to the school bus within five minutes of the dismissal bell.

**Who decides if occupational therapy or physical therapy should be included in the IEP?**

After the team identifies the educational goals and objectives, and determines the placement decision, the team decides which professionals are needed to "assist the student" in achieving educational goals, or with access to and participation in the educational environment. (see the **Occupational Therapy and Physical Therapy Services in the School Setting: An Overview** chapter of this document). Note that related services should not be determined by a student's test scores on a test.

**May parents decide the amount of therapy a student will receive?**

Parents may make a recommendation. It is not appropriate for parents or professionals to make recommendations based solely on the child's diagnosis or disability, or without considering the recommendations of the rest of the IEP team. It is more appropriate to focus on the outcomes desired for the child (the goals), determine the type of expertise needed to achieve those outcomes, and then determine who on the team has that expertise and how much time will be required. If the desired outcome for a child is to walk to the cafeteria, for example, the team my need guidance from the physical therapist. Depending on the knowledge and skills of other team members, that guidance may be five times per week or only one time per month. It also may be that an occupational therapist who already works with the child can address this need, or that the child's special education teacher has the necessary knowledge and skill and does not need support from a related services provider.

**Must occupational therapists and physical therapists document the amount of their services to be provided in terms of hours or minutes on the IEP?**

Yes. The IEP must specify the amount of services to be provided *"so that the level of the agency's commitment of therapy resources will be clear to parents and other team members"* [34 CFR Appendix A (IV. 35.) to Part 300]. The IEP must include a statement of the anticipated frequency, location, and duration of special education, related services and supplementary aids and services [20 USC 1414(d)(1)(A)(vi)]. The Office for Special Education Programs (OSEP), however, does not require the school districts to specify the amount of services to be provided in terms of daily hours and minutes to comply with the IDEA, unless the nature of the service lend itself to such description (Gorn, 1997). When on the other hand, the service is one that cannot be expressed meaningfully by use of a daily allocation, then an estimated weekly allocation should be included (Gorn, 1997).

The amount of related services "to be provided to a child may be stated in the IEP as a range . . . (i.e., three times per week for 30-45 minutes per session) only if the IEP team determines that stating the amount of services as a range is necessary to meet the unique needs of

the child." "A range may not be used because of personnel shortages or uncertainty regarding the availability of staff" [34 CFR Appendix A (IV. 35) to Part 300]. The OSDE/SES IEP states "the amount of service needed for the child should include the amount of time per session or per day and the frequency per week or per month (e.g., 30 minutes per day, five days a week, 30 minutes one time per month, etc.). The frequency description should not lock therapists into providing services only on a specific day of the week, each week (e.g., only on Thursday mornings at 10:00 a.m.). Therapist necessity in making phone calls to vendors and doctors, attending IEP meetings, and consulting with teachers and parents should allow for flexibility in the IEP and not be negated when determining frequency.

**When are placement decisions decided?**

In Oklahoma, initial placement decisions, which determine the specific placement option or facility in which a student's IEP can be implemented, are made by the IEP team. This placement decision does not necessarily decide the student's specific classroom or teacher. The team bases placement decisions on the completed IEP and considers the most appropriate educational services and environment for the student. In the past, IEP teams often placed students in programs or classrooms based on their disabilities, rather than designing programs to fit the unique needs of the student. As an example, placing all students with mild cerebral palsy in an orthopedically handicapped classroom rather than placing them in age appropriate general curriculum classroom would not be an appropriate placement. An individual team member should not make placement decisions nor should the team make decisions without regard to the previously established educational goals, objectives, and service needs. Each local education agency shall ensure that the parents of each child are members of any group that makes decisions on the educational placement of their child [20 USC 1414(f)]. The IEP will determine where services will be delivered in the least restrictive environment.

The IEP team reviews placement decisions at least annually. Students in Oklahoma should be served as close as possible to their home and are to be placed in the least restrictive environment with the most appropriate individualized program. The LEA must make available a continuum of alternate placements and must consider any potential harmful effects on the student or on the quality of services the student needs. Continuum of placements may include, for example, regular classes full time, special classes part time, special classes full time, or instruction in home, hospital or other setting. School districts must educate students with disabilities with their typical peers to the maximum extent possible. Teams may decide to remove students with disabilities from the regular educational environment only when the "nature or severity of the disability is such that education in regular classes cannot be achieved satisfactorily, even with the use of supplementary aids and services" (OSDE/SES IEP).

**What are supplementary aids and services?**

*"Supplementary aids and services means aids, services, and other supports that are provided in regular education classes or other education-related settings to enable children with disabilities to be educated with nondisabled children to the maximum extent appropriate in the*

*least restrictive environment"* (34 CFR 300.28).

Supplementary aids and services for the child or on behalf of the child must be described in the child's IEP if these services are necessary to assist the child to advance toward attaining annual goals, to be involved and progress in the general curriculum, and to participate in extracurricular and other nonacademic activities or education-related settings with nondisabled children (OSDE/SES IEP). Additionally, the regulations state that *"a statement of the program modifications or supports for school personnel that will be provided for the child"* must be included [34 CFR 300.347(a)(3)].

**What are program modifications?**

Program modifications include modifications in the administration of assignments, and/or tests, (i.e., provide word banks for tests, reduce the reading level of tests, take tests orally). Program modifications for the student or on behalf of the student must be described in the child's IEP if these modifications are necessary to assist the child to advance toward attaining annual goals, to be involved and progress in the general curriculum, and to participate in activities with nondisabled students.

**Can therapists change the objectives or frequency of time on an IEP during the school year?**

School districts must have IEPs in place at the beginning of each school year and they must review them at least annually. IEP teams may review more frequently than annually, at which time they may make changes in goals, objectives, frequency, and other IEP elements. The *Policies and Procedures for Special Education in Oklahoma* state that as long as there are no changes in the overall amount of services, some adjustment in scheduling is possible, based on the judgment of the service provider, without holding another IEP meeting. The *Policies and Procedures for Special Education in Oklahoma* also state that if the team makes "significant" change in the amount of services, parents must have an opportunity for an IEP review.

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## INTERVENTION

Occupational therapy and physical therapy in medical, rehabilitation and private settings operate within different contextual realities than school based therapists. In schools, the occupational therapist and physical therapist must assure that services directly support the goals agreed on by the educational team. As discussed within the chapter, **Occupational Therapy and Physical Therapy Services in the School: An Overview**, related services are necessary if they "are required to assist a child with a disability to benefit from special education."

As related service providers, occupational therapists and physical therapists have a responsibility to: (a) understand the educational expectations of the student, (b) collaborate with the team to develop meaningful goals and objectives, and (c) make explicit their potential contributions to the IEP.

### How do therapists provide occupational therapy or physical therapy in the schools?

See "How are occupational therapy and physical therapy defined in IDEA?" in the chapter, **Occupational Therapy and Physical Therapy Services in the School Setting: An Overview**. Occupational therapists and physical therapists typically evaluate student's motor function as it relates to achievement of educational goals, and evaluate the student's access and participation in the educational environment. Occupational therapists and physical therapists plan and implement activities that will support the team identified functional goals and objectives/benchmarks of the student's educational program (IEP). Additionally, occupational therapists are usually involved in recommending writing devices, adaptive equipment, and other assistive devices. And physical therapists are usually involved in recommending seating and standing options, assistive devices, and in identifying architectural barriers that may limit a student's participation in educational activities.

### How can the therapist provide therapy services effectively if our school does not have an OT/PT room?

Occupational therapy and physical therapy services rarely should be provided in an OT/PT room or other isolated setting. By IDEA definition, related services (OT and PT) are supportive services required to assist a child with a disability to benefit from special education; therefore, occupational therapists and physical therapists primarily should work in the classroom or other places in the school and/or community that support the student's special education program. Communication between the student's teachers and therapist is crucial if the student is to successfully accomplish the IEP goals and objectives, and communication is best accomplished when the therapist and teacher work with the student in the same location.

Working with students in the classrooms and other natural environments is current "best practice" in pediatric therapy (McEwen & Shelden, 1995; Rainforth & York-Barr, 1997). Best practices are the most current beliefs describing how professionals should provide services to students. Best practices change over time, and Calculator and Jorgensen (1994) suggest that

standards of practice change every three to five years. In education and related services for students with disabilities many changes have occurred over the past ten years. One change is that teachers, therapists, and other service providers no longer develop discipline-specific goals and objectives. Rather the team collectively develops the highest priority educational goals for each student. Our understanding of motor learning principles also has altered our approaches, from a focus on promoting the developmental sequence of tasks to an emphasis on functionally-based activities. If occupational therapists and physical therapists understand current best practices in education and the contemporary occupational therapy and physical therapy literature, they are likely to integrate intervention into natural environments to help students achieve functional, age-appropriate skills that the IEP team agrees are important.

**What are service delivery models?**

A service delivery model is a general approach or method of providing a service. In an educational setting, occupational therapists and physical therapists provide services for students, parents, and staff in several ways, with these various methods or approaches commonly called service delivery models. The type and amount of interaction and collaboration among members of the educational team generally define these models of service delivery. Therapists enable students to succeed in school by providing services in several different models. The IEP team, through consensus, may select the model of service for a student based on the student's individual needs (Campbell, VanderLinden & Palisano, 1994; Rainforth & York, 1987), but IDEA does not require that the service delivery model be written on the IEP. By not requiring one type of service delivery model, IDEA encourages occupational therapists and physical therapists to meet all the needs of the student as they relate to occupational therapy and physical therapy.

Three well known models are; direct, consultation, and monitoring. In most cases, therapists using only one of these three service delivery models for a student's educational program would limit the scope of their expertise, within their profession. As an example, rarely is it appropriate for a therapist to provide only direct services (e.g. one-to-one intervention) without collaborating with the teacher, parent, or other team member (consultation model) and/or training team members in necessary procedures such as positioning or mealtime skills (monitoring model). Direct services, if necessary, should generally be provided for a limited period of time to address a specific student identified need. In this model, block practice of a particular skill or component skill may be obtained through focused one-to-one intervention. However, functional goals or routine skills and activities needed by the student in a variety of settings may not be generalized by the student who has received only direct services (Bundy, 1995).

**What is integrated therapy?**

Integrated therapy is a family-focused team-oriented approach to service delivery that promotes student's achievement of functional skills (Rainforth & York-Barr, 1997). In the past, families have often had minimal involvement in decision-making of services for their children.

The school personnel typically made decisions in isolation with little carry-over between service providers. Presently, an integrated approach to service delivery is considered best practice; that is, the entire team, including the family, if they choose to, participate in developing and implementing the student's goals and objectives. Rainforth and York (1987) identified the following essential components for team members to consider when collaborating in the development and implementation of "an integrated educational program":

1. All goals and objectives belong to the learner, rather than to individual team members.
2. All team members are responsible for contributing information and skills that will maximize learner success in accomplishing all goals and objectives.
3. Each team member has specialized disciplinary methods and skills, many of which can be taught to other team members.
4. Combining methods from a variety of disciplines allows all team members to address the needs of the learner more successfully and in more natural contexts.
5. Individually selected, meaningful activities are the logical and necessary focus around which team members identify and integrate effective instructional methods for each learner. (p.191)

**What are some examples of integrated therapy activities?**

Examples are wide and varied! A therapist might (a) develop a seating system for a student in third grade so the student can use the classroom computer, (b) teach the preschool teacher and aid how to transfer a child out of his wheelchair onto the carpet for story time, (c) help a student with visual and motor impairments to become independently mobile on a school campus, (d) teach a student with traumatic brain injury to eat lunch in the school cafeteria, or (e) support a student and his high school IEP team in the student's transition from school to work. Obviously, the student would rarely practice these activities in an OT/PT room. Instead the student would perform these activities in their naturally occurring environments, such as the classroom, bathroom, school campus, or job site.

It rarely is sufficient for a therapist to work only with a student; therapists also must work with parents, teachers, paraprofessionals, and other team members who can provide students with multiple opportunities to practice motor skills in as many environments as the skill is needed. Thus, another feature of integrated therapy is teaching parents, teachers, paraprofessionlas, and other to help students practice motor skills throughout each day, not only during therapy time (McEwen & Shelden, 1995).

***Practical application:*** A sample goal and benchmarks/objectives:

I. Jake will sit on the floor during story time.
   a. Jake will wheel his chair from his desk to the carpet, each day, five minutes before story time.
   b. After he arrives at the carpet and an assisting adult is by his side, Jake willlock his wheel chair brakes and unfasten his seatbelt, without verbal cues, each day before story time.
   c. Jake will scoot forward on his wheelchair seat using his arms for assistance,

without verbal cues each day after unfastening his seatbelt prior to story time.

d. Jake will reach his arms around the assisting adult, and support his upper trunk as he is lowered to his cushion on the carpet/floor, from his chair, each day prior to story time.

e. Jake will move his floor cushion, with his arms, to provide a stable support, each day after being placed on the cushion.

f. Jake will maintain his sitting balance, with and without his arms for support during story time each day.

In this example, the goal belongs to Jake and is meaningful, the therapist will teach specific methods/skills to the "assisting adult", and the activity will happen in Jake's natural environment.

**What is the difference between "medical" therapy and "educational" therapy?**

As "medical" therapy has become more family-centered and oriented toward functional goals, former differences in therapy provided for students with disabilities in clinical and educational environments have largely disappeared (see McEwen & Shelden, 1995, for a complete discussion of this topic). The difference is in the priorities, not in the type of therapy provided.

In the educational environment, the team chooses the educational program for a student with a disability (see **IEP** chapter for details of this process). If the team decides that learning to walk independently, for example, is a high priority for a student, given everything the physical therapist and other team members know about the student and the likelihood that the student can learn to walk, then independent ambulation is an appropriate educational goal. Physical therapy provided to help the student learn to walk may be identical to physical therapy provided in a clinical setting. In either setting, therapists should use the most effective methods.

On the other hand, if the team (including the family and physical therapist) decides that walking is not an educational priority for this student, then walking would not be an educational goal and the school-based therapist would not work with the student on walking. Walking might not be an educational priority either because the team decides that other goals are more important or because walking is unlikely to be achievable. If other educational goals, rather than walking, take priority, the family may wish to seek other physical therapy services. The school district would not be responsible for paying for these "outside" physical therapy services, which may help the child learn to walk. If walking is unlikely to be achievable, then walking also would probably be an inappropriate goal for clinically-based services.

**How does sensory integration therapy fit into schools?**

Sensory integration (SI) is one of many frames of reference, used by therapists, to guide evaluation and intervention. SI is a neurobiological process that refers to the assimilation, organization, and use of sensory information to allow an individual to interact effectively with

the environment in daily activities at home, school, and in other settings (Ayers, 1972). When a student demonstrates deficits in sensorimotor performance that contribute to discrepancy in achieving their educational goals, the therapist may chose to use a sensory integrative approach for intervention (AOTA, 1997a; AOTA, 1997b). Refer to the **Appendix G** for additional information that can be used by the therapist for independent study.

**Who is responsible for "carrying out" a student's exercise program?**

When the student's IEP goals are functional, each team member can assist the student in "carrying out" the IEP goals and objectives. A specific exercise program might not be considered a functional goal on the IEP. Questions arise, for example, if the program is for muscle strengthening, is it a program that the student could perform at home? Does the program assist the student to benefit from special education? Must it be performed daily? Does the exercise program enhance any functional activity, and if it does, is the activity rather than the exercise program the functional goal? Could the exercise program be an independent activity in gym class or recess? If, after answering these and other related question, the team decides that a specific exercise program is needed for a student, then all team members have an equal part in "carrying out" the program. The occupational therapist, physical therapist, physical education teacher, or other team member who demonstrates expertise and has received training in this activity, will take the lead for teaching the student and the rest of the team about the activity.

**How many students should a therapist serve on a full time caseload?**

No regulations exist on the number of students an occupational therapist or physical therapist may have on their caseload. Each school district may develop guidelines related to this issue considering such factors as; the number of schools the therapist will cover, the amount of travel required, the number of evaluations necessary, the therapist’s experience, administrative and/or supervisory activities the therapist will conduct, the number of support personnel available, the needs of the students, and the availability of other therapists. See the case load chart in the **Appendix F** as an example.

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## MEDICAL PRESCRIPTION

**How often must therapists obtain medical referrals/ prescriptions for students to ensure that occupational and physical therapists comply with professional requirements?**

According to the *Oklahoma Occupational Therapy Practice Act*, a medical referral or prescription from a physician is **not** required for an occupational therapist to provide occupational therapy services for a student (Oklahoma State Board of Medical Licensure and Supervision, 2000). Occupational therapists may practice without obtaining medical referrals for students.

The *Oklahoma Physical Therapy Practice Act* **requires** physical therapists to provide physical therapy, only under the referral of a licensed physician, surgeon, dentist, chiropractor, or podiatrist (Oklahoma State Board of Medical Licensure and Supervision, 1999, p. 117). The Act does not, however, indicate how often referrals are required. In Oklahoma, the physical therapy community considers annual required referrals for students as adequate unless the student experiences significant changes prior to the annual renewal; therefore a student's prescription is considered current if it is received at least annually. **Note:** Physical therapists do not need a medical prescription prior to evaluation of a student. The Oklahoma State Department of Education Special Education Services (OSDE/SES) acknowledges physical therapists securing medical prescriptions for Oklahoma students receiving physical therapy annually or when the student experiences "significant changes" that may affect the child's educational goals. Significant changes might include, for example, a recent medical injury or a dramatic change in health status. An annual prescription promotes annual review of the student's medical conditions by a physician. **Additional Note:** Senate Bill 32, May 2001, states that physical therapists may accept referrals from Physician Assistants. This new policy (referral base) will go into effect November 2001.

Because the *Oklahoma Physical Therapy Practice Act* does not require annual medical prescriptions nor a specific medical referral form, the *Policies and Procedures for Special Education in Oklahoma* does not include a statement requiring the therapist to obtain an annual student medical prescription before receiving physical therapy nor does it include a standardized physical therapy referral form.

LEAs, with therapist input, may develop independent referral forms and referral time lines or both. Please check your own district's policies and procedures. **Note:** To include a statement requiring a student to obtain an annual medical prescription and to include a standardized referral form in the *Policies and Procedures for Special Education in Oklahoma,* the OSDE/SES would have to adopt these items as policy. OSDE/SES would then require approval from the Office of Special Education Programs in Washington, D.C.

**Can therapists perform evaluations without a medical referral/prescription?**

Yes. In Oklahoma both occupational therapists and physical therapists may perform

student evaluations without a medical referral/prescription. Refer to the chapter on **Evaluation** for additional information.

**How can the district expedite the return of the signed medical referral from the family or from the physicians's office?**

Each district has different mechanisms in place for securing signed medical referrals. It is up to the IEP team, and ultimately the physical therapist, to acquire a signed medical referral prior to the initiation of physical therapy services. Physical therapists should follow their districts' policy when attempting to acquire a referral. Sometimes it helps to make a phone or personal contact with the family of the student and ask the family to secure a medical referral from the physician within a specific time frame. If the family is unable or refuses to get the medical referral, the physical therapist might ask the family for permission to mail an unsigned referral form to the student's physician. It would be helpful to include a school-addressed envelope along with the unsigned referral. The therapist also could send a faxed copy of an unsigned referral form to the physician or family and/or receive a faxed copy of a signed referral. Note that professionals should use a fax for temporary purposes only. The original referral form should be kept in the student's confidential file. Photocopies of the original referral form may be kept in the therapists' files.

If the physician is unwilling to sign a referral it is important for a representative of the IEP team, presumably the physical therapist, to have an open discussion with the physician regarding the needs of the child. The therapist should provide information to the physician regarding the need for services required to assist the student to benefit from special education. If the student's physician continues to disagree, the IEP team might reconvene to review the IEP and decide to either omit physical therapy from the current IEP or seek a second medical referral.

**What can be done if physical therapy is on the IEP but the therapist cannot acquire a medical referral?**

If the IEP team included physical therapy on a student's IEP, then the district is responsible for providing physical therapy services. If, however, a medical referral for physical therapy is not acquired then the physical therapist cannot provide services to the student per the regulations of the *Oklahoma Physical Therapy Practice Act.* The physical therapist should document every attempt to secure the medical referral. Ultimately, the team will need to review and possibly amend the IEP to omit physical therapy if the therapist does not receive a medical referral. Note that under the comments section of the IEP form, the team may write a statement that states that physical therapy will begin only after the physical therapist receives a medical referral.

## References - Medical Prescription

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## DOCUMENTATION

**Why should therapists document in the public schools?**

Documentation is the written evidence that therapists have provided therapy services and shows the professionals' efforts, intervention, and student outcomes. Both of the professional organizations have documents to assist therapists in documentation; *The Guidelines for Physical Therapy Documentation* (APTA, 1997) and *The Guidelines for Occupational Therapy Services in School Systems* (APTA, 1989). *The Guidelines for Occupational Therapy Services in School Systems* suggests the following purposes for documentation:

1. Documentation provides a mode for the members of the IEP team to communicate effectively with each other and with outside individuals who may provide services to the student.
2. Documentation provides a method for planning services for identified students with disabilities.
3. Documentation records the type, frequency, duration, and outcome of therapy services rendered.
4. Documentation records the information required for legal protection (i.e., due process) and insurance or other types of reimbursement.
5. Documentation communicates the student's strengths and needs (weaknesses) to the educational team and tells how these areas will affect the student's participation in the educational process (AOTA, 1989).

**Explain what you mean by documentation?**

For purposes of this technical assistance document and adhering to the *Policies and Procedures for Special Education in Oklahoma,* documentation is any entry into the student record that identifies the care/service provided by occupational therapy or physical therapy services. Documentation primarily includes, but may not be limited to the (a) initial or preplacement evaluation, (b) IEP, (c) students' therapy progress notes, (d) annual program summary, and (e) reevaluation.

Prior to the initial placement of a student with a disability in a program providing special education and related services, a comprehensive individual multidisciplinary initial evaluation must be completed in all areas related to the suspected disability of the student. See the chapter on **Evaluation** for further information.

Oklahoma has established specific qualifications for team members related to each of the suspected disability categories. Occupational therapists and physical therapists are specifically included as multidisciplinary evaluation team members in evaluating the disability category of Orthopedic Impairment, but therapists should provide additional evaluative information as deemed necessary for evaluating any student's suspected disability. For further information on the preplacement evaluation, please review the *Policies and Procedures for Special Education in Oklahoma,* and refer to the chapter on **Evaluation** included within this document.

Occupational therapists and physical therapists are members of a team that develops the IEP. The IEP team determines the goals and objectives to be written on the document. For additional information on the IEP refer to the section on **IEP** included within this document.

The student's therapy progress notes are notes written by the therapist or therapy(ist) assistant that describe the services provided to the student by the therapist or therapy(ist) assistant. The OSDE/SES does not require progress notes, nor does the OSDE/SES require official progress note forms; however, current best practice recommends progress notes for occupational therapists and physical therapists. Therapists should maintain progress notes as a record of therapy services to the student. These notes can be written in any format that the therapist chooses, however, some school districts may use a specific form for progress notes. **Consult your district's policies before writing therapy progress notes.** Generally the therapist records the time spent with the student as well as the activity performed and the goal(s) addressed in the progress note. Physical therapists should review the American Physical Therapy Association (APTA) Practice Guidelines for recommendations in progress note time lines, that is, how often the therapist should write the notes. Occupational therapists should consult the OT school guidelines.

The annual program summary is not considered an official document of the OSDE/SES. The purpose of this documentation is to reassess the student during the school year, either at the beginning or end of the year, before the IEP meeting, following the extended school year, or whenever deemed appropriate by the student's therapist. Therapists, teachers, parents, and administrators may consider the annual program summary to be an important part of service delivery to students with disabilities as this summary provides ongoing assessment of the students' progress. It also provides written communication to parents and referring physicians.

The team conducts a reevaluation if conditions warrant a reevaluation, of if the child's parents or teacher request a reevaluation, but at least once every three years. Therapists should review IEP goals prior to the reevaluation, but do not have to use the same evaluation methods that were used in the initial evaluation. For further information on the reevaluation, refer to the chapter on **Evaluation** and review the *Policies and Procedures for Special Education in Oklahoma.*

**What documentation is needed for Medicaid?**

Medicaid has established that school districts, enrolled as Medical providers, can bill for health-related services provided to students enrolled in Medicaid, however the services must be a medical necessity. The EPSDT School-Based Services program provides for reimbursement to local, regional and state educational agencies for providing medically necessary health and related services to children eligible for Medicaid. Private schools are not eligible to participate in this program [Oklahoma Health Care Authority (OHCA) & Oklahoma State Department of Education (OSDE), 2000]. Medicaid expenditures and reimbursement must be coded in accordance with the Oklahoma Cost Accounting System (OCAS).

The procedure code is the code used to identify EPSDT School-Based Services in the State's Medicaid billing system. An IEP School Based procedure code is to be used whenever the child receiving services has an IEP (e.g., W4550, W4511). A School Based procedure code is used whenever the child receiving services has a treatment plan other than an IEP, such as an IFSP or IHSP (e.g., W4651, W4553). Examples of Procedure Codes that are appropriate for occupational therapy and physical therapy services:

W4526 IEP Child Health Encounter
W4550 IEP Physical Therapy (per 15 minutes, Individual)
W4651 School Based Physical Therapy (per 15 minutes, Individual)
W0065 IEP Physical Therapy (per 15 minutes, Group Rate)
W0066 School Based Physical Therapy (per 15 minutes, Group Rate)
W4551 IEP Occupational Therapy (per 15 minutes, Individual)
W4553 School Based Occupational Therapy (per 15 minutes, Individual)
W0067 IEP Occupational Therapy (per 15 minutes, Group Rate)
W0068 School Based Occupational Therapy (per 15 minutes, Group Rate)
W4781 IEP Assistive Technology (per 15 minutes, Individual)
W4782 School Based Assistive Technology (per 15 minutes, Individual)
W0073 IEP Assistive Technology (per 15 minutes, Group Rate)
W0074 School Based Assistive Technology (per 15 minutes, Group Rate)
W0093 IEP Physical Therapy Evaluation
W0094 School Based Physical Therapy Evaluation
W0095 IEP Occupational Therapy Evaluation
W0096 School Based Occupational Therapy Evaluation
W0075 School Based Targeted Case Management

Please refer to the *EPSDT School-Based Services: An Overview for Providers* (OHCA & OSDE, 2000) for explanation of these codes. **Note** that these codes were current when this document was published. Codes and procedures may change so therapists should keep abreast of current documentation for EPSDT School Based services.

All documentation should include (a) child's name and Medicaid number (and person code), (b) date of service, (c) description of the service performed, (d) duration (or unit) of the service, with start and stop time, and (e) original signature of the individual who furnished the service (OHCA & OSDE, 2000)

**What are the minimum essential elements therapists should include in their documentation?**

Therapists should make all handwritten entries in ink, and should correct documentation errors by drawing a single line through the error and initializing and dating the record. All records must include the student's full name. Therapists must date and sign all entries with the provider's full name and appropriate designation (e.g., PT, OTA). A licensed therapist must countersign all documentation by students or nonlicensed graduates. Official documents/forms of the OSDE/SES will specify additional required information.

**What are the minimal essential elements a therapist should include in a student's preplacement evaluation and reevaluation?**

Therapists should include the student's (a) full name, (b) school, class/teacher/program, (c) date of birth, and (d) age at the time of the evaluation. The therapist should also include assessments to determine the students' current level of performance in the educational environment that may include but is not limited to the student's ability to function in the classroom, on the playground, through the school campus, and during physical education. Evaluation results must explain how motor deficits affect education. Therapists should give recommendations, but they must be careful not to develop specific educational goals or frequency and duration recommendations. The IEP team will decide the need for related services and ultimately decide the educational goals, benchmarks, and frequency of services for the student. Please refer to the chapter on **Evaluation** for additional information related to the essentials of the evaluation.

**How often should progress notes be written?**

Therapists should write progress notes as often as necessary to document intervention and the student's response to the intervention, to report progress toward functional goals, and to update intervention plans. A summary of the progress should be sent to parents, at least as often as parents of typical children (scheduled report cards) or on a basis established by the IEP team.

**Where should therapists maintain student therapy progress notes?**

Therapists should maintain progress notes or other "nonofficial" personal records that include student information in a file cabinet, typically located in the related services office. Personal records may consist of written observations, personal anecdotal notes, and other recorded information maintained solely for personal use. Though these records are used personally by the therapist, they are considered "education records" and therefore are confidential and protected under the Family Educational Rights and Privacy Act of 1974. "Official records" include all OSDE/SES forms and any written reports/evaluations and interpretation of test material. The local school must maintain official records in the student's confidential file. The school should place the confidential file in a locked file cabinet, customarily housed in the school's administrative office.

**Can therapists charge for "documentation time?"**

Yes. Therapists can charge for documentation time if prearranged with the school district. School districts can develop different methods for therapist documentation procedures. Some districts allow 30 minutes a day or two ½ hours a week of nonstudent/teacher time for documentation time. Other districts suggest five minutes of documentation time following each student interaction. Ultimately it is the responsibility of the therapist to assure that all documentation is completed in a timely manner. For the therapist, time management becomes an important factor. Therapists document before, during, or after an individual student session. Before and after school hours are also appropriate times to complete documentation. A

therapists should make suggestions for and negotiate documentation time with the district supervisor, if they think the district has not allotted adequate time for documentation.

**Is there any type of documentation specifically related to the related service provider, rather than related to the student, which the therapist must maintain (e.g. personnel files)?**

Each district will decide how they maintain personnel files/documentation on related service providers. Supervising therapists should keep documentation on their supervisees. Also, it is important for physical therapists to "demonstrate their commitment to quality assurance by peer review and self assessment" (APTA, Code of Ethics). It would be appropriate for occupational therapists to also conduct peer reviews.

**Why should school therapists conduct peer review?**

Though the OSDE/SES does not require peer review, the American Physical Therapy Association (APTA) and the American Occupational Therapy Association (AOTA) recognize peer review and quality assurance respectively in their discipline code of ethics. As stated in the OPTA Code of Ethics;

Principle 3: Occupational therapy personnel shall achieve and continually maintain high standards of competence. (duties)

3.E: Occupational therapy practitioners shall protect service recipients by ensuring that duties assumed by or assigned to other occupational therapy personnel are commensurate with their qualifications and experience.

Principle 5: Occupational therapy personnel shall provide accurate information about occupational therapy services.

As stated in the APTA Code of Ethics;

Principle 4: Physical therapists maintain and promote high standards for physical therapy practice, education, and research.

4.2A: Physical therapists shall provide for utilization review of their services.

4.2B: Physical therapists shall demonstrate their commitment to quality assurance by peer review and self assessment.

Some malpractice insurance companies ask about peer review programs and frequency on their initial applications. Peer review enables therapists to track trends in service delivery and identify any problems or strengths of individual programs.

**What are useful components of a peer review program?**

Useful components of a peer review include, but are not limited to (a) review of the chart contents for completeness, (b) review of the evaluations for best practice trends, (c) review of the IEP for quality goal writing, and (d) review of the annual assessments.

**How can a district choose indicators for a peer review program form?**

Indicators (questions) should be chosen according to specific needs of a given program.

For example if therapists have problems contacting parents for their opinion during reevaluation, they might add a question related to parent contact on the peer review form (see an Oklahoma Public School sample form at the end of this chapter on page 57).

**How often should therapists perform peer reviews?**

No set rules exist regarding the frequency of peer review. It would be appropriate for district occupational therapy and physical therapy staff to learn and decide on their individual needs. Some districts perform peer review every three months, others once a semester, and others perform the review once a year.

**How can rural districts with only one therapist perform a peer review?**

The therapist can exchange peer review information with a nearby district or mail the information to a larger district for a collaborative approach to peer assessment. It also would be appropriate for a physical therapist and an occupational therapist to exchange information.

OKLAHOMA PUBLIC SCHOOL
PHYSICAL THERAPY - QUALITY IMPROVEMENT PROGRAM

**CHART CONTENT INDICATORS:**

Does the chart contain?

1. progress notes Y N N/A
2. attendance record Y N N/A
3. complete, current IEP Y N N/A
4. photocopy of current prescription Y N N/A

**EVALUATION & IEP INDICATORS:**

5. Is history documented? Y N N/A
6. Is there a statement demonstrating therapist/parent contact? Y N N/A
7. Was appropriate testing performed? Y N N/A
8. Was appropriate classroom, PE and/or playground observation made? Y N N/A
9. Is the assessment related to educational performance? Y N N/A
10. Are treatment recommendations outlined and logical in view of evaluative findings? Y N N/A
11. Is there a statement of discussing findings at the team IEP meeting with parents? Y N N/A
12. Is the child receiving PT from a private therapist? Y N N/A
    If yes, who? _____
    What kind of contact has the school therapist made? _____
13. Are all sections of the IEP complete? Y N N/A
14. Are goals functional and relevant to the educational program? Y N N/A

**For Annual Assessments:**

15. Are educationally relevant problems restated? Y N N/A
16. Is status of previous IEP goals discussed? Y N N/A
17. Is current intervention summarized? Y N N/A

Therapist_____ % Compliance_____ Reviewed By_____
Comments:

## References - Documentation

American Occupational Therapy Association. (1989). Guidelines For Occupational Therapy Services In School Systems (2nd ed.). Rockville, MD: Author.

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American Physical Therapy Association. (1997). The Guidelines for Physical Therapy Documentation. Alexandria, VA: Author.

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Oklahoma Health Care Authority and the Oklahoma State Department of Education. (2000). EPSDT School-Based Services: An Overview for Providers. Oklahoma City, OK: Oklahoma Health Care Authority.

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## USE OF OCCUPATIONAL THERAPY ASSISTANTS AND OCCUPATIONAL THERAPY AIDES

**How do occupational therapists use occupational therapy assistants in the school setting? *Or* What exactly is a COTA?**

Certified Occupational Therapy Assistants (COTA) receive their education at the associate level to provide occupational therapy services under the supervision of a licensed occupational therapist. As defined in Title 59 O.S., Section 888.3 of the Oklahoma Occupational Therapy Practice Act, "Occupational Therapy Assistant means a person licensed to provide occupational treatment under the general supervision of a licensed occupational therapist" (Oklahoma State Board of Medical Licensure and Supervision, 2000). Any person holding a license as an occupational therapy assistant issued by the Board may use the title "Occupational Therapy Assistant," "Certified Occupational Therapy Assistant," or "Licenced Occupational Therapy Assistant," or use the letters "O.T.A.," "C.O.T.A.," or "O.T.A./L."(Oklahoma State Board of Medical Licensure and Supervision, 2000). In this document, the letters OTA will be used.

The American Occupational Therapy Association has published several documents related to occupational therapy roles. A helpful resource is the *Occupational Therapy Roles* (AOTA, 1993). **Note:** The utilization of occupational therapy assistants and aides varies from state to state. Refer to the **Appendix B** for the *State of Oklahoma Occupational Therapy Practice Act and the Administrative Guidelines* for specifics.

**What does "under the general supervision" of a licensed occupational therapist mean?**

The administrative structure of the local school system, adhering to the Oklahoma State Board of Medical Licensure and Supervision licensure information, determines the supervision of the occupational therapy assistant by the occupational therapist. The supervision of the OTA by the OT may vary from consultation to direct supervision to general supervision. Supervision of Occupational Therapy Assistants is defined in Section 435.30-1-2 (Definitions) of the Oklahoma Administrative Code as follows:

> "Consultation" means periodic meetings to review and to provide recommendations and resource information regarding methods of implementation of the occupational therapy programs.
> "Direct supervision" means personal supervision and specific delineation of tasks and responsibilities by an Oklahoma licensed occupational therapist and shall include the responsibility for personally reviewing and interpreting the results of any habilitative or rehabilitative procedures conducted by the supervisee. It is the responsibility of the Oklahoma licensed occupational therapist to ensure that the supervisee does not perform duties for which he is not trained.
> "General supervision" means responsible supervision and control, with the Oklahoma licensed occupational therapist providing both initial direction in developing a plan of

treatment and periodic inspection of the actual implementation of the plan. Such plan of treatment shall not be altered by the supervised individual without prior consultation with and approval of the supervising occupational therapist. The supervising occupational therapist need not always be physically present or on the premises when the assistant is performing services; however, except in cases of an emergency, supervision shall require the availability of the supervising occupational therapist for consultation with and direction of the supervised individual.
"In association with" means a formal working relationship in which there is regular consultation.

Entry-level OTAs require "close" supervision by OTs. "Close" supervision requires daily, direct contact at the site of work. Intermediate-level OTAs, require "routine" supervision. "Routine" supervision requires direct contact as least every two weeks at the site of work, with interim supervision occurring by other methods, such as telephonic or written communication. Advanced-level OTAs, require "general" supervision. "General" supervision requires at least monthly direct contact, with supervision available as needed by other methods (AOTA, 1999). “The level of supervision required for the OTA is determined by the supervising OT and is based on an assessment of the OTA’s skills, the demands of the job, the needs of the service recipients, and the service setting requirements”(AOTA, 1999).

Occupational therapy aides who are providing client-related tasks require continuous supervision. “Continuous” supervision means that the occupational therapy supervisor is in sight of the aide who is performing delegated client-related tasks (AOTA, 1999). Occupational therapy aides who are providing non-client-related tasks, including clerical, maintenance, and preparation of work area, receive a level of supervision determined by the supervisor (AOTA, 1999). This supervision generally ranges from routine to minimal. Minimal supervision is provided only on a need basis and may be less than monthly (AOTA, 1999).

**Describe supervision as related to occupational therapy students.**

Level I occupational therapy fieldwork students, and Level I and II occupational therapy assistant fieldwork students require "close" supervision by an OTR, or an advanced-level OTA respectively, who is under the supervision of an OTR. Level II occupational therapy fieldwork students require "general" supervision, to be used only after the supervising OTR determines the service competencies (AOTA, 1993).

**What exactly is an Occupational Therapy Aide?**

As defined in Title 59 O.S. Sect 888.3 of the Occupational Therapy Practice Act, an occupational therapy aide means a person who assists in the practice of occupational therapy and whose activities require an understanding of occupational therapy, but do not require the technical or professional training of an occupational therapist or occupational therapy assistant (Oklahoma State Board of Medical Licensure and Supervision, 2000). “An occupational therapy aide is assigned by the OT to perform delegated, selected, skilled tasks in specific situations under the intense close supervision of an OT” (AOTA, 1997). Skilled tasks means components

of specified purposeful activities or therapeutic methods used to achieve intervention goals. Intense close supervision means daily direct on-site contact (AOTA, 1997). The aide does not obtain professional or advanced training to perform delegated job duties but instead receives site-specific training from the OT. For further information, refer to the AOTA Guidelines entitled *Guidelines for using Aides in Occupational Therapy Practice* (AOTA, 1999).

**How many OTAs and occupational therapy aides may one occupational therapist supervise?**

The Occupational Therapy Practice Act does not specifically answer this question. Occupational therapists must use their best professional and ethical judgment in deciding the number of individuals one occupational therapist might supervise.

**What is the role of the OTA?**

The OTA's primary role is implementation of an occupational therapy intervention plan. The OTA may not evaluate students independently or initiate the education program plan before the registered occupational therapist's evaluation; however, the OTA does contribute to the evaluation process by gathering data, administering structured tests, and reporting observations. Specific guidelines related to the school setting screening, evaluation, and reassessment can be found in the *Occupational Therapy Services for Children and Youth Under the IDEA (*AOTA, 1997*)*. With the supervision of an OTR, the OTA contributes to the development of the occupational therapy plan, the implementation of that plan, and the monitoring and documentation of the students' response (AOTA, 1987).

**Can the OTA perform administrative and/or screening activities?**

Yes. In the school setting, the occupational therapy assistant may follow established administrative procedures, including keeping records and inventory, ordering supplies and equipment, and scheduling in consultation with the supervising therapist. The occupational therapy assistant also may assist the occupational therapist by screening students, providing school-wide education, and in performing selected measurement procedures such as adaptive equipment.

Occupational therapists and occupational therapy assistants may participate in two types of screening as members of the school evaluation team. Type I screening occurs prior to a formal referral, and Type II screening occurs after a student receives a formal referral to special education. Occupational therapy assistants: a) establish service competency with the occupational therapist for all screening tasks performed, b) participate in collection of data for Type I screening and may act independently if the OTR has established service competency, c) assists in collection of Type II screening data such as record review, interviews, observations, and behavioral checklists, and d) reports orally and in writing or both to the supervising occupational therapist. For further information consult the *Occupational Therapy Services for Children and Youth Under the IDEA (*AOTA, 1997*).*

**If supervised, can the OTA perform all school-based OT services?**

No. A school-based OTA should not perform all school-based OT services. For information specific to evaluation services, refer to the question above related to screening. Occupational therapy assistants assist the occupational therapist in the IEP process by helping in developing team goals, objectives, and schedule recommendations, and by attending IEP meetings as directed by the occupational therapist to report findings and recommendations. The occupational therapy assistant does not interpret findings or negotiate changes and does not recommend referral of students for specialized assessment or to community resources for evaluations. The occupational therapy assistant assists the occupational therapist with the development of the occupational therapy service plan and assists with documentation as directed by the occupational therapist. For additional information on services of the occupational therapy assistant including intervention and discontinuation of services consult the *Occupational Therapy Services for Children and Youth Under the IDEA (*AOTA, 1997*).*

**Must an OT document the activities of the OTA?**

Requirements for documentation vary from school district to school district. Because the occupational therapist delegates a plan of care that the occupational therapy assistant will implement, the occupational therapist must document the delegation of activities and services the occupational therapy assistant provides to the student (AOTA, 1989).

**Are OTAs required to have licensure?**

Yes. The Oklahoma state law regulates occupational therapy assistants through licensure. **Note:** occupational therapy assistants who are members of the American Occupational Therapy Association also are bound by the Standards of Ethical Conduct for the Occupational Therapy Assistant (AOTA, 1998).

**Are occupational therapy aides required to have licensure?**

No. Occupational therapy aides are not required to have licensure.

**Is an occupational therapist responsible for services provided by the OTA and the occupational therapy aide?**

Yes. The supervising occupational therapist is ultimately and legally responsible for the provision of <u>all</u> occupational therapy services. Occupational therapy assistants and occupational therapy aides should be used in ways that are consistent with safe, legal, and ethical occupational therapy practice. The occupational therapist should be aware of the occupational therapy assistant's and aide's education and scope of knowledge, and ensure that the OTA follows Oklahoma regulatory mandates and ethical professional standards.

Both the occupational therapist and the occupational therapy assistant have a responsibility to each other. Through the communication process, both individuals are mutually responsible for clarifying competencies and responsibilities within the scope of the educational environment (AOTA, 1987).

**How do therapists supervise OTAs and occupational therapy aides in the SoonerStart Early Intervention Program?**

Oklahoma's Early Intervention program, SoonerStart, does not hire OTAs, occupational therapy aides, (or physical therapist assistants) at this time; therefore, supervision is not applicable.

## References- Use of OTAs And OT Aides


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## USE OF PHYSICAL THERAPIST ASSISTANTS

**How do physical therapists use physical therapist assistants in the school setting? *OR* What exactly is a PTA?**

A physical therapist assistant (PTA), as described by the American Physical Therapy Association (APTA) in the *Guide to Physical Therapist Practice* (2000), is a technically educated health care provider who assists the physical therapist in the provision of physical therapy. The physical therapist assistant, under the direction and supervision of the physical therapist, is the only paraprofessional who provides physical therapy interventions. The physical therapist assistant is a graduate of a physical therapist assistant associate degree program accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE). Further, the Oklahoma State Board of Medical Liscensure and Supervision (OSBMLS) (1999) in the Oklahoma Administrative Code, defines a PTA as a licensed paraprofessional health care worker who is a graduate of a program accredited by an agency recognized by the Commission on Accreditation of Physical Therapy Education or approved successor organization, and who performs selected physical therapy procedures and related tasks under the direction and supervision a Physical Therapist (p.15).

In the *Utilization of Physical Therapist Assistants in the Provision of Pediatric Physical Therapy* (APTA, 1997a), the APTA Section on Pediatrics recommends that physical therapy services for children who are physiologically unstable not be delegated to the physical therapist assistant. **Note:** Because licensure and utilization of physical therapist assistants vary from state to state, therapists should refer to their state physical therapy practice act and special education rules and regulations for additional information specific to their location. See **Appendix D** for *State of Oklahoma Physical Therapy Practice Act and the Oklahoma Administrative Code Title 435 Chapter 20* for specifics.

**What does "direction and supervision" of a licensed physical therapist mean?**

Direction and supervision are essential in the provision of quality physical therapy services (APTA, 2001; OSBMLS, 1999; APTA, 1996a). The level of direction and supervision necessary for assuring quality physical therapy services depend on many factors, including the education, experience, and responsibilities of the PTA and the type of intervention needed by the student (APTA, 2001). Watts (1971) provided a classic guide for physical therapist-physical therapist assistants supervisory relationships. She delineated responsibility through consideration of five factors: (1) predictability of the consequences, (2) stability of the situation, (3) observability of basic indicators, (4) ambiguity of basic indicators, and (5) criticality of results. Prior to delegating any physical therapy services, the physical therapist should determine that the consequences of the services are predictable, the situation is stable, and the basic indicators are not ambiguous and do not require ongoing observation by the physical therapist.

Supervision of the physical therapist assistant by the physical therapist may vary from direct on-site supervision to general supervision, in which the physical therapist is not routinely on-site but is accessible by direct telecommunications. The level of supervision will depend on

the experience and abilities of the PTA, and upon the responsibilities of the PTA within the educational team. In Oklahoma, supervision of physical therapist assistants is defined in the *Oklahoma Administrative Code Title 435 Chapter 20,* Section 435.20-7-1 (see **Appendix D)**.

Roles and responsibilities of both the physical therapist assistant and the supervising physical therapist should be clearly defined by the school district or state, or both. The person who directs physical therapy services in a school or district must (a) establish guidelines that describe the role and responsibilities of the PTA in the services and the supervisory relationships inherent in the education environment; (b) ensure that physical therapy services are provided efficiently and effectively and in accordance with safe physical therapy practice; and (c) interpret administrative policies, act as a liaison between PTA and administration, and foster the professional growth of the PTA (APTA, 2001).

Supervision is directly related to student safety. Verbal and written communication between the physical therapist and the physical therapist assistant, and on-site instruction by the physical therapist should be ongoing to ensure the safety and progress of the student. The physical therapist assistant is responsible for each student's care and safety during service delivery. The PTA should observe and report responses of students to the supervising physical therapist at regular intervals, or in a timely manner if concerns arise. **Note:** The state of Oklahoma requires supervising physical therapists to have an Oklahoma license to supervise the physical therapist assistant.

**How many PTAs may one physical therapist supervise at once?**

As outlined in the *Oklahoma Administrative Code Title 435 Chapter 20,* Section 435:20-7-1(c) a physical therapist will not supervise "more than a total of three physical therapist assistants or applicants for licensure regardless of the type of professional licensure or level of training." It is the responsibility of the physical therapist to monitor the number of persons under his/her direct supervision. It is the responsibility of the physical therapist assistant to ask the number of persons that the physical therapist directly supervises.

**What is the role of the PTA?**

Generally, in the school setting the physical therapist assistant is professionally responsible to and under the supervision and direction of a licensed physical therapist for all job-related issues. The physical therapist assistant is considered a team member and may provide input when establishing educational goals and objectives/benchmarks for the student's Individualized Educational Program (IEP). After the IEP team develops the student's goals and objectives/benchmarks, the team then determines whether or not physical therapy services are required to assist the student to benefit from the team developed educational program. If physical therapy will assist the student to benefit from special education, the team, with input from the physical therapist will define the frequency and duration of the physical therapy services needed. The physical therapist may delegate aspects of the student's physical therapy to a PTA that are appropriate for the PTA's experience, knowledge, and skill. The physical therapist will design a plan to meet the IEP goals and the PTA may follow through and assist in

the management and maintenance of the physical therapy plan as delegated and directed by the physical therapist APTA, 1997b).

**Can a PTA perform administrative and/or screening activities?**

Yes. In the school setting, the physical therapist assistant may follow established administrative procedures, including keeping records and inventory, ordering supplies and equipment, and scheduling in consultation with the supervising therapist. The physical therapist may ask the PTA, if appropriately trained and knowledgeable, to assist in student screening (such as for scoliosis), participate in school-wide education, perform selected measurement procedures, and care for braces, orthoses, prosthesis, and adaptive equipment (Martin, 1990). The PTA's experience, participation in continuing education courses, and education in other areas, such as psychology, early childhood development, or special education, should be considered by the physical therapist when delegating duties, such as screening and measurement procedures, to the physical therapist assistant (APTA, 1997a).

**If supervised, can a PTA perform all school-based PT services?**

No. A school-based physical therapist assistant should not interpret any student referrals, perform any student evaluation or reevaluations, develop or modify a student's physical therapy service plan (educational program), determine when it is appropriate to use a PTA, release or discharge a student from physical therapy services, recommend wheelchairs, orthoses, prostheses, or other assistive devices, or alterations to architectural barriers to persons other than a physical therapist, nor perform any skills or activities beyond the knowledge base of the physical therapist assistant (APTA, 2001, APTA, 1996a; APTA, 1996b).

**Must a physical therapist document activities of a PTA?**

Requirements for documentation vary from school district to school district. If a physical therapist has delegated a plan of care to be implemented by the physical therapist assistant, the physical therapist must document the delegation of activities and services to be provided by the PTA (APTA, 1997a; APTA, 1997c).

**Are PTAs required to have licensure?`**

Yes. Oklahoma state law through licensure regulates physical therapist assistants. Physical therapist assistant members of the American Physical Therapy Association also are bound by the *Standards of Ethical Conduct for the Physical Therapist Assistant* (APTA, 1996a).

**Is a physical therapist responsible for PT services provided by a PTA?**

Yes. The supervising physical therapist is ultimately responsible for the provision of <u>all</u> physical therapy services. Use of a physical therapist assistant by the physical therapist should be in a way that is consistent with safe, legal, and ethical physical therapy practice (APTA, 1996b). The physical therapist should be cognizant of the physical therapist assistant's education and

scope of knowledge, and ensure that the PTA follows Oklahoma regulatory mandates and ethical professional standards. Physical therapists have a responsibility to deliver services in ways that protect the public safety an maximize the availability of the services (APTA, 1997a).

**What are appropriate roles for PTAs in classrooms and other natural settings that are not appropriate for teachers and classroom paraprofesionals?**

Direction for the use of assistants and paraprofessionals is being established by individual states to address current concerns about (a) a critical shortage of personnel to meet service demand, (b) specialized training required to provide services to young children, (c) distance and travel time constraints, (d) full inclusive placement for children and students, and (e) budget and monetary constraints (Striffler, 1993). States are guided by their own unique needs as they address appropriate roles of personnel providing services for students with disabilities.

As discussed in a previous question, physical therapy services must be delegated by the physical therapist on an individual basis. Educational teams may have more than one person who could provide related services and so are responsible for selecting the most appropriate and best qualified person to provide the service for the student.

As an example, an IEP team might agree that a student's goals is to use the restroom independently, and that physical therapy services are needed to assist the student to learn to transfer from the wheelchair to the toilet seat. The team, with input from the physical therapist, would determine which team member was the most appropriate to provide transfer training. If the student was new to the district and had not previously attempted toilet transfers, the physical therapist might initially be responsible for the physical therapy services. Later, after determining how best to teach the student to transfer, the therapist might delegate the service delivery to the PTA. If, however, the student is well-known to the physical therapist and only needs continued practice, the most appropriate team member to begin intervention might be the PTA.

Teachers and paraprofessionals also may assist students with motor-related activities that are within the scope of their education and experience, that they can carry out safely, and in accordance with applicable laws and regulations (APTA, 2001). When physical therapists make recommendations to classroom staff for positioning, promoting motor function, or similar activities, they are responsible for ensuring that the staff have the necessary skills and knowledge. Physical therapists assistants should not make such recommendations. PTAs may modify an intervention, within the scope of the physical therapy plan, according to changes in student status, but teachers or paraprofessionals should not modify a specific approach (APTA, 2001). The physical therapist assistant may provide students/families with information about provision of physical therapy services, however a teacher or paraprofessional should not (APTA, 2001).

**What is a physical therapy aid?**

The Oklahoma Physical Therapy Practice Act does not define physical therapy aides; therefore, the term or title "physical therapy aide" should not be used to define individuals, paid

or volunteer, who assist with activities that require consultation or instruction by a PT or PTA. [APTA defines physical therapy aides as non-licenced workers who are specifically trained under the direction of a physical therapist (APTA, 2001). The physical therapy aide provides support that may include student-related and non-student related duties only with continuous on-site supervision of the physical therapist or by the physical therapist assistant where allowed by law or regulation (APTA, 2001).]

**How do therapists supervise PTAs in the SoonerStarts Early Intervention Program?**

Oklahoma's Early Intervention program, SoonerStart, does not hire PTAs (or occupational therapy assistants or aides) at this time. Therefore, supervision is not applicable.

## References - Use of PTAs


American Physical Therapy Association. (2001). Guide to physical therapist practice 2nd ed. Physical Therapy: 81: 9-752.

American Physical Therapy Association, Section on Pediatrics. (1997a). Utilization of the Physical Therapist Assistants in the Provision of Pediatric Physical Therapy. Alexandria, VA: Author.

American Physical Therapy Association, Section on Pediatrics. (1997b). Draft - Providing physical therapy services under part B and H (now part C) of the Individuals with Disabilities Education Act (IDEA). Alexandria, VA: Author.

American Physical Therapy Association. (1997c). Guidelines for Physical Therapy Documentation. Alexandria, VA: Author.

American Physical Therapy Association. (1996a). Standards of Ethical Conduct for the Physical Therapist Assistant/ Guide for Conduct for the Affiliate Member. Alexandria, VA: Author.

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Oklahoma State Board of Medical Licensure and Supervision. (1999). State of Oklahoma Physical Therapy Practice Act and the Oklahoma Administrative Code Title 435 Chapter 20. Oklahoma City, OK: Central Printing.

Striffler, N. (1993). Current Trends in the Use of Paraprofessionals in Early Intervention and Preschool Services. Chapel Hill, NC: National Early Childhood Technical Assistance System: 1993.

Watts, N. T. (1971). Task analysis and division of responsibility in physical therapy. Physical Therapy, 51:23-35.

## EXTENDED SCHOOL YEAR SERVICES

**What does "extended school year (ESY) services" mean?**

Extended school year (ESY) services are special education and related services which are provided to a student with a disability beyond the normal school year in accordance with the student's IEP and as a necessary part of a free appropriate public education [34 CFR 300.309(b)]. ESY services usually take place during the summer, but could occur at other times if districts have major breaks at other times of the year. Each school district usually has specific ESY policies. ESY services should not be confused with traditional summer school or with summer services typically made available to all students. ESY services must be developed and documented through the IEP process and be provided at no cost to parents of eligible students. For additional information review the *Technical Assistance Document: Extended School Year (ESY) Services For Children and Youth With Disabilities* published by the Oklahoma State Department of Education Special Education Services.

**Who is eligible for extended school year (ESY) services?**

The team decides, on an individual basis, whether a particular student requires ESY. The team determines if the child has regressed or is predicted to regress, to such a degree in a critical skill area that recoupment of such skill loss following the summer break in programming is likely or would require an unusually long period of time. Although the IDEA does not directly address the terms "regression" and "recoupment," case law has interpreted the terms to mean the amount of regression (lost and regressed skills) that a student with a disability has during school breaks and the amount of time required to recoup those lost skills when school resumes, as determined by the individual IEP team (Gorn, 1999; Gorn, 1997). Students require ESY services when regression is "significant" or "substantial."

**Are 'regression' and 'recoupment' the only considerations for ESY services?**

No. Other factors may be considered in determining the need for ESY services for each individual student. Factors to be considered might include, but are not limited to, the degree of the student's disability, the degree of regression experienced in the past, the parent's ability to provide education in the home, the child's rate of progress, availability of alternate resources, the child's needs for interaction with nondisabled peers and vocational training; and whether the requested services are an integral part of a program for children with similar disabilities [*Johnson v. Independent School District*, 17 EHLR 170 (10th Cir. 1990)].

**Can occupational therapists and physical therapists decide if a student is eligible for ESY services?**

No. Therapists cannot independently make decisions about service delivery for students. Rather, the IEP team, of which the occupational therapist and physical therapist should be a part, determines if a student is eligible for ESY services. Occupational therapists and physical therapists can provide information to assist the members of the team to make an educated

decision regarding a student's needs for ESY services.

**Should the school district provide ESY services to a student to substantially enhance the student's education?**

No. Although the IDEA provides for an appropriate education it does not guarantee the best possible education (Gorn, 1999). ESY services cannot be provided just for the purpose of maximizing a student's educational opportunities. Similarly, it is not enough that the student will regress if the student does not receive educational programming over the break. Students in general education lose some skills or knowledge during the summer. As stated above, the amount of regression must be significant or substantial. Though the terms significant and substantial are not defined, OSDE/SES explains in the *Technical Assistance Document: Extended School Year (ESY) Services For Children and Youth With Disabilities* that the severity of the regression-recoupment problem is central to deciding eligibility. This document continues to explain that "a child would be eligible for ESY services if it is determined that the child might regress to such an extent in a skill area that recovery of such a skill would be unlikely or impossible, and therefore, would necessitate an unusually long period of time to recoup the present level of performance" (OSDE/SES, 1992). The IDEA cannot be used to fund a level of educational programming that exceeds the level of benefit to which general education students are entitled.

**Can students in private schools receive ESY services?**

Yes. Students with disabilities who have been placed in private schools retain all of their rights under the IDEA, including the right to ESY services (34 CFR 300.133, 300.400-401). Private schools, however, are not responsible for ensuring FAPE and therefore are not obligated to offer ESY services. The LEA is obligated to provide alternate placements for the summer months if a private school chooses not to provide ESY for an eligible student (Gorn, 1997).

**Can states and/or districts categorically deny ESY services to students with severe disabilities?**

No. Just as students can not be categorically placed in classrooms or programs, districts cannot categorically deny ESY services (Gorn, 1999). To categorically deny services would violate the IDEA. The public agency may not limit ESY services to particular categories of disability or unilaterally limit the type, amount, or duration of services [34 CFR 300.309(a)(3)]. Though school districts cannot establish general rules for deciding which students with disabilities are eligible for ESY, school districts must have an ESY policy which assists IEP teams in making decisions regarding ESY services. IEP teams determine ESY service individually, taking into account the particular circumstances of each student who is potentially in need of such services.

**Does ESY apply to students whose third birthdays are in the summer?**

Yes. The U.S. Department of Education has interpreted Part B of the IDEA to extend the

ESY entitlement to preschool programs. This extension includes children who have received Part C services and reach age three during the summer months [34 CFR 300.121(c), 300.342(c)].

## References - ESY

Federal Regulations, United States Government Department of Education. (1999). 34 C.F.R. Parts 300 to 399. Washington, DC: US Government Printing Office.

Gorn S. (1997). What Do I Do When...The Answer Book on Individualized Education Programs. Horsham, PA: LRP Publications.

Gorn S. (1999). What Do I Do When...The Answer Book on Special Education Law (3rd ed.). Horsham, PA: LRP Publications.

Oklahoma State Department of Education Special Education Services. (1992). Technical Assistance Document: Extended School Year (ESY) Services For Children and Youth With Disabilities. Oklahoma City, OK: Author.

Johnson v. Independent School District, 17 EHLR 170 (10th Cir. 1990)].

## TRANSITION SERVICES

**What are transition services?**

Transition services means a coordinated set of activities for a student with a disability that:

(A) is defined within an outcome-oriented process, which promotes movement from school to post-school activities, including post secondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation;
(B) is based upon the individual student's needs, taking into account the student's preferences and interests; and
(C) includes instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and when appropriate, of acquisition daily living skills and functional vocational evaluation [20 USC 1401(30)].

The IDEA promotes planning for the changes that occur during transition to minimize stress on the student and family and to promote successful post school opportunities for the graduating student.

**Does the term "transition services" include children transitioning out of the SoonerStart Early Intervention Program and transitions made within various grade school levels?**

No. In the IDEA, "transition services" only includes students transitioning from school to post-school activities. Transition issues related to other students will be discussed within this chapter.

**At what age are students' eligible for transition services?**

Beginning at age 14, and updated annually, the IEP team must develop a statement of the transition service needs of the student under the applicable components of the student's IEP that focuses on the student's course of study (such as participation in advanced-placement courses or a vocational education program). And beginning at age 16 (or younger, if determined appropriate by the IEP Team), a statement of needed transition services for the student, including, when appropriate, a statement of the interagency responsibilities or any needed linkages must be developed [20 USC 1414(d)(1)(A)(vii)(I)-(II)].

**Can students, prior to the age of 16, receive transition services to post school activities?**

Yes. If the IEP team decides that transition services are required by the student before the age of 16, then the team must include a statement of needed transition services on the IEP. The Federal Regulations provide no further stipulations, except that IEP teams may determine appropriate post school transition services for students under the age of 16 years.

**How do children transition from Part C to Part B (preschool programs) in IDEA?**

Upon approaching age three, the district determines the child's eligibility for the receiving program. Three to six months prior to the child's third birthday, the LEA will participate in transition planning conferences. Ideally, sending and receiving programs and agencies are working closely together to prevent redundancy of evaluations and with permission from the family, share appropriate information for determining eligibility for programs. The IDEA states that children participating in early intervention programs assisted under part C, and who will participate in preschool programs assisted under Part B (or who are not eligible for preschool programs, but may require other appropriate services), shall experience a smooth and effective transition, with family collaboration, to those preschool programs [20 USC 1412 (a)(9)].

**What are the responsibilities of a therapist during transition?**

1. Effective communication. The transition process for children transitioning from Part C to Part B should be initiated at least six months before the child's third birthday, and at age 14 for children in Part B transitioning into post-school activities. For children in part C, the receiving team should begin to work with the family to determine what related services will be necessary. If a child has been receiving therapy services then the sending (SoonerStart) and receiving therapists must communicate with the family and insure that they are addressing the families' concerns. Refer to the SoonerStart program for further information on Part C transition. For students receiving part B transition services, statements addressing transition service needs, at age 14, and statements of needed transition services, at age 16, must be written on the IEP. Additionally the receiving therapist and agency should strive for continuity in service delivery when addressing the needs of the student.

2. Knowledge of skills required in the subsequent environment(s). For children transitioning out of Part C, focusing on developmental age appropriate activities and effective educational planning should help families to decide what and/or how to address the skills used by students without disabilities in the immediate and future environments. The more transitional skills are incorporated into the child's activities the less stressful transitions will be. The therapist should insure that the family is aware of activities and/or requirements of the next transition setting such as getting to the lunchroom, moving about in the classroom, playing on the outdoor equipment, or coloring/handwriting. The therapist then helps the team in finding strategies to address these activities. The therapist may also participate in evaluations and assessments prior to the child's third birthday. Consideration of immediate and future environments for older students might include helping the team in preparing the student for homemaking, use of community resources, transportation options, access to leisure and recreational activities, and community living arrangements. The therapist can also provide inservice instruction to the student's peers and co-workers if deemed necessary by the team.

3. Knowledge of community and environmental resources and obstacles (Kilgo, Richard, & Noonan, 1989). This may include providing inservice instruction to service providers or teachers, assessing environmental barriers, or collaborating with team members to find assistive

devices or equipment necessary to insure the student's success in the new educational, work, or home environment(s).

4. Knowledge of time lines and eligibility requirements. Insure time lines for testing and ecological assessments are established allowing adequate opportunities for communication with team members before the transition date (Kilgo, Richard, & Noonan, 1989).

**What is the role of the family in transition planning?**

While families will differ in their ability to participate in transition planning, the decision as to the extent and nature of the families involvement should be the decision of the family. The family is the most constant person in the child's life, and will go through more of the future transitions than any other team member. Family involvement in transition planning promotes child advocacy, provides for greater continuity during transitions, and increases a parental sense of autonomy while decreasing stress. The family is also more likely to understand the needs of their child across environments and therefore can assist in deciding appropriate members of the transition team (Noonan & Kilgo, 1987; Wolery, 1988).

Common concerns of families relate to establishment of rapport and trust with new team members, determination of service delivery, and fear of social acceptance by peers without disabilities. Families of children transitioning from an early intervention program have additional concerns: 1) Will the parent's role change in a school setting regarding decision making and involvement in intervention strategies? 2) Will the focus on the child vs. family centered services decrease the support they receive? Because parents may have different concerns, members of the team should try to get information from both parents. Therapists from the receiving program should communicate with the family before transition to decrease stress and allow the family enough time to express concerns.

## References - Transition

Individuals with Disabilities Education Act Amendments of 1997. Pub. L. No. 105-17, 20 U.S.C. 1400-1487. Washington: US Government Printing Office.

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Wolery, M. (1988). Transitions in early childhood special education: Issues and procedures. Focus Exceptional Child in Special Education, 8,39-50.

## CONTINUING EDUCATION

**What are the continuing education unit (C.E.U.) requirements for therapists?**

In Oklahoma, occupational therapists are required to obtain 20 contact hours every two years to fulfill the continuing education requirements for liscensure. Physical therapists, beginning with the renewal period ending January 31, 2000, an every two years thereafter, are required to obtain 20 contact hours of approved continuing education experiences. All therapists are responsible for contacting their respective licensing board to keep updated on the current requirements of C.E.U.s for professional liscensure.

**Who pays for therapists' continuing education and is leave time with or without pay available for attending continuing education programs?**

The Oklahoma State Department of Education, Special Education Services (OSDE/SES) does not have a written policy related to these questions; however, Comprehensive System of Personnel Development (CSPD) monies flow directly to the LEAs for staff development. Related service providers are part of the staff covered with CSPD money. Individual therapists must negotiate with the school districts how and when continuing education monies are spent and how and when leave time for continuing education is taken. Districts may choose to give salaried therapists a specific amount of leave with pay for continuing education and they typically decide on leave time through individual district policies. If a therapist is working through a contract service, the therapist would negotiate decisions related to C.E.U.s with the contract service.

**Who decides which continuing education courses therapists attend, the district, the principal, the therapists' supervisor, or the therapists?**

The OSDE/SES does not have a written policy related to this question, and school districts may or may not have specific policies related to which continuing education courses a therapist may attend. The therapist may collaborate with the district or the contract service on decisions related to which continuing education courses to attend. Training should be related to job responsibilities and needs.

**Are there local continuing education opportunities sponsored by the State?**

The Statewide Training and Regional Support (STARS) is a coordinated statewide training system sponsored by the Lee Mitchener Tolbert Center for Developmental Disabilities, Department of Rehabilitation Science, College of Allied Health, University of Oklahoma Health Sciences Center and funded through the Oklahoma State Department of Education, Special Education Services, the SoonerStart Early Intervention Program, and the Department of Human Services, Developmental Disabilities Services Division. STARS offers over 40 free programs throughout the state for those who live and work with people with disabilities. For more information please contact Ms. Pat Diaz at (405)271-1836 or email: stars@ouhsc.edu

## References - Continuing Education

Oklahoma State Board of Medical Liscensure and Supervision. (2000). State of Oklahoma Occupational Therapy Practice Act and the Oklahoma Administrative Code Title 435 Chapter 30. Oklahoma City, OK: Central Printing.

Oklahoma State Board of Medical Liscensure and Supervision (1999). State of Oklahoma Physical Therapy Practice Act and the Oklahoma Administrative Code Title 435 Chapter 20. Oklahoma City, OK: Central Printing.

# APPENDICES

# Appendix A

## Occupational Therapy Code of Ethics

# Appendix B

## Occupational Therapy Practice Act and the Oklahoma Administrative Code (Rules)

# Appendix C

## Physical Therapy Code of Ethics

# Appendix D

## Physical Therapy Practice Act and the Oklahoma Administrative Code (Rules)

# Appendix E

## OSDE/SES Instructions for Completing the IEP (DRAFT)

# Appendix F

## Caseload Chart

# Appendix G

## Sensory Integration Statement