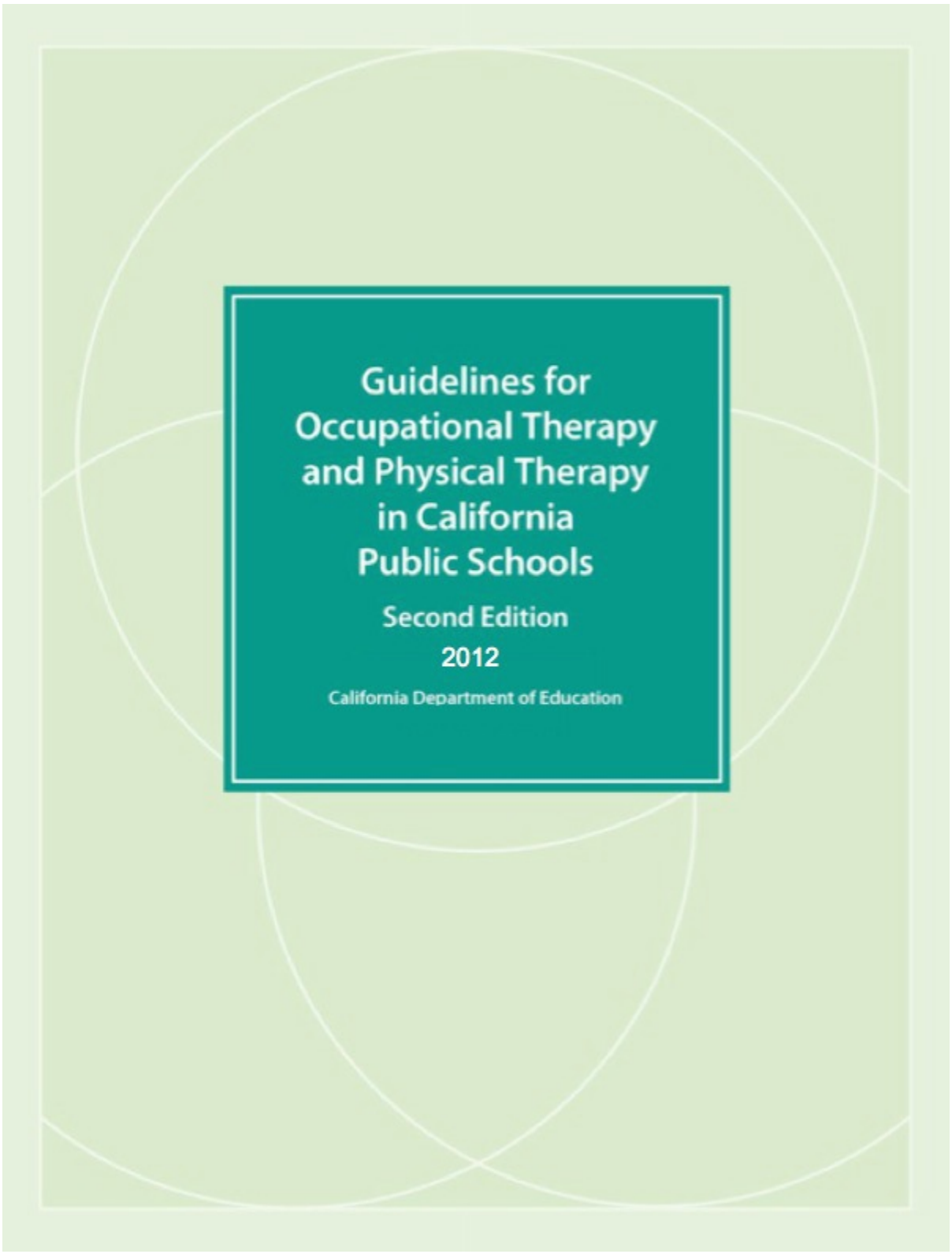
Guidelines for
Occupational Therapy
and Physical Therapy
in California
Public Schools
Second Edition
2012
California Department of Education

Guidelines for Occupational Therapy and Physical Therapy in California Public Schools

Publishing Information

The *Guidelines for Occupational Therapy and Physical Therapy in California Public Schools (Second Edition)* was developed by the Special Education Division, California Department of Education. It was edited by Faye Ong, working in cooperation with Dan Boomer, Consultant. It was prepared for printing by the staff of CDE Press and published by the Department, 1430 N Street, Sacramento, CA 95814-5901. It was distributed under the provisions of the Library Distribution Act and *Government Code* Section 11096.

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Notice

The guidance in *Guidelines for Occupational Therapy and Physical Therapy in California Public Schools (Second Edition)* is not binding on local educational agencies or other entities. Except for the statutes, regulations, and court decisions that are referenced herein, the document is exemplary, and compliance with it is not mandatory. (See *Education Code* Section 33308.5.)

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A Message from the State Superintendent of Public Instruction

In California, as in every state across our nation, educators, administrators, associated service providers, parents and guardians, and the public at large are paying ever more attention to finding solutions to closing the achievement gap, improving academic performance and securing higher levels of postsecondary outcomes for all public school students. Standards-based instruction, early intervening services, progress monitoring, evidence-based education, use of advanced technology and post-secondary preparation models exemplify California public schools' active approaches to these priority issues.

Occupational therapists and physical therapists in California public schools are uniquely positioned to build self-determination and independence—the keys to academic success for children with cognitive, physical, or emotional disability.
They work closely with students and their families to uncover hidden potential, build skills and abilities, understand and adapt to barriers, and capitalize on real-world supports in order to ensure that students with special needs have the optimal opportunities to pursue their lifetime goals.

This document is organized into four major sections: (1) overview and framework; (2) laws and scope of practice; (3) provision of occupational therapy and physical therapy services in the educational setting; and (4) administration of occupational therapy and physical therapy services. Resource information is also provided for those seeking a more in-depth understanding.

This publication is intended to be useful to both the entry-level therapist just starting practice in California as well as to the therapist with many years of experience who needs a reference guide to current laws and practice. It will also be useful to parents, teachers, and school administrators who may not yet fully appreciate the extent to which occupational therapists and physical therapists contribute to California students' educational process. Considering the increased interest in transition services and postsecondary outcomes of children with special needs, it will also prepare service providers with the knowledge and tools to access advanced and emerging technologies necessary to support our students' success.

Educators and professionals, including occupational therapists and physical therapists, can assist all students with special needs in California public schools to succeed academically and to live independent and productive lives.

Tom Torlakson
State Superintendent of Public Instruction

Acknowledgments

The second edition of *Guidelines for Occupational Therapy and Physical Therapy in California Public Schools* has been a collaborative effort of more than 25 occupational therapists (OTs) and physical therapists (PTs) throughout the state of California. The therapists who worked on this publication donated their time and expertise, many with the support of the school districts, therapy clinics, and organizations by whom they are employed. The goal of updating the parameters under which OT and PT are provided in the educational setting is set forth in this document. As an electronic document, this publication is designed to be updated at regular intervals and be available to a wide range of individuals, including consumers of service, educational personnel, and legislative officials, as well as OTs and PTs throughout the state of California. The preparation of this important document would not have been possible without the support, hard work, and relentless efforts of a large number of individuals and institutions.

We are particularly grateful for the initiation of the project by Dennis Kelleher, PhD, Consultant, Special Education Division, and the ongoing leadership and direction of J. Daniel Boomer, PhD, Consultant and Liaison, Special Education Division, California Department of Education, throughout the five-year project. With Dr. Boomer's guidance and vision, the guidelines were developed with the focus of educating children and leading them into a promising future. Julie Bissell and Lisa Test shared leadership of the 2010 and 2012 Revision Committee.

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Chapter 1
Mission, Beliefs, and Purpose

This publication is a revision of the *Guidelines for Occupational Therapy and Physical Therapy in California Public Schools* published in 1996. Since that time, numerous laws, regulatory decisions, service delivery models, and policies and procedures have been initiated, developed, and/or changed.

Mission Statement

The mission of the *Guidelines for Occupational Therapy and Physical Therapy in California Public Schools*, aligned with the mission and vision of the California Department of Education (2009a), is to facilitate standards of excellence in occupational therapy (OT) and physical therapy (PT) practice. The guidelines are aimed at creating a wholesome learning environment, a high standard of student accomplishment, and accountability for positive ongoing and long-term postsecondary child outcomes. All California students of the 21st century will attain the highest level of knowledge and apply learning and performance skills to have fulfilling personal lives and careers and contribute to civic and economic progress in a diverse society.

California Department of Education Beliefs

The Department holds the following beliefs: (http://www.cde.ca.gov/eo/mn/mv/) California will provide a world-class education for all students from early childhood to early adulthood. The Department of Educations serves our state by innovating and collaborating with educators, schools, parents and community partners. Together, as a team, we prepare students to live, work and thrive in a highly connected world.

Purpose of the Guidelines

The primary purpose of the *Guidelines for Occupational Therapy and Physical Therapy in California Public Schools (Second Edition)* is to define and describe the occupational therapy (OT) and physical therapy (PT) services to be provided in an educational setting, compliant with the Individuals with Disabilities Education Act (IDEA) of 2004; Title 20, *United States Code*[1] Section 1400 et seq.; and the OT and PT scopes of practice and state license requirements. Special education local plan areas (SELPAs), county offices of education (COE), local educational agencies (LEAs), school district staff, other agencies (e.g., regional centers, California Children's Services, etc.), and parents may better understand the scope of OT and PT practice and ways in which OTs and PTs can contribute to a world-class educational system in California. OT and PT staff may also find this resource useful for guiding current practice. Additionally, this document is meant to assist administrators, legislators, and OTs and PTs in formulating policies and procedures to implement OT and PT services in the public school setting.

The terms used in the *Guidelines for Occupational Therapy and Physical Therapy in California Public Schools (Second Edition)* are as follows: The profession of OT, for the purposes of this document, includes California licensed OTs, as well as certified OT assistants. The profession of PT, for the purposes of this document, includes California licensed PTs and licensed PT assistants (5 CCR § 3051.6).[1] According to California law, OT and PT may include limited services provided by OT and PT "aides" who are not

licensed or certified and do not have specified educational requirements, but who may provide certain functions under the direct supervision and within eyesight of a licensed therapist (BPC §§ 2570 et seq. [OT] and 2620 et seq. [PT].[1] The abbreviations OT and PT refer both to occupational therapists and physical therapists, as well as to the professions of occupational therapy and physical therapy, throughout the document.

The term "child" used throughout is consistent with terminology in the legislation that applies to birth through age twenty-two, except in direct quotations or situations in which another term is used. Thus, the terms "child" and "children" often include infants and toddlers, although the more specific terms are used in chapters related to the younger population (20 USC § 1401(3); EC § 56026).

The IDEA was reauthorized in 2004, and the new name became the Individuals with Disabilities Education Improvement Act (IDEIA); however, it is still commonly called IDEA or IDEA 2004, so that is the term used throughout this manual (Public Law [PL] 108-446 [December 3, 2004].

The content is consistent with federal regulations, state laws, professional licensure and standards of OT and PT practice. This manual is not regulatory but is a resource providing suggestions for OT and PT practice in an educational setting.

OT and PT services function as "related services" under IDEA 2004, which are defined as those services "required to assist a child with a disability to benefit from special education" (34 CFR § 300.34(a)). In addition, OTs and PTs play an important role in early intervention and early intervening services (EIS) designed to help children with disabilities gain access to and succeed in the general education curriculum (GC § 95000 et seq.). Under the IDEA, OTs and PTs, as members of the child's educational team, share in the decision making process regarding how to meet the educational needs of individual children so that they will make adequate yearly progress and reach positive outcomes through public education (20 USC § 1414(d)).

Purpose of Public Education

Public education is designed to prepare children to obtain further education as well as to become employable and independent citizens who contribute to the overall benefit of society (20 USC § 1400(d)(1)(A)). The federal, state, and local laws, regulations, and policies (discussed in detail in Chapter 4) provide guarantees and safeguards for children who have disabilities.

Purpose of OT and PT in Public School Settings

The purpose of OT and PT in the public school setting is to support positive educational outcomes as described by the State of California State Performance Plan (California Department of Education 2009). Occupational therapy and physical therapy, two distinct and unique professions, work with the educational team to support a child's ability to gain access to the general education curriculum, meet state standards, make adequate yearly progress, participate in postsecondary education, and become functional independent citizens upon graduation.

[1]Key: *Business and Professions Code* = BPC *California Code of Regulations* = CCR *Code of Federal Regulations* = CFR *Education Code* = EC *Government Code* = GC *U.S. Code* = USC

The purpose of OT and PT in the public schools is best understood from a broad perspective. The American Occupational Therapy Association (2008) and the American Physical Therapy Association (2003) aligned the professions with the values of the World Health Organization (2001) when identifying core values of the profession. WHO disseminated a classification system known as the International Classification of Functioning, Disability and Health (ICF) (http://www.who.int/classifications/icf/en/) to develop a uniform language for discussion of function and disability.

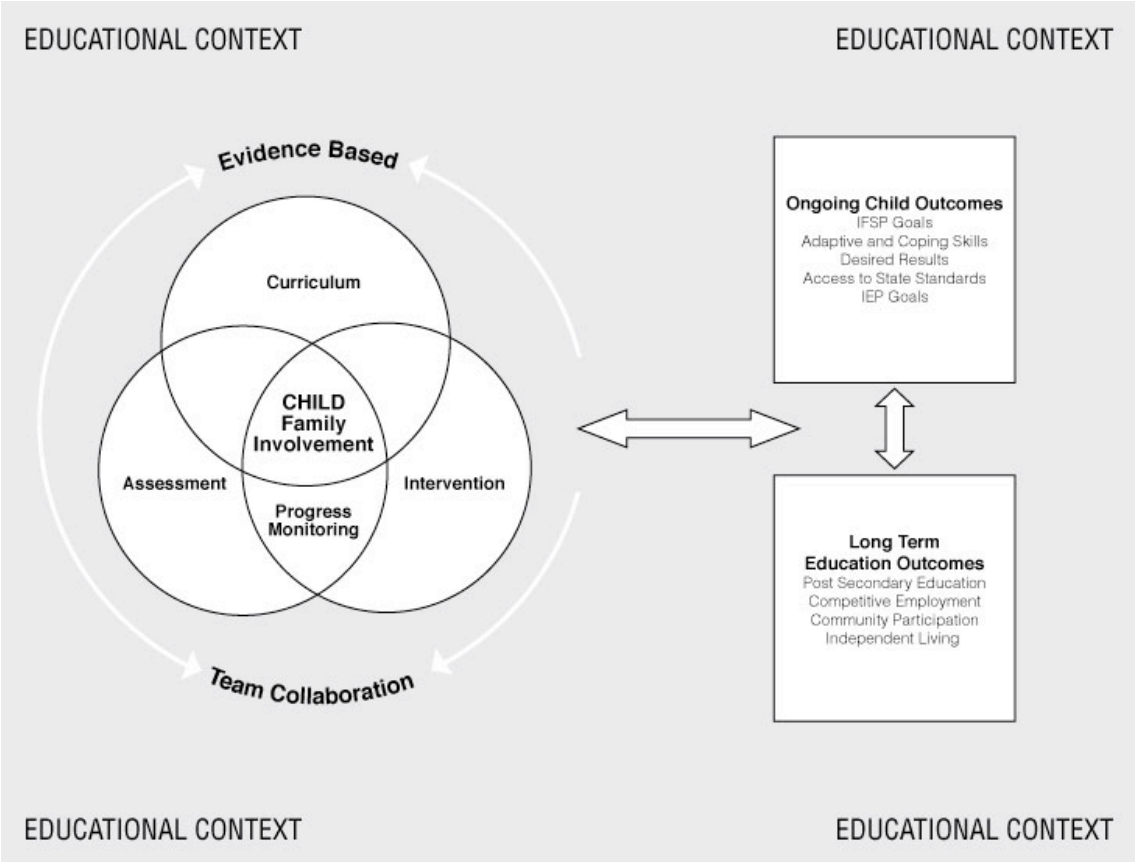
This system provides a common international language to share information and develop policy. The ICF focuses on human functioning and components of health and wellness while addressing environmental factors, such as the context in which the individual operates, and recognizing unique personal and cultural expectations. The ICF recognizes that two individuals may have the same disorder and yet their level of functioning, specifically the individual's level of activity and participation in life situations, may be substantially different (WHO 2001). These health and wellness concepts underlie the ways in which OT and PT are implemented under educationally related legislation in the schools.

In school-based practice, both OTs and PTs view disability in terms of the ways in which a child is faced with activity limitations and participation restrictions, instead of a focus on projected limitations of a singular diagnosis, disease, or disorder. The child's activity limitations and participation restrictions experienced in gaining access to the educational program are assigned a high priority.

The Guidelines Revision Workgroup (2010) expanded the Ecological Model of Student Performance (EMSP) found in the original *Guidelines for Occupational Therapy and Physical Therapy, Second Edition* (California Department of Education 1996). The new model embraces the World Health Organization focus on unique personal factors, a child-centered approach, the importance of the child's interaction in the educational environment, and access to activities for full participation in education to reach ongoing and postsecondary goals.

The Educational Framework for Child Success (EFCS), which continues to emphasize the importance of performance in the context of the school environment also highlights the importance of curriculum; evidenced-based practice; team collaboration; and ongoing as well as future postsecondary child outcomes, in alignment with IDEA 2004 and NCLB 2002 (see figure 1.1). OTs and PTs, as members of the educational team, work in a community of practice collaboratively with families; local and state departments; and community agencies to help children progress to postsecondary education and succeed.

Figure 1.1 The Educational Framework for Child Success (EFCS)



In the EFCS model, there is a direct relationship between curriculum based on the common core state standards (http://www.cde.ca.gov/re/cc) assessed need, goals, intervention, and projected outcomes. Monitoring progress and providing services on the basis of data are essential to promote consistency and effective learning.

Case Example

The story of John is used to illustrate how the Educational Framework for Child Success is applied in OT and PT practice. John is a third-grade boy with a specific learning disability and diagnosis of developmental coordination disorder according to the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association 2002). He attends a general education classroom, receiving instructional support from a special education teacher for spelling, writing, and math. His mother and teacher are concerned because it takes John all evening to finish his homework, and he cries when it is time to go to school. John is able to read and comprehend language at grade level but has trouble starting and finishing his school work. John's written work is poorly spaced and difficult to read, and his personal belongings are disorganized. John also has difficulty with mobility on the playground and does not play sports with the other children.

The OT and PT evaluations show that John has needs in the area of sensory processing and motor development that interfere with his ability to benefit from his education. The IEP team collaboratively decides that John needs OT and PT in order to make progress in his educational program. John's family and teacher are an integral part of the intervention and contribute to the strategies that can be readily integrated into John's daily routine. John's intervention is driven by his assessment, related to state standards, and focuses on his ability to gain access to the third-grade curriculum in his educational environment.

Evidence-based intervention and ongoing progress monitoring are implemented and aimed at targeted outcomes to support his annual IEP goals as well as his long-term success in education. John's growing physical, sensory, motor planning, organizational, and adaptive skills support his confidence in movement on the playground and the organization to more readily complete his written work. John soon looks forward to school and is beginning to talk about going to college someday.

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Chapter 2
Definitions, Qualifications, and Functions of Occupational Therapists and Physical Therapists in Public Schools

In school-based practice, OTs and PTs support a child's ability to gain access to and make progress in the school curriculum. OTs are health professionals whose purpose in a public school setting is to support a child's engagement and participation in daily occupations, which include activities of daily living, education, prevocational work, play, rest, leisure, and social participation (American Occupational Therapy Association 2008). PTs are health professionals whose purpose is to correct, facilitate, or adapt the child's functional performance in motor control and coordination, posture and balance, functional mobility, accessibility, and use of assistive devices (see http://www.apta.org). OTs and PTs have unique roles in the educational setting in working both on remediation (e.g., improving sensory and motor foundations of learning and behavior) and compensation (e.g., modifying the environment, tools, or task) to help a child succeed at school.

This chapter provides definitions, the educational qualifications, and functions of OTs and PTs in the school setting.

Definition of Occupational Therapy

The California Occupational Therapy Practice Act, *Business and Professions Code* Section 2570.2 (k) states:

> Practice of occupational therapy means the therapeutic use of purposeful and meaningful goal-directed activities (occupations) which engage the individual's body and mind in meaningful, organized, and self-directed actions that maximize independence, prevent or minimize disability, and maintain health.

Under IDEA regulations, Title 34, *Code of Federal Regulations,* Section 300.34(c)(6) defines "occupational therapy" as "services provided by a qualified occupational therapist; and includes (a) improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation; (b) improving ability to perform tasks for independent functioning if functions are impaired or lost; and (c) preventing, through early intervention, initial or further impairment or loss of function."

Qualifications of the Occupational Therapist

Occupational therapists must possess the educational background and a license to practice OT in California.

Educational Requirements

Beginning in 2007, the minimum educational requirement to become an OT is a master's degree in OT from an accredited program verified by the Accreditation Council for Occupational Therapy Education (ACOTE). OTs who entered educational programs

prior to 2007 may practice with a bachelor's degree. Included in the OT's education are courses in human anatomy and physiology, human development across the life span, kinesiology, neurology, medical diagnoses, physical disabilities, mental health, and activity and skills analysis. Course work includes biometry, qualitative and quantitative analysis, and occupational science. OTs study the occupation, habits, routines, engagement and participation of children and adults in the context of daily living throughout the life span. An OT must successfully complete appropriate clinical fieldwork requirements (usually six to nine months) as required by the educational program. Advanced training programs are also available to OTs in specialized practice areas (e.g., sensory integration, school-based practice, assistive technology, social skills, feeding, etc.).

Licensure Requirements

Currently, OTs must have graduated from an accredited institution to be licensed to practice OT in the state of California. They are required to pass the National Board for Certification in Occupational Therapy (NBCOT) examination and obtain a license in California through the California Board of Occupational Therapy. OTs must earn the minimum professional development units and meet professional and ethical standards to maintain licensure (BPC §§ 2570-2570.32).

Qualifications of Certified Occupational Therapy Assistants

Certified OT assistants (COTAs) provide OT, under the supervision of a licensed OT, to the child within the regulations and scope of practice as determined by the California Board of Occupational Therapy (BPC § 2570.2(h)).

Educational Requirements

COTA candidates must graduate from an accredited OT educational program at the associate or technical degree level. A COTA must satisfy the appropriate clinical fieldwork requirement (usually six to nine months) as required by the education program.

Certification

A COTA must apply for and attain a passing score on a national certification examination and obtain a certification through the California Board of Occupational Therapy. Minimum continuing education units and maintenance of professional and ethical standards are required to maintain certification (BPC § 2570.3(a)).

Definition of Physical Therapy

The California Physical Therapy Practice Act, in *Business and Professions Code* Section 2620, states:

> Physical therapy means the art and science of physical or corrective rehabilitation or of physical or corrective treatment of any bodily or mental condition of any person by the use of the physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and active, passive, and resistive exercise, and shall include physical therapy evaluation, treatment planning,

> instruction and consultative services. The practice of physical therapy includes the promotion and maintenance of physical fitness to enhance the bodily movement related health and wellness of individuals through the use of physical therapy interventions. The use of roentgen rays and radioactive materials, for diagnostic and therapeutic purposes, and the use of electricity for surgical purposes, including cauterization, are not authorized under the term "physical therapy" as used in this chapter, and a license issued pursuant to this chapter does not authorize the diagnosis of disease.

Under IDEA regulations, Title 34 of the *Code of Federal Regulations,* Section 300.34(c)(9) states, “Physical therapy means services provided by a qualified physical therapist.”

Qualifications of the Physical Therapist

A physical therapist must possess the educational background and a license to practice in California.

Educational Requirements

Beginning in 2002, the minimum educational requirement to become a PT is a master’s degree from an accredited program verified by the Council for Accreditation in Physical Therapy Education (CAPTE). PTs who entered educational programs prior to 2002 may practice with a bachelor’s degree or professional certificate. PTs are health professionals with specific training in kinesiology, human development, and the remediation of posture and movement dysfunction. Included in the PT’s education are courses in human anatomy and physiology; physical pathophysiology; joint and whole-body kinesiology; gait and posture analysis; human development, especially gross motor development and physical growth; motor control and motor learning; physical treatment modalities; and cardiopulmonary, orthopedic, and neurological rehabilitation. Advanced training and/or certification programs are also available to PTs in specialized practice areas. In addition, advanced training and postgraduate certification is available for various specialized areas (e.g., pediatrics, orthopedics, geriatrics, sports, etc.).

Licensure Requirements

Currently, to be licensed to practice PT in the state of California, individuals must have graduated from an accredited institution and passed national and state licensure examinations. Minimum continuing education units and maintenance of professional and ethical standards are required to maintain licensure (BPC §§ 2650–2655.93).

Qualifications of the Physical Therapist Assistant

Physical therapist assistants (PTAs) provide PT, under the supervision of a licensed PT, to the child within the regulations and scope of practice as determined by the Physical Therapy Board of California (BPC §2655(b)).

Educational Requirements

PTA candidates must graduate from an accredited PT assistant education program approved by the Board or have training or experience or a combination of training and experience that, in the opinion of the Board, is equivalent to that obtained in an approved PT assistant education program (BPC § 2655.9).

Licensure Requirements

A PTA must apply for and attain a passing score on a national examination and state license examination and obtain a license through the California Physical Therapy Board. Minimum continuing education units and maintenance of professional and ethical standards are required to maintain licensure (BPC § 2655(b)).

Functions of Therapists

Table 2.1 is provided to assist therapists and administrators in developing job descriptions, designating responsibilities, or considering roles and workloads. OTs and PTs are responsible for understanding their roles, responsibilities, practice standards, and legal mandates for each step of the special education, early intervention, or processes required under Section 504 of the Rehabilitation Act of 1973 (AOTA, APTA). A broad overview of OT and PT scope of practice and areas of expertise in relation to educational curriculum is included in Chapter 7. More detail regarding administrative issues is presented in Chapter 11.

Table 2.1. Functions of OTs and PTs in the School Setting

Process	Functions of the School Occupational and Physical Therapist
1. Pre-referral services and supports as part of general education process	• Assist in the identification and provision of appropriate pre-referral services to support a child's learning and behavior in the general education environment. • Assist with the development and delivery of in-service training or team teaching school wide or classroom-wide programs, curricula, or environmental modifications as an approach to the Response to Intervention and Instruction (RtI^2) process. • Contribute to team-based problem solving by attending a pre-referral meeting consisting of general education staff and any other professional(s) who may be able to offer suggestions for overcoming difficulties. • May screen an individual child to identify appropriate curriculum, instructional strategies, or classroom accommodations. • Collaborate with other professional(s) to provide assessment(s) and services. • May provide early intervening services (EIS) for selected populations or individual children in order to determine if a child may improve without the need to refer for special education assessment. • Participate in progress monitoring; assists in gathering and analysis of pre- and post-early intervening data for RtI^2 strategies. • May assist in determining effectiveness of EIS and the need for a referral for special education if not successful. Data collected regarding specific interventions and response are then used as part of the special education assessment.
2. 504 referral and services as part of general education	• May assist in determining child eligibility, identification of services and development of the 504 Plan in order to provide for appropriate education services designed to meet the needs of children with disability to the same extent as for children without disabilities.

Process	Functions of the School Occupational and Physical Therapist
	• May provide OT and PT as part of the 504 Plan. • Conduct re-evaluations periodically as specified on the 504 Plan or when there is a significant change of placement or services.
3. Special education referral and request for assessment	• May participate in the special education referral process for a child with suspected disabilities. • Assist in the development of the educational agency's OT and PT assessment request process and written procedures. • Facilitate the assessment request process for OT or PT services with general education, special education, and early intervention staff.
4. Special education assessment	• Complete the educationally related or early intervention OT or PT assessment, which includes child observation, record review, interview, performance-based, and standardized/non-standardized testing procedures in areas of suspected disability according to specified timelines. • Evaluate the child within educational setting assessing strengths as well as what may be interfering with learning and participation in the context of his or her curricular activities, routines, and environments. • Evaluate the child as requested by the IEP or IFSP team. • Consider parental concerns. • Consider the effect of cultural differences and language differences. • Consider the effect of existing special education supports and services (including strategies already utilized to improve performance). • Identify barriers to learning, participation, and independent functioning. • Assist the IEP team in identifying children with low-incidence disabilities and whether specialized equipment, materials, and services are required. • Assist in the evaluation of assistive technology needs and the functional impact of using a recommended device in the child's customary environment. • Consider future needs of the older child, including further education, employment and independent living skills. • Write the assessment report
5. IFSP infant and toddler program planning	• Review the OT or PT assessment findings at the IFSP meeting. • Assist in the identification of a child's present levels of educational, developmental, and functional performance abilities and needs. • Interpret report and links now the OT or PT findings relate to a child's performance in behavior, developmental, or functional abilities. • Develop outcomes at an IFSP meeting. • Assist the IFSP team in considering adapted equipment, modifications, or assistive device needs for the child. • Coordinate the implementation of goals/outcomes that support a child's transition to their future educational environment.
6. IEP planning	• Review the OT or PT assessment findings at the IEP meeting. • Assist in the identification of a child's present levels of educational, developmental, and functional performance abilities and needs. • Interpret report and link how the OT and PT findings relate to a child's performance in behavior and developmental or functional abilities. • Develop long-term and short-term goals and objectives at the IEP meeting. • Assist the IEP team in considering assistive technology needs of the child. • Coordinate the implementation of goals within the team to provide integrated services. • Collaborate with IEP team to develop goals/objectives that support the child's future needs and the transition plan. • Assist in developing appropriate measurable postsecondary goals based upon age-

Process	Functions of the School Occupational and Physical Therapist
	appropriate transition assessments related to participation, performance, training, education, employment, and independent living skills.
7. Transition planning and services	• May assist in the development of the transition plan, beginning when the child is age sixteen (and updated annually) to support future needs and further education, including postsecondary education, employment, and/or independent living. • Assist in developing and implementing curricular or instructional programs designed to prepare children for the transition to adult occupations and to reach established transition goals.
8. Intervention planning and implementation of IEP services	• Develop a therapy intervention plan that supports the IEP or IFSP goals and objectives and is based on peer-reviewed research to the extent practicable. • Develop a therapy intervention plan that includes adaptation or modification of the child's environment, materials, and curriculum if possible. • Develop a therapy intervention plan that may consist of a continuum of services including integrated classroom activities, group and individual interventions, and home programs as appropriate in meeting the child's needs in the least restrictive environment. • Implement the plan in appropriate setting and curricula. • Collaborate continually with the IEP team to develop and modify instructional and intervention strategies and monitor progress. • Assist in providing assistive technology services, such as the selection, procurement, adaptation, maintenance, and training in the use of assistive technology devices. • Consult with and train educational personnel, family members, or other professionals involved with the child in order to implement activities, strategies, use of assistive technology, or adapted equipment for use in the child's routines.
9. Documentation	• Document the findings, actions taken, and/or recommendations made regarding involvements in the special educational process (e.g., pre-referral services and supports, 504 referral and services, special education processes). • Document additional information as recommended by professional standards (e.g., summary of treatment, progress notes, discharge reports). • Maintain additional records as required by the therapist's employer or terms of contract.
10. Liaison	• Communicate by oral, written, or electronic means with all involved staff, co-workers, administration, children, and parents to ensure timely and efficient services. • May act as a liaison between the local school district and other entities (e.g., Department of Vocational Rehabilitation, Department of Mental Health, CCS, regional centers, community programs, physicians, etc.).
11. Staff development	• Develop and implement training opportunities and in-service training for other educational staff, parents, and administrators. • Attend workshops, in-service training, seminars, and other continuing education courses as required by licensure as to foster professional growth and knowledge of school-based practices. • Share continuing education information with coworkers.

Process	Functions of the School Occupational and Physical Therapist
12. OT and PT program management	• Perform activities required to plan, develop, implement, and evaluate school-based OT and PT services in conjunction with educational administrators. • Develop methods of quality assurance and program evaluation. • Develop procedures, reporting forms, and records to manage the program. • Coordinate child caseloads and assignments. • Participate in the development of the OT and PT budget. • Assist in the maintenance of the program and office materials, equipment, and supplies. • Establish and maintain assessment and protocol materials. • Provide guidelines for professional practice. • Participate on various committees for decision making. • Communicate with administration and other services units and departments. • Perform other activities as required to maintain the integrity of OT and PT services.
13. Supervision of therapy staff	• Supervise therapy staff in accordance with laws and regulations set forth by California licensure, professional organizations, and local school district procedures. • Communicate with administration regarding established policies and procedures for therapy staff.
14. Education system and facilities	• Participate in the development and implementation of new programs for children, staff, or departments. • Participate in the general decision-making process for OT and PT services and related issues or policies. • Participate in the assessment of school facilities and educational activities and make recommendations to ensure accessibility and reasonable accommodations to school environments for individuals with disabilities as mandated by federal and state laws.

The references below provide obtain more information regarding the functions of OT and PT in the school setting.

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Chapter 3
Evidence-Based Practice and Accountability

Utilizing evidenced-based practice and monitoring progress will facilitate meeting the child's ongoing and desired long-term educational outcomes. This chapter provides guidance and information on effective and efficient evidence-based practice.

Accountability and the Importance of Using Evidence-Based Practice

Education systems nationwide endorse the need for an evidence-based education approach and "the integration of professional wisdom with the best available empirical evidence in making decisions about how to deliver instruction" (Whitehurst 2002). Federal education statutes and regulations, including IDEA 2004 and NCLB 2002, stress accountability as measured by the "use of effective methods and instructional strategies that are based on evidence-based practice" (20 USC §§ 1401 and 6301). Those federal education laws, requiring scientifically based research, make it clear that evidence-based practice is the standard for accountability and must be utilized by school-based OTs and PTs. Evidence-based practice is the "integration of best research evidence with clinical expertise and [child] values" (Sackett et al. 2000, 1). The laws, as well as AOTA and APTA professional documents, recognize that evidence-based practice is a continuous, dynamic integration of research evidence, professional expertise, and child factors.

In addition to using evidence to inform practice, education professionals collect data to review intervention effectiveness in order to comply with the mandate for systematic and quantitative monitoring of the child's progress. Data can be collected through various methods during both general education, including early intervening services and Response to Intervention, and special education in order to document whether intervention strategies, including environmental adaptations and modifications, are effective at increasing the child's ability to gain access to the general curriculum and make progress.

See appendix 3.1 for a comprehensive list of federal education laws, regulations, and documents as well as AOTA and APTA professional documents that endorse evidence-based practice.

The Steps of Evidence-Based Practice

Evidence-based practice follows a five-step process designed to gather quality research evidence (Lin, Murphy, and Robinson 2010; Rappolt 2003; Sackett et al. 2000; Salmond 2007; Sarracino 2002; Tickle-Degnen 1999, 2000a, 2000b):

- Step 1: Ask a relevant practice question
- Step 2: Gather the best available research evidence
- Step 3: Critically appraise the research

- Step 4: Integrate research evidence
- Step 5: Evaluate the outcomes

Step 1: Ask a Relevant Practice Question
Relevant practice questions directly relate to a child's educational needs. Well-structured questions will assist the therapist in developing key search words and finding research on how to improve the effectiveness and efficiency of treatment. In school-based practice, relevant practice questions can directly incorporate the intent of therapy as reflected in a child's IEP goals/objectives.

Step 2: Gather the Best Available Research Evidence
A combination of research evidence, professional expertise, and consensus views should be used to answer the relevant practice question. Research evidence can be gathered from a variety of resources (see appendix 3.2 for a list of resources).

Step 3: Critically Appraise the Research
The appraisal process guides the OT and PT in evaluating the study's findings, deciding whether a research study is of sufficient quality with results that are applicable to school-based therapy (Kellegrew 2005). This step may be difficult, and many factors need to be considered for this process to be constructive. To begin, the OT or PT determines if the study is quantitative or qualitative. If the study is quantitative, the study must be categorized according to its research design and level of evidence. If the study is qualitative, it uses different research designs to examine the subjective views, experiences, and values of individuals and does not follow hierarchical quantitative levels of evidence. During the appraisal process, it is imperative to remember that the evidence-based practice philosophy utilizes the best available external research applicable to the situation. If no high level quantitative research is found, the practitioner should consider the next level of best available research (Sackett et al. 1996).

Appendixes 3.3 and 3.4 describe the various research designs and levels of evidence including OT and PT examples of research articles. Appendix 3.5 contains general questions that the school-based OT and PT should consider when reviewing a research article.

Step 4: Integrate Research Evidence
Therapists use their professional expertise coupled with knowledge of the child's functional needs to determine how to best integrate research evidence into service delivery. Well-informed collaborative decisions are made with the IEP team regarding when, where, and how often the intervention will be implemented to achieve the highest probability of desired outcomes.

Step 5*:* Evaluate the Outcomes
It is essential to evaluate whether the intervention used has research evidence for its effects on child progress (Tickle-Degnen 2000b). The evaluation process documents the outcomes of intervention and can uncover new areas of educational concern

(Rappolt 2003). Outcomes can be evaluated through observations, data collection, interviews, standardized and criterion-referenced tools, work samples, ratings, goal attainment scaling, and treatment notes (Elliot et al. 2002). If evaluation of the outcomes indicates that the child is not improving, the therapist can go back to the results of the current search to see if there are other viable resources or interventions to consider based upon the child and the context of the relevant practice question.

Becoming an Evidence-Based Practitioner

Whereas evidence-based practice is considered the gold standard for providing efficient services, it is acknowledged that many OTs and PTs often confront barriers to the implementation of evidence-based strategies into their workload. Barriers such as limited time, decreased access to research, and lack of appraisal skills have been cited through multiple studies (Cameron et al. 2005; Illiot 2004, Rappolt 2003). Appendix 3.6 provides some strategies to overcome these barriers.

OTs and PTs integrate evidence-based practice into their daily routine by fostering a culture of inquiry. A culture of inquiry is developed when the therapist examines his/her current treatment routines reflectively and seeks new knowledge to improve therapy outcomes. Examples of questions of inquiry include:

- “Why am I using this particular intervention?”
- “What is the evidence to support what I am doing?”
- “Is this intervention as effective as another intervention?”

Monitoring and Documenting a Child’s Outcomes

Monitoring a child’s progress and outcomes is essential for supporting decisions in a systematic and objective manner. Data collection consists of four stages in which information is analyzed and synthesized (Lehman and Klaw 2006; Sarracino 2002).

- Stage 1: Define the target functional outcome(s)
- Stage 2: Document the baseline
- Stage 3: Create measurable goals
- Stage 4: Implement the intervention; collect and evaluate the data

Stage 1: Define the Target Functional Outcome(s)

The target functional outcome(s) is the child’s performance, behavior, or skill that the team has identified as an area of needed educational improvement. OTs and PTs use a comprehensive screening and/or assessment process to identify the underlying supports and limitations that are affecting the child’s ability to gain access and make progress in the educational setting. Once underlying supports and limitations are hypothesized, functional outcomes can be identified. Optimal target functional outcomes consider the family’s priorities and are child-focused. Outcomes are operationally defined in measurable and functionally based terms.

Stage 2: Document the Baseline

A baseline is a child's current performance, behavior, or skill level prior to a selected intervention. In accordance with laws and regulations, OTs and PTs use multiple sources to establish and gather a baseline in order to obtain an accurate understanding of the child's current level. Sources for establishing a baseline may include criterion-referenced and standardized assessment tools; structured observations over various times of day with consideration of environmental demands; information from data collection sheets, parent/teacher interviews/questionnaires, and the IEP team (Asher 2007; Elliot et al. 2002).

Stage 3: Create Measurable Goals

A goal allows one to measure change over time. Short-term and long-term progress may be documented. Goals to address targeted behavior are supported by theoretical constructs and evidence in OT and PT practice that predict change as a result of therapy.

For example, goal attainment scaling (GAS) (Mailloux et al. 2007) is a sensitive and effective tool to gather baseline data and create goals to demonstrate progress in OT and PT intervention.

Stage 4: Implement the Intervention; Collect and Evaluate the Data

In OT and PT practice, the choice of an intervention is supported by research evidence and/or the therapist's expertise combined with child factors. OTs and PTs use their professional judgment and clinical reasoning, informed by current research, to determine the frequency and duration of an intervention. Once an intervention is in place, data are collected (using the same tools for establishing baseline) to determine the effectiveness of an intervention.

Case study examples supporting the use of evidence-based practice and data collection as a means of monitoring progress can be found in appendixes 3.7 and 3.8.

Evidence-based practice and progress monitoring are integral components of the Educational Framework for Child Success and are endorsed by federal education laws, regulations, and documents. OTs and PTs use evidence-based practice to monitor and document child outcomes and incorporate them into routine service delivery. Increased accountability results from those components.

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Appendix 3.1
Endorsements for the Use of Evidence-Based Practice and Data Collection for Progress Monitoring

Endorsing Body	Focus of Evidence-Based Practice Endorsement
Federal education laws, regulations, and documents	No Child Left Behind (NCLB 2001) • School personnel will "use effective methods and instructional strategies that are based on evidence-based practice" (20 USC 6301 et seq.) • Scientifically based research is defined as "(A) research that involves the application of rigorous, systematic and objective procedures to obtain reliable and valid knowledge relevant to education activities and programs" (20 USC § 7801(37).) Individuals with Disabilities Education Act (IDEA 2004) • The child's individualized education program (IEP) will provide "a statement of the special education and related services and supplementary aids and services, based on peer reviewed research to the extent practicable" (20 USC § 1414(d)(1)(A)(i)(IV)). • The education of children with disabilities can be made more effective by ''supporting high-quality, intensive preservice preparation and professional development for all personnel who work with children with disabilities in order to ensure that such personnel have the skills and knowledge necessary to improve the academic achievement and functional performance of children with disabilities, including the use of scientifically based instructional practices, to the maximum extent possible" (20 USC § 1414(c)(5)(E)). ***Response to Intervention (RtI)*** • Ensures "the access of all children to effective, scientifically based instructional strategies" (20 USC § 1413(f)(2)(A). • "Data-based documentation reflecting continuous monitoring of child performance and progress during interventions" (NJCLD, 2005). ***Core Content Access: Curriculum Guide for Children with Moderate to Severe Disabilities*** • Monitoring of progress includes "establish[ing] method(s) of collecting data" (CCESA/SEACO 2005, A-3).

Endorsing Body	Focus of Evidence-Based Practice Endorsement
AOTA	***Occupational Therapy Code of Ethics*** (2005) • Occupational therapists must "critically examine available evidence so they may perform their duties on the basis of current information" (p. 640). • It is an occupational therapist's duty to further expand professional knowledge by "maintaining and documenting competence in practice, education, and research by participating in professional development and educational activities" (p. 640). ***Standards of Practice*** (2005) • "An occupational therapist has the overall responsibility for the development, documentation, and implementation of the occupational therapy intervention based on evaluation, client goals, current best evidence, and clinical reasoning" (p. 664). ***Standards for Continuing Competence*** (2005) • An occupational therapist's knowledge must represent an "integration of relevant evidence, literature, and epidemiological data related to primary responsibilities and to the consumer population(s) served" (p. 661). • Critical reasoning should include an "application of evidence, research findings, and outcome data in making decisions" (p. 661). ***AOTA's Centennial Vision 2017*** • "Envision[s] that occupational therapy is a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society's occupational needs."
APTA	***APTA Code of Ethics*** • "Physical Therapists shall demonstrate professional standards, evidence (including current literature and establishing best practice), practitioner experience and patient/client values." (HOD S06-09-07-12) ***APTA Guide for Professional Conduct*** (2010) • ""It is the physical therapist's obligation to exercise sound professional judgment, based upon his/her knowledge, skill, training, and experience." ***APTA Vision Statement for Physical Therapy 2020*** • "Physical therapists and physical therapist assistants will render evidence-based services throughout the continuum of care and improve quality of life for society." ***APTA Professionalism in Physical Therapy: Core Values (2009)*** • "Excellence is physical therapy practice that consistently uses current knowledge and theory while understanding personal limits, integrates judgment and the patient/client perspective, embraces advancement, challenges mediocrity, and works toward development of new knowledge." This includes: "using evidence consistently to support professional decisions" and "pursuing new evidence to expand knowledge".

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Appendix 3.2
Resources for Gathering Research Evidence

Type of Resource	Name of Resource	Main Focus	Accessibility
Databases and search engines	Medline/ PubMed	Database for medical topics	Free www.pubmed.gov http://www.nlm.nih.gov/medlineplus/
	Ovid	Database of medical, scientific and academic research	Free www.ovid.com
	ERIC	Education bibliographic references and full-text articles	Free www.eric.ed.gov
	What Works Clearinghouse	Educational intervention reports and systematic reviews	Free www.whatworks.ed.gov
	TRIP database	Systematic reviews, Medline articles, full-text articles and medical guidelines	Free www.tripdatabase.com
	Free medical journals	Full-text articles in medical journals	Free www.freemedicaljournals.com
	Biomed Central	Full-text articles in medical journals (including pediatric journals)	Free www.biomedcentral.com
	ACP Journal Club	Critical appraisals of systematic reviews and research articles	Must purchase subscription www.acpjc.org
	Cochrane Library	Systematic reviews	Accessible through academic or hospital libraries or by purchase www.the cochranelibrary.com
	Google Scholar	Internet database	Free www.scholar.google.com
	OT Seeker	Systematic reviews and randomized controlled trials relevant to OT	www.otseeker.com
	PEDro	Physiotherapy bibliographic references and abstracts of randomized controlled trials, systematic reviews and guidelines for physiotherapy	Free www.pedro.org.au

Type of Resource	Name of Resource	Main Focus	Accessibility
Journals	American Journal of Occupational Therapy	OT research articles	Must be an AOTA member or purchase individual subscription www.aota.org/pubs/ajot_1.aspx
	Occupational Therapy International	International OT research articles	Must purchase a subscription
	OTJR: Occupation, Participation and Health	Research articles that advance the science of OT practice	Must purchase a subscription www.healio.com/journals/otjr
	Journal of the American Physical Therapy Association	PT research articles	Must be an APTA member www.apta.org

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Appendix 3.3
Quantitative Research Designs

Level	Research Design	Description	Research Example
I	**Systematic review**	A comprehensive literature review that highlights the validity of research methods and results on a specific topic	While, A., A. Forbes, R. Ullman, S. Lewis, L. Mathes, and P. Griffiths.2004. Good practices that address continuity during transition from child to adult care: Synthesis of the evidence. *Child: Care, Health & Development* 30*:* 439-52. • A systematic review of articles that identify how to best assist children and their families with disabilities in the transitioning process to adulthood and adult care.
	Meta-analysis	A type of systematic review that utilizes a statistical summary.	Pless, M. and M. Carlsson.2000. Effects of motor skill Intervention on developmental coordination disorder: A meta-analysis. *Adapted Physical Activity Quarterly* 17 381–401. • A meta-analysis of 13 studies to support motor skill intervention for children with DCD. This analysis can be used to help a school practitioner to decide whether to use a motor skill intervention approach to facilitate the child's access to education.
	Randomized controlled trial	Participants are randomly assigned to either an experimental group or a control group. This type of research design ensures that both groups are equivalent, which controls for confounding variables.	Smith-Zuzovsky, N., and C. E. Exner. 2004. The effect of seated positioning quality on typical 6- and 7-year-old children's object manipulation skills. *American Journal of Occupational Therapy* 58(4), 380-388. • Object manipulation skills were compared between children seated in appropriate size classroom furniture compared with children seated in large inappropriate size classroom furniture. The study's results suggest that the fit of furniture relative to the child's size impacts a typical child's in-hand manipulation skills.
II	**Two groups, nonrandomized**	Causative events are identified and predictions made (does not prove causality); examples include cohort study (examines a cohort of participants who share a specific condition or receive the same intervention) and case control study (retrospectively examines what makes a group of individuals different in comparison with a control group).	Parham, L. D. 1998. The relationship of sensory integrative development to achievement in elementary students: Four-year longitudinal patterns. *Occupational Therapy Journal of Research* 18: 105–27. • A longitudinal study in which the SIPT was administered to 32 children identified with a learning disability and 35 children with no learning disability. Sensory integrative factors (particularly praxis) were found to be strongly related to arithmetic achievement at younger ages.

Level	Research Design	Description	Research Example
III	**One group, non-randomized**	Initial baseline data and outcome data for a group of participants (e.g., before and after, and pre-test and post-test) are evaluated.	Stuberg, W. S., and L. DeJong. 2007. Program evaluation of physical therapy as an early intervention and related services in special education. *Pediatric Physical Therapy* 19: 121–127. • This article evaluated the child at the time of the IEP or IFSP at the beginning of the year and then tracked the progress for the IEP or IFSP at the end of the year using a computer system. The results found that 91 percent of the children in the study met their goals and objectives.
IV	**Single-subject design**	Initial baseline data and outcome data for an individual participant are evaluated.	Schilling, D. L., K. Washington, F. F. Billingsley, and J. Deitz.2003. Classroom seating for children with attention deficit hyperactivity disorder: Therapy balls versus chairs. *American Journal of Occupational Therapy* 57(5): 534–41. • Evaluates three students' with ADHD in-seat behavior and legible word productivity when seated on a chair or a therapy ball. The results found that sitting on a therapy ball increased students' in-seat behavior and legible word productivity.
	Case series	Collection of reports on the treatment of individual participants.	LaForme-Fiss, A. C., and S. K. Effgen. 2007. Use of groups in pediatric physical therapy: survey of current practice. *Pediatric Physical Therapy*, 19, 154-159. • Looks nationwide at physical therapists that are using groups within physical therapy treatment and the setting those occur in. The results found that 41.4% use groups with children of similar disabilities and occurred more in the school setting.
V	**Case report**	A written summary of a clinical suspicion or possibility.	Montgomery, P. C. 2000. Achievement of gross motor skills in two children with cerebellar hypoplasia: longitudinal case reports. *Pediatric Physical Therapy*, 12, 68–76. • This article looked at two children with this diagnosis as they attained gross motor skills. The article follows the children into the school system and how they were able to gain access to the educational environment with their peers.

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Appendix 3.4
Qualitative Research Designs

(Adapted from Letts et al. 2007)

Research Design	Description	Research Examples of a Qualitative Study
Ethnography	Describes a culture.	Spitzer, S. 2003. With and without words: Exploring occupation in relation to young children with autism. *Journal of Occupational Science* 10(2): 67–79. A phenomenological observation method was used to explore what constitutes an occupation of five young children diagnosed with autism who seldom use language to communicate. The findings suggest that everyday activities can be defined through observations in the moment. Wiseman, J. O., J. A. Davis, and J. Polatajko. 2005. Occupational development: Towards an understanding of children's doing. *Journal of Occupational Science* 12(1): 26–35. Use of semistructured child and parent interviews to identify the factors contributing to children's occupational development. The study found two emerging themes: children's occupations develop over time following a process (e.g., opportunities, resources, motives, parental views and values), and the occupation choice is influenced by various factors (e.g., innate drive, exposure, initiation, continuation, transformation, cessation, and outcomes). These findings could be useful in understanding sociocultural issues in school-based practice.
Phenomenology	Seeks to understand the phenomenon of a lived experience (e.g., an emotion, a diagnosis, being part of an organization or group).	
Grounded theory	Generates a theory through continuous data analysis	
Participatory action research	Individual(s) or groups research their own personal beings, socio-culture and experiences through reflecting on their values, shared realities/meanings, needs and goals	

Selected References

Letts, L., S. Wilkins, M. Law, D. Stewart, J. Bosch, and M. Westmorland. 2007. Guidelines for Critical Review Form: Qualitative Studies(version 2.0). http://www.srsmcmaster.ca/Portals/20/pdf/ebp/qualguidelines_version2.0.pdf (accessed May 2007)

Appendix 3.5
Appraisal of a Research Study's Applicability to the Educational Setting

(Adapted from Law et al. 1998; Letts et al. 2007; Sackett et al. 2000)

Components of a Research Article	Questions to Consider *
Study purpose	• What is the study's purpose? • Are all terms operationally defined? • Does the study's purpose apply to your relevant practice question?
Literature	• What is the justification for the need of this study?
Design	• What is the study's design? If it is a quantitative study, what level of evidence is the study? • Is there bias resulting from the study's design that may influence the results?
Sample	• What is the study's sample (e.g., number of participants, participant characteristics, how the sample was chosen)? • Is the sample similar to the school-based OT or PT caseload?
Method	• What method was used? • Does the methodology address the study's purpose? • Are there any methodological limitations that may influence the study's outcomes? • Could the methodology be replicated in school-based practice (e.g., feasible in terms of cost, time, space, etc.)?
Data collection	• How and with what frequency are the data collected (e.g., if it is a quantitative study, are the outcome measures reliable and/or valid; if it is a qualitative study, is there procedural rigor)? • Can similar data collection strategies be used within the school setting to monitor child progress?
Data analysis and results	• What are the study's results? • Are the findings consistent and reflective of the data collected? • If a quantitative study, are the results statistically significant (e.g., $p < 0.05$)? If the results are not statistically significant, was the study size large enough to show an important difference if it should occur? If there were multiple outcomes, was that taken into account for the statistical analysis?
Conclusions and limitations	• What did the study conclude? • What were the main limitations or biases of the study? • What meaning and relevance does the study have for school-based OT or PT? • Can the study's findings directly support a child's education or access to the school environment?

*There are similarities in the questions to consider for critically appraising both quantitative and qualitative research; however, there are also distinct differences. For further information, please see Selected References.

Selected References

Law, M., D. Stewart, N. Pollock, L. Letts, J. Bosch, and M. Westmorland. 1998. Critical Review Form: Quantitative Studies. http://www.srs-mcmaster.ca/Portals/20/pdf/ebp/quanreview.pdf (accessed August 2010).

Letts, L., S. Wilkins, M. Law, D. Stewart, J. Bosch, and M. Westmorland. 2007. Critical Review Form: Qualitative Studies (Version 2.0). http://www.srsmcmaster.ca/Portals/20/pdf/ebp/qualreview_version2.0.pdf (accessed August 2010).

Sackett, D. L., S. E. Straus, W. S. Richardson, W. Rosenberg, and R. B. Haynes. 2000. *Evidence-Based Medicine: How to Practice and Teach EBM.* 2nd ed. Edinburgh: Churchill Livingstone.

Appendix 3.6
Strategies for Becoming an Evidence-Based Practitioner

Challenges	Potential Solutions
Finding time	• Request administration for additional workload time and explain federal education's mandate for implementing evidence-based practice and progress monitoring. • Join/create a monthly departmental meeting or journal club to share the task of searching and critiquing evidence. • Accumulate found research into a departmental evidence-based practice library.
Increasing access to research literature	• Become an AOTA or APTA member to gain access to journals, professional magazines/periodicals, listservs, and special interest sections. • Use electronic databases, journals, and Web sites that are free of charge. • Encourage administration to purchase subscriptions to electronic databases and journals. • Attend professional conferences and continuing education classes that are research based. • Join a regional group. • Join a listserv and ask members questions about the latest research/references relating to clinical questions. • Assign fieldwork students to find relevant evidence relating to practice questions (therapy fieldwork students have access to university libraries and databases of evidence). • Often university alumni associations provide access to university libraries and databases of evidence
Critically appraising articles	• Enroll in a statistics or research methods course or use an online tutorial to learn how to critically appraise an article. • Request a district in-service on the topic of critical appraisal. • Join/create a departmental meeting or journal club to critically appraise research with colleagues. • Assign fieldwork students to critically appraise evidence relating to a relevant practice question (most therapy fieldwork students have taken a research methods class). • Practice finding and appraising research regularly.

Appendix 3.7
Occupational Therapy Case Study

A bright seven-year-old child in a general education first-grade classroom with a medical diagnosis of attention deficit hyperactivity disorder (ADHD) is having difficulties attending throughout the day (particularly in math). Decreased attention is interfering with the child's ability to make educational progress (the child is completing less than 50 percent of assigned class work). The child lives at home with his parents and older sister in a supportive and stable family environment.

In accordance with a Response to Intervention (RtI) multitiered approach, the OT addresses child learning through first examining the general education curriculum. The OT has already participated in Tier I teacher consultation (e.g., presented a teacher in-service on sensory motor development) and Tier II general classroom screening (e.g., discussed changing classroom desk structure to increase chalkboard and teacher visibility) See Chapter 7 for a detailed description of RtI and the three tiers of the pre-referral process.

These prevention techniques have not increased the child's ability to attend; therefore, the child is now being referred to the Student Success Team (SST) for targeted intervention strategies (Tier III). The OT observes the child fidgeting and rocking while seated in a desk chair and leaning rather than sitting upright. The OT hypothesizes that those behaviors may be sensory-related. The OT uses an evidence-based practice approach and a systematic method to monitor and document the child's outcomes. The effectiveness of intervention and of the accommodation strategies (see Chapter 3) may be determined by this approach.

Stage 1 of Monitoring and Documenting the Child's Outcomes: Define the Target Functional Outcome(s). The SST identifies the target functional outcome as improving the child's independence in attending to assigned classwork while the child is seated at the desk.

Stage 2 of Monitoring and Documenting the Child's Outcomes: Document the Baseline. In order to systematically and objectively monitor the child, the OT first decides to collect data to document the child's baseline. The OT provides a simple data collection sheet for the teacher to fill out at least three out of five days for two weeks to document the child's current level of attention to task. In creating a data collection sheet, the OT follows these recommendations:

- The data sheet must be easy to understand and simple to use, with operationally defined terms.
- The template should include the child's name, data collector's name, dates/times observed, instructions/examples of how to fill out the form, and a section to report possible outside factors (Honaker 2005; Lehman and Klaw 2003).
- Data should be collected during the same type of day/activity.

- Data should be collected discreetly to protect the dignity of the student (SEACO 2005).
- The more data points that are gathered, the more information can be captured about variability of change, and the more accurate inferences may be made regarding child progress (Elliot et al. 2002).

An example of the data collection sheet is below:

Data Sheet for Child's Ability to Attend During Math *"Attention" is defined as working independently and attending to task with no more than two prompts from the teacher (e.g., verbal reminders or physical cues).*		
Directions: This form must be filled out by the child's teacher during math (10:00-10:30) at least three out of five days a week and collected over a two-week period.		
Date	**Number of Individual Prompts (does not include general prompts given to the entire class)**	**Comments/observations pertaining to outside factors (e.g., health, arousal, extenuating circumstances, medications, etc.)**
4/7	4	N/A
4/9	4	N/A
4/11	5	Child is observed to have a runny nose.
4/14	3	Good day ☺
4/15	4	N/A
4/17	5	Very fidgety today

Stage 3 of Monitoring and Documenting the Child's Outcomes: Implement the Intervention and Collect and Evaluate the Data. The OT uses an evidence-based practice approach to determine what type of classroom accommodation should be implemented in order to comply with federal education laws and regulations as well as fulfill AOTA's ethical requirements to utilize best available research. The OT undertakes the following evidence-based practice steps:

Step 1: Ask a relevant practice question. The OT formulates a relevant practice question: "Is the use of sensory strategies effective to increase on-task performance in the classroom for children with ADHD?"

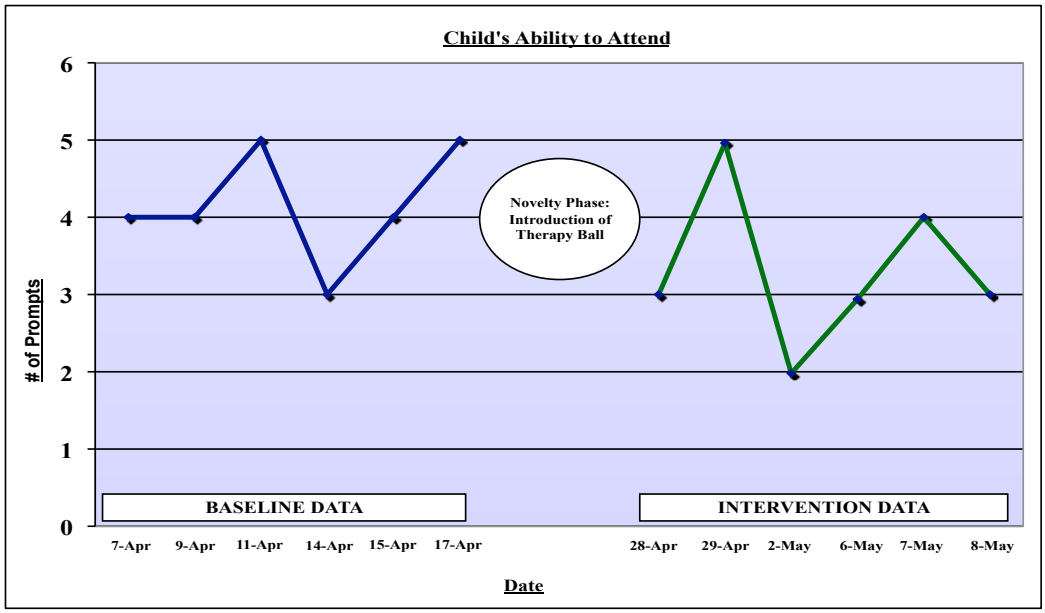
Step 2: Gather research evidence. The OT gathers research evidence using online resources (appendix 3.2) with the assistance of her fieldwork occupational therapy student (who has access to the university library).

Step 3: Critically appraise the research. After examining the found research, the OT critically appraises a research article by Schilling and others (2003). The findings report that therapy balls are an alternative classroom seating accommodation for children with ADHD in order to increase a child's in-seat behavior and legible word productivity. Even though this study is categorized as lower-level research (e.g., Level IV single subject, withdrawal design), the OT critically appraises the research and determines that the study is well designed

and the findings applicable to the child in the school setting.

Step 4: Integrate research evidence. Prior to collecting data on the effects of the therapy ball seating accommodation for the child, the OT introduces an appropriate sized therapy ball to the child for one week in order to account for novelty effects. The OT then instructs the teacher to use the same data collection sheet (see above) to monitor the child's progress.

Step *5:* Evaluate the outcomes. To evaluate the data, the OT graphs the documented data to assess the presence of a positive trend, negative trend, or variability (see below). The data are found to not represent child outcomes in the desired direction of improved attention.



Selected References

Elliot, S. N., J. C. Witt, T. R. Kratochwill, and K. C. Stoiber. 2002. Selecting and Evaluating Interventions. In *Interventions for Academic and Behavioral Problems II: Preventive and Remedial Approaches,* ed. M. Shinn, H. Walker, and G. Stoner. Bethesda, MD: NASP Publications.

Honaker, D. 2004. Got Proof? Gathering Evidence in School-Based Practice. Orange County OT and PT Professional Development. Anaheim, CA. October.

Lehman, J., and R. Klaw. 2006. *From Goals to Data and Back Again: Adding Backbone to Developmental Intervention for Children with Autism.* London: Jessica Kingsley Publishers.

Schilling, D. L., K. Washington, F. F. Billingsley, and J. Deitz. 2003. Classroom Seating for Children with Attention Deficit Hyperactivity Disorder: Therapy Balls Versus Chairs. *American Journal of Occupational Therapy* 57(5): 534–41.

Special Education Administrators of County Offices (SEACO). 2005. *Instructional Best Practices: Curriculum Guide for Students with Moderate to Severe Disabilities.* Los Angeles: Lakeshore Learning Materials.

Appendix 3.8
Physical Therapy Case Study

Judy is a physical therapist with ten years of experience, who works for the California public school system. Joey is a three-year-old child with an orthopedic impairment, a condition that makes him eligible for PT on the basis of educational need. Joey has begun preschool in a special day class. Joey is a twin with an unremarkable birth history. He lives at home with his parents and twin brother.

His teacher reports that Joey is not able to negotiate the three stairs leading to the playground without assistance, and he has difficulty maintaining his balance when sitting in a chair. The teacher refers Joey for a PT evaluation. A PT evaluation revealed decreased muscle tone throughout all muscle groups. He exhibited decreased strength as demonstrated by his inability to sustain antigravity positions. He demonstrates decreased balance as he has difficulty ambulating over uneven surfaces and does so slowly to compensate. He demonstrates only momentary single limb balance. His posture is lordotic, his knees are hyperextended, and his ankles are pronated. Previous developmental testing using the Bayley Scales of Infant and Toddler Development, Third Edition (Bayley III) placed him in the mildly delayed range for gross motor skills. He is unable to negotiate stairs without handheld assist, jump, or get access to age-appropriate play structures without assistance. Joey's mother reports that he is not as active as his twin and is not as strong. Joey's mother was given the Evaluation of Sensory Processing (ESP), and Joey received a score of 209—possibly suggestive of sensory processing issues.

Joey's PT, teacher, and parents are concerned that his gross motor delays hinder his ability to gain access to the playground safely and independently in order to participate with his peers in age-appropriate activities. The teacher is concerned that he cannot maintain balance when sitting and reaching. The following IEP goals were established:

1. "By May 30 to demonstrate improved strength and balance, Joey will be able to descend a flight of three regular height stairs with one hand on the rail using a step to pattern with stand-by assist, 80 percent."
2. "By May 30 to demonstrate improved strength and balance, Joey will be able to ascend a flight of three, regular-height stairs using one hand on a rail using a reciprocal pattern, 80 percent."
3. "By May 30 to demonstrate improved strength and balance, Joey will be able to reach 10 degrees off his base of support while sitting with feet unsupported, without losing balance or seeking support, 80 percent."

At the IEP meeting, it was determined that Joey would receive PT services twice per week, 30 minutes each in the school setting. Based on the physical therapy evaluation (developmental testing using the Bayley III and the ESP), Judy hypothesizes that Joey's gross motor delays may be due to poor sensory processing and poor motor learning resulting in decreased activity and decreased strength. Judy is aware of several

treatment strategies, which could be implemented to help Joey achieve his goals. In order to provide effective intervention grounded in research, she looks for evidence as to which approach is the most beneficial for a child with gross motor delays and which approach can best be provided in the school setting.

Step 1: Ask a Relevant Practice Question. Judy is aware of two treatment approaches that she feels would be the most beneficial to treat a child with gross motor delays, sensory processing deficits, and hypotonia. She wonders which treatment would be most beneficial. She formulates a relevant practice question: "In young children with gross motor delay and hypotonia and sensory processing deficit, is physical therapy intervention using a structured sensorimotor approach more beneficial than intervention using a sensory integration approach as measured by goal attainment?"

Because Judy wants to use goal attainment as an outcome measure, she wonders if goal attainment scaling (GAS) is a valid outcome measure. To decide, she formulates another relevant practice question: "In young children with gross motor delay receiving physical therapy, is goal attainment scaling a valid outcome measure?"

Step 2: Gather Research Evidence. Using the relevant practice questions, Judy develops the following key words to be used in an online PubMed literature search:

First search-question key words: physical therapy, motor learning, gross motor delay, sensorimotor, and sensory integration.

Second search-question key words: goal attainment scaling and validity.

The literature review found several intervention articles for children with gross motor delays, developmental coordination disorder, and sensory integration deficits. One article reported on a randomized clinical trial comparing a sensorimotor approach with a sensory integration approach:

DeGangi, G., S. Wietlisbach, M. Goodin, and N. Schnier. 1993. A Comparison of Structured Therapy and Child-Centered Activity in The Treatment of Preschool Children with Sensorimotor Problems. *American Journal of Occupational Therapy* 47: 777–86.

To answer the second question regarding the validity of GAS, a validity study was found:

Palisano, R. 1993. Validity of Goal Attainment Scaling in Infants with Motor Delays. *Physical Therapy* 73: 651–60.

Step 3: Critically Appraise the Research. The DeGangi study is a randomized clinical trial using a repeated measures crossover design. Twelve children were randomly assigned to a therapist, the evaluators were blinded, and the intervention order was randomized. All of these procedures protect the internal validity. This study represents level I research on the evidence hierarchy. The results of this study indicated that when the structured sensorimotor approach was used, the children improved more in gross motor skills than when they were treated with the child-centered approach. This study presents some evidence that a structured sensorimotor approach is beneficial in

treating children with gross motor delay and sensory motor dysfunction. Judy decided that the children in the study presented with similar problems as Joey.

The Palisano study researched content validity of GAS, the concurrent validity between GAS and the Peabody Developmental Gross Motor Scale, and the responsiveness of GAS compared with behavioral objectives. Content validity was measured by ten pediatric PTs that rated the goals established by three treating therapists. Content validity was supported as the percentages of favorable ratings were high (88 percent, 77 percent, and 79 percent). Correlations between the GAS T scores and the Peabody were low. The authors stated that this supports the conclusion that GAS and the Peabody measure different components of motor development. The study provides evidence that the GAS can be useful to measure outcomes that are small and are directly related to treatment objectives.

Step 4: Integrate the Research Evidence. Judy decides to use a sensorimotor approach as a frame of reference for providing PT services to Joey in the school setting.

Step 5: Evaluate the Outcomes (using GAS). Judy used her professional expertise to develop five levels of each IEP goal (two levels above expected performance and two levels below expected performance):

GAS Goal 1

+2 Child will be able to descend a flight of three regular-height stairs without a handrail by using a reciprocal pattern with stand-by assist.
+1 Child will be able to descend a flight of three regular-height stairs with one hand on handrail by using a reciprocal pattern and verbal cues.
0 Child will be able to descend a flight of three regular-height stairs with one hand on handrail by using a step-to pattern with stand-by assist.
-1 Child will be able to descend a six-inch step independently.
-2 Child will be able to descend a six-inch step with minimal assist.

GAS Goal 2

+2 Child will be able to ascend a flight of three regular-height stairs without a handrail by using a reciprocal pattern and verbal cues.
+1 Child will be able to ascend a flight of three regular-height stairs without a handrail by using a step-to pattern and verbal cues.
0 Child will be able to ascend a flight of three regular-height stairs by using one hand on a rail using a reciprocal pattern.
-1 Child will be able to ascend a flight of three regular-height stairs by using one hand on a rail using a step-to pattern and stand-by assist.
-2 Child will be able to ascend a flight of three regular-height stairs, with one hand held, using a step-to pattern.

GAS Goal 3

+2 Child will be able to reach 15 degrees off his base of support while sitting with feet unsupported, without losing balance or seeking support, five of ten times.

+1 Child will be able to reach 10 degrees off his base of support while sitting with feet unsupported, without losing balance or seeking support, eight of ten times.
0 Child will be able to reach 10 degrees off his base of support while sitting with feet unsupported, without losing balance or seeking support, five of ten times.
-1 Child will be able to reach 10 degrees off his base of support while sitting with feet unsupported, without losing balance or seeking support, three of ten times.
-2 Child will be able to reach 5 degrees off his base of support while sitting with feet unsupported, without losing balance or seeking support, five of ten times.

Judy then placed the above numbers into a formula in order to calculate a T score:

Goal	Wi	Xi	Wi Xi	Wi2
1	2	0	0	4
2	1	1	1	1
3	3	1	3	9
∑	6		4	14

$$T = 50 + \frac{(10 \sum Wi\ Xi)}{\sqrt{(1-r)\sum Wi2 + r(\sum Wi)2}}$$

Abbreviations: Wi = Weight Xi = Outcome ∑ = Total

Conclusion

Judy concluded that Joey shows improvements as measured by the Goal Attainment Scaling. He achieved all of the goals established. His goal attainment T score was 58.81, which demonstrated a significant change.

Chapter 4
Laws, Regulations, and Policies

OT and PT in the educational system are mandated in federal and state laws, regulations, and policies. Over the years, a change has occurred in special education laws, regulations, and policies: from giving children with disabilities the same access to public education as their nondisabled peers have, to, most recently, a model of accountability that looks at results and outcomes of education (for both general education and special education). This chapter reviews laws, regulations, and policies such as those in the *United States Code* (USC), *Code of Federal Regulations* (CFR), *Education Code,* and *California Code of Regulations* (CCR) that provide the basis for understanding the role of OT and PT in education.

The three key federal statutes affecting public education, including special education and the provision of OT and PT, are the:

- Individuals with Disabilities Education Act (IDEA 2004),
- No Child Left Behind Act of 2001 (NCLB), and
- Rehabilitation Act of 1973, Section 504 (29 USC § 794).

NCLB and the IDEA work hand in hand to improve educational standards for all children. Section 504 is a civil rights statute, similar to the American Disabilities Act, that prohibits discrimination on the basis of disability by any recipient of federal funds. The mission of Section 504 includes making America accessible to individuals with disabilities so that they do not suffer discrimination from lack of access to a public education.

No Child Left Behind Act of 2001

No Child Left Behind was enacted to address accountability and ensure success for all children receiving a public education. This act articulated four main concepts in public education: (1) accountability for results and adequate yearly progress in education with an emphasis on reading and mathematics; (2) flexibility for states and communities use of educational funds; (3) use of research-proven instructional methods and materials; and (4) parental information, influence, and choices regarding educational services (20 USC § 6301 et seq.).

Individuals with Disabilities Education Act

IDEA 2004 is a federal law that ensures that children who have disabilities receive a free appropriate public education (FAPE) designed to meet their unique needs (34 CFR § 300.17). As a condition of federal funding, IDEA requires states to provide a FAPE in the least restrictive environment. That is, to the extent appropriate, children with disabilities must be educated with nondisabled children and not segregated (34 CFR § 300.114).

IDEA 2004, Part A

Part A addresses general provisions and refers to the use of high-quality personnel who have the necessary knowledge and skills to effectively teach and intervene with children with disabilities (20 USC § 1401(10)). Qualifications for related services are addressed under Part B.

IDEA 2004, Part B

Part B provides assistance for education of all children with disabilities (20 USC § 1411, et seq.) Under Part B, states are required to specifically establish and maintain qualifications for personnel and paraprofessionals providing relating services that are consistent with any discipline-specific "state-approved or state recognized certification, licensing, registration, or other comparable requirements" and that those requirements cannot have not been waived on an "emergency, temporary, or provisional basis" (20 USC § 1412(a)(14)(B)). Policy language at 20 USC § 1412(a)(14)(D) also directs states to require local districts to "take measurable steps to recruit, hire, train, and retain highly qualified personnel" to provide special education and related services.

Part B requires that a child must be found eligible for special education under one of 13 disabling conditions. These disabilities, defined in regulations are:

> Autism, deaf-blind, deafness, emotional disturbance, hearing impairment, intellectual disability, multiple disabilities, orthopedic impairment, other health impairment, specific learning disability, speech or language impairment, traumatic brain injury, and visual impairments including blindness (34 CFR § 300.8(c)).

In California, an additional eligibility category of "established medical disability" is defined as "a disabling medical condition or congenital syndrome that the individualized education program team determines has a high predictability of requiring special education and services" (EC § 56441.11(d)*)*.

The IEP team first determines whether the general education teacher and special education teacher can meet the needs of the child who has been found eligible for special education. If the child presents with additional needs that cannot be met by the teacher, then related services should be explored. Special education means educating the child, at no cost to the parents, to meet the unique needs of a child with a disability, including specially designed instruction (34 CFR § 300.39; EC § 56031).

"Related services" are defined by IDEA 2004 as:

> Transportation and such developmental, corrective, or supportive services as are required to assist a child with a disability to benefit from special education…(34 CFR §300.34(a)). They may not be offered separately from special education unless state standards consider the service to be special education [34 CFR §300.8(a)(2)(i) and (ii)) . . . and includes speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes (34 CFR 300.34(a)).

In California, related services are also defined as “designated instruction and services” according to EC § 56363)(a).

The specific wording in Title 34 of the *Code of Federal Regulations* Section 300.34(c)(6) states:

> Occupational therapy includes-
> (A) Improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation;
> (B) Improving ability to perform tasks for independent functioning when functions are impaired or lost; and
> (C) Preventing, through early intervention, initial or further impairment or loss of function.

The federal regulation in Title 34 of the *Code of Federal Regulations,* Section 300.34(c)(9), simply states: “Physical therapy” means “services provided by a qualified physical therapist.”

The IDEA requires an IEP for each child with a disability. The IEP addresses, among other things, the least restrictive environment (LRE), transition services, and assistive technology (AT) services (34 CFR §§300.320; 300.114; 300.43; and 300.105). The IEP is considered a working document under Part B, specifying the special education services to be provided to children age three to twenty-one (EC § 56026(c)). The IEP documents a child’s eligibility for services; the present level of functioning by the child; appropriate goals, objectives, services, and service providers as well as specific modifications and accommodations needed for a child to benefit from education (34 CFR § 300.320; EC § 56345).

OT and PT services are provided when the IEP team designates such services as necessary for the child to meet goals and objectives or outcomes (*id*). The IEP will also designate the frequency and duration of the OT or PT services needed to meet the specific goals and objectives or outcomes (EC § 56345(a)(7)). OT or PT is specified on an IEP when it is determined that a child needs these services in order to work toward meeting the established goals and objectives. In this case, these services are considered, and often referred to, as “educationally necessary” OT or PT related services. Such services are subject to the LRE requirement described earlier. Each educational agency needs to provide a continuum of alternative placements and related service options to meet the needs of children with disabilities. OT and PT services must be considered within the context of a child’s total educational program (EC § 56360 et seq.).

Under Part B, transition must be included on the IEP of all children sixteen years or older (34 CFR § 300.43; EC §§ 56345(a)(8) and 56345.1). “Transition services” means a coordinated set of activities for a child with a disability that:

> (1) Is designed to be within a results-oriented process, that is focused on improving the academic and functional achievement of the child with a disability to facilitate the child's movement from school to post-school activities, including postsecondary education, vocational education, integrated employment (including supported employment), continuing and adult education service is, independent living, or community participation;

(2) Is based on the individual child's needs, taking into account the child's strengths, preferences, and interests; and includes--

(i) Instruction;
(ii) Related services;
(iii) Community experiences;
(iv) The development of employment and other post-secondary adult living objectives; and
(v) If appropriate, acquisition of daily living skills and provision of a functional vocational evaluation

Federal regulations (20 USC § 1401(2)) define the meaning of assistive technology services: “assistive technology service means any service that directly assists an individual with a disability in the selection, acquisition, or the use of an assistive technology device.” The term includes:

(A) the evaluation...;
(B) purchasing, leasing...;
(C) selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
(D) coordinating and using other therapies, interventions, or services with assistive technology devices...;
(E) training or technical assistance for such child, or where appropriate, the family of such child; and
(F) training or technical assistance for professionals (including individuals providing education).

In California regulations, OTs and PTs are specifically listed among those who may provide assistive technology services (5 CCR § 3065(b)(2)(A),(B). An overview of the key changes in IDEA 2004 Part B regulations that may affect related services is included in appendix 4.1.

IDEA 2004, Part C

Part C encompasses laws pertaining to infants and toddlers with disabilities. Under Part C, an infant or toddler is eligible when:

> Experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive development, physical development, communication development, social or emotional development an), adaptive development, or has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, and may also include, at a State’s discretion, at-risk infants and toddlers (20 USC §§ 1432(3) and (5)(B)(i).

California has chosen to include at-risk infants and toddlers as eligible under the Early Intervention Services Act (GC § 95014(a).) In California, both regional centers (under the Department of Developmental Disabilities) and local educational agencies (LEAs under the Department of Education) are considered the lead (or payer of last resort) agencies for infants and toddlers with a disability. The LEA is responsible for infants and toddlers who have a medical diagnosis categorized as a solely low-incidence disability. This category refers to those children with visual, hearing, or severe orthopedic impairments. The regional center is the lead agency for all other infants and toddlers

with a disability (GC §§ 95007(j) and 95014(b) and (c)).

Part C defines early intervention services as follows:

> Designed to meet the developmental needs of an infant or toddler with a disability, as defined by the individualized family service plan team . . .[and] include occupational therapy [and] physical therapy (20 USC § 1432(4)(C) and (E) (iv)-(v)) along with other services.

Any early intervention service prescribed for an eligible infant or toddler may be a stand-alone service. All services must be specified on the individualized family service plan (IFSP), which is updated at least annually. The IFSP must state the:

- Child's current levels in all areas of development
- Family's resources, priorities, and concerns
- Measurable results or outcomes being targeted on the plan along with criteria, procedures, and timelines to measure progress for each outcome
- Specific early intervention services needed, based on peer-reviewed research, to the extent practicable, along with frequency, intensity, and method of delivery for each service
- Location where each service will take place and a justification of the extent, if any, to which services will not be provided in a natural environment.[1]
- Projected start date, anticipated length, duration, and frequency of each service

In addition, California requires that the IFSP name the agency responsible for providing each service. Legislation also designates each service as an early intervention service, a service from other state programs, or a referral to a non-required service (GC §§ 95020(d) and (e)).

As service providers, OTs and PTs are responsible for consultation, training, assessment, and program planning. State laws deem that OTs and PTs may be part of the transdisciplinary team providing early education services (EC §§ 56426.6(c)(5) and (6)).

All assessment and services are provided only upon parental written consent. Parent may agree to some or all of the services proposed on an IFSP. Federal regulations (20 USC § 1436(e)) ensure that the agreed-upon services are to be provided even if the family does not want other services or if some of the services remain in dispute. Under federal law, families have a right to use mediation if there is a dispute (20 USC § 1439(a)(8)).

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[1]"Natural environments" are the settings in which children without disabilities typically spend their time. Legislation has been written to ensure that children with disabilities have access to those same environments. The concept of providing all services within the "natural environment" has been amended in current law to "recognize that there may be instances when a child's individualized family service plan cannot be implemented satisfactorily in the natural environment. The Conferees intend that in those instances, the child's parents and other members of the individualized family service plan team will together make this determination and then identify the most appropriate setting in which early intervention services can be provided (Raimondo 2004, 11).

IDEA 2004, Part D

Part D includes national activities to improve the education of all children with disabilities: professional development, personnel preparation, parent training and information centers, technical assistance, dissemination of information, and special education research. There are no specific obligations related to the provision of OT and PT in Part D. It places an emphasis on professional development; research-to-practice dissemination; and the use of recruitment, induction, and retention strategies.

Section 504 of the Rehabilitation Act

In addition to specific educational laws, a federal civil rights law known as Section 504 of the Rehabilitation Act of 1973 and addenda derived from the Americans with Disabilities Act (ADA) provide protection for individuals with disabilities by prohibiting discrimination related to access. Children with disabilities must be able to gain access to and receive the same education and services (academic and nonacademic) that are available to nondisabled peers (20 USC § 794; 34 CFR § 104.1 et seq.).

Under Section 504, the definition of disabled is broader than the disabling conditions defined in Part B of IDEA. Under Section 504,

> "Individuals with disabilities" means any person who: (i) has a physical or mental impairment which substantially limits one or more major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment. (34 CFR §104.3(j)(1))
>
> "Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. (34 CFR § 104.3(j)(2))

A fair appropriate public education must meet the needs of an individual with a disability as adequately as the needs of an individual without disabilities. A child who has a disability, as defined under Section 504, but who does not meet eligibility criteria for an educationally disabling condition under the IDEA may still be eligible to receive federally defined related services pursuant to a 504 Plan. A child identified as having a disability under Section 504, but not under the IDEA, and who is found to need either OT or PT services as a reasonable accommodation to the general education program may receive the services as defined in the 504 Plan. The Student Success Team (SST) in general education monitors the 504 Plans.

California Education Laws and Local Educational Agency Policies

State education laws, regulations, and policies help to ensure that federal laws are carried out in California and help to define practice when federal laws remain silent on an issue or when federal laws give states discretion for participation. LEAs and SELPAs must comply with federal and state mandates; however, they may design programs that address local, unique needs and may provide more (but not less) than federally required services. Numerous procedural safeguards are in place to ensure appropriate provision of services and child/parent's rights. Key concepts for related services to understand the California *Education Code* is included in appendix 4.2.

Interagency Responsibilities

State government codes and regulations also provide for interagency cooperation in the delivery of OT and PT services, from birth until the child reaches age twenty-two, provided by public funds. These public agencies may include Department of Health Care Services, Department of Developmental Disabilities, and Department of Education.

In California, the responsibility for providing OT and PT related services as part of a free appropriate public education is shared by the Department of Education and the Department of Health Care Services. California Children's Services (CCS) and the LEA must have local interagency agreements. In *Education Code* Section 56426.7 and Section 7575(a) of the *Government Code,* CCS is responsible for the provision of medically necessary OT and PT when the child is eligible by medical diagnosis and when the related service is specified in the child's IEP. The child's IEP may include one or more goals that CCS will address as medically necessary therapy. Related services, including OT and PT, not deemed to be medically necessary by the State Department of Health Care Services (i.e., CCS) are the responsibility of the LEA.

Government Code sections 7575 et seq. state the interagency responsibilities of Department of Health Care Services, , and its designated local agencies and the California Department of Education and its local agencies, including LEAs and SELPAs (2 CCR § 60000).

(a) Notwithstanding any other provision of law, all services assessed and determined as educationally necessary by the individualized education program (IEP) team contained in the child's IEP or individualized education plan shall be provided in accordance with the federal Individuals with Disabilities Education Act (IDEA; 20 U.S.C. Sec. 1400 et seq.).
(b) If a child applies to the California Children's Services Program pursuant to Section 123865 or 123875 of the Health and Safety Code, the State Department of Health Care Services shall determine whether the child needs medically necessary occupational therapy or physical therapy. A medical referral to the California Children's Services Program shall be based on a written report from a licensed physician and surgeon who has examined the pupil. The written report shall include the following:
(1) The diagnosed neuromuscular, musculoskeletal, or physical disabling condition prompting the referral.
(2) The referring physician's treatment goals and objectives.
(3) The basis for determining the recommended treatment goals and objectives, including how these will ameliorate or improve the pupil's diagnosed condition.
(4) The relationship of the medical disability to the pupil's need for special education and related services.
(5) Relevant medical records.
(c) If the child has an IEP pursuant to the federal IDEA, the parents or the estate of the child shall disclose that IEP to the California Children's Services Program at the time of application and on revision of the child's IEP.

(d) The department shall provide the service directly or by contracting with another public agency, qualified individual, or a state-certified nonpublic nonsectarian school or agency.
(e) Local education agencies shall provide necessary space and equipment for the provision of occupational therapy and physical therapy in the most efficient and effective manner.
(f) The department shall also be responsible for providing the services of a home health aide when the local education agency considers a less restrictive placement from home to school for a pupil for whom both of the following conditions exist:
(1) The California Medical Assistance Program provides a life-supporting medical service via a home health agency during the time in which the pupil would be in school or traveling between school and home.
(2) The medical service provided requires that the pupil receive the personal assistance or attention of a nurse, home health aide, parent or guardian, or some other specially trained adult in order to be effectively delivered.

Appendix 4.1
Key Changes in IDEA 2004 Part B and Related Regulations

IDEA Part B	Description of the Regulation
Definition of scientifically based research (34 CFR 300.35)	The definition of scientifically based research as defined in the No Child Left Behind Act (20 USC7801(37) has been incorporated. The definition reads: "…(A) research that involves the application of rigorous, systematic and objective procedures to obtain reliable and valid knowledge relevant to education activities and programs; and (B) includes research that (i) employs systematic, empirical methods that draw on observations or experiment; (ii) involves rigorous data analyses that are adequate to test the stated hypotheses and justify the general conclusions drawn, (iii) relies on measurements or observational methods that provide reliable and valid data across evaluators and observers, across multiple measurements and observations, and across studies by the same or different investigators; (iv) is evaluated using experimental or quasi-experimental designs in which individuals, entities, programs, or activities are assigned to different conditions and with appropriate controls to evaluate the effects of the condition of interest, with a preference for random-assignment experiments, or other designs to the extent that those designs contain within-condition or across-condition controls; (v) ensures that experimental studies are presented in sufficient detail and clarity to allow for replication or, at a minimum, offer the opportunity to build systematically on their findings; and (vi) has been accepted by a peer-reviewed journal or approved by a panel of independent experts through a comparably rigorous, objective, and scientific review."
Supplementary aids and services (34 CFR 300.42 34 CFR 300.107(a) 34 CFR 300.117)	Language has been included that specifies supplementary aids, services, and other supports be provided not only for the student to benefit from instruction but also to enable children with disabilities to participate in extracurricular activities in nonacademic settings. Specific steps are outlined regarding how the LEA must provide necessary supplemental aids and services according to the IEP team, nonacademic and extracurricular services and activities that afford a child with a disability equal opportunity to participate in those activities with nondisabled peers to the extent deemed appropriate.
Pre-referral Response to Intervention (RtI) (34 CFR 300.307)	Criteria used to determine special education eligibility under the classification of specific learning disability must permit the use of a process based on the child's response to scientific, research-based intervention (RtI) before referral to special education.
Documenting the Response to Intervention (RtI) process (34 CFR 300.311(a)(7))	If a child has participated in a process that assesses the child's response to intervention, the documentation must include the instructional strategies used, the data collected regarding student performance, and documentation that parents were notified about the state's policies with regard to data collection, the general education services that will be provided, the strategies for increasing the student's rate of learning, and the parent's right to request an evaluation.

IDEA Part B	Description of the Regulation
Required IEP attendance (34 CFR 300.321)	IEP team members whose attendance at an IEP may not be needed may be excused from IEP attendance if a parent provides written consent prior to the meeting.
Resolution meeting requirement prior to due process (34 CFR 300.510(b)(3) 34 CFR 300.510(b)(4))	An attempt to resolve a dispute or disagreement through an alternative dispute resolution process is now a required step in the filing for due process. Except in the case where both parties jointly agree to waive the resolution process, parents declining to participate in the resolution process will not be able to pursue due process until a resolution meeting is held. An LEA may request that a hearing officer dismiss a due process complaint filed against the district if a parent does not agree to a resolution meeting.
Stay-put from IFSP to IEP (34 CFR 300.518)	If a parent files a due process complaint regarding their child's turning three and the student had previously received infant/toddler services under an individualized family service plan (IFSP), the school district is not obligated to continue the IFSP services pending the resolution of the due process. The "stay put" provision requires that the district provide only those IEP-proposed services to which the parents provide consent during the pendency of the due process proceeding.
Entitlement to Independent Educational Evaluation (IEE) at public expense (34 CFR 300.502(b)(5))	The regulations clarify that a parent is entitled to only **one** independent evaluation at public expense each time the school district conducts an evaluation and the parent disagrees with that evaluation. The district continues to have the option to defend its own assessment through a due process hearing if it is thought that the assessment is appropriate and meets the California *Education Code* criteria for an educational assessment.
Obligation to consider Independent Educational Evaluation (IEE) (34 CFR 300.502(c))	Language has been provided that clarifies that the public agency (school district) must consider an independent evaluation provided by a parent, whether obtained at private expense or provided at public expense, if it meets public agency evaluation criteria, in any decision made with respect to the provision of the free and appropriate public education (FAPE) of the child.
Confidentiality and disclosure of information (34 CFR 300.622(a), (b)(1))	This section was changed to clarify that parental consent is required to share personally identifiable information with parties other than officials of participating agencies, unless the information is contained in educational records, and the disclosure is authorized without parental consent under the Family Educational Records Practice Act regulations. Additional language was added to clarify that parental consent is not required before personally identifiable information is released to officials of participating agencies for purposes of meeting the requirement of Part B of IDEA or IDEA regulations.

Appendix 4.2
Key Concepts about "Related Services" and the *Education Code*

Education Code	Description of the Regulation
Timelines Sections 56043(c)(f); 56302.1; 56344	For an **initial** assessment, the district has up to 60 days from the receipt of the parent's consent to complete the assessment and convene the IEP team to determine eligibility and the student's educational needs. If the student is eligible, the school district has another 30 days to hold a second IEP team meeting and develop an IEP (EC 56043(f)(2), 56344(a).) The 60-day period may be extended for school breaks over five days, but the 30 days may not. For reassessment, only the 60-day timeline applies.
Triennial assessment Sections 56043(k); 56381(a)(2)	A student may not require triennial testing if the parent and school district agree that no assessment is necessary or agree that continuing eligibility and educational needs can be determined without additional assessment.
Transition IEP Sections 56043(e)(g)(h); 56341.5(e); 56345(a)(8); 56345.1	Transition IEP is now required when a child turns sixteen and must include measurable postsecondary goals.
Screening to provide instructional strategies Section 56321(f)(g)	Parental consent is not required before reviewing existing data or before administering a test or other assessment that is administered to all children. Screening by a teacher or specialist to determine the appropriate instructional strategies for curriculum implementation is not considered to be an assessment for eligibility for special education and related services.
Response to Intervention (RtI^2) Sections 56337; 56329(a)(2)	Aligns state law with federal law allowing consideration of a child's response to intervention as part of the assessment process as to whether or not a child may be a child with a specific learning disability. Eligibility may **not** be based upon lack of appropriate instruction.
IEP team meeting attendance requirements Sections 56341, 56341.1	An IEP team member may be excused from attending an IEP team meeting if the member's curriculum area is not a subject of discussion at the IEP meeting or if the IEP team member provides written input. Both of these provisions are contingent upon written parental consent.
Short-term objective or benchmark requirements Section 56345(a)	Only IEPs for students with more severe disabilities who take alternate assessments aligned to alternate achievement standards are required to contain short-term objectives or benchmarks.
Statute of limitations Section 56505(l)(n)	Aligns state with federal law outlining that the statute of limitations for a due process complaint is now two years.
Resolution Section 56501.5	Aligns state with federal law requiring an attempt at resolution prior to a due process complaint proceeding.
DIS versus related services Section 56363(a)	Prior state law provided that designated instructional services (DIS) were services to assist a student to benefit from his/her "instructional program." OT and PT were considered DIS services. Currently, the state law provides that OT and PT services are now termed "related services," which are those services necessary for a student to benefit from his/her "special education," clarifying that a student must be receiving special education to receive such services under IDEA. The state law is now consistent with federal law.

Education Code	Description of the Regulation
Provision for IEP changes without a meeting Section 56380.1	A school district and parent may agree to change an IEP by written document without reconvening the team once the annual IEP is developed.

Any changes that may affect educationally based OT and PT services should be discussed with the LEA administrators to ensure conformity with not only IDEA regulations, but also state regulations and local policies and procedures. The state may provide more than, but not less than, the federal law and regulations require; likewise LEAs may provide more, but not less than, the state law and regulations require.

Chapter 5
Scope of Practice

Federal and state educational laws, regulations, and advisories affect the roles of OT and PT in the California educational system, as discussed in Chapter 4. In addition, California state business laws and codes govern the practice of OT and PT. California *Business and Professions Code* sections 2570.3(a) and 2630 state that OTs and PTs must be licensed by their respective governing state boards to practice. Also, certified OT assistants (COTAs) must be certified by the state Board of Occupational Therapy, and PTAs must be licensed by the Physical Therapy Board of California (BPC §§ 2570.3(a) and 2655(b)). Although other non-licensed individuals (e.g., parents or classroom aides, etc.) may assist OTs and PTs with non-patient tasks, their activities do not fall under the scope of therapeutic intervention and therefore their roles are not included here (http://www.bot.ca.gov/; http://www.ptb.ca.gov/).

This chapter outlines and highlights the scope of practice for OT and PT and the documentation and supervision requirements for therapists in California public schools.

Scope of Practice for Occupational Therapy

In the field of OT, the *Business and Professions Code* related to OT is also referred to as the Occupational Therapy Practice Act (OTPA).

As outlined in the OTPA, the “practice of occupational therapy” means the therapeutic use of purposeful and meaningful goal-directed activities (occupations) that engage the individual's body and mind in meaningful, organized, and self-directed actions that maximize independence, prevent or minimize disability, and maintain health. Occupational therapy services encompass occupational therapy assessment, treatment, education of, and consultation with, individuals who have been referred for occupational therapy services subsequent to the diagnosis of a disease or disorder (or who are receiving occupational therapy services as part of an individualized education program (IEP) pursuant to the federal Individuals with Disabilities Education Act (IDEA)). Occupational therapy assessment identifies performance abilities and limitations that are necessary for self-maintenance, learning, work, and other similar meaningful activities.

Occupational therapy treatment is focused on developing, improving, or restoring functional daily living skills; compensating for and preventing dysfunction; or minimizing disability. Occupational therapy techniques that are used for treatment involve teaching activities of daily living (excluding speech-language skills); designing or fabricating selective temporary orthotic devices, and applying or providing training in the use of assistive technology or orthotic and prosthetic devices (excluding gait training). Occupational therapy consultation provides expert advice to enhance function and quality of life. Consultation or treatment may involve modification of tasks or environments to allow an individual to achieve maximum independence. Services are

provided individually, in groups, or through social groups (BPC § 2570.3(a)).

Documentation Requirements for Occupational Therapy

The OTPA mandates that “An occupational therapist shall document his or her evaluation, goals, treatment plan, and summary of treatment in the patient record. Patient records shall be maintained for a period of no less than seven years following the discharge of the patient, except that the records of un-emancipated minors shall be maintained at least one year after the minor has reached the age of 18 years, and not in any case less than seven years” (BPC § 2570.185).

Supervision Requirements for Occupational Therapy

State laws and regulations set forth the requirements for supervision of therapy assistants and aides. COTAs must work under the supervision of a licensed OT. Appropriate supervision of a COTA includes, at a minimum, the weekly review and inspection of the supervising occupational therapist. Weekly review should occur once each calendar week (16 CCR § 4181(a)(3)) and requires the supervising occupational therapist to provide periodic on-site supervision and observation of the assigned client care rendered by the COTA. Periodic review is defined in Section 4181(e) as at least once “every thirty days” (16 CCR § 4181(e)). The supervision process is aimed at ensuring the safe and effective delivery of OT services and fostering professional competence and development. Supervision may include observation, modeling, co-treatment, discussions, teaching and instruction, and may be provided face to face or by telephone, written correspondence, or electronically.

One OT may supervise no more than two COTAs at a time without Board approval (BPC §2570.3(j)). (See 16 CCR § 4181 and § 4183 for regulations that apply to supervision of OT students and interns awaiting licensing, certification, or approval by the California Board of Occupational Therapy). Additional regulations are in place for advanced practice certification in several areas. (See www.bot.ca.gov for all laws and regulations.)

Scope of Practice for Physical Therapy

California *Business and Professions Code* § 2620(a) defines PT as:

> The art and science of physical or corrective rehabilitation or of physical or corrective treatment of any bodily or mental condition of any person by the use of the physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and active, passive, and resistive exercise, and shall include physical therapy evaluation, treatment planning, instruction and consultative services. The practice of physical therapy includes the promotion and maintenance of physical fitness to enhance the bodily movement related health and wellness of individuals through the use of physical therapy interventions. The use of roentgen rays and radioactive materials, for diagnostic and therapeutic purposes, and the use of electricity for surgical purposes, including cauterization, are not authorized under the term "physical therapy" as used in this chapter, and a license issued pursuant to this chapter does not authorize the diagnosis of disease."

Direct Access to Physical Therapy and Diagnosis

This bill would specify that patients may access physical therapy treatment directly, and would, in those circumstances, require a physical therapist to refer his or her patient to another specified healing arts practitioner if the physical therapist has reason to believe the patient has a condition requiring treatment or services beyond that scope of practice, and, with the patient's written authorization, to notify the patient's *primary* physician and surgeon, if any, that the physical therapist is treating the patient. The bill would prohibit a physical therapist from treating a patient beyond 30 business days or 12 visits, whichever occurs first, unless the physical therapist receives a specified authorization from a person with a physician and surgeon's certificate *or from a person with a podiatric medicine certificate and acting within his or her scope of practice*.

Documentation Requirements for Physical Therapy

The patient record shall be signed legibly and shall indicate actual care provided to a patient including the date and nature of the services provided and the name, title, and role of any person providing service.

Specifically, a Physical Therapist must document in the patient record the following: examination and re-examination, evaluation and re-evaluation, diagnosis, prognosis and intervention, treatment plan and modification of the plan of care, each treatment provided by the physical therapist or a physical therapy aide, and a discharge summary (16 CCR § 1398.13).

The physical therapist assistant shall document and sign in the patient record any treatment provided (16 CCR § 1398.13). In addition, the physical therapist assistant shall notify the physical therapist of record and document in the patient record any change in the patient's condition not within the planned progress or treatment goals, and any change in the patient's general condition **(**16 CCR § 1398.44)**.**

Records are to be maintained for a period of no less than seven years following the discharge of the patient, except that the records of emancipated minors shall be maintained at least one year after the minor has reached the age of 18 years, and not in any case less than seven years (BPC § 2620.7).

Supervision Requirements for Physical Therapy

The law states that a physical therapist is responsible at all times for all physical therapy services provided by the physical therapy assistant and shall ensure that the physical therapy assistant does not function autonomously (16 CCR § 1398.44). Furthermore, a PT may not supervise more than 2 PTAs without approval from the Physical Therapy Board of California (BPC § 2655.2). The physical therapist that performs the initial evaluation is considered the "therapist of record" for the patient and shall remain as such until reassignment has occurred. The physical therapist of record is responsible for determining which elements of a treatment plan may be assigned to a physical therapy assistant and shall provide supervision and direction to the physical therapist assistant in the treatment of students. The physical therapist assistant shall be able to communicate with the physical therapist of record at all times during treatment sessions. Finally, the while the physical therapist assistant may attend IEPs and other related meetings, the PTA shall not be the sole physical therapy representative in any meeting

where the patient's plan of care is assessed or may be modified (16 CCR § 1398.44). Regulations that apply to supervision of PT Aides, PT students and PT license applicants, who are waiting for licensing or approval by the Physical Therapy Board of California, as well as regulations for advanced practice certification, can be found at www.ptbc.ca.gov.

Selected References

Occupational Therapy Board of California. 2012. *Occupational Therapy Practice Act (California Business and Professions Code, Section 2570-2571).* http://www.bot.ca.gov

Occupational Therapy Board of California. 2012. *Occupational Therapy Regulations (Title 16, Division 39, California Code of Regulations 4100-4184).* http://www.bot.ca.gov

Physical Therapy Board of California. 2012. *Physical Therapy Practice Act (California Business and Professions Code, Section 2600).*http://www.ptbc.ca.gov

Physical Therapy Board of California, 2012. *Physical Therapy Regulations (Title 16, Division 13.2, California Code of Regulations 1398-1399.99).).*http://www.ptbc.ca.gov

U.S. Department of Education http://idea.ed.gov

Appendix 5.1
Summary of State Requirements for Occupational Therapists and Physical Therapists

Abbreviations for Professional Credentials	Regulated by State Board	Requires Supervision by Practice Acts	Co-signature Required for Documentation
Occupational Therapist • OT, OTR, OTR/L	***Yes*** Licensed	***No***	***No***
Occupational Therapy Assistant • OTA, COTA, COTA/L	***Yes*** Licensed; certified	***Yes*** • Minimally weekly review of the OT plan and implementation • Periodic onsite review; supervision and observation are required • Available in person or by telecommunication	***Yes*** • Requires co-signature of supervising OT
Occupational Therapy Aide (must be spelled out; no recognized abbreviation)	***No***	***Yes*** • Direct, within immediate proximity at all times	***Yes*** • Requires co-signature of supervising OT
Physical Therapist • LPT, DPT, PT	***Yes*** Licensed	***No***	***No***
Physical Therapist Assistant • PTA	***Yes*** Licensed	***Yes*** • PT always available in person or by telephone and conducting periodic site reviews • Hold case reviews at least every 30 days • Available in person or by telecommunication	***No***
Physical therapy aide (must be spelled out; no recognized abbreviation)	***No***	***Yes*** • Direct, within immediate proximity at all times	***Yes*** • Requires co-signature of supervising PT on the same day

Chapter 6
Early Intervention Services for Infants and Toddlers

This chapter highlights the roles and issues relevant to OTs and PTs who serve infants and toddlers and their families, including evaluation and eligibility determination, assessment and service planning, individualized family service plan (IFSP) development, and transition to preschool services. This chapter also focuses on IDEA 2004, Part C early intervention services for infants and toddlers (i.e., individuals under three years of age) in California.[1]

Under IDEA 2004, early intervention services are "designed to meet the developmental needs of an infant or toddler with a disability meeting eligibility requirements, in the areas of:

(i) physical development;
(ii) cognitive development;
(iii) communication development;
(iv) social or emotional development; or
(v) adaptive development" (20 USC § 1432(4)(C))

In addition, early intervention services are required to assist the family to facilitate their infant's or toddler's development. Services are selected in collaboration with the parents and other IFSP members and are provided by qualified early intervention personnel. Services are provided at no cost to the family, except where federal or state law provides for a system of payments.

The Educational Framework for Child Success (EFCS) model presented in Chapter 1 is consistent with the general provision in the California Early Intervention Services Act. The Act states that "there is a need to provide appropriate early intervention service individually designed for infants and toddlers from birth through two years of age who have disabilities or are at risk of having disabilities, to enhance their development and to minimize the potential for developmental delay. . . early intervention services for infants and toddlers with disabilities maximize the potential to be effective in the context of daily life and activities, including the potential to live independently, and exercise the full rights of citizenship. The earlier the intervention is started, the higher is the educational attainment and quality of life achieved by children with disabilities.

"The family is the constant in the child's life, while the service systems and personnel within those systems fluctuate. Because the primary responsibility of an infant or toddler's well-being rests with the family, services should support and enhance the family's capability to meet the special developmental needs of their infant or toddler with

[1] Final regulations governing the Early Intervention Program for Infants and Toddlers with Disabilities were issued by Department of Education effective on October 28, 2011. These regulations are needed to reflect changes made to the Individuals with Disabilities Education Act, as amended by the Individuals with Disabilities Education Improvement Act of 2004 (Act or IDEA) **34 CFR Part 303, RIN 1820–AB59,** Please see http://www.gpo.gov/fdsys/pkg/FR-2011-09-28/pdf/2011-22783.pdf

disabilities" (14 CCR § 95001(a)(3)). "Meeting the complex needs of infants with disabilities and their families requires active state and local coordinated, collaborative and accessible service delivery systems that are flexible, culturally competent and responsive to family identified needs" (14 CCR § 95001(a)(5)). This principle is consistent with the ECFS and a focus on child- and family-centered services and outcomes.

Early Intervention as Prevention

In California, IDEA Part C services are provided under a program called Early Start. The California Early Start program aims "to enhance the development of infants and toddlers with disabilities and to minimize their potential for developmental delay. . ." and under IDEA, ". . . to recognize the significant brain development that occurs during the child's first three years of life" (20 USC § 1431(a)(1)). The Department of Developmental Services (DDS) is the lead agency to provide early intervention services to eligible infants and toddlers and their families (GC § 95004). The DDS collaborates with the California Department of Education and LEAs for provision of early intervention services. The LEAs are designated as the lead agency for those infants and toddlers who meet the criterion for a solely "low-incidence disability" (i.e., vision, hearing, and orthopedic disabilities).

Referral to Early Intervention

"Child Find," a term used in federal and state regulations, refers to a system for identifying children with disabilities who might be eligible for early intervention services under Part C or school-based services under Part B. Early intervention Child Find includes the potential identification of "all infants and toddlers with disabilities in the state who are eligible for services including those who are Indian infants and toddlers with disabilities residing on reservations in the state, and infants and toddlers who are homeless, in foster care, and wards of the state." Child Find activities under Part C of IDEA provide a comprehensive program that is consistent with Part B and includes procedures for making referrals to service providers within specified timelines and with participation by primary referral sources. The Part C 2007 proposed regulations (34 CFR § 303.301) state that the lead agency must ensure that the Child Find system includes identification, location, and evaluation of all infants and toddlers with disabilities in the state who are eligible. The lead agency must take steps to prevent unnecessary duplication of effort by the various agencies involved in the Child Find system and make use of the resources available through the early intervention service provider in the state to implement the Child Find system effectively.

Appendix 6.1 shows a comparison of the regional centers and LEAs as the lead agencies for early intervention services in California.

Eligibility

Infants and toddlers eligible for receiving early intervention services are those who have been evaluated (and/or diagnosed) by qualified personnel as part of a multidisciplinary team, including the parents, and found to have one of the following three conditions:

- **Developmental delay**: Infants and toddlers who display a significant difference between the expected level of development for their age and their current level of functioning in one or more of five areas: cognitive development; physical and motor development, including vision and hearing; communication development; social or emotional development; or adaptive development (GC § 95014(a)(1)).
- **Established risk condition**: Infants and toddlers with ". . . conditions of known etiology or conditions with established harmful developmental consequences [that are] diagnosed by qualified personnel recognized by, or part of, a multidisciplinary team, including the parents. The condition shall be certified as having a high probability of leading to developmental delay if the delay is not evident at the time of diagnosis" (GC § 95014(a)(2)). In addition, an established risk condition also exists when an infant or toddler has a solely low-incidence disability (17 CCR § 52022(b)(2)), which includes orthopedic impairment, visual impairment or blindness, and hearing impairment or deafness.
- **High risk**: Those infants and toddlers "at high risk of having substantial developmental disability due to a combination of biomedical risk factors, the presence of which is diagnosed by qualified clinicians recognized by, or part of, a multidisciplinary team, including the parents" (GC § 95014(a)(3)). Specifically, if the multidisciplinary team determines that an infant or toddler has a combination of two or more of factors that require early intervention services based on evaluation and assessment Title 17of the *California Code of Regulations* Section 52022(c)(1)(A) –(N)] or if the team determines that the parent of the infant or toddler is a person with a developmental disability and the infant or toddler requires early intervention services.

It is also specified that a developmental delay shall not be determined based on a temporary physical disability, cultural or economic factors, the normal process of second language acquisition, or manifestation of dialect and sociolinguistic variance (17 CCR § 52022(d)(1) – (4)).

Dual Eligibility

Some infants and toddlers may be dually eligible, as delineated in appendix 6.2. It is important for the responsible regional center and local educational agency to work collaboratively and communicate effectively with families to ensure that services are coordinated and delivered smoothly. The California regulations also state that "no agency or multidisciplinary team . . . shall presume or determine eligibility, including eligibility for medical services, for any other agency" (GC § 95014(d)).

Service Coordination

California law (17 CCR § 52122) outlines specific qualifications for the role of service coordinator to identify persons who have demonstrated knowledge about the process of early intervention services. The service coordinator is responsible for facilitating the exchange of information between all persons and agencies involved in providing services for the infant or toddler, including service providers, health providers, medical managers, and regional centers and LEAs. The service coordinator assists families in procuring resources for their child and facilitates the development of the transition steps in the IFSP.

It is important for the responsible regional center and local educational agency to work collaboratively and communicate effectively with families to ensure that services are coordinated and delivered smoothly. The California regulations also state that "no agency or multidisciplinary team . . . shall presume or determine eligibility, including eligibility for medical services, for any other agency" (GC § 95014(d)).

Appendix 6.3 highlights the expertise and experiences of the agencies that implement comprehensive services for infants and toddlers.

Evaluation and Assessment

Evaluation procedures are designed to determine an infant's or toddler's eligibility for early intervention services. Assessment procedures are ongoing and are designed to determine the:

- Infant's or toddler's unique strengths and needs and level of development
- Family's resources, priorities, and concerns
- Early intervention services to meet identified needs of the infant or toddler and the supports and services needed by the family to enhance the capacity to meet the developmental needs of the infant or toddler

Each discipline has its own perspective and definitions for the evaluation and assessment procedures used within their scope of practice. However, under Part C of IDEA 2004, the definitions of these procedures may differ from those used in other practice settings; therefore, providers must be well informed about the definitions under Part C. See appendix 6.4 for definitions in the proposed regulations compared with the current California definitions.

OTs and PTs utilize a variety of evaluation and assessment procedures and methods, including standardized and criterion-referenced measures, interviews, questionnaires and ratings scales, and skilled clinical observations. The evaluation measures may focus on overall development, or specific areas of development such as motor development, or specific skills areas and processes (e.g., reflexes, postural control, oral-motor skills and sensory aspects of feeding and eating, sensory processing and self-regulation, gross motor skills, fine motor skills, play, perceptual-motor skills, self-care skills, etc.). Documentation in the form of a written report that synthesizes all the information for informed eligibility decisions and identifies needs and services to

address them is typically presented once the evaluation or assessment is completed. Although OTs and PTs, as well as other members of the team, may use the same evaluation measures (e.g., developmental tests) and even assess some of the same skills or areas of development, they will interpret results and findings from their unique professional perspectives. When working together as part of a team, the OT, PT, teacher, and parent can share and integrate multiple perspectives to arrive at a comprehensive picture of the child's functioning in order to meet the common objective of determining eligibility for early intervention services and planning for them (AOTA 2004; APTA 2008).

Other Practice Considerations in Early Intervention

Two important practice considerations for OT and PT in early intervention are the concepts of natural environment and family-centered care. As defined in the current California regulations, "Natural environment means settings that are natural or typical for the infant's or toddler's age peers who have no disability including the home and community settings in which children without disabilities participate" (17 CCR § 52000(35)).

Current California regulations provide examples of natural environment settings that include home, child care, school program, or private programs. Early intervention services must be provided , when possible, in a natural environment by qualified personnel to meet the identified developmental needs of an infant or toddler, based on results of comprehensive evaluation and assessment (20 USC § 1435(16)(A) & (B)).

Early intervention services provided under IDEA 2004, including OT and PT, strongly encourage collaboration with families, through family-centered care, so that the family, infant, or toddler can develop and learn in family environments and through routines. Services in this population are carried out through integrated service delivery models designated in the IFSP, respectful of the family needs and priorities (AOTA 2004; APTA 2008).

Individualized Family Service Plan

The IFSP is a written plan for providing early intervention services to an infant or toddler with a disability and his or her family (GC § 95020; 17 CCR § 52100 and §§ 52102–52108). It includes statements of the decisions and actions of the multidisciplinary team and parents or caregivers at the initial IFSP meeting, as well as at subsequent annual meetings, and periodic reviews of progress (34 CFR § 303.20). The document contains:

> a statement of measurable results or outcomes expected to be achieved for the infant or toddler and the family, including pre-literacy and language skills, as developmentally appropriate for the child, and the criteria, procedures, and timelines used to determine the degree to which progress toward achieving the results or outcomes is being made and whether modifications or revisions of the results or outcomes or services are necessary (20 USC §1436 [d][3]).

As a written document, the IFSP defines a process for putting into practice services for infants or toddlers and their families who meet eligibility criteria. To fully participate in the IFSP process, occupational therapy and physical therapy practitioners need to be aware of their role and contributions to content, procedures, and timelines to develop and carry out the IFSP.

OTs and PTs can perform several different roles at the IFSP meetings. For example, a practitioner might participate in the meeting after conducting an initial evaluation of the infant or toddler or providing services to the infant or toddler, or both. Along with other members of the multidisciplinary team and family, OTs and PTs contribute to the written statements of the infant's or toddler's present levels of development and the results or outcomes expected to be achieved "based on peer-reviewed research to the extent practicable" (20 USC § 1436(d)(3) and(4)). If a member of the multidisciplinary team, including the OT and PT, cannot attend an initial or annual IFSP meeting, or a periodic review meeting, the team member should make arrangements to contribute through other means, including participating in a telephone conference call, asking a knowledgeable representative to attend, or by making records and information available for the meeting.

Content of the IFSP

Under California regulations (GC § 95020; 17 CCR § 52016), the written IFSP document must include the following information:

- Documentation that the parents were fully informed of their rights
- The infant's or toddler's present levels of development in all five areas (physical, cognitive, communication, social or emotional, and adaptive development), based on evidence that can be measured or observed by qualified professionals
- A statement of the family's concerns, priorities, and resources (if the family agrees)
- Measurable results or outcomes expected to be achieved
- Results or outcomes for the family when services for the family are related to meeting the special developmental needs of the infant or toddler
- Criteria, procedures, and timelines used to determine progress toward achieving outcomes and whether revisions are necessary
- Specific early intervention services necessary to meet the unique needs of the infant or toddler, including:
  - Length (the amount of time per session that the service is provided)
  - Frequency and intensity (the number of days or sessions that a service will be provided and whether the service is provided on an individual or group basis)
  - Location (the actual place or places where a service will be provided)
  - Duration (projecting when a given service will no longer be needed and when the child is expected to achieve the results or outcomes
  - Method (how a service is provided) of delivering services
  - Consideration of participation in natural environments

- Scheduled days when services/programs will not be available when the service provider operates a program that has a fixed schedule and includes breaks in service for periods such as holidays or vacations
- Agency name and service coordinator responsible for the implementation of the components of the IFSP
- Steps to be taken to ensure the child's transition upon reaching three years of age
- Projected dates for initiation or beginning date of services
- Designation of each service identified (required, non-required, other)
- Funding source for other or non-required services provided by any entity other than regional centers or the LEA, including procedures to obtain such funding

Timelines and Reviews

The IFSP is a document that should evolve as the child's and family's needs change. For that reason, IDEA 2004 and California regulations related to early intervention provide specific guidelines for initial, periodic, annual, and transitional IFSP meeting timelines. As outlined previously, the initial and annual IFSP and changes resulting from the periodic review should be fully explained to the family and a copy of the document given to the family.

- Parents of children birth to three in California suspected of having special needs must be contacted within two days after a referral has been made to identify the lead agency and assessment plan.
- An initial IFSP is developed by the regional center or LEA or both agencies within 45 days of an oral or written referral when an infant or toddler does not qualify for an interim IFSP (17 CCR § 52107) and is found to be eligible through evaluation and assessment for early intervention services.
- A periodic review is conducted at least every six months; however, a review is conducted more frequently when a change of service is indicated for the infant or toddler, or the parent requests a review. The multidisciplinary team and parents may, but do not have to, meet to document a periodic review of an infant's or toddler's progress toward achieving outcomes or a modification to services, if another form of communication is acceptable to the participants of the team, including the parent.
- An annual IFSP meeting is held at least annually to document progress and revise any provisions in the document. At the time of the meeting, the team and parent review ongoing assessments, revise the IFSP and the outcomes of the IFSP, and determine the appropriate services to be provided or continued.

- Six months before the toddler's third birthday, the parent is notified that his/her toddler may be eligible for special education and related services under Part B of the IDEA and that transitional planning will occur within three to six months.

Interim IFSP

When there is an immediate need to provide services, early intervention services may begin before the completion of an assessment if the infant or toddler is determined eligible and parental consent is given. The interim IFSP should contain the following elements:

- Timelines for completing assessments
- Name of the service coordinator responsible for completion of evaluation and assessment within the 45-day timeline and implementation of the interim IFSP
- Documentation of immediate need
- Services agreed upon at the interim IFSP meeting
- Participation of the parent, service coordinator, and persons responsible for the assessment at a minimum; provisions shall be made for participation of family members, an advocate or person outside of the family at the parent's request

Existence of an interim IFSP does not absolve the regional center or LEA from complying with the 45-day period to complete the initial assessment in all five areas of development.

An interim IFSP developed to meet an immediate need shall be followed by an IFSP meeting within the 45-day period that commenced with the referral, except as provided in regulations pertaining to parent request for extension of the 45-day timeline.

Early Intervention Services and Service Coordination

The Department of Developmental Services (DDS) is the lead agency designated to provide early intervention services to eligible infants and toddlers and their families (GC § 95004). The DDS collaborates with the California Department of Education and LEAs for provision of early intervention services. The LEAs are designated as the lead agency for those infants and toddlers who meet the criteria for solely "low-incidence disability" (i.e., vision, hearing, and orthopedic disabilities).

IDEA 2004 and proposed regulations in Part C identify early intervention services and other services; whereas the current California regulations indicate that designation of services on the IFSP should be indicated as required, non-required, or other services. Appendix 6.5 lists the types of early intervention services and other services as specified in the Part C proposed regulations. Appendix 6.6 provides a list of the required, other, and non-required services under Part C as currently delineated in the California regulations.

The IFSP must also identify medical or other services for which the child is eligible that will be or are being provided by other private or public agencies. The services include residential care, family reunification services, Head Start, Supplemental Security Income, Medi-Cal, Temporary Assistance to Needy Families, and food stamps. "Non-required" services are "those community services that may be provided to an eligible

infant or toddler or his/her family but are not required under the California Early Intervention Services Act, such as child care, employment, housing, immunizations, medical services such as surgery or medication, marital counseling unrelated to the infant or toddler's development, and substance abuse counseling, etc. The granting or denial of non-required services by any public or private agency is not subject to appeal under this title" (GC § 95020(e)(3)).

Ideally, a team of professionals from several disciplines, which may include OT and PT, are involved in integrating infant and toddler intervention services so that families benefit from coordinated and diverse services from different professionals. Following the guidelines set out by the IFSP team, the degree and amount of involvement of each professional, including direct and consultative support, may vary and change over time as the family and child's needs change.

Transition from Early Intervention Services

The transition from early intervention services is a key event for families and their toddlers who have been receiving early intervention services (California Department of Education 2005). For many parents and caregivers, there is some degree of uncertainty about the changes that will occur and how these changes will affect their children's functioning (after the age of three years) upon entering the preschool stage of their development. As indicated previously, the content of the IFSP must include transition services and a plan for implementation to ensure that the transition process is coordinated between the regional center and the LEA, as specified in the regulations. Depending on the evaluation and assessment of the infant or toddler, the possible transition outcomes are as follows:

(1) The child exits the California Early Start Program and enters general education preschool.
(2) The child makes the transition from Part C early intervention services to Part B special education services under IDEA.
(3) The child makes the transition from Part C early intervention services to regional center services under the Lanterman Act.
(4) The child makes the transition from Part C early intervention services to both Part B special education and regional center services.

Transition Planning

The LEA and the regional center each have certain responsibilities during the transition process (17 CCR § 52112). Whether it is the regional center providing early intervention services or the LEA, both must initiate the transition planning process prior to the toddler reaching two years nine months of age, or at the discretion of all parties, up to six months before the child turns three to ensure that an individualized education program (IEP) is developed and implemented by the toddler's third birthday. For regional centers providing early intervention services, the service coordinator shall notify the parents of a toddler (at two years six months) who may be eligible under Part B, that

transition planning will occur within the next three to six months.

The service coordinator will also notify the LEA where the toddler resides that there will be an IFSP meeting. An LEA representative is required to attend the meeting to specify the transition steps necessary to move the child to Part B services.

For LEAs providing early intervention services (i.e., to infants and toddlers with solely low-incidence conditions), the service coordinator (e.g., the primary early interventionist, the early childhood special education teacher, etc.) will notify the parent and the designated contact person for the LEA of residence (e.g., the special education director or preschool program specialist) to inform them, initiate the transition planning process, and schedule the meeting. Within 30 days of notification, the family, service coordinator, and LEA shall agree on the date of the transition IFSP meeting to identify the steps necessary for making the transition.

Steps for a Smooth Transition

For all toddlers with an IFSP, the steps, at the time of the transition meeting, shall include provision of information; parent training and discussion of transition needs, as appropriate, regarding future placements; and plans for the transition to special education programs under Part B, to early education, Head Start, or child care programs, or other appropriate services (34 CFR § 303.344(h); 17 CCR § 52112(c) and (d)).

The transition IFSP must also include the procedures to prepare the toddler for changes in service delivery. Steps to help the toddler adjust to and function in a new setting, as well as a projected date are established for conducting a final review of the IFSP to document progress toward achieving early intervention outcomes by age three (17 CCR § 52112(c)(3)).

For toddlers who may be eligible for preschool services from the LEA under Part B (e.g., special education and related services), the transition must include the following steps:

- Obtain parental consent for exchange of information about the toddler with the LEA (e.g., progress reports, evaluation/assessments).
- Review IFSPs that have been developed and implemented and other relevant information.
- Identify the needed assessments to determine regional center and special education eligibility.
- A statement of the process necessary to ensure that the LEA receives the referral in a timely manner to ensure that assessments required are completed and that an IEP is implemented by the toddler’s third birthday.

This means that the referral must be received by the LEA no later than the time the toddler is two years nine months old, or before the LEA’s break in school services if the toddler will become three years of age during a break in school services. The regional center and the LEA each have their own evaluation and assessment procedures to determine eligibility. The eligibility criteria reflect differences in the populations served,

as well as the focus and purpose of the services that are needed, as a result of these evaluations and assessments. Appendix 6.7 summarizes the roles of the regional center and LEA and services and supports.

One of the key changes at the time of transition from early intervention services to Part B services is the shift in service delivery, primary focus, and purpose of services. Specifically, OT and PT, under Part C of IDEA, may be required or primary early intervention services if the multidisciplinary team determines that they are needed and they are specified on the IFSP. However, once the child becomes eligible for special education services, OT or PT may be identified as a related service, which means that OT or PT may be determined to be necessary for the child to benefit from his/her special educational program as a related service.

The transition plan, then, must also include identification of the people responsible for convening an IEP and the final IFSP meeting, (or the individual program plan (IPP) when the child is over three years old) if necessary for a toddler by age three years. The purpose of these meetings is to review the toddler's progress toward achieving outcomes specified in the IFSP; determine eligibility for special education and develop the IEP; and to develop an IPP if the toddler is determined to be eligible for regional center services under the Lanterman Act.

The participants of the final IFSP meeting are the same as those identified for the annual IFSP or periodic review and any other persons requested by the parent or other representatives as determined appropriate, which may include the early intervention service provider(s). However, if the final IFSP and the initial IEP meeting occur concurrently, the participants must also include those persons required for an initial IEP as specified under Part B. Similarly, if the final IFSP and the initial IPP meeting for the regional center occur concurrently, the participants must also include those persons required for an initial IPP under the Lanterman Act. Appendix 6.8 outlines agency responsibilities for the child during transition and beyond.

Initial IFSP

If a toddler is older than two years six months on the date of the initial IFSP, the IFSP shall include steps to ensure transition to special education services under Part B of IDEA or other services that would be appropriate. Regional centers may continue providing or purchasing services for a preschooler who has been determined eligible for regional center services until:

(1) the beginning of the next school term after the toddler's third birthday during a period when the LEA special education preschool program is not in session; and
(2) when the multidisciplinary team determines that services are necessary until the LEA special education program resumes (17 CCR § 52112(e) and (f)).

Continuing Regional Center Services and Other Agencies or Programs

Children who received early intervention services through the regional center may continue to be eligible for its services under the Lanterman Act. As previously discussed and summarized in appendix 6.2, eligible children are those who have been evaluated and assessed and meet criteria for having a developmental disability. Some children who have received early intervention services through the LEA on the basis of a solely low-incidence disability but are suspected to have a developmental disability may be referred to the regional center for evaluation and assessment.

The provision and coordination of OT and PT services may become confusing to families whose children who are eligible to receive special education services and who are also eligible to continue as clients, with a developmental disability, of the regional center under the Lanterman Act. In addition, a child might also be eligible to receive services through other programs or agencies, such as California Children's Services (CCS), compounding the complexity. Each agency has procedures and criteria in place to determine the type and the level of services that can be provided. It is important for OTs and PTs to be knowledgeable of the scope and limitations of service provision for each agency or program that may be involved with the child.

Part C early intervention involves a complex set of legal, philosophical, and clinical systems that influence how therapists provide services to infants and toddlers and their families. The expertise that OTs and PTs bring is an integral part of this service provision. OTs and PTs can promote and facilitate, as well as benefit from, the interdisciplinary and interagency collaboration that facilitates a family-centered and relationship-focused transition from early intervention to preschool services.

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Laws and Regulations: California Special Education and Related Laws (New 15-Jun-2012) Searchable Database for *Education Code*, Part 30, Other Related Laws and *California Code of Regulations*, Title 5.

Appendix 6.1
Comparison of Regional Centers and Local Educational Agencies in the Role of Lead Agency under Part C

Regional Centers	Local Educational Agencies
Admit all eligible infants • High risk • Established risk • Developmental delay (in one or more developmental areas)	**Admit all eligible infants with a solely low-incidence disability*** • Orthopedically impaired • Visually impaired • Hearing impaired *Not eligible for regional center service
All components of Part C • Intake and eligibility • Evaluation and assessment • Service coordination • IFSP • Transition	**All components of Part C** • Intake and eligibility • Evaluation and assessment • Service coordination • IFSP • Transition
Service coordination for • Required services • Non-required services • Other services	**Service coordination for** • Required services • Non-required services • Other services
Transition • Part C to general education (i.e., regular preschool) • Part C to Part B • Part C to ongoing regional center services (Lanterman Act)	**Transition** • Part C to general education (i.e., regular preschool) • Part C to Part B • Part C to regional center (if not already referred)

Appendix 6.2
Infants and Toddlers Dually Eligible for Part C Services

Regional Centers (RCs)	Local Educational Agencies (LEA)
All Part C eligible infants (GC 95014 (c) and 17 CCR 52022) with a developmental delay. Significant difference between the infant's or toddler's current level of functioning and the expected level of development for his/her age in one or more of the following areas: • Cognitive • Physical, including fine and gross motor, vision, and hearing • Communication • Social or emotional • Adaptive • Established risk • High risk • Except infants and toddlers with a solely low-incidence disability	Infants and toddlers with exceptional needs (EC56026 and 5 CCR 3031) Functioning at or below 50 percent of his/her chronological age level in any one of the following skills areas: • Gross or fine motor development • Receptive or expressive language development • Social or emotional development • Cognitive development • Visual development; or • Functioning between 51 percent and 75 percent of his/her age level in any two of the above skill areas • Has a condition of known etiology that has a high probability of resulting in developmental delay, as specified in *Education Code* Section 52055 (b)(1) The LEA is operating below the funded capacity as required by *Government Code* Section 95014.
For dually eligible children, the RC shall be the agency responsible for providing or purchasing appropriate early intervention services that are beyond the mandated responsibilities of the LEA. The RC is the payer of last resort for dually eligible children.	

Appendix 6.4
Definitions of Evaluation and Assessment

Part C Proposed Regulations	Current California Regulations
• **Evaluation "**is the method used to review the assessments of the child and the family to determine a child's initial and continuing eligibility under this part, consistent with the definition of *infant or toddler with a disability…"* (34 CFR 303.320(a)(2)(i)) • **Assessment of the child** "means reviewing available pertinent records that relate to the child's current health status and medical history and conducting personal observation and assessment of the child in order to identify the child's unique strengths and needs, including an identification of the child's level of functioning in each of the following developmental areas: ▪ Cognitive development; ▪ Physical development, including vision and hearing; ▪ Communication development; ▪ Social or emotional development and ▪ Adaptive development based on objective criteria, which must include informed clinical opinion." (34 CFR 303.320(b)(1)) • **Assessment of service needs** is conducted if a child is determined to meet the definition of *infant or toddler with a disability* and "must include a review of the evaluation (including the assessment of the child and family) and available pertinent records and conducting personal observation and assessment of the infant or toddler with a disability in order to identify the early intervention services appropriate to meet the child's unique needs in each of the developmental areas identified" above (34 CFR 303.320 (d)). • **Assessment of the family** "means identification of the family's resources, priorities, and concerns, and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the family's infant or toddler with a disability, as determined not just through the use of an assessment tool, but through a voluntary personal interview with the family. (34 CFR 303.320 (c))	• **Evaluation** refers to the specific procedures used by qualified personnel to determine an infant's or toddler's present level of development (7 CCR 52000 (13)). Each infant or toddler referred for evaluation for early intervention services shall have a timely, comprehensive, multidisciplinary evaluation of his or her needs and level of functioning in order to determine eligibility (GC 95016(a)). • **Assessment** refers to the overall "ongoing procedures used by qualified personnel throughout the period of an infant's and toddler's eligibility for early intervention services to identify the infant's or toddler's unique strengths and needs and the services appropriate to meet identified needs. The assessment also includes the identification of the family's resources, priorities, and concerns regarding the development of the infant or toddler and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the eligible infant or toddler" (17 CCR 52000(4)). "In the process of determining the eligibility of an infant or toddler, an assessment shall be conducted by qualified personnel, and shall include a family interview, to identify the child's unique strengths and needs and the services appropriate to meet those needs; and the resources, priorities and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler" (GC 95016(a)).

Appendix 6.5
Definitions of Early Intervention Services and Other Services

Early Intervention Services	Other Services
34 CFR 303.13 (b). **Types of early intervention services** Assistive technology devices and services Audiology services Family training, counseling, and home visits Health services Medical services Occupational therapy Physical therapy Psychological services Service coordination Social work services Special instruction Speech-language pathology services Transportation and related costs Vision services California includes respite and other family support services 34 CFR 303.13 (c). **Qualified personnel** Audiologists Family therapists Nurses Occupational therapists Orientation and mobility specialists Pediatricians and other physicians for diagnostic and evaluation purposes Physical therapists Psychologists Registered dietitians Social workers Special educators, including teachers of children with hearing impairments (including deafness) and teachers of children with visual impairments (including blindness) Speech and language pathologists Vision specialists, including ophthalmologists and optometrists 34 CFR 303.13 (d). “The services and personnel identified and defined [above] do not comprise exhaustive lists of the types of services that may constitute early intervention services or the types of qualified personnel that may provide early intervention services. Nothing in this section prohibits the identification on the IFSP of another type of service as an early interventions service provided that the service meets the criteria identified in paragraph (a) of this section or of another type of personnel that may provide early intervention services in accordance with this part, provided such personnel meet the requirements in 34 C.F.R. § 303.31.”	34 CFR 303.344 (e) **Other services** To the extent appropriate, the IFSP also must identify medical and other services that the child or family needs or is receiving through other sources, but that are neither required nor funded under this part; and If those services are not currently being provided, include a description of the steps the service coordinator or family may take to assist the child and family in securing those other services.

Appendix 6.6
Required, Other, and Non-required Services under Part C

Required Services **(17 CCR 52108 (1))**	**Other Services** **(17 CCR 52108 (2))**	**Non-required Services** **(17 CCR 52108 (3) (A))**
Those services designed to meet the developmental needs of each eligible infant or toddler and the needs of the family related to the infant or toddler's development. The services include but are not limited to: • Assistive technology (device or services) • Audiology • Early identification, screening, and assessment services • Family training, counseling and home visits • Health services necessary to enable the infant or toddler to benefit from the other early intervention services • Medical services (only for diagnostic or evaluation purpose) • Nursing services • Nutrition services • Occupational therapy • Physical therapy • Psychological services • Service coordination • Social work services • Special instruction • Speech-language pathology and audiology services, and sign language and cued language services • Transportation and related costs • Vision services • Respite services (in California) and other family support services	Those public programs that may benefit the infant, toddler, and/or family if the infant or toddler or his/her family is eligible to receive services subject to statutory, regulatory, and other program criteria of those programs or agencies. The services include but are not limited to • Residential care • Family reunification services • Head Start • Supplemental Security Income (SSI) • Supplemental Security Programs (SSP) • In-Home Health Services (IHSS) • Temporary Assistance to Needy Families (TANF) and food stamps • Medi-Cal • Child Health and Disability Prevention (CHDP) Program • Hospice Care • WIC • Child protective services	Those community services that may be provided to an infant or toddler or his/her family eligible under Part C, but are not required under the California Early Intervention Services Act. The IFSP shall, to the extent appropriate, include the steps and timelines for the service coordinator to assist the parent to secure those services through public or private sources. The services include but are not limited to: • Employment • Child care • Housing • Medical service such as surgery • Hospitalization • Medical devices necessary to control or treat a medical condition • Immunizations • Well-baby care • Income support • Child support advocacy • Family or marital counseling unrelated to the infant or toddler's development • Substance abuse counseling

Appendix 6.7
Agency Roles in Coordinating the Transition of a Special-Needs Child to Preschool and Beyond

Regional Centers (RCs)	Local Educational Agencies (LEAs)
Under Lanterman Act and amendments (*Welfare and Institutions Code* Section 4646) • Developmental disability • Originates before age eighteen • Continues or can be expected to continue indefinitely Constitutes a substantial disability Includes: • Mental retardation • Cerebral palsy • Epilepsy • Autism • Other disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals • Shall not include other handicapping conditions that are solely physical in nature • Shall not include individuals with a learning disability as the sole condition	**Under IDEA 2004 and California regulations** Individuals up to twenty-two years of age with exceptional needs (Article 3.1 Section 3030) Degree of pupil's impairment requires special education in one or more of the program options authorized by Section 56361 of the *Education Code*: Hearing impairment Concomitant hearing and visual impairment Speech or language disorder Visual impairment Severe orthopedic impairment Other health impairments Autistic-like behaviors Mental retardation Serious emotional disturbance Specific learning disabilities Early childhood special education services (preschool) are identified as services rendered to a young child having one of the following disabling conditions: Autism Deaf-blindness Deafness Hearing impairment Multiple disabilities Orthopedic impairment Other health impairment Serious emotional disturbance Specific learning disability Speech or language impairment Traumatic brain injury Visual impairment Established medical disability "Needs specially designed instruction or services" is defined in *Education Code* sections 56441.2 and 56441.3. A child with a disability has needs that cannot be met without modification of a regular environment in the home or school, or both, without ongoing monitoring or support as determined by an IEP team pursuant to *Education Code* Section 56431 Meets eligibility criteria specified in Section 3030 of Title 5 of the *California Code of Regulations*

Regional Centers (RCs)	Local Educational Agencies (LEAs)
Services and Supports • Specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disabilities or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives • Determination shall be made on the basis of the needs and preferences of the consumer or, when appropriate, the consumer's family, and shall include consideration of a range of service options proposed by IPP participants, the effectiveness of each option in meeting the goals stated in the IPP, and the cost-effectiveness of each option.	**Special Education Programs** • Continuum of program options (*Education Code* Section 56361) • Regular education programs • Resource specialist programs • Special classes and centers • Nonpublic, nonsectarian school services • State special schools • Instruction in settings other than classrooms where specially designed instruction may occur **Related Services** (*Education Code* Section 56363) As specified in the IEP, shall be available when the instruction and services are necessary for the pupil to benefit educationally from his or her instructional program Shall meet standards adopted by the board

Appendix 6.8
Agency Responsibilities for Early Intervention Services, Related Services, and Regional Center Services

Early Intervention Services Part C (17 CCR 52000) [34 CFR 303.12]	**Related Services–Part B (17 CCR 56363)**	**Services and Supports Lanterman Act (*Welfare and Institutions Code* 4512 (b))**	
• Assistive technology • Audiology • Family training, counseling, and home visits • Health services • Medical services for only diagnostic or evaluation purposes • Nursing services • Nutrition services • ***Occupational therapy*** • ***Physical therapy*** • Psychological services • Service coordination • Social work services • Speech and language services • Transportation and related costs • Vision services • Respite care and other family support services	• Language and speech development and remediation • Audiology services • Orientation and mobility instruction • Instruction in the home or hospital • Adapted physical education • ***Physical therapy*** • ***Occupational therapy*** • Vision services • Specialized driver training instruction • Counseling and guidance • Psychological services other than assessment and development of the IEP • Parent counseling and training • Health and nursing services • Social worker services • Specially designed vocational education and career development • Recreation services • Specialized services for low incidence disabilities, such as readers, transcribers, and vision and hearing services	• Diagnosis • Evaluation • Treatment • Personal care • Day care • Domiciliary care • Special living arrangements • ***Occupational therapy*** • ***Physical therapy*** • Speech therapy • Training • Education • Supported and sheltered employment • Mental health services • Recreation • Counseling of the individual and his/her family • Facilitating circles of support • Habilitation • Homemaker services • Infant development programs • Paid roommates • Paid neighbors • Respite • Short-term out-of-home care • Social skills training • Specialized medical and dental care • Supported living arrangements	• Protective and other social and sociological services • Information and referral services • Follow-along services • Adaptive equipment and supplies • Advocacy assistance • Assessment • Assistance in locating a home • Child care • Behavior training and behavior modification programs • Camping • Community integration services • Community support • Daily living skills training • Emergency and crisis intervention • Technical and financial assistance • Travel training • Training for parents of children with developmental disabilities • Training for parents with developmental disabilities • Vouchers • Transportation services necessary to ensure delivery of services to persons with developmental disabilities
Regional center or LEA is responsible.	LEA is responsible for services that support the child's ability to gain access to the curriculum and benefit from the educational program.	Regional center is responsible.	Regional center funds shall not be used to supplant the budget of any agency that has a legal responsibility to serve all members of the general public and is receiving public funds for providing those services (*Welfare and Institutions Code* Section 4648 (8))
OT, PT, ST, etc. may be ***required*** and a primary early intervention service designed to meet developmental needs of infant or toddler	OT, PT, ST, etc. are ***related*** services designed to support or enable children with special needs to access the educational curriculum or program	Centered on the individual and the family, taking into account the needs and preferences of the individual and family, where appropriate…(WIC 4646 (a))	

Chapter 7
Services for School-Age Children

This chapter provides guidelines for the provision of child-related services in accordance with the Individuals with Disabilities Education Improvement Act (IDEA 2004), Part B for children from three to twenty-one years old, the California *Education Code,* and the Educational Framework for Child Success (EFCS). The roles of OT and PT are expanded upon as they relate to the pre-referral supports provided to children in the general education curriculum, including the early intervening services and Response to Instruction and Intervention (RtI^2) models of practice. Also outlined in this chapter are the roles of therapists pertaining to program accommodations, referral process, assessment, individualized education program (IEP), goal development, service delivery for children, and role of other professionals in the educational setting.

Appendixes 7.1 and 7.2 provide a comprehensive overview of practice for OT and PT in school settings. The examples of educational goals and outcomes are broad and may not apply to some ages and developmental levels. See appendix 7.3 for a specific example of how OT and PT interface with an educational curriculum.

Service Coordination and Role of Other Professionals

The educational team consists of many different professionals (school psychologists, nurses, teachers, speech therapists, counselors, administrators, etc.) who provide a variety of services and focus on a range of goals. Collaboration among these providers allows for a comprehensive educational program for the child.

With a strong background in health care, OTs and PTs play an important role as liaison between the education team and other health care providers. For example, the school nurse is a member of the team who monitors health care needs and often provides case management for children with specialized medical needs. Orientation-and-mobility specialists provide services to blind or visually impaired children to enable those children to attain systematic orientation to and safe movement within the school, home, and community. Children with exceptional needs who are unable to participate in physical education programs may receive adapted physical education with a credentialed teacher who possesses a certificate in adapted physical education. These examples showcase various professionals that bring unique and distinct contributions to the IEP team.

Prevention Strategies

Among the strategies used to prevent students from negative learning outcomes is one called Response to Intervention (RtI). OTs and PTs have emerging roles in the RtI process.

Response to Intervention

Response to Intervention (RtI) is a prevention-oriented approach to linking assessment and instruction that can inform educators' decisions about how best to teach their students. A goal of RtI is to minimize the risk for long-term negative learning outcomes by responding quickly and efficiently to documented learning or behavioral problems and ensuring appropriate identification of students with disabilities" (National Center on Response to Intervention 2010, 4).

RtI is emerging nationally as an effective strategy to support every student. It is cited in the reauthorization of the Individuals with Disabilities Education Act (IDEA) of 2004 related to the determination of a specific learning disability and in 34 Code of Federal Regulations sections 300.307, 300.309, and 300.31.

The California Department of Education is coining the term "Response to Instruction and Intervention (RtI^2)" to define a general education approach of high-quality instruction and early intervention, prevention, and behavioral strategies. RtI^2 offers a way to eliminate the achievement gap through a schoolwide process that provides assistance to every student, both high-achieving and struggling learners (California Department of Education 2009).

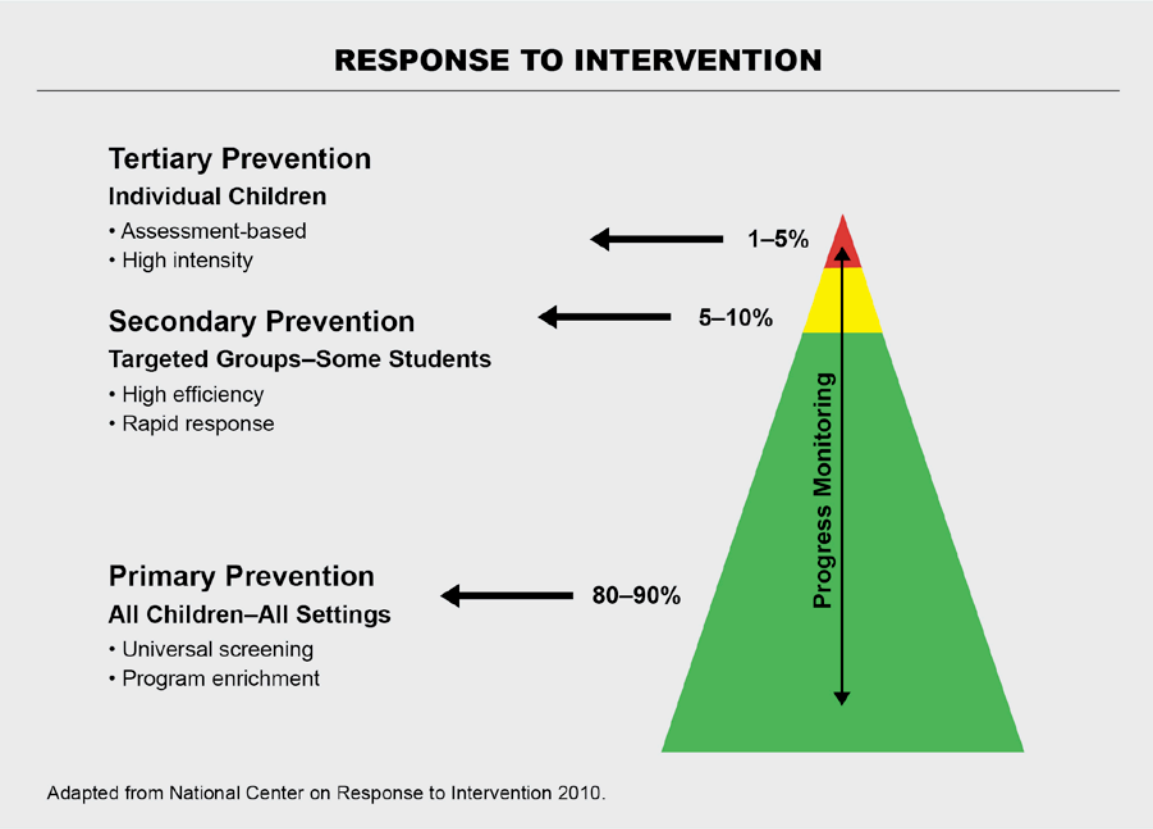
The state of California, in response to the IDEA 2004 requirement that school districts use prevention and early intervening services for all school-age children, supports methods to identify the learning needs of children through ongoing progress monitoring to individualize appropriate instruction and intervention. The local district's responsibility is to make an effort to resolve the presenting challenges that interfere with progress in the general education environment before referring a child to special education. The laws are designed to ensure that "scientifically based academic instruction and behavioral interventions, including scientifically based literacy instruction" (20 USC § 1413(f)(2)(A)), are provided to all children.

Response to Instruction and Intervention (RtI^2) is a methodical, data-driven approach to instruction that benefits every child. RtI^2 is intended to speak to the full range of instruction, from the general core curriculum, to supplemental or intensive instruction, to meet the academic and behavioral needs of children (34 CFR § 300.226). In California, the hope is that the RtI^2 approach can close the achievement gap. There are 10 central components: high-quality classroom instruction; research-based instruction; universal screening; continuous classroom progress monitoring; research-based interventions; progress monitoring during instruction and interventions; fidelity of program implementation; staff development and collaboration; parent involvement; and specific learning disability determination. School OTs and school PTs may play an integral role in assisting California schools with RtI^2.

Recognition and Response (see www.recognitionandresponse.org), for young children ages three through five, is based on the RtI approach and guides educators with

information and resources to address the needs of children who may not be earning in an expected manner. It aims to create high-quality early childhood classrooms. Periodic universal screening for all children is administered by teachers, and the team must provide research-based interventions and progress monitoring for those children who show signs of learning difficulties. Figure 7.1 illustrates the RtI process (National Center on Response to Intervention 2010).

Figure 7.1 Example of the Response to Intervention Process



Tier I: Universal Screening and Intervention

In Tier I, the OT and PT collaborate with educational staff on curriculum enrichment providing universal, proactive, and preventive intervention strategies to support a high-quality core instructional program and progress monitoring of all students in all settings. Program enrichment and accommodations are made in order to support the success of all children in the educational setting. The curriculum and activities become more accessible and meaningful. At this level of service, children have not been identified as requiring OT or PT as a related service to special education. However, OTs and PTs may be involved in the following tasks:

- In-service training sessions and provision of resources
- Accommodations for all children to gain access to the curriculum, classroom, and campus, including modifications of tools, tasks, materials, or the environment or

all four
- Seating and/or positioning of the desk and chair for proper ergonomic fit
- Sensory-enriched classroom and curriculum design
- Adaptations to support fine and gross motor development
- Activity analysis and activity demonstration
- Universal design

For example, at Tier I the OT may make suggestions to the classroom teacher regarding different handwriting curriculum and strategies for fine motor and visual motor development; discuss appropriate ergonomic posture for desktop activities; make suggestions to facilitate improved core muscle strength; and illustrate the importance of children using an efficient pencil grasp and activities to improve hand strength and dexterity. Handwriting samples or a child's portfolio may be used to monitor progress toward meeting language arts state standards. After providing a universal screening of writing samples, the teacher and OT may identify a small group of children who need additional support in language arts for developing handwriting skills.

At Tier I, the PT may discuss gross motor skill development and milestones with the classroom teacher; identify specific motor skills needed to participate in the educational environment; pinpoint modified motor skills that children may use to accomplish the same activities with their peers; discuss sitting and standing posture and the importance of maintaining proper alignment for motor activities; or make suggestions for decreasing the level of difficulty of the motor skills required (e.g., use the ramp instead of the stairs). The PT may observe the children participating in natural opportunities (physical education, recess, free-play) using their motor skills and, based on this general observation, target a group of children for further screening if motor skills difficulty is noted.

Tier II: Targeted Group Intervention—Strategic

In Tier II, the role of the OT or PT may include an analysis of the screening of all children. The screening assists in forming highly structured groups of children with similar needs for appropriate evidence-based instructional strategies and interventions for success in the curriculum. Screenings are conducted in a natural environment conducive to eliciting a representative sample of a child's functional abilities in the school setting. Screenings must not involve any activity that removes a child from regular school activities. Screenings may include observation of a child in a peer group if the observation does not identify or single out a particular child (EC § 56301).

A teacher or specialist may screen a child to determine appropriate instructional strategies for curriculum implementation. Screening is not considered an assessment for determining eligibility for special education and related services and therefore does not require parental consent (34 CFR § 300.302; EC § 56321(g)).

Tier II intervention targets at-risk students and is short term in duration. Typically, the OT and PT may provide one or more of the following services:

- Review teacher data and the outcomes of Tier 1 classroom accommodations.
- Consult with parents, teachers, and other school staff to learn about their concerns regarding participation of various groups of children in the general education curriculum.
- Review group work samples identifying groups of children with specific needs.
- Review curriculum and propose modifications to meet targeted needs.
- Analyze ongoing curriculum data collected by the teacher and assist with disability identification.
- Assist in designing and implementing targeted group instruction.
- Review scientifically based data collected through the pre-referral process.
- Provide follow-up screening and intervention for a targeted group, as appropriate.

The following outcomes may result from the screening:

- Information to the teacher, school staff, or parent supports the determination that the child's abilities are adequate to gain access to educational opportunities.
- Targeted interventions, program accommodations, and data collection are recommended and implemented by the classroom teacher or parents or both.
- There is follow-up support in the form of a referral to the Student Success Team (SST) or other general education process for RtI^2.

At Tier II, the OT may assist the teacher in developing a handwriting center in the classroom where children receive strategic instruction in targeted groups with ongoing monitoring and feedback from the teacher. The OT may suggest developmentally appropriate accommodations based on research, such as various handwriting programs, physical and sensory strategies, the use of a pencil grip, or paper with clear visual boundaries. If a child continues to demonstrate difficulties meeting state standards even with Tier II supports, more individualized attention may be suggested.

At Tier II, the teacher, parent, and school staff may discuss with the PT concerns about the child's gross motor skills. In turn, the PT analyzes the concerns and then may form a gross motor challenge (e.g., obstacle course) in which the entire class participates. This strategy allows the PT to note general performance patterns and to observe if any child demonstrates difficulties with these skills. From the general screening, the PT may discern that the majority of children demonstrate similar patterns or that more specific data are required to determine differences in performance. In addition, if the majority of the children demonstrate similar patterns, the PT may suggest skills for the children to practice and rescreen them in a given time frame to note any changes in the children's performances (National Center on Response to Intervention 2010).

Tier III: Individualized Consultation–Intensive

In Tier III, the OT and PT provide follow-up consultation to the classroom teacher, staff, and parents and support the collection of progress-monitoring data to help identify more effective individualized intervention strategies and accommodations. In collaboration with the teacher, the OT or PT develop a measurable goal and implement a specific,

targeted intervention to address the area of concern. A systematic method of data collection is employed to monitor the child's progress toward the goal is. Upon review of the data, the SST determines whether the intervention was successful and further intervention is necessary. If the child did not make adequate progress, the SST modifies the intervention method and may refer the child for a special education assessment for all areas of a suspected disability.

Typically, the OT and PT may provide one or more of the following services:

- Participate on the SST or other general education processes for RtI^2.
- Develop and monitor measurable goals.
- Assist the SST in providing systematic monitoring of the child's progress by reviewing the data.

Progress Monitoring

Progress monitoring is a method of analyzing a child's academic development. Progress monitoring requires frequent data collection with technically adequate measures, interpretation of the data at regular intervals, and changes to instruction based on the interpretation of data on child progress (see http://www.studentprogress.org/).

In California, the Child Development Division of the Department of Education has implemented statewide assessment of children in state-funded preschool programs by using the Desired Results Development Profile (DRDP) assessment system. In addition, IDEA 2004 requires (for accountability purposes) the inclusion of children with disabilities in any district or statewide assessments (20 USC § 1412(a)(16)(A)). Therefore, preschool children with disabilities are assessed through the DRDP instruments. The general statewide instrument utilized to assess skills typically mastered by children three to five years of age is called the *Preschool Desired Results Developmental Profile – Revised* (PS DRDP-R). However, children with disabilities who do not yet demonstrate skills typically mastered by three-year-old children, are assessed using the *Desired Results Developmental Profile access* (DRDP *access*) instrument, which measures skills from birth to kindergarten. The data for children with IEPs are reported to the California Department of Education's Special Education Division. For more information, see http://www.wested.org/desiredresults/training/ and www.draccess.org.

Referral for Special Education

Each LEA or special education local plan area (SELPA) develops referral procedures consistent with federal and state laws (refer to Chapter 2). Children are referred for special education instruction and services after the general education program's resources have been considered and, if applicable, utilized (EC § 56303). Parents may request a referral for special education at any time, and procedural safeguards and timelines then take effect.

The general education resources consist of the SST team interventions, as well as other early intervening strategies, including OT and/or PT screenings that have been completed. Upon reviewing the referral, an OT or PT can decide to conduct a screening to assess the areas of concern to determine whether further evaluation is needed. Parental permission is required for screening that is conducted after a referral. All referrals for special education or related services are documented in writing (5 CCR § 3021(a)). A referral for an assessment to identify an individual with exceptional needs can be made by a parent, guardian, foster parent, teacher, or other service providers of the individual (EC § 56029). In the school setting, a PT may conduct an assessment in accordance with the referral without a specific medical diagnosis (www.ptb.ca.gov).

Many school districts develop and use a variety of forms and questionnaires to assist in referring a child for assessment. See appendix 7.4 for a sample form. Appendix 7.5 provides an example of typical information that may be included in a referral for an OT or PT assessment.

Evaluation

The purpose of an initial special education eligibility evaluation is to determine whether a child has a disability and the nature and extent of the special education and related services that the child needs (34 CFR § 300.15). This evaluation may or may not include an OT and PT as part of the team, depending on the areas of concern identified. The OT or PT evaluates areas of need in which he or she is qualified to gather information regarding a child's ability to participate in and gain access to the general education curriculum in various contexts throughout the day. The intent is to assess a child in all areas of a suspected disability and then determine the child's needs and provide a rationale for addressing those needs as they relate to a child's education.

The evaluation process in school-based practice is collaborative, fluid, and ongoing. It often begins in the informal pre-referral prevention stage and continues throughout intervention. The regulations specify that a reevaluation may not occur more than once a year, unless both the parent and the LEA have agreed upon this. However, a reevaluation may be conducted every three years (triennial). Reevaluations are conducted if the conditions warrant a new evaluation: the pupil continues to need special education and related services, or additions or modifications to the special education and related services are necessary to enable the pupil to meet the measurable annual goals set out in the IEP and to participate, as appropriate, in the general curriculum (34 CFR § 300.304).

Notice of Proposed Assessment Plan

Parents and guardians must receive prior written notice of a proposed assessment of their child. The notice must include an explanation of the procedural legal safeguards (20 USC § 1400 et seq.). The notice must also include, in language easily understood by the general public and in the native tongue of the parent, a description of the types of assessments to be conducted.

Timelines

Federal and state education mandates provide the following assessment timelines:

- An assessment plan (notice) must be prepared and sent to the parent or guardian for review and consent within 15 days after the receipt of the referral.
- The parent or guardian has 15 days to give or withhold written consent to the proposed plan.
- Upon receipt of the signed assessment plan, there are 60 calendar days (including weekends but not including school vacations of five days or more in length) to complete the assessment and hold an IEP meeting (EC § 56344; 34 CFR § 300.301(c)).

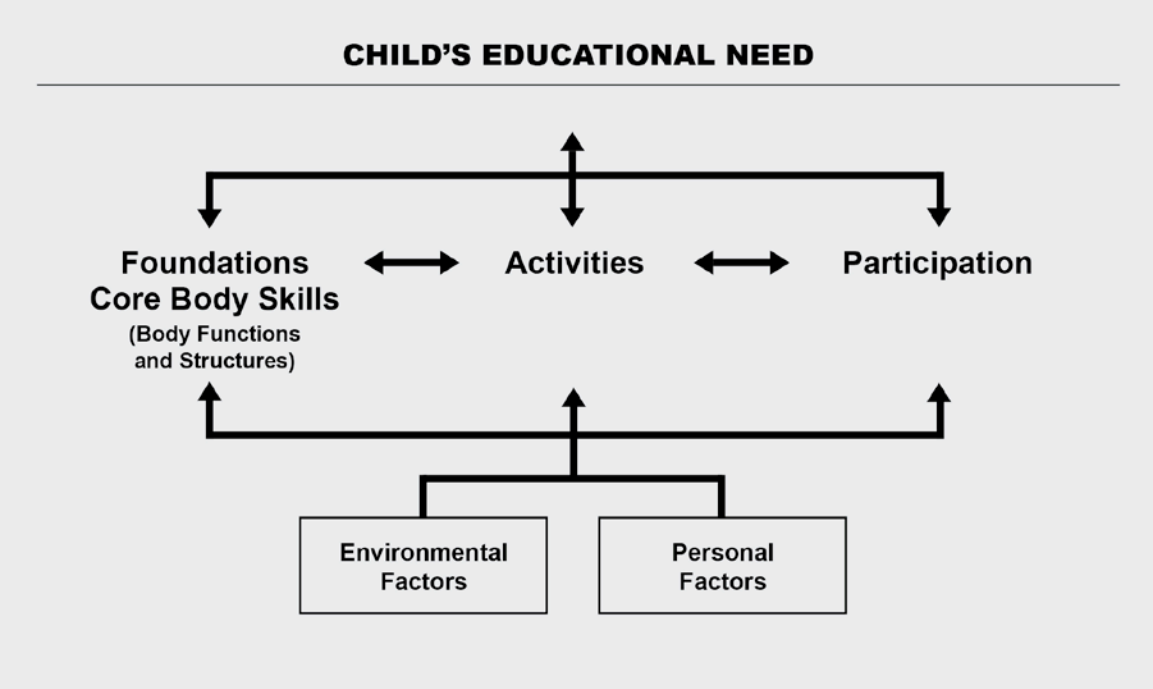
Children transferring into any public school in California, with OT and/or PT services specified on their current incoming IEP, must receive a "like" program while the team determines, within 30 days, if that IEP continues to be appropriate or, if any changes to the IEP are necessary. This may or may not require an assessment to determine the need for services in the child's new educational environment.

OT and PT Assessments

OT and PT are health science professions with distinct and unique scopes of practice and practice frameworks that guide the assessment process (www.aota.org; www.apta.org). The *Occupational Therapy Practice Framework* (AOTA 2008) and the *Guide to Physical Therapist Practice, 2nd Edition* (APTA 2003) are both derived from the World Health Organization's International Classification of Functioning, Disability and Health, which evaluates an individual's health status in terms of an ability to gain access to activities and participate in everyday life. Appendixes 7.6 and 7.7 review specific details regarding the content and process of OT and PT assessments. OT and PT assessments in public schools address both the individual child's abilities and participation in the educational environment. Another purpose of the OT and PT assessment may be to determine equipment needs for a child. See appendix 7.8,"Funding for Children with Low-Incidence Disabilities," for a summary of the conditions to be eligible.

Figure 7.2 illustrates the International Classification of Functioning, Disability and Health model (World Health Organization 2001) applied in the educational setting. Environmental factors include the child's school campus, classroom, playground, and cafeteria. Additional environmental factors include culture, social norms the built-environment, institutions, agencies (services), and products available. Personal factors include age, gender, health conditions, personal interests, coping style, social background, past experience, and character style. Environmental and personal factors provide the foundation for an OT and PT evaluation. The OT and PT practicing within distinct professional practice frameworks and guidelines evaluate a child's participation at school, curriculum activities, and core body skills that support or limit participation and access to the general education curriculum.

Figure 7.2 Adaptation of the International Classification of Function Model to the Child's Educational Needs



The Educational Framework for Child Success (EFCS) found in Chapter 1 further describes OT and PT assessment priorities in the educational setting. As shown in this model, child performance cannot be evaluated accurately apart from the context of the child's educational program and must incorporate evidence based assessment methods. It is important to evaluate a child's performance through observation in the educational setting, during every day routines and activities in the classroom and other contexts (e.g., playground, lunch area, assembly rooms, etc.). It is also important to evaluate his/her ability to adapt to and meet the demands of current and future expectations. Standardized tests, while not required by law, provide reliable and evidence-based methods of examining discrete abilities or skills to identify or rule out the possible factors that contribute to a child's ability to participate in the general education curriculum.

Assessment Procedures

OT and PT assessments may involve the following procedures:

- Review of records including classroom-based, local, or state assessments
- Interviews, including observations of the teacher, parents, and personnel knowledgeable about the child
- Observation of the child in the educational environment
- Informal assessments, including non-standardized measures and observations
- Formal assessment, including standardized measures

The key consideration in the OT and PT assessment process is the degree of the child's access to the general education curriculum, as well as the child's progress in meeting state standards.

In conducting an evaluation, a school district must use a variety of tools and strategies to gather relevant information about the child's functional, developmental, and academic abilities, including information provided by the parent that will assist in determining whether the child has a disability and the extent to which the child is able to gain access to and make progress in the general education curriculum (20 USC § 1414(b)(2)(A); 34 CFR § 300.304(c)(6); EC § 56320).

A district must not use any single measure or assessment as the sole criterion for determining whether a child has a disability or an educational need. Instruments or measures must be technically sound to assess the relative contribution of cognitive and behavioral factors in addition to physical and developmental factors.

Assessments and other such materials are used to determine an area of function or ability and administered so as not to be discriminatory on a racial or cultural basis. They are provided and administered in the language and form most likely to elicit what the child knows and can do academically, developmentally, and functionally, unless it is not feasible to do so. Assessments are used for the purposes for which they were found to be valid and reliable are administered by trained and knowledgeable personnel in accordance with instructions of the producer of such assessments (34 CFR §§ 300.532 and 300.304 (b)(2) and (3)). Requirements for an evaluation in the public school setting can be found in 20 *United States Code* sections 1412(a)(6)(B), 1414(b)(2) and (c)(3) and *Education Code* Section 56320.

The therapist selects the appropriate assessment method, procedure, or tool "that directly assists persons in determining the educational needs of the child" (34 CFR § 300.532(g)). There are numerous evaluation tools that OTs and PTs can use in the educational setting. Many sources provide lists and reviews of these assessments (Asher 2007; APTA 2005; Long and Cintas 1995; Mulligan 2003; Stewart 2005). Appendix 7.9, "Educational Assessment Methods, Procedures, and Tools," provides examples.

School-based OT and PT evaluations with a consideration of mental health and medical management needs address a child's ability to participate in and make progress in the general education curriculum. Children may receive OT and PT evaluations and services from the school district (i.e., local educational agency) as well as from California Children's Services, and private agencies funded through parents and private insurance. It is expected that therapists and professionals from various agencies collaborate in order to complement and not duplicate therapy services.

Children with Mental Health Needs

The identification and evaluation of mental health needs is often overlooked and requires careful observation and team collaboration. Occupational therapists with skills in activity analysis and knowledge of nervous system regulation contribute unique and valuable information to the development of positive behavior support strategies, the identification of children with mental health needs, and the functional behavior assessment process as part of the IEP team (AB 114)

Children with Medical Management Needs

As part of the school-based OT and PT evaluation, a child who presents with medical management needs is referred to the California Department of Health to be considered for OT and PT services through California Children's Services (CCS). If a child qualifies for medically necessary OT or PT or both, the California Department of Health Services, or any designated local agency administering CCS, shall be responsible for implementtation and provision of medically necessary OT and PT services (GC §§ 7570–7575).

A child may qualify for services provided by CCS, if he/she has a "medical therapy program eligible condition" (5 CCR § 60300(j)), which include a diagnosed neuromuscular, musculoskeletal, or muscular disease. (The conditions that qualify a child for a medical therapy program are found at 5 CCR §§ 60300-1(a)–(d); 60300-2; 60300-3; 22 CCR §§ 41515.1–41518.9 provide a full description.) A child who has a condition making him/her eligible for a medical therapy program will receive a comprehensive evaluation of physical and functional status to determine if CCS services are warranted (5 CCR § 60300a).

School-based OT and PT evaluations with a consideration of medical needs, precautions, and prognosis address a child's ability to participate in and gain access to the general education curriculum. Children may receive OT and PT evaluations from the school district or LEA as well as from CCS and private agencies funded through parents and private insurance.

Children with Feeding Needs

Evaluations of children with feeding needs are complex and require much expertise, collaboration and involvement of family members, caregivers, and other professionals. An IEP team determines the supports needed to ensure that a child has access to safe participation in school-time meals (e.g., recess and lunch). However, some areas related to meal management, such as eating and swallowing, may be medical management issues that are the responsibility of the family and require multiple-agency collaboration. The Occupational Therapy Practice Act (BPC §§ 2570.2 and 2570.3) requires advanced training for practitioners to provide assessment, evaluation, and intervention for swallowing disorders.

The *Curriculum Guide for Students with Moderate to Severe Disabilities* was designed by the Special Education Administrators of County Offices (2005) to enable children with disabilities access to core curriculum areas of the California State Framework. Included in this guide under "Health Skills" are examples of educationally related functional performance indicators to evaluate present levels of performance and to create goals for children to develop oral motor skills for feeding and drinking purposes, fine motor skills for feeding and drinking purposes, and adaptive behavior skills to accept new food choices.

Children with Mobility Needs

Children with moderate to severe mobility needs can be evaluated in the school setting by using Movement Opportunities Via Education (MOVE). The focus of MOVE is to improve the child's ability to sit, stand, and walk, which increases mobility and overall health. Classroom teachers work with the IEP team to determine the needs of the child within the curriculum. MOVE was developed by a teacher and physical therapist and is an approved curriculum by the California Department of Education (see http://www.move-international.org/).

Report of the Assessment

Once the assessment has been completed, information is synthesized for presentation to the IEP team. Assessment findings and results and the implications for the child's ability to gain access to and make progress in the curriculum must be conveyed in a way that can be clearly understood by all members of the IEP team: parents, teachers, and other related services providers and professionals. Use of technical terms and jargon should be well defined

California *Education Code* Section 56327 requires that, after an assessment has been made a report be written and include, but not be limited to, all of the following information, as appropriate to the discipline:

- Whether the pupil may need special education and related services
- The basis of such a determination
- The relevant behavior noted during observation of the pupil in an appropriate setting
- The relationship of that behavior to the pupil's academic and social functioning
- The educationally relevant health and development, and medical findings, if any
- For pupils with learning disabilities, whether there is such a discrepancy between achievement and ability that it cannot be corrected without special education and related services
- A determination concerning the effects of environmental, cultural, or economic disadvantage, where appropriate
- The need for specialized services, materials, and equipment for pupils with low-incidence disabilities, consistent with guidelines established pursuant to Section 56136 of the *Education Code.*

In addition to the inclusion of the legally required elements of the assessment report noted above, the following sections are typically included in most OT and PT evaluation reports:

- **Reason for referral**: Reason for referral, purpose of the assessment, and concerns of the IEP team (e.g., child, parents, and educational staff).
- **Background:** Educational and therapeutic history; relevant health and developmental history; current program and services and supports.
- **Evaluation procedures:** Methods and dates (e.g., observations, interviews, questionnaires, non-standardized or standardized tests in pertinent areas related to child's suspected disability with an explanation of purpose and rationale for methods used). Review of existing evaluation data is mandated (Public Law 108-446).
- **Validity of findings:** Assessments must be completed within the parameters of *Education Code* Section 56320 (e.g., "testing procedures . . . are selected and administered so as not to be racially, culturally, or sexually discriminatory . . . materials and procedures shall be provided in the pupil's native language or mode of communication, unless it is clearly not feasible to do so") and in such a manner that the child's behavior during testing is an accurate reflection of performance. In addition, assessments must be administered by trained and knowledgeable personnel in a valid and reliable manner and in accordance with instructions provided by the publisher of the assessment (20 USC §§ 1412(a)(6)(B) and 1414 (b)(2)).
- **Findings:** Findings include all suspected areas of dysfunction related to the OT and PT domains of practice, an interpretation of the educational relevance of these findings, the discrepancies between test scores (prior and current), and the need for specialized services, materials, and equipment.

Summary and implications for education: The significance of the supports and barriers revealed by the assessment results. Sufficient evidence from the assessment results is required to support clinical reasoning and final recommendations regarding child needs.

Individualized Education Program

The individualized education program (IEP) is a written document for each child with exceptional needs. It is developed, reviewed, and revised (EC § 56341) by a team of professionals in collaboration with the child's family and includes a statement of the child's present academic achievement and functional performance. The IEP includes how the disability affects the child's involvement and progress in the general education curriculum.

The OT or PT's responsibilities in the IEP process are, first, to interpret the results of the evaluation of a child's performance and, second, to recommend whether a child needs OT or PT as a related service, including appropriate goals. In addition the therapist

discusses the educational needs of a child and general recommendations for educational planning. Recommendations for OT and PT must be linked to educationally relevant outcomes. Under the law, OT and PT are considered "related services" necessary "to assist the child with a disability to benefit from special education" (34 CFR § 300.346).

Clear and concise "present levels of educational performance" are determined as part of the IEP and indicate how the disability affects the child's participation and progress in the general curriculum and the educational needs that result from the disability. This part of the IEP reports baseline measurements and levels of functional skills in objective and measurable terms. The present level of educational performance provides a rationale for the other components of the IEP.

According to *California Code of Regulations,* Title 5, Section 56363(a), related services, "as specified in the individualized education program shall be available when the instruction and services are necessary for the pupil to benefit from his or her instructional program". The general education teacher and/or the special education teacher provide the instruction and services if the provision of the instruction and services by the teacher(s) is feasible. If not, the appropriate designated instruction and services (i.e., related service) specialist shall provide the instruction and services".

Goals

After discussing the child's present levels of academic achievement and functional performance, the IEP team discusses the child's area(s) of concern in the educational setting. The IEP team collaboratively develops annual goals or objectives/benchmarks or both and discusses what services the child will need to achieve them. IEP goals are aligned with the state standards from the general education and preschool curriculum and the *Curriculum Guide for Students with Moderate to Severe Disabilities.*

Components of a Performance Goal and Objective

A well-written and measurable performance goal answers six questions: who, what is done, when, given what, how much (criteria), and how it will be measured (www.calstat.org/iep/). The components are as follows:

Who—relates to the student?

Does what— describes observable behavior that the student will do to complete the goal or objective/benchmark.

When—relates to a specific point in time when something will have been learned or completed.

Given what—describes the conditions that will need to be in place for the goal or objective/benchmark to be completed.

How much—Criteria describes how many times the behavior must be observed for the goal or objective/benchmark to be considered completed

Mastery – describes the performance accuracy of the behavior needed for the goal and objective/benchmark to be considered completed.

How it will be measured – describes performance data

A child's progress toward the IEP goals is documented at least as often or as frequently as children in general education receives progress notes. At a minimum, goals are reviewed annually.

Need for OT and/or PT as Related Services

IDEA requires that the IEP and services provided be driven by the child's needs and goals. Determining related service needs for children, must, therefore, be determined on an individual basis. For this reason no specific entrance and exit criteria are given as part of this document. The recommendations for OT or PT (or both) are based on the therapist's professional judgment and are derived from interpretation of findings, the child's academic achievement and functional performance, and the IEP process. Factors that contribute to clinical reasoning include age, expected response to therapy, possibility of needs being met by others, stability of status, and the pattern and severity of difficulties. PT cannot be provided without a diagnosis (for the condition being treated) from a physician or other duly licensed practitioner (unless the service is for "the purpose of general fitness and health services" according to http://www.ptb.ca.gov).

Parents may request and receive an independent educational evaluation (IEE) as part of the IEP process (34 CFR § 300.502). On occasion, a private OT or PT assessment may be presented during the IEP meeting. It is the responsibility of the OT or PT on the IEP team to summarize the findings, analyze the report, and consider its relevance to the child's needs in the educational setting.

Intervention Plan

In addition to participating in the IEP process, OTs and PTs develop an intervention plan based upon the results of the assessment. The intervention plan is guided by multiple professional frames of reference linked to an intervention hypothesis and provides the clinical reasoning used to reach measurable goals. Measurable goals, the scope of intervention; treatment strategies; and frequency, duration, and outcomes of service are identified; and a pre-plan is made for discharge in line with IEP team and parent priorities.

Intervention plans are required under both OT and PT standards of practice, codes of ethics, and licensure regulations. (See www.bot.ca.gov; www.aota.org; www.ptbc.ca.gov; and www.apta.org for more information.) A sample intervention plan is provided in appendix 7.10. (State licensure laws provide guidelines for the role of

assistants and aides and the supervising therapists.)

Services

The IEP specifies the services necessary for the child to achieve the established goals and gain access to and make progress in the general education curriculum. When OT and PT are identified as necessary related services as part of the IEP, the OT and PT recommend how and where the services will be provided, including the frequency, duration, and location of services. The delivery models can include program enrichment, accommodations, consultation, direct intervention, and other types of professional service.

Intervention and Progress Monitoring

Once the IEP team determines that the child needs OT or PT as a related service, the OT or PT develops an intervention plan based on the child's unique needs. Appendix 7.11 is consistent with the Educational Framework for Child Success and assists an OT or PT in the clinical reasoning process used during intervention. Intervention may include prevention, enrichment, collaborative consultation, monitoring, individual or group treatment, and accommodations and/or modifications. Progress monitoring data can be collected related to specific OT and PT goals. Sample forms can be found in appendixes 7.12 and 7.13.

Changes in Provision of Services

IDEA requires that the IEP service provision system be driven by the child's individual needs. Changes in service delivery (such as changes in frequency, duration, location, or discontinuation of services) must therefore be determined on an individual basis. For this reason no specific entrance and exit criteria are given as a part of this document.

The team may consider the following conditions when determining that a child no longer needs OT or PT or either one to benefit from the education program when the:

- Child's needs are being addressed by OT or PT no longer negatively affect his/her educational performance in the general education or special education program, is functional within the educational environment, and therapy services are no longer indicated.
- Child no longer requires OT or PT as a related service in order to benefit from his or her special education program.
- Child consistently demonstrates behaviors that inhibit progress in OT or PT, such as lack of cooperation, motivation, or chronic absenteeism. In those circumstances, the IEP team should consider the initial eligibility decisions since the behaviors may reflect social maladjustment, environmental, cultural, or economic factors rather than an actual disability. The IEP team may also explore alternative services or strategies to remedy the interfering behaviors or conditions.
- Child's needs are better served by an alternative program and/or service, as

determined by the IEP team.
- Therapy is contraindicated because of the change in medical or physical status.
- Child graduates from high school with a diploma.
- Child reaches the age of twenty-two years.
- When the student's anticipated goals and expected outcomes related to OT or PT intervention have been met for a particular episode of care.
- When based upon the therapist's judgment it is determined that the student will no longer benefit from therapy.

OTs and PTs may support a child's change in service delivery through collaboration, communication and implementation of intermediary steps to facilitate the child's success. For example, a child moving from elementary to middle school may need intensive services at the beginning of the school year that are not necessary once that child has mastered skills and program supports are in place that allow the child to be successful in school.

OTs and PTs have unique roles in working with school-age children. They assist with prevention and service delivery to support a child's ability to gain access to, participate, and progress in the general educational setting. OTs and PTs also collaborate with team members utilizing evidence-based intervention in order to achieve short- and long-term outcomes.

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Appendix 7.1
Examples of Occupational Therapy in the Educational Setting

Possible concerns related to curriculum and participation in the educational context	Examples of participation goals and outcomes related to the child's needs within the educational context	Examples of body functions and structures and performance skills and/or environmental modifications
Completion of written work and organization of materials in the classroom	Use classroom tools appropriately (scissors, pencils, crayons, keyboard). Hold materials steadily when working (stabilize paper, stabilize contains for opening) Follow classroom routines. Tolerate sensory demands of the educational environment. Attend to classroom instruction. Organize personal belongings. Find required materials. Complete activities with multiple steps. Copy letters, numbers, and shapes accurately. Identify letters, numbers, and shapes accurately. Write in assigned spaces and on the writing line. Identify single letter/word from a field of many.	Strength Grasp/prehension Skills, precision, and dexterity Hand dominance Bilateral coordination Eye-hand coordination Postural stability Sensory modulation and sensory perception (e.g., tactile, visual, proprioceptive, vestibular, etc.) Ability to motor plan sequenced steps of activity Ocular control Visual motor integration
Participation in leisure and playground activities	Maintain required body movements and activities for the required amount of time without difficulty. Share materials with peers. Learn new motor tasks within a reasonable time frame (such as games in PE/recess). Perform playground activities with sufficient skill. Navigate the school environment efficiently and safely. Learn new motor tasks and perform motor tasks required by the child's daily routines. Engage peers cooperatively in class, play, and games. Follow rules, such as taking turns. Win and lose games graciously. Identify own interests and goals. Comply with requests from peers and adults. Engage in sports, games, hobbies, or other structured activities.	Strength and endurance Balance Bilateral coordination Eye-hand coordination Quality of movement Proximal joint and trunk stability Imitation of body positions Sensory modulation and sensory perception (e.g., tactile, visual, proprioceptive, vestibular, etc.) Ability to act upon verbal commands and/or sequence movements Ability to initiate, organize, and execute motor plans Ability to engage in cooperative relationships Maintenance of personal space Ability to transition
Self-care activities during the school day	Manage clothing and clothing fasteners for activities, such as toileting. Feed self with appropriate utensils, including opening food containers. Self-help skills, such as washing hands, using the drinking fountain, etc.	Postural stability Fine motor manipulation Sensory modulation and sensory perception (e.g. tactile, visual, proprioceptive, vestibular, etc.) Motor planning and coordination Visual-motor and visual perceptual abilities Ability to analyze, organize, and complete self-help task (motor plan)

Possible concerns related to curriculum and participation in the educational context	Examples of participation goals and outcomes related to the child's needs within the educational context	Examples of body functions and structures and performance skills and/or environmental modifications
Prevocational skills and secondary transition	Maintain attention/stable emotional state during school activities and during transitions between activities. Identify situations that may cause stress and utilize strategies to minimize environmental stressors. Ask for help when needed. Use communication devices (e.g., telephone, computer, communication boards). Engage in community mobility when appropriate. Develop understanding of basic safety precautions. Participates in leisure activities individually or socially. Freely get access to and participate in all campus activities. Gain access to community transportation system. Navigate the entire campus safely. Use map to navigate school grounds. Use map to navigate unfamiliar community locations.	Sensory modulation and sensory perception (e.g., tactile, visual, proprioceptive, vestibular, etc.) Postural stability Fine motor manipulation Motor planning and coordination Visual-motor and visual perceptual abilities Motor planning/praxis Self-regulation Ability to analyze, organize, and complete tasks Self-determination

Appendix 7.2
Examples of Physical Therapy in the Educational Setting

Possible concerns related to curriculum and participation in the educational context	Examples of activities, goals, and outcomes related to the child's needs within the educational context	Examples of body functions and structures and performance skills and/or environmental modifications
Participation in classroom, educational and/or academic activities	Sits with good posture for designated time periods in classroom environments. Transfers to/from chair and floor. Navigates classroom with functional mobility. Opens/closes classroom door. Maintains functional/dynamic postures for educational activities. Responds to balance demands in classroom. Utilizes effective manipulation and reaching skills. Has access to the same instructional materials and areas as nondisabled peers.	Balance Environmental barriers Ergonomics and body mechanics Motor function Muscle performance (strength, power, force, etc.) Neuromuscular development Orthotic, protective, and supportive devices Posture Postural stability and control Sensory integrity (proprioception and kinesthesia)
Functional mobility in the classroom and on campus	Walk or use alternative method of mobility. Walk on ramps, grass, sand mats, and curbs. Make the transition between varied surfaces. Ascend/descend school stairs or bus steps. Enjoy mobility around campus. Climb in/out of a car or bus seat. Develop understanding of basic safety precautions. Maintain endurance during required tasks. Perform classroom chores that require mobility. Lift and carry objects. Use different types of equipment required by the work/school environment. Show speed and accuracy of new motor skills Manipulate classroom/work materials, tools, utensils, and assistive devices. Navigate/mobilize to access work location. Manage shopping materials (push cart, carry bags, obtain items). Engage in community mobility.	Aerobic capacity Balance Body mechanics Efficiency of movement Endurance Environmental barriers Ergonomics and body mechanics Gait Joint integrity Locomotion Mobility Motor function Muscle performance (strength, power, force, etc.) Nerve and reflex integration Pain Postural stability and control Range of motion Sensory integrity (proprioception and kinesthesia) Strength
Leisure and recreational activities, including playground environments	Get access to playground structures (steps, slide, ladders). Get access to swings (on/off, balance, pumps, gains momentum). Ride tricycle (on/off, pushes with feet, pedals, steers). Run, jump, hop, and gallop. Throw, catch, and kick ball. Use a variety of ball skills (throw, bounce, dribble, toss/catch). Imitate simple to complex motor movements (dance). Engage in sports, games, hobbies, or other	Aerobic capacity Balance Endurance Environmental barriers Gait Joint integrity Locomotion Mobility Motor function Muscle performance (strength, power, force, etc.) Pain Range of motion

Possible concerns related to curriculum and participation in the educational context	Examples of activities, goals, and outcomes related to the child's needs within the educational context	Examples of body functions and structures and performance skills and/or environmental modifications
	structured activities. Participate in individual or social leisure activities.	Sensory integrity (including proprioception and kinesthesia)
Self-care activities during the school day	Transfer on/off toilet. Mobilize around restroom and sink for hygiene activities. Mobilize while carrying items (meal tray, book, backpack). Mobility skills for mealtime preparation and/or eating Mobility skills for dressing and grooming activities Manage personal orthotic devices, equipment, or supportive device(s)	Balance Endurance Gait Locomotion Motor function Muscle performance (strength, power, force, etc.) Pain Postural stability and control Sensory integrity (including proprioception and kinesthesia)

Appendix 7.3
Examples of Occupational Therapy and Physical Therapy Interface with a Specific Curriculum

Examples of Kindergarten State Standards	Body Functions, Structures, and Performance Skills Addressed by OT	Body Functions, Structures, and Performance Skills Addressed by PT
English Language Arts 1.0 Writing Strategies Students write words and brief sentences that are legible. 1.3 Write by moving from left to right and from top to bottom. **Penmanship** Write uppercase and lowercase letters of the alphabet independently, attending to the form and proper spacing of the letters.	Postural ocular control Visual motor integration (eye, hand, and visual perception) Fine motor (in hand manipulation skills, hand strength, finger dexterity, motor precision) Motor planning the direction of the hand and fingers motion to form letters Muscle and joint body awareness (kinesthesia) regarding appropriate pressure used with the writing tool	Ability to sit with balance and stability in a child-sized chair Postural trunk control Trunk strength Appropriate co-contraction of synergistic muscle groups Functional range of motion (active and passive) Dissociation of proximal support muscles from distal limb muscles Appropriate grading of force, speed, and direction
Mathematics Algebra and Functions 1.1 Identify, sort, and classify objects by attribute and identify objects that do not belong to a particular group (e.g., all these balls are green, those are red).	Tactile and visual discrimination Fine motor strength, dexterity, and object manipulation	Dissociation of proximal support muscles from distal limb muscles Appropriate grading of force, speed, and direction
Science Physical Sciences 1(a) Students know objects can be described in terms of the materials they are made of (e.g., clay, cloth, paper) and their physical properties (e.g., color, size, shape, weight, texture, flexibility, attraction to magnets, floating, sinking). Investigation and Experimentation 4(a) Observe common objects by using the five senses. (b) Describe properties of common objects. (c) Describe the relative position of objects by using one reference (e.g., above or below).	Body awareness (muscle and joint discrimination of size, force, weight, and distance) Body awareness in relation to space Tactile discrimination (texture, shape, flexibility)	Ability to sit or stand with stability and balance in a variety of environments Maintain center of mass over narrow base of support Dissociation and rotation of trunk and pelvis Intermittent single limb support

Examples of Kindergarten State Standards	Body Functions, Structures, and Performance Skills Addressed by OT	Body Functions, Structures, and Performance Skills Addressed by PT
History/Social Science K.1 Students understand that being a good citizen involves acting in certain ways: 1. Follow rules such as sharing and taking turns, and know the consequence of breaking them.	Physical, social, and adaptive developmental readiness Sensory and praxis ability to play Analysis of core adaptive components of play	Activity-specific: sitting versus standing versus playing
Visual and Performing Arts Development of Motor Skills and Technical Expertise .1 Build the range and capacity to move in a variety of ways. .3 Understand and respond to a wide range of opposites (e.g., high/low, forward/backward, wiggle/freeze). .2 Respond to a variety of stimuli (e.g., sounds, words, songs, props, and images) with original movements. .3 Respond spontaneously to different types of music, rhythms, and sounds.	Body awareness of muscles and joints in space Ideational praxis: the ability to recognize novel stimuli and its potential to create a new ideas about how to move or play Sequencing praxis: the ability to sequence a series of motor actions Postural praxis: the ability to follow directions using imitation of a visual demonstration. Praxis on verbal command: translating a verbal direction to a motor action	Ability to stand and dynamically change center of mass Postural trunk control Trunk strength Appropriate co-contraction of synergistic muscle groups Functional active and passive range of motion Dissociation and rotation of trunk and pelvis Intermittent single limb support Ability to maintain balance as center of mass changes both height and displacement from midline over changing base of support
Physical Education Standard 1. Students demonstrate motor skills and movement patterns needed to perform a variety of physical activities.	**Sensory Integration and Praxis** Analysis of the functional, physical, social, and developmental expectations related to a child's medical diagnosis	Ability to stand, changing both position and direction of body with velocity and acceleration Appropriate co-contraction of synergistic muscle groups Functional range of motion (active and passive) Dissociation and rotation of trunk and pelvis Intermittent single limb support Ability to maintain balance as center of mass changes both height and displacement from midline over changing base of support Asymmetrical limb position Reacquisition of stable base of support after flight Appropriate grading of force, speed, and direction

Appendix 7.4
Sample OT and PT Screening/Evaluation Referral Form

Name: _____ Date:_____

School: _____ Birthdate:_____

Teacher: _____ Parent:_____

Grade: _____ Address _____

Referred by: _____

Cell Phone: _____

Language Spoken: Home _____ School _____

Educational Eligibility: _____ Not Determined

School Status: Reg Ed ____ RSP ____ Speech ____ 30-day transfer _____

SDC_____ Child Find _____ Home School ____ Hospital _____

Dates: IFSP_____ 30-day Review _____ Annual IEP Review_____ Triennial_____

Agency Status: CCS ____ Regional Center _____ Private OT or PT _____ Contact Information: _____

Medical Diagnosis: _____ **Medications**: _____

Presenting Problem(s):

What is this child not able to do that other children in the classroom are able to do? Summarize concerns.

_____

_____

Who is expressing the most concern?

Parent Teacher Principal Psychologist RSP Speech Nurse Physician

Estimated Ability: Not Tested Above Average Average Suspect Developmental Delay

Estimated Curriculum Level: Lang Arts ____ Math ____Science ___ History/Social Science ___ P.E. ___

Functional Ability: Please indicate the child's level of independence and participation.

5 = Independent, 4 = Needs Occasional Assistance, 3 = Requires Some Supervision, 2 = Constant Supervision, 1= Dependent

					Comments
General education classroom:	1	2	3	4	5 _____
Special education classroom:	1	2	3	4	5 _____
Campus:	1	2	3	4	5 _____
Playground: motor ability:	1	2	3	4	5 _____
Social skills:	1	2	3	4	5 _____
Bathroom:	1	2	3	4	5 _____
Lunch: Uses utensils	1	2	3	4	5 _____
Opens containers	1	2	3	4	5 _____
Transitions:	1	2	3	4	5 _____
Transportation:	1	2	3	4	5 _____

Accommodations and modifications: _____

_____

Percentage of expected written work child is able to complete _____

Quality of work: Excellent Good Fair Poor

***Note*:** Please attach an Educational Assessment, a writing sample, and any medical, OT, PT, or APE reports

Source: Anaheim City School District 2009.

Appendix 7.5
Typical OT and PT Assessment Considerations

Referral Information
• Child information: Name, school of attendance, date of birth, parents' name, contact information • Reason for referral: Areas of concern that impact the child's ability to successfully participate in the curriculum • Documentation of the regular education program resources that have been considered, modified, and (when applicable) the results of intervention • Current educational program, including classroom placement and related services • Health and medical records: medical diagnoses, developmental history, medications, allergies. and precautions/contraindications • Classroom information obtained from sources such as checklists, observations, interviews, and work samples • Relevant educational assessment reports by the psychologist, speech and language teacher, adapted physical education teacher. "Parental consent is not required before reviewing existing data as part of an assessment" (*Education Code* Section 56321e) • Appropriate private assessment reports by the OT, PT, psychologist, speech and language teacher Note: Confidentiality laws require permission for the release of information to be obtained from pertinent entities outside the school district.

Appendix 7.6
Occupational Therapy Evaluations

OT evaluations in the educational setting are guided by the *Occupational Therapy Practice Framework* (AOTA 2008). *Occupational therapy assessment identifies performance abilities and limitations that are necessary for self-maintenance, learning, work, and other similar meaningful activities*. This document describes the OT's role in promoting health and participation in life through engagement in everyday activities, which are referred to as "occupations." The OT gathers information through an evaluation process that provides an understanding of the child's history, experiences, performance skills, patterns of daily living (habits and routines), interests, cultural and personal values, and educational needs. Activity demands and factors supporting or hindering participation in daily life activities to gain access to the state standards at school are identified. The OT considers the various domains that influence the child's function (cognition, language and communication, social/emotional development, adaptive function, physical development, and play) and conducts tests and measures to develop a summary of the child's strengths and needs.

Although testing in many areas is needed in a comprehensive OT evaluation, not all of these tests and measures are necessary for every child. Common child-specific areas assessed by OTs related to participation in school activities may include:

- Activities of daily living
- Arousal, attention, adaptive behavior, and organizational skills
- Assistive and adaptive technology
- Community integration
- Environmental, home, and work (school/play/job) modifications
- Ergonomics and body mechanics
- Fine motor and gross motor function (motor control and motor learning)
- Habits, routines, and roles
- Leisure skills
- Neuromuscular functions
- Occupational profile, interests, values
- Play
- Praxis
- Rest and sleep
- Self-determination
- Social participation
- Tool use
- Visual motor integration
- Work and prevocational skills

Selected References

American Occupational Therapy Association. 2008. *Occupational Therapy Practice Framework: Domain & Process.* 2nd ed. Bethesda, MD: American Occupational Therapy Association.

Appendix 7.7
Physical Therapy Evaluations

PTs in the educational setting utilize the *Guide to Physical Therapist Practice* (APTA 2003). The guide is based on the process of enablement and the integration of prevention and wellness strategies. The PT gathers information regarding examination, evaluation, diagnosis, prognosis, and intervention for the each child evaluated (APTA 2003), including a thorough history and systems review. The PT considers the various domains that influence the child's function (cognition, language, and communication; social/emotional development; adaptive function; physical development; and play) and conducts tests and measures to develop a summary of the child's strengths and needs.

Common child-specific areas assessed by PTs related to the child's participation in school activities may include:

- Aerobic capacity/endurance
- Arousal and attention
- Assistive and adaptive devices
- Circulation
- Cranial and peripheral nerve integrity
- Environmental, home, and work (job/school/play) barriers
- Ergonomics and body mechanics
- Gait, locomotion, and balance
- Integumentary integrity
- Joint integrity/mobility
- Motor function (motor control and motor learning)
- Movement frequency, pattern, and controlled muscle performance (including strength, power, and endurance)
- Neuro-motor development and sensory integration
- Orthotic, protective, and supportive devices
- Posture
- Prosthetic requirements
- Range of motion (ROM) (including muscle length)
- Reflex integrity
- Self-care (including ADL [activities of daily living])
- Sensory integrity (including proprioception and kinesthesia)
- Ventilation and respiration
- Work (job, school, play), community, leisure physical access

Although testing in many areas is needed in a comprehensive PT evaluation, not all of those tests and measures are necessary for every child. The PT identifies the unique pediatric considerations related to each individual child and interprets the fundamental areas to be examined (APTA 2003).

Selected References

American Physical Therapy Association. 2003. *Guide to Physical Therapist Practice.* 2nd ed. Alexandria, VA: American Physical Therapy Association.

Appendix 7.8
Funding for Children with Low-Incidence Disabilities

Children with disabilities often require highly specialized services, equipment, and materials. If a group of children with a specific condition make up less than 1 percent of the total statewide enrollment in K – 12, then that disability is eligible for funding as a "low-incidence" disability. Grant applications for Low Incidence Funds (LIFs) must be completed for each fiscal year and are available through the California Department of Education (CDE). Guidelines for each low-incidence disability are published by the CDE and may be ordered at http://www.cde.ca.gov./re/pn/

Low-incidence disabilities that make a child eligible, under *Education Code* Section 56026.5, for special services, equipment, and funding are:

- Hearing impairments
- Vision impairments
- Severe orthopedic impairments
- Any combination thereof (e.g., deaf and blind)

Note: Visual perception problems and learning disabilities are not eligible for LIFs.

LIFs may be used for all children with LI disabilities from birth to age twenty-one years in public school programs even if they were counted in a different pupil count category. This provision allows funding for children with multiple disabilities. For example, a child with a visual impairment who also has a developmental delay would qualify under visual impairment, even though the pupil-count category was for developmental delay. Services, equipment, and materials for infants are an allowable expenditure for children with an LI disability qualified under Part C.

There are two distinct types of LIFs:

- Funding for books, equipment, and materials granted with state funds
- Funding for specialized services granted with federal funds

State and federal funds are distinct from one another and may not be combined or commingled. They must be used for the specific purposes they were appropriated. Both state and federal LIF are used to "supplement," not to "supplant," other funding sources. These funds are not to be used for purchasing items or services needed for the base educational program. For example, regular textbooks would not qualify; whereas large print or braille books would qualify. Lab computers would not qualify, whereas an adapted keyboard would qualify to be purchased for giving equal access to a child with an LI condition. Bolsters and mats would not qualify, while adapted feeding and self-care equipment would qualify. Specialized teachers who are credentialed to serve students with specific LI disabilities should be involved in the assessment process and in IEP meetings to:

- Ensure that services and items considered for funding are directly related to the LI disability,

- Are needed for the child's educational benefit, and
- Are not automatically provided through the base program for general education and/or special education.

Federal Low-Incidence Funds

Federally funded LI specialized services include but are not limited to notetakers, transcribers, interpreters, drivers, instructional assistants, health aides, and assessment services. *Education Code* 56320(g) requires that students with a suspected LI disability be assessed by qualified staff knowledgeable in the area of the suspected disability. The assessment report must address the need for specialized equipment for the child. Federal LIF for specialized services must be entirely spent during the fiscal year in which they were allocated and *may not* be carried over.

State Low-Incidence Funds

State LIF are limited to books, materials, and equipment that relate to the unique educational needs indicated in the IEP of the eligible child. Technical support and training can be included, as well as repair and inventory maintenance of equipment previously purchased. The item purchased must be needed as a direct result of the eligible disability and must be required for the child to benefit from special education. The item should be stated in the child's IFSP/IEP/ITP and relates to goals/objectives or some other need indicated in the plan. These funds are *not* to be used to purchase medical equipment, furnish medical therapy units, construct or alter facilities, assess the student, or provide in-service/parent education. Items purchased may be used in nonpublic and private schools or in the child's home when required under the IEP. There is no limit on the amount of funding for any particular child; however, funding is limited. It is permissible to purchase items for use by one or more children as long as all children using the items have LI disabilities. State LIFs may be carried over into the next fiscal year.

Books, equipment, and materials purchased by LIFs are the property of the state. As a condition of receiving these funds, the Special Education Local Plan Area (SELPA) is responsible for the appropriate use of the purchased items. It is also responsible for reassigning the items in the SELPA or neighboring SELPAs once the items are no longer needed. If the items are still needed by other children with LI disabilities in a SELPA, there is no requirement to send it with the student who moved. Once a child graduates from high school, he/she is no longer eligible to receive special education services and therefore may not take the items even if he/she attends college. To do so would be a gift of public funds, which is a violation of law. It is also a violation to sell items purchased by LI funds to parents or outside agencies. The Clearinghouse for Specialized Media and Translations (CSMT) of the California Department of Education can assist in reassigning usable surplus material and equipment statewide and disposal of unusable surplus items. The CSMT may be reached through its Web page at http://www.cde.ca.gov/spbranch/State_Spec_Schools/csmt.html/

Appendix 7.9
Educational Assessment Methods, Procedures, and Tools

Method of Analysis	Record Review/Checklist	Parent and Teacher Interview	Observation of the Child	Non-standardized and Standardized Assessment	Summary
Environmental Factors Participation To what extent is the child included in or restricted from participating in the educational environment?	• What is the program placement and classroom setting? • Who are the educational personnel addressing educational areas of concern or IEP goals?	• In which setting(s) is the child having the greatest difficulty? (Assess in all settings, but pay close attention to those settings that challenge the child.) • How does the child interact and work with peers in the classroom? • Which other staff members might contribute information about this child's performance in the areas of concern?	• Does the physical environment (child's desk, educational technology, lighting, acoustics, instructional materials, classroom design, etc.) support or limit child performance and/or access to the curriculum? • Do the organization, structure, and routine meet the child's needs? • Is the child able to follow the social rules and interact with classroom personnel and peers? • What is the overall pattern of engagement and participation?	• Physical, social, and functional participation in multiple contexts: classroom, playground, cafeteria/lunch area, bathroom, etc. • Pattern of engagement and participation	• Would modifications or classroom adaptations alone suffice as an intervention? • What environmental accommodations would assist the child in functioning? • Would changes in structure, routine, or the social environment assist the child in participating in the educational program? • Are there other educational personnel who can address the child's areas of need?

Method of Analysis	• Record Review/Checklist	• Parent and Teacher Interview	• Observation of the Child	• Non-standardized and Standardized Assessment	• Summary
Curriculum To what extent is the child currently meeting expectations for the performance of important tasks expected of his/her same age peers to gain access to the curriculum?	• Which IEP goals are related to OTs' and PTs' areas of expertise? • What strategies, accommodations, modifications, adaptations, and interventions have been tried or are currently in place?	• What type of curriculum is being used? • In which areas of the instructional program is the child having the greatest difficulty? (Assess in these instructional areas.) • What are the teacher's expectations for the child in the classroom? • What are the methods of behavior management?	• Do the curriculum demands match or accommodate the child's abilities? • Is the child sufficiently challenged within his/her educational environment?	• Important tasks typically expected in each of the above contexts or settings in which the child performs the classroom tasks, playground tasks, etc. and the nature of these tasks (e.g., physical, cognitive, social) • Measure of the supports (i.e., adaptations, assistance) needed by the child to perform each major task	• Within the curriculum, what does the child do well? What is specifically expected of the child that he/she is not accomplishing? • Are there modifications that could enable the child to participate more successfully?
Child Factors What are the child's current strengths and limitations in performance of specific activities required to accomplish the major education- and school-related tasks expected or desired by him or her? What is the status of the basic performance skills and processes necessary for the performance of daily education- and school-related activities?	• What makes the child eligible for special education? • What is the medical diagnosis (if any)? • What previous assessments have been conducted?	• Does the child have the ability to participate in the ongoing structure/routine of the class? • What does the teacher/parent see as the child's strengths and weaknesses? • What are the parent's/teacher's priorities and concerns regarding this child's functioning in his/her educational program?	• Establish a profile of child strengths and needs based on available information and identified areas of concern and assess in these areas. • Focus observation on OT and PT areas of expertise relevant to the educational program. • Do the OT's and PT's classroom observations match the expressed concerns and reason for referral?	• Essential activities in the task area during the school day; activity demands • Extent of child's contribution to performance of the activity (versus extent of limitation), and performance patterns • Targeting areas of concern, focus assessment on OT's and PT's areas of expertise to discern additional relevant factors and underlying skills that impact child performance(e.g., performance skills, client factors)	• What does the assessment reveal about the child's abilities? What is his/her profile of strengths and needs compared with the areas of concern? • What is the child's potential for improvement, maintenance, or regression? • Would therapeutic interventions likely result in improved functional performance in the classroom?

Appendix 7.10
Sample Intervention Plan

Child's Name: _____ **Initial Annual IEP:** _____

D.O.B. _____ **Three-Year IEP:** _____

Special Education Eligibility: _____ **LI:** _____

Medical Diagnosis: _____

Extended School Yr: _____

CCS Client (Active):
Receiving OT: Time & Freq.:

Receiving PT: Time & Freq.:

Service Provider:

_____ (OT / PT) _____ (COTA / PTA) _____

Classroom _____ **Time/Frequency:** _____ / _____ /

School Campus _____ _____

Therapy Room _____ **Time/Frequency:** _____ **Location:** _____

Other Designated Instructional Services: _____

PRESENT LEVELS

IEP Goals: Relationship to participation in curriculum

Goal 1:	
Goal 2:	

Foundational Components: Rationale

Treatment Strategies/Recommendations:

Progress Monitoring:

Baseline:	Measurement Tools:

Comments/Precautions:

Source: Los Angeles Unified School District 2009

Appendix 7.11
OT and PT Clinical Reasoning and Intervention Approaches

Factors	Prevention Enrichment	Collaborative Consultation	Monitoring	Individual or Group Treatment	Accommodations/ Modifications
Environment To what extent is the child included in or restricted from participating in the educational environment?	Sensory-enriched playgrounds and classrooms Classroom ergonomics, including seating and positioning Designed classroom environments	Collaborate with school personnel to ensure the child can safely gain access to the environment. Collaborate to design appropriate equipment to allow for participation in curriculum	Collect data to monitor the effectiveness of recommended strategies, equipment, and adaptive devices.	Work with individual to problem-solve ways to gain physical access to the school environment. Plan group activities to prepare students for effective participation in the educational environment. AT strategies and devices for individuals and groups	Analyze and make changes to the environment, tools, and task to ensure access and child safety
Curriculum To what extent is the child currently meeting expectations for the performance of important tasks expected of his or her same-age peers to gain access to the curriculum?	In-service training sessions regarding foundations and skills needed to meet curriculum demands Task analysis of skills needed to meet state standards	Troubleshooting and devising strategies to support access to general education curriculum Therapists collaborate with team members to ensure carryover of strategies, especially in shared areas. Therapists collaborate with families for carryover of goals and provide home assignments to facilitate learning of new skills	Progress monitoring to update strategies and recommendations to support child success	Activity analysis of curriculum standards	Therapists assist the team in determining what accommodation and/or modifications to the curriculum would assist the child to gain access to and make progress in the curriculum. Staff training regarding activity analysis and modifications
Child What are the child's current strengths and limitations in performance of specific activities required to accomplish the major education- and school-related tasks expected or desired by him or her? What is the status of the basic performance and foundational skills and processes necessary for the performance of daily education- and school-related activities?	Work with child and educational staff to increase knowledge of disability. Work proactively on self-determination strategies Maintain high expectations for child abilities	Collaboration and transdisciplinary work with team members to support child's specific needs Collaboration with agencies such as Dept. of Mental Health, Dept of Health to facilitate optimal services for the child Collaborate with community resources	Monitor child's response to intervention. Therapist uses and monitors development of to support selected interventions	Child benefits from direct intervention to address the foundational components in order support functional outcomes. Child-specific program planning such as sensory diet and individual positioning in the educational environment Intervention may be provided in a pullout model when specialized equipment is required and/or service delivery would interfere with instructional time. Services may be integrated in the classroom or natural environment to facilitate generalization of skills across settings	Therapist monitors child to ensure ongoing access to the curriculum and that the proper supports are in place

OTs and PTs in the school setting consider activities that are appropriate for the child in the general education curriculum regardless of the child's special education eligibility and educational setting.

Appendix 7.12
Sample OT Data Collection Measure

Name: _____Date:_____
School: _____Teacher: _____
Grade: _____Room:_____

N = Not observed
1 = 0-30% of the time
2 = 30-60% of the time
3 = 60-90% of the time
4 = 90-100% of the time

Academic Readiness

1. Copy letters, numbers, and shapes accurately	**N 1 2 3 4**
2. Identify letters, numbers, and shapes accurately	**N 1 2 3 4**
3. Write in assigned spaces and on the writing line	**N 1 2 3 4**
4. Write/copy without omitting letters or words	**N 1 2 3 4**
5. Identify single letter/word from a field of many	**N 1 2 3 4**
6. Maintain functional body positions during daily school activities	**N 1 2 3 4**
7. Maintain endurance to engage in activities for the duration of the school day and keep pace with peers	**N 1 2 3 4**
8. Maintain required body movements and activities for the required amount of time without difficulty	**N 1 2 3 4**
9. Learn new motor tasks within a reasonable time frame (such as games in PE/recess)	**N 1 2 3 4**
10. Perform required school-based motor activities with sufficient skill on verbal command or demonstration	**N 1 2 3 4**
11. Navigate the school environment efficiently and safely	**N 1 2 3 4**
12. Demonstrated consistent hand dominance for required motor tasks	**N 1 2 3 4**
13. Learn new motor tasks and perform motor tasks required by the child's daily routines.	**N 1 2 3 4**
14. Appropriately attend to classroom instruction	**N 1 2 3 4**
15. Organize personal belongings	**N 1 2 3 4**
16. Independently find required materials	**N 1 2 3 4**
17. Tolerate ambient noise of the learning environment	**N 1 2 3 4**

Self-Care

1. Manage clothing and clothing fasteners	**N 1 2 3 4**
2. Feed self with appropriate utensils, including opening food containers	**N 1 2 3 4**
3. Use utensils appropriately (fork/spoon)	**N 1 2 3 4**
4. Complete dressing and hygiene habits and routines	**N 1 2 3 4**
5. Develop understanding of basic safety precautions	**N 1 2 3 4**

Vocation/Pre-Vocation

1. Complete required tasks with minimal adult prompting	**N 1 2 3 4**
2. Complete activities with multiple steps	**N 1 2 3 4**
3. Organize desk/backpack/cubby so items can be retrieved upon request	**N 1 2 3 4**

Social Participation

1. Maintain attention/stable emotional state during school activities and during transitions between activities	**N 1 2 3 4**
2. Identify situations that may cause stress and utilize strategies to minimize environmental stressors	**N 1 2 3 4**
3. Tolerate a variety of sensory experiences without emotional disturbance	**N 1 2 3 4**
4. Ask for help when needed	**N 1 2 3 4**
5. Share materials with peers	**N 1 2 3 4**
6. Settle disputes without aggression	**N 1 2 3 4**
7. Engage in appropriate play and leisure activities	**N 1 2 3 4**
8. Engage peers cooperatively in class, play, and during games	**N 1 2 3 4**
9. Follow rules such as taking turns	**N 1 2 3 4**
10. Win and lose games graciously	**N 1 2 3 4**
11. Comply with requests from peers and adults	**N 1 2 3 4**

Recreation/Leisure

1. Engages in sports, games, hobbies, or other structured activities during child's free time	**N 1 2 3 4**
2. Participates in leisure activities individually or socially	**N 1 2 3 4**

Source: San Diego Unified School District 2008.

Appendix 7.13
Sample PT Data Collection Measure

Name: _____ Date:_____
School: _____Teacher:_____
Grade: _____ Room: _____

N = Not observed
1 = 0-30% of the time
2 = 30-60% of the time
3 = 60-90% of the time
4 = 90-100% of the time

Academic Readiness	
1. Independently transfers to/from chair and/or floor (when appropriate)	**N 1 2 3 4**
2. Navigates classroom with functional classroom mobility	**N 1 2 3 4**
3. Opens/closes classroom door	**N 1 2 3 4**
4. Maintains functional/dynamic postures for educational activities	**N 1 2 3 4**
5. Responds to balance demands when occupied by school activities	**N 1 2 3 4**
6. Utilizes effective manipulation and reaching skills	**N 1 2 3 4**
Self Care	
1. Independently walks or uses alternative mobility on flat surfaces	**N 1 2 3 4**
2. Independently walks on ramps, grass, sand, mats, curbs	**N 1 2 3 4**
3. Transitions between varied surfaces	**N 1 2 3 4**
4. Independently ascends/descends school or bus stairs	**N 1 2 3 4**
5. Independently transfers/climbs in/out of car or bus seat	**N 1 2 3 4**
6. Plans and navigates destination/course around campus	**N 1 2 3 4**
7. Independently transfers on/off toilet	**N 1 2 3 4**
8. Mobilizes around restroom and sink for hygiene activities	**N 1 2 3 4**
9. Mobilizes while carrying items (lunchbox, book, backpack)	**N 1 2 3 4**
10. Uses adequate mobility skills for mealtime preparation/eating	**N 1 2 3 4**
11. Independently uses mobility skills for dressing and grooming at school	**N 1 2 3 4**
12. Demonstrates adequate safety awareness for school activities	**N 1 2 3 4**
13. As needed, manages own orthotics, equipment, or supportive devices to participate at school	**N 1 2 3 4**
Vocation/Pre-Vocation	
1. Maintains endurance during required tasks	**N 1 2 3 4**
2. Participates in classroom chores that require mobility	**N 1 2 3 4**
3. Uses different types of equipment required by the work/school environment	**N 1 2 3 4**
4. Gains new motor skills within a reasonable time frame	**N 1 2 3 4**
5. Improves speed and accuracy of new motor skills	**N 1 2 3 4**
6. Maintains body stability/mobility to use classroom/work materials, tools, toys, utensils, and AT devices	**N 1 2 3 4**
7. Participates in community mobility	**N 1 2 3 4**
Physical Participation	
1. Participates physically, gaining access to school activities with peers for the duration of the school day	**N 1 2 3 4**
2. Keeps pace with peers, maintains endurance	**N 1 2 3 4**
3. Has physical access to play games	**N 1 2 3 4**
Recreation/Sports	
1. Uses playground structures (steps, slide, ladders, swings)	**N 1 2 3 4**
2. Rides tricycle (on/off, pushes with feet, pedals, steers)	**N 1 2 3 4**
3. Hangs/crosses monkey bars	**N 1 2 3 4**
4. Runs, jumps, hops, gallops	**N 1 2 3 4**
5. Throws, catches, kicks ball, including bouncing, dribbling	**N 1 2 3 4**
6. Imitates simple/complex motor movements (dance)	**N 1 2 3 4**
7. Engages in sports, games, or other structured activities during free time	**N 1 2 3 4**
8. Has physical access to leisure activities	**N 1 2 3 4**
Accessibility and Extra-curricular Activities	
1. Has access to the same instructional materials and areas as nondisabled peers	**N 1 2 3 4**
2. Has access to and participates in campus activities	**N 1 2 3 4**
3. Navigates the school campus	**N 1 2 3 4**
4. Navigates the classroom/campus by using modifications and accommodations	**N 1 2 3 4**
5. Navigates obstacles (various doors, potholes, people)	**N 1 2 3 4**

Source: San Diego Unified School District 2008

Chapter 8
Secondary Transition for Youths

Federal legislation has supported the needs of individuals with disabilities in the transition from school to adult life since the early 1970s (deFur and Patton 1999). This movement began with supporting vocational education programs in the schools and continues today with a stronger emphasis on quality of life and community membership through the requirement of state systems to formally plan the child's transition to adulthood.

This chapter focuses on secondary transition services as they facilitate a child's movement to adult roles. It will include information on the current laws related to secondary transition as stated in IDEA 2004. An overview of the programming available and state agencies involved with school to adulthood transition, as well as the role of OT the PT practitioners, will be presented.

Overview of the Law

OT and PT are considered related services under IDEA 2004. In short, the IDEA is designed "to ensure that all children with disabilities have available to them a free appropriate public education that emphasized special education and related services designed to meet their unique needs and prepare them for employment and independent living." The IDEA contains language that expresses an implicit assumption that education professionals, including occupational therapists and physical therapists, will help families with long-term planning.

Educational transition services, as detailed by IDEA 2004, define transition services as a process that focuses on "improving academic and functional achievement" to promote a child's transition from school to post-school activities. These activities include postsecondary education, vocational education, integrated/supported employment, continuing and adult education, adult services, independent living or community participation (34 CFR § 300.43(a); 20 USC § 1401(34)).

The Educational Process

Formal planning for transition to adulthood begins no later than sixteen years of age. Planning may begin when the child is younger if deemed appropriate by the IEP team. It should be a collaborative process among the education professionals, family, and the child. The process begins with an initial meeting to begin planning for the child's move away from school and into adulthood.

Appropriate measurable goals are developed from transition assessments providing information related to training, education, employment, and independent living skills (34 CFR § 300.320(b) and (c); 20 USC § 1414(d)(1)(A)(i)(VIII)). The activities developed are "based on the individual child's needs, taking into account the child's strengths, preferences and interests" (34 CFR § 300.43). The child is invited to participate in the

meetings and express his/her interests and/or needs. Through participation in meetings, the child can gain skills in self-determination, social interaction, and self-advocacy (deFur and Patton 1999).

Self-determination—making one's own choices in the world with the expectation of success—encompasses the willingness and the motivation to "go to the next step", to build on past successes and to learn from past mistakes (Boomer 2010, Ryan and Deci 2000). When assisting individuals with special needs, OTs and PTs take into consideration the many influential factors that build autonomy, competence, and confidence in one's own ability to achieve. OTs and PTs play important roles in developing self-determination by working closely with children and families to discover hidden potential. OTs and PTs provide in-depth activity analysis based upon personal, environmental, physical, and cultural factors in order to identify opportunities and reduce barriers to success. The hope is to lead a child to a more empowered vision of possibilities for the future, which includes a close look at opportunities for postsecondary education.

The transition program is developed and reviewed for progress and changes each year until graduation. This process typically entails choosing a path, whether academic or vocational, that the child will take and developing the educational plan to support transition into adulthood. The plan developed emphasizes the social, vocational, and life skills needed to make the transition to adulthood. IDEA 2004 states that activities related to transition services includes instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and, when appropriate, acquisition of daily living skills and functional vocational evaluation (34 CFR § 300.43). Once a plan is put into motion, IDEA 2004 strongly encourages the LEA to assist the child and family in connecting with a variety of state and local agencies that will support the transition into adult services post-school.

The law delineates many of the activities needed to support a successful transition to adulthood: planning around the child's interests, developing skills for adulthood, consideration of the post-school environment (e.g., work or postsecondary education) and cultural and linguistic needs, and connecting the family with support agencies for post-school needs. Many high schools throughout California provide course work to support skills needed for transition to work, independent living, or postsecondary education.

OT and PT Participation in the Secondary Transition Process

OTs' and PTs' knowledge of diagnostic and prognostic parameters related to participation can support children's transition beyond high school in a variety of ways. OTs and PTs have experience with adaptive equipment, analysis of activities, and functional living skills, as well as knowledge of the roles and resources of related agencies. Their background in health, fitness, and the prevention of further impairment

may assist in the transition process and address the future needs of children and their families (deFur and Patton 1995). Therapists working closely with children and their families can support the development of self-determination and personal interests through successful adaptation and assistive technology that lead to higher learning experiences and goals for the future.

Therapists consider the following factors regarding transition for children:

- Individual values, interests, strengths, challenges, and goals
- Child self-advocacy and self-determination
- Environmental access
- Participation in daily activities
- Adaptive equipment
- Technology
- Adaptive transportation
- Interagency collaboration and community of service

These factors may need to be expanded to meet the individual and unique needs of children. Additional supports and related agencies may also be considered at the campus for higher learning.

Language of the Individualized Education Program

Transition language must be written into the IEP, prior to a child's sixteenth birthday, although in many cases, it is appropriate to begin this process earlier. The individualized transition plan (ITP) is a component of the IEP. The language of the ITP should focus on the needs and interests of the child as well as their strengths and preferences (20 USC § 1401(34)(B) and (C)). Goals should be written with a focus on the future. The activities that will be considered for the child should include instruction, related services, community experiences, development of employment and other post-school adult-living objectives, daily living skills, and functional vocational evaluations. Additionally, there should be a statement referring to responsibilities or connections to the interagency relevant to the child's needs (SEACO 2005).

Investigating the current programs available may be helpful in determining whether OT or PT services are warranted and the level that would best benefit the child. The initial ITP may be the ideal time for an OT or PT to become involved as a consultant to ensure there are appropriate recommendations for mobility, transportation, biomechanics, environmental and materials access, and equipment or task modifications.

Agencies Involved in Transition

A single agency may not possess the expertise to cover all the necessary transition services. The IDEA encourages interagency and interdisciplinary collaboration with a variety of agencies to promote the design and delivery of transition services. While a child is in school, adult service agencies are not mandated to provide services. However, collaborating with adult services will ensure that the child has access to and identifies services that will best meet his/her needs post-school.

Appendix 8.1 presents a comparison of the roles of local educational agencies and adult service agencies during a child's transition.

The Post-School Environment

Children with special needs and their parents may require the expertise of OTs and PTs to help them prepare for college and competitive employment. Many children with disabilities who could be eligible for college are often overlooked. One of the roles of the OT and PT may be to help identify a child's potential educational strengths, physical needs and need for adaptive devices, together with the IEP team and facilitate solutions to any anticipated barriers in applying to and eventually attending college. OTs and PTs, by training, are equipped to identify a child's solution to educational, physical and adaptive challenges and can be an instrumental member of the IEP team identifying modifications, special training, and assistive technology needed for success. Those services can help an individual with special needs to reach ever higher levels of education and, ultimately, professional competitive employment.

Children who choose to leave secondary education after graduation and seek employment often have educational plans that emphasize preparation for entering the workforce. As part of the ITP, the child may become connected with WorkAbility as a means to foster job-related skills. WorkAbility, a state-funded project developed and supported by the California Department of Education, is just one example of a statewide program that provides job skills training and the vocational skills needed to support employment. It provides high school children with direct experience in the workplace as well as referrals to the Department of Rehabilitation (California Department of Education 2007). (For more information on the WorkAbility program in California, see http://www.cde.ca.gov/sp/se/sr/wrkabltyl.asp/)

The child who goes onto postsecondary education faces challenges in adapting to increased independence with minimal support. An early OT and PT focus in junior high school and high school on college may reduce the many potential barriers to college. In addition to the state-required curriculum, a transition plan should focus on skills to prepare a child to enter a college campus, live independently or interdependently, and independently obtain appropriate support services. OT and PT can be important support services in the provision of a fair appropriate public education for a successful transition into postsecondary education.

Conclusion

A review of literature related to educational transition services reveals support for inclusion of OT and PT in transition programming (deFur and Patton 1999; Effgen 2000; Orentlicher and Michaels 2003; Spencer 2010; Spencer, Emery, and Schneck 2003). When deemed appropriate, relevant support services should be utilized to further promote a successful transition to adulthood.

Services for a child early in school should focus on building life skills relevant to the next life stage, ultimately leading into adulthood (Clark 1993; Poole 1983). Support services may not be required at all developmental stages; however, OT and PT may be supportive in adapting activities, ensuring appropriate access, defining strengths and skills relevant to the transition goals, facilitating skills to support the transition into community, postsecondary education, and vocational life skills (Effgen 2000; Spencer, Emery, and Schneck 2003). When goals relevant to transition are developed, it is important to consider cultural and/or environmental factors that may influence how the transition plan is executed and the support services that are needed (California Department of Education 2007).

Therapists may find a unique niche in their school district to develop programs supporting children's life skills and transition to adulthood. A multidisciplinary approach will limit duplication of services and encourage success for all children.

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Appendix 8.1
Comparison of Agency Roles in Coordinating Transition

Local Educational Agencies	Adult Service Agencies
• They are mandated to serve all eligible individuals identified as having a disability. • They are not allowed to maintain waiting lists. • They use a broad range of criteria for eligibility • Comprehensive services are designed from a review of the individual's needs. • The school system provides all services.	• They are not mandated to accept all individuals with a disability. • There may be long waiting lists. • They use a narrow range of eligibility criteria. • They have a limited range of available services. • They may use multiple providers for service delivery.

Chapter 9
Assistive Technology and Universal Design

Professionals providing services to children need to be on the forefront of developments in technology. It is critical for professionals to have the knowledge and ability to prepare a child for access to advanced and emerging technologies. OTs and PTs are in a unique position to assist children and families to focus on long-term future outcomes.

The law defines "assistive technology service" as any service that directly assists individuals with a disability in the selection, acquisition, or use of an assistive technology device (20 USC § 1401(1)). Assistive technology (AT) services provide children who have disabilities with access to participation in school tasks and the least restrictive environment. AT devices range from simple to complex and include adaptation, fabrication, and customization of materials, which are activities that OTs and PTs engage in as part of their domains of practice. Therapists working in the school setting play an integral role in all aspects of the AT process. AT is not a last resort for children who reach a plateau or who lack progress toward therapeutic goals; rather, it is a consideration for all children with disabilities. OT and PT support successful integration of AT across educational environments via underlying skill acquisition, product procurement, consultation, training, and ongoing progress monitoring.

This chapter serves as a guide in understanding AT services: from consideration, evaluation, and implementation to gathering data on outcomes. It discusses educationally relevant tools that are useful in guiding the selection of appropriate technology and giving children access to the curriculum.

Overview of Assistive Technology and the Law

The law defines AT devices as any piece of equipment or product system (whether acquired commercially off the shelf, modified, or customized) that is used to increase, maintain, or improve "functional" capabilities of a child with a disability (20 USC § 1401(2)). AT is required by law to be considered for every child with an IEP or an IFSP. Appendix 9.1, "Worksheet for Considering Assistive Technology," can help an IEP team determine whether a student is a candidate for AT. In the 2000–2005 Assistive Technology Training Online Project, Zabala and Reed (2000) suggest that the IEP team ask questions to guide the consideration process, such as:

- Is the child currently able to independently complete expected educationally related tasks with current strategies or accommodations? If so, AT may not be indicated.
- If the current strategies and accommodations are not sufficient, what task(s) is the child unable to do at a level that reflects the child's skills and abilities?
- Has a form of AT (e.g., strategies, devices, tools, hardware, software, etc.) been used to address this task? How successful is/was it?
- Would the use of new or different AT help the child perform this task more easily or efficiently?

AT provides alternative ways for children to gain access to educational technology and the curriculum that is in place for the child. AT may include instructional strategies; low- or no-tech and mid- and high-tech equipment but differs from educational technology. Educational technology supports the teaching of a skill or concept, most commonly in the form of software.

Assistive Technology and Education

Applying the Educational Framework for Child Success considers the child's curriculum and progress in the educational environment as it relates to current and postsecondary goals. Occupational therapy and physical therapy address areas of strengths and concerns and the impact of disability on participation in the educational process. The academic curriculum includes activities relevant to the child's placement and IEP goals written to meet state standards in the areas of reading, writing, mathematics, science, history, music, art, and vocational or life skills. Many components need to be considered: placement in the general or special education setting, the social and cultural milieu, and the encompassing attitudes, perceptions, and policies regarding technology. Resources and the availability of funds to purchase technology, as well as the willingness of the school site to support its use, are also important considerations. Finally, the physical environment— the physical space and layout of the classroom and school campus—is another consideration. The physical environment should be accessible to the child as to both physical and learning needs. For example, if a child needs to use a classroom computer for writing, is the classroom computer in the most suitable location to support the child's learning? Does the child have physical access to the computer, and is she able to use it (Cook and Hussey 2002)?

Team Approach to Service Delivery

Interdisciplinary teams in the educational system design and implement curricula, instruction, and intervention and evaluate outcomes for special education children. The law requires a consensus from the child's IEP team to determine the related services and AT that he or she will receive, as part of an offer of a free appropriate public education.

The composition of the team providing related services may vary based on the needs of a particular child, but it may include the school OT or PT or both. Team members recognize that their knowledge, skills, roles, and responsibilities overlap and therefore routinely meet to discuss and clarify their roles regarding a certain child (Case-Smith 2005).

Implementation of AT can shift the focus of a child's educational program, and team members' roles may also shift in focus to support the successful integration of a device or AT system. The OT and PT provide a broad range of services in the application of AT, including evaluation, recommendations, justification of need, and awareness of funding sources, fabrication, customization, training integration, and follow-up (Buning et al. 2004).

A separate multidisciplinary team of AT specialists may be available to offer assistance and consultation to the local school site teams in determining AT equipment or provide training, support, and ongoing follow-up. This specialized team may consist of an educator, OT, PT, augmentative and alternative communication specialist, AT specialists, and technical support personnel. Consultation with an AT team is especially helpful when children demonstrate severe needs and require a complex device or AT system. Appendix 9.2 displays the roles of AT team members.

Types of Assistive Technology

Technological advancements force IEP team members to keep current on the many products and solutions available both on and off the market. The Wisconsin Assistive Technology Initiative (WATI) can serve as a useful guide to understand the different categories of AT devices available and when devices should be considered for a child (http://www.wati.org/). Technology can include instructional strategies and task modifications as well as the use of equipment, commonly referred to as "no-tech," "low-tech," "mid-tech," and "high-tech" equipment. For a sample AT checklist, see appendix 9.3.

Instructional strategies and modifications, includes classroom techniques. Teachers may create quiet writing areas; use stamps, graphic icons, pictures, and photographs; and arrange the classroom so it is accessible to the children. These modifications can be determined by an SST, 504 Plan, or an IEP under the accommodations and modifications sections.

Adaptive equipment considered "no" or "low tech: includes products that are customized to meet the child's needs or products acquired off the shelf. Products may consist of adapted writing equipment, switches, single message devices, and accessibility features built into computer systems. "No-tech" or "low-tech" devices may be determined by the IEP team members or via an AT assessment.

"Mid-tech" and "high-tech" equipment includes static and or dynamic display communication devices, portable word processors, multistep switch access, adaptive keyboards, and word-prediction software. An AT and/or augmentative and alternative communication assessment should be conducted to determine appropriate mid- and high-tech AT equipment. Appendix 9.4 categorizes examples of AT considerations by type and academic area. However, the categories are loosely defined and should be considered more as a continuum to guide in the selection of AT.

Determination of the Need for Assistive Technology

Determining the need for AT is based on the child's eligibility, placement, and the curriculum. A child's physical and cognitive resources and needs will determine his ability to participate in the educational process. For some children, the use of AT allows them access to the general education curriculum and a less restrictive environment.

AT bridges the gap between a child's functional skills and ability to participate in the educational process. The goal of an AT assessment is to determine a child's ability to gain access to the curriculum. The AT assessment is a collaborative process with information gathered by various professionals across a variety of settings at school. It includes the examination of specific skills including:

- Sensory—auditory, tactile, and visual (functional vision and visual perception)
- Physical—seating and positioning needs to identify potential anatomical access sites for control and selecting and testing control interfaces
- Cognitive—attention, memory, ability to follow directions, understanding of cause and effect, and the degree of motivation
- Language—expressive and receptive skills, including categorization, sequencing, matching, the degree of interaction, recognition of words and symbols, understanding simple commands, and motor and pragmatic skills associated with speech.
- Social participation—relating to others, initiating interactive play, sharing, and taking turns

Evaluations should be comprehensive to identify all of the child's skills, the academic activities that make up the curriculum, and the educational environment. There are many tools available to streamline the AT assessment process. Appendix 9.5 lists commonly used tools in determining access.

It is important that all special education professionals become familiar with the use of assistive technology to help children gain access to the curriculum. OTs and PTs play a vital role in evaluating specific skills in the sensory, physical, and cognitive skills areas important in the determination of AT needs. Speech and language therapists often offer expertise in augmentative and alternative communication and language development. Team collaboration is essential in the consideration of AT.

AT should not be considered an alternative to intervention, although it may shift the focus. Therapeutic intervention for children using AT should address the underlying skills required to use the device effectively, custom features, and training of the child, school staff, and the family in the care and use of the device. Combinations of direct and consultative services are often necessary to best serve the child.

Universal Design for Learning and Universal Access

The intent of the law is for public education to become more inclusive for all children. Universal design for learning (UDL) is defined "as the process for creating general education curricula (including the standards, materials, methods, and assessments) of which they are comprised) that are conceived, designed, developed and validated to achieve results for the widest spectrum of children, including those with disabilities, without the need for subsequent adaptation or specialized design" (Hitchcock and Stahl 2003).

UDL means that teaching methods must be carefully chosen, and classroom materials are selected and arranged so that all children receive the same opportunity to learn. AT services support UDL by providing consultation to establish alternative methods of participation in, or universal access to, classroom activities. Universal access also implies that materials that are already available in the classroom are tried first, in addition to generic strategies and no- or low-tech solutions, prior to more restrictive technology. The advances of computer technology permit greater consideration of individuals with disabilities. Options such as built-in accessibility features and wireless access to the Internet, printers, and infrared devices make it easier to incorporate AT into the least restrictive environment.

Funding Assistive Technology

- Funding for assistive technology in public schools is available through a variety of public and private sources such as Medi-Cal/Early Periodic Screening Diagnosis and Treatment (EPSDT); Special Education (see appendix 7.8, "Funding for Children with Low-Incidence Disabilities"); California Children Services; Department of Rehabilitation (DOR);AT Network; Regional Centers; and NonProfit Disability Organizations and Community Organizations. For more information, visit the State of California Department of Developmental Services at http://cate.ca.gov/how-to/funding/dev-funding-strategy.php and http://www.dds.ca.gov/AT/Funding.cfm for the second reference for "California Department of Developmental Services"

Avoiding Product Abandonment

Products often fail or are abandoned in the educational environment for many reasons. Swinth (2005) found several factors through a careful literature review of current publications. Abandonment was linked to a mismatch between the user and the technology, complexity of the device, ineffectiveness of the device, inefficient training, device failure, and the amount of user input into the selection of the device.

In the school setting, lack of a good fit between the child's skills and the features of the device lead to inefficient use. A device must also match both the child's (and/or family's) and teacher's performance expectations. If a product is not easy and comfortable to use, then the child will often abandon the equipment for an easier means. For example, a child may prefer manual writing instead of an adapted keyboard if it is more comfortable. Initially, when AT equipment is introduced, work production may decline while learning and practice occurs. Training on the equipment and follow-up with the classroom teacher can promote effective integration of the AT into the curriculum and ensure a greater understanding of the time and energy needed to learn and use the equipment.

Successful implementation implies that there is a good fit between the child's skills, the curriculum, and the features of the AT device. Zabala's (2002) Student, Environment, Tasks, Tools (SETT) Framework considers the child, the environment in which the child will use the AT tools, and the academic tasks that the child is required to do. The SETT

Framework is a widely accepted tool that can organize a team's thinking in selecting AT, from no-tech to high-tech solutions. Successful implementation of AT also implies that solutions to individual barriers be carefully considered, such as technical support to address issues of compatibility, connectivity, and repair or whether an adult assistant is needed to carry or set up a device.

Measuring Outcomes

There are two primary ways to measure outcomes of AT in the school system. The effectiveness of devices and equipment is first measured by the child's ability to meet IEP goals. Since IEP goals are reviewed on annually, it is important for the team to consider the length of time in which the child uses the device(s) (or strategies), whether the device continues to be appropriate for the upcoming year and whether an equipment change is necessary.

The second way of determining effectiveness is by trial use. Consultation with the classroom teacher will identify whether trial use of a product or device meets the needs of the child to gain access to the curriculum. Appendix 9.6 includes a template for more structured means of gathering data regarding trial usage. This method can be modified to compare how a child uses different devices or how a single device improves a child's performance.

Quality Indicators for Assistive Technology (QIAT), a consortium of technology professionals developed by Zabala et al. (2000) include consideration of the need for AT, IEP documentation, implementation, and the evaluation of the effectiveness of AT. (The full documents for QIAT are viewable at http://www.qiat.org) Use of these indicators can support the process of successful integration of AT. Appendix 9.7 provides the QIAT for the evaluation of the effectiveness of AT.

Additional information and resources for AT may be obtained through the contacts listed in appendix 9.8.

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Appendix 9.1
Worksheet for Considering Assistive Technology

Child:	Date of Birth:	Current Date:
Contact or Location:		
IEP Team Members:		

The child's IEP team considers the assistive technology needs of the child in accordance with the provisions of the IDEA. Consideration of the child's possible need for assistive technology is directly related to the implementation of the child's IEP, which is directly related to the provision of a free appropriate public education.

Instructions:

1. In the first column, review each domain. Considering this child's IEP, identify in the second column areas of concern and related tasks that the child needs to be able to do that would be difficult or impossible to do without assistance.
2. If there are no areas of concern, proceed to Step #9.
3. If concerns are identified, place a check in each appropriate box in column 2 and briefly describe the expected task. Document only those tasks relevant to the child's IEP and successful participation in various environments.
4. For each task listed, determine if the child is currently able to complete designated tasks with special strategies, accommodations, or modifications. Is the child currently using any assistive technology tools, or has the child used assistive technology tools in the past? If yes, describe in column A.
5. Are there any continuing barriers that the child encounters when attempting a task? If yes, complete column B.
6. Consider whether the use of new or additional assistive technology would (a) help the child perform this task with more ease or efficiency in the least restrictive environment, or (b) perform the task successfully with less personal assistance. If yes, indicate in column C.
7. If members of the IEP team are not familiar with assistive technology tools that could address remaining barriers or need additional assistance, indicate in column C that further investigation is necessary in this area.
8. Use the information that has been entered in proceeding through steps 1 through 6 to complete step 9.
9. Summary**:** If the IEP team has determined that a need exists, describe what will be provided (more specific assessment of need for assistive technology; existing tools, adaptation or modification of existing tools; additional tools; technical assistance on device operation or use; or training of child, staff, or family).

Domains relating to the child's IEP	**Consider all environments in which the IEP is to be implemented**			
	Area of concern	**A. Describe the special strategies, accommoda-tions, and tools currently being used to remove barriers to the task**	**B. Are there continuing barriers that the child encounters when attempting this task? If so, describe.**	**C. Describe new or additional AT to be tried, or indicate a need for further investigation or consultation with an AT specialist**
Physical: Vision, hearing, health, motor abilities, speech mechanism	❑ Vision			
	❑ Hearing			
	❑ Positioning and seating			
	❑ Mobility			
	❑ Mechanics of writing			
	❑ Computer access			
Communication: Speech sound production and use, receptive and expressive language, voice, fluency, augmentative and alternative communication	❑ Communication			
Cognitive: An appraisal of aptitude and mental processes by which an individual applies knowledge, thinks, and solves problems	❑ Learning and studying			
Social competence: Adaptive behaviors and social skills that enable a child or youth to meet environmental demands and to assume responsibility for one's own and others' welfare	❑ Social Participation			
Academic performance: Basic and content reading; reading comprehension; mathematics calculation, reasoning, and application; written expression; oral expression; listening comprehension; learning preference; learning style, strategies; effect of the disability on acquisition, development, mastery, and applications of academic skills	❑ Reading			
	❑ Math			
	❑ Composing written material			

Domains relating to the child's IEP	Consider all environments in which the IEP is to be implemented			
	Area of concern	**A. Describe the special strategies, accommoda-tions, and tools currently being used to remove barriers to the task**	**B. Are there continuing barriers that the child encounters when attempting this task? If so, describe.**	**C. Describe new or additional AT to be tried, or indicate a need for further investigation or consultation with an AT specialist**
Vocational functioning: General work behaviors; following directions; working independently or with job supports; job preferences or interests; dexterity abilities; interpersonal relationships and socialization; related work skills	❑ Prevocational			
Recreation/leisure functioning: Free time, maintenance of physical fitness, use of generic community recreation facilities and resources and degree of social involvement	❑ Leisure skills			
Environmental functioning: Relationship with family; relationship with peers; family's dominant language; cultural influences; expectations of the parents for the child or youth in the home, school, and community environments; services received in the community; economic influences	❑ Activities of daily living (ADL) ❑ Environmental control			

Consideration of Need	Agree? (Give reasons)	Disagree? (Give reasons)	
Child's needs are currently being met. AT is not necessary at this time.			
AT devices / services are required by the child and will be used for designated tasks in customary instructional environments. (Specify in the IEP.)			
AT devices / services are of potential benefit to the child and will be included in extended trials. (Specify in the IEP)			
Further investigation / assessment is necessary to determine what AT devices and services may be required. (Specify in the IEP)			
AT devices and services (include those currently used successfully and those to be tried or added)	**Responsible Parties**	**Initiation**	**Duration**

Appendix 9.2
Roles of Assistive Technology Team Members

Team Member	Roles
Child and/or family	Communicates needs/concerns regarding access to the educational environment; the family also provides support in implementation and carryover to the home environment.
OT	Determines occupational and educational relevance and physical motor access; addresses positioning of the child and modifications of materials and equipment; helps identify funding source; and orders equipment.
PT	Addresses seating, mobility, and positioning needs of the child; provides equipment training; helps identify funding; and orders equipment.
Speech therapist/augmentative and alternative communication (AAC) specialist	Addresses communication needs; determines the communication system/device; provides equipment training on AAC devices; helps identify funding; and orders equipment.
Classroom teacher	Identifies academic concerns; incorporates assistive technology (AT) into the curriculum.
AT specialist	Determines equipment needs to address academic areas; consults with classroom teacher on implementation of AT equipment; provides equipment training; helps to identify funding; and orders equipment. Also provides technical support in installation, repair, and maintenance of equipment.
Technology support staff	Provides technical support in installation, repair, and maintenance of equipment.

Appendix 9.3
Sample AT Checklist

Wisconsin Assistive Technology Initiative (WATI) Checklist

COMPUTER ACCESS

- ☐ Keyboard using accessibility options
- ☐ Word prediction, abbreviation/expansion to reduce keystrokes
- ☐ Keyguard
- ☐ Arm support
- ☐ Track ball/track pad/joystick with on-screen keyboard
- ☐ Alternate keyboard
- ☐ Mouth stick/head mouse with on-screen keyboard
- ☐ Switch with Morse code
- ☐ Switch with scanning
- ☐ Voice recognition software
- ☐ Other: _____

WRITING

Motor Aspects of Writing

- ☐ Regular pencil/pen
- ☐ Pencil/pen with adaptive grip
- ☐ Adapted paper (e.g., raised line, highlighted lines)
- ☐ Slant board
- ☐ Use of prewritten words/phrases
- ☐ Portable word processor to operate keyboard instead of writing
- ☐ Computer with word processing software
- ☐ Portable scanner with word processing software
- ☐ Voice recognition software to do word processing
- ☐ Other: _____

Composing Written Material

- ☐ Word cards/word book/word wall
- ☐ Pocket dictionary/thesaurus
- ☐ Writing templates
- ☐ Electronic/talking dictionary/thesaurus/spell checker
- ☐ Word processing with spell checker/grammar checker
- ☐ Talking word processing
- ☐ Abbreviation/expansion
- ☐ Word processing with writing supports
- ☐ Multimedia software
- ☐ Voice recognition software
- ☐ Other: _____

COMMUNICATION

- ☐ Communication board/book with pictures/objects/ letters/words
- ☐ Eye gaze board/frame communication system
- ☐ Simple voice output device
- ☐ Voice output device w/levels
- ☐ Voice output device w/icon sequencing
- ☐ Voice output device w/dynamic display
- ☐ Device with speech synthesis for typing
- ☐ Other: _____

READING, STUDYING, AND MATH

Reading

- ☐ Standard text
- ☐ Predictable books
- ☐ Changes in text size, spacing, color, background color
- ☐ Book adapted for page turning (e.g., page fluffers, three-ring binder)
- ☐ Use of pictures/symbols with text
- ☐ Talking electronic device/software to pronounce challenging words
- ☐ Single word scanners
- ☐ Scanner with OCR (optical character reader) and text-to-speech software
- ☐ Software to read Web sites and e-mails
- ☐ Other: _____

Learning/Studying

- ☐ Print or picture schedule
- ☐ Low tech aids to find materials (e.g., index tabs, color-coded folders)
- ☐ Highlight text (e.g. markers, highlight tape, ruler, etc.)
- ☐ Recorded material (books on tape, taped lectures with number coded index, etc.)
- ☐ Voice output reminders for assignments, steps of task.
- ☐ Electronic organizers
- ☐ Pagers/electronic reminders
- ☐ Handheld scanners
- ☐ Software for concept development/manipulation of Objects–may use alternate input device (e.g., switch)
- ☐ Touch window
- ☐ Software for organization of ideas and studying
- ☐ Palm computers
- ☐ Other: _____

Math

- ☐ Abacus/Math line
- ☐ Enlarged math worksheets
- ☐ Low-tech alternatives for answering
- ☐ Math “Smart Chart”
- ☐ Money calculator
- ☐ Tactile/voice output measuring devices
- ☐ Talking watches/clocks
- ☐ Calculator/calculator with printout
- ☐ Calculator with large keys and/or large display
- ☐ Talking calculator
- ☐ Calculator with special features (e.g., fraction translation)
- ☐ On-screen/scanning calculator
- ☐ Alternative keyboard
- ☐ Software with cueing for math computation (may use adapted input methods)
- ☐ Other: _____

Source: Wisconsin Assistive Technology Initiative (WATI). 2009. *Assessing Students' Needs for Assistive Technology: A Resource Manual for School District Teams.* This manual was made possible by funding from IDEA grant number 9906-23. Its content may be reprinted in whole or in part, with credit given to the Wisconsin Assistive Technology Initiative (WATI) and the Wisconsin Department of Public Instruction (DPI) acknowledged. For additional information and WATI materials, contact www.wati.org

Appendix 9.4
Assistive Technology Considerations

Source: Adapted from SEACO 2005.

	Handwriting	Reading	Mathematics	Written Expression	Daily Organization
Instructional strategies	• Multimodality instruction • Practice tracing • Dot-to-dot • Verbal prompting of formation	• Story frame (before, during, and after echo reading) • Story mapping • Multimodality teaching • Structured story guides • Preferential seating	• Number lines • Pneumonic devices • "Two-finger" counting aids • Color-coding strategies (green to start, red to stop) • Multimodality teaching • Computational aids	• Content outlines • "Webbing" strategies • Process writing • Writing/ story starters • Formulate sentences aloud	• Color coding • Post signs or pictures and label area in room • Homework journal • Pocket schedule • Notebook schedule • Desk schedule • Schedule on bulletin board • Assignment sheets • Appointment book • Reminder cards • Structured study guides
Task modifications	• Adapt test to fill-in-the-blank, multiple choice, or true/false • Provide additional time • Shorten assignments • Provide photocopied notes or peer note taker • Allow different writing tools • Check positioning of paper, the child, and the desk height • Provide keyboarding instruction • Provide instruction on use of AT devices	• Highlight key concepts • Allow extra time • Shorten assignments • Simplify text • Use chapter outlines • Encourage peer support • Organize cross-age tutoring • Provide information organizer • Provide study carrel • Provide tactile letters/words • Provide instruction on use of AT devices	• Reduce number of problems • Eliminate need to copy items • Enlarge worksheets • Avoid mixing "signs" on a page • Allow extra time for completion • Encourage peer support • Organize cross-age tutoring	• Extra time • Shortened assignments • Sentence "shells" • Key words • Peer support • Cross-age tutoring • Study carrel • Instruction on use of AT devices	• Peer support • Cross-age tutoring • Study carrel • Organized desk • Instruction on use of AT devices

	Handwriting	Reading	Mathematics	Written Expression	Daily Organization
Adaptive AT (No-tech and low-tech)	• Pencil holders/grips • Large primary pencils • Paper kind, color, line spacing • Acetate sheets with markers • Dry-erase/ magnetic boards • Magnetic letters • Tape or clipboard to hold paper • Stencils/templates • Rubber stamps • Slant board/easels • Wrist rest/support • Mobile arm supports	• Page magnifiers • Bar magnifiers • Colored acetate/ overlay • Sentence/word isolator • Flash cards • Letter/word cards • Highlighter • Self-sticking tape flags • Color paper clips to mark page or paragraph • Page fluffers to help turn pages • Page-turning devices	• Counters (spools, buttons, etc.) • Manipulatives • Flash cards • Automatic number stamps • Magnetic numbers on board • Personal whiteboard • Raised or enlarged number line • Graph paper • Number fact charts	• Word cards • Sentence cards • Pocket dictionary • Pocket thesaurus • Personal “word” book	• Pocket organizer/ • Planner • Clipboard • Sticky notes • Notebook tabs • Post-it flags • Color paper clips; • Highlighter • Storage cubicles; • Timer
Alternative AT (Mid- to high-tech)	• Keyboard/word processor with correction feature • Keyguard or typing aid • Word processor that interfaces with computer • Computer with spell checker • Computer with alternative input (e.g., on-screen keyboard, switch interface, expanded or mini keyboard) • Voice activation software	• Audio-recorded readings and assignments • “Books on Tape” • Language Master • Speaking Language Master • Electronic dictionary with voice output • Computer with voice output and text-to-speech software • Computer screen readers • Handheld reading devices	• Advanced calculator with visual display, recording, and voice output • Calculator with printout • Talking calculator Language Master + Math • Audio player and recorder or MP3 player with auditory and visual support for learning math facts, formulas, counting, and multiplication tables combinations • Computer AT software for math with voice output	• Electronic spell checker • Electronic dictionary and thesaurus • Speaking dictionary • Word Master Companion or Talking Language Master; • Word processor with spelling/ grammar checker; • Word processor with text-to–speech software	• Audio recording of schedule/ assignments • Electronic pocket organizer/ Personal Digital Assistant • Digital diary • Computer with calendar and reminder software

Selected References

Special Education Administrators of County Offices (SEACO). 2005. *Instructional Best Practices: Curriculum Guide for Students with Moderate to Severe Disabilities*. Los Angeles: Lakeshore Learning Materials.

Appendix 9.5
Tools for Gathering Information

Tool	Purpose
Wisconsin Assistive Technology Initiative (WATI)	Guides equipment trials from strategies and modifications to high-tech solutions.
The SETT Framework. Developed by Joy Zabala, Ed.D., 1983.	Considers the child's abilities, needs, environment, tasks, and the tools or strategies that should be tried.
Life Space Access Profile	An assessment that considers physical and cognitive abilities in identifying primary and secondary access sites.
Georgia Assistive Technology Project (Tools for Life)	Offers an AT screening and initial toolkit for teachers to screen students with learning disabilities.
Functional Evaluation for Assistive Technology (FEAT)	Provides an ecologically based assessment protocol for all ages.
Matching Person and Technology (MPT), Institute for Matching Persons with Technology	Matches users of technologies with the most appropriate devices for their use. Provides information and solutions on research, assessment, training, and consultation.

Appendix 9.6
Assistive Technology Intervention Data Collection Trial Tool

Child _____ Dates: _____ to _____

Expected functional outcome			
Child's present level			
Data-collection method			
Person responsible			
AT solution 1			
AT solution 2			
Outcome	Solution 1	Solution 2	Comments
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Total			

Appendix 9.7
Quality Indicators for Evaluation of Effectiveness

Indicator	Intent
1. Team members share clearly defined responsibilities to ensure that data are collected, evaluated, and interpreted by capable and credible team members.	Each team member is accountable for ensuring that the data collection process determined by the team is implemented. The team assigns individual roles in the collection and review of the data. The collection, evaluation, and interpretation of data are led by persons with relevant training and knowledge.
2. Data are collected on specific child behaviors that have been identified by the team and are related to one or more educational goals.	Data are collected on various aspects child performance to evaluate the success of the AT use. The behavior targeted for data collection is related to one or more IEP goals (e.g., ability to accomplish the task, use of the technology, changes in child behavior).
3. Evaluation of effectiveness reflects the objective measurement of changes in the child's performance (e.g., student preferences, productivity, participation, independence, quantity, quality, speed, accuracy, frequency, or spontaneity).	The IEP team determines the anticipated changes in the child's performance. The behavior targeted for data collection must be observable and measurable. Data that capture changes in student behaviors may be quantitative, qualitative, or both.
4. Effectiveness is evaluated across environments, including natural opportunities, as well as across structured activities.	The team determines the environments where changes in child performance are expected to occur and prioritizes the appropriate activities for data collection in those environments.
5. Evaluation of the effectiveness of technology in meeting a child's educational needs is a dynamic, responsive, ongoing process.	Scheduled data collection occurs over time and is modified in response to both expected and unexpected results. Data collection reflects measurement strategies appropriate to individual child needs. Team members evaluate and interpret data during periodic progress reviews.
6. The data collected provide a means to analyze response patterns and child performance.	The team regularly analyzes data to determine child progress and error patterns.
7. The team makes changes in the child's educational program based on data.	During the process of reviewing data, the team determines whether program changes/modifications need to be made in the environment, tasks, or tools. The team acts on these decisions and makes needed adjustments.

Source: Adapted from Zabala et al. 2000.

Appendix 9.8
Assistive Technology Resources

Resources and Organizations	Contact Information
Alliance for Technology Access	http://www.ataccess.org/
Apple Computer's Worldwide Disability Solutions Group	http://www.apple.com/accessibility/
Assistive Technology Online	www.asel.udel.edu/
Center for Assistive Technology	http://cat.buffalo.edu/
Center for Applied Special Technology (CAST)	http://www.cast.org/
Closing the Gap Newsletter	http://www.closingthegap.com/
Council on Exceptional Children	www.cec.sped.org/
Education Tech Points	http://www.educationtechpoints.org/
Family Center on Technology and Disability	http://fctd.ucp.org/
Georgia Project for Assistive Technology (GPAT)	http://www.gpat.org/
IBM's Special Needs Solutions	http://www-03.ibm.com/able/access_ibm/index.html/
Journal of Special Education Technology	Kyle Higgins and Randall Boone JSET Editors Department of Special Education, University of Nevada, Las Vegas 4505 Maryland Parkway Box 453014 Las Vegas, NV 89154
National Technology Center	http://www.nationaltechcenter.org/
Oregon Technology Access Program, AT Consideration Guide	www.otap-oregon.org/
Quality Indicators for Assistive Technology (QIAT) Web site	http://www.qiat.org/
Student, Environment, Tasks, Tools (SETT) Framework	joy@joyzabala.com/
Special Education Technology Practice	http://www.setp.net/
Texas Assistive Technology Network, Considering AT in the IEP	http://www.texasat.net/
The Center for Applied Special Technology (CAST)	http://www.cast.org/
Wisconsin Assistive Technology Initiative	http://www.wati.org/ 715-565-8135

Chapter 10
Fiscal Considerations for Therapy Programs

This chapter presents information for administrators, coordinators, and special education personnel to consider so they can effectively budget for school-based OT and PT. Topics cover departmental needs assessment and fiscal considerations for personnel, equipment, and materials.

Departmental Needs Assessment

A needs assessment for a therapy department is the first step to determining the amount, extent, and type of projected therapy services for which planning will be required. Budget considerations include the staff, space, supplies, and equipment needed to implement appropriate OT and PT services. Review of the regional demographics and population served may be helpful in identifying the needs of a particular community when the development of a therapy department is planned Jacobs & McCormack, 2011). Appendix 10.1 presents some key factors to consider in a needs assessment.

Developing a Quality OT and PT Program

Quality OT and PT programs need funding, personnel, space, and equipment. Well-staffed and equipped OT and PT departments provide high returns on the investment for school districts.

Funding

Potential funding for OT and PT programs includes state and federal resources for special education programs, non-public agency funds, general school funds, and third party reimbursements. For example, federal sources that can be obtained include grants such as Title I funds http://www2.ed.gov/policy/elsec/leg/esea02/pg1.html State sources may include mechanisms for CCS and regional center funding of therapy services.

As a response to IDEA 2004 Part D http://idea.ed.gov/explore/view/p/%2Croot%2Cstatute%2CI%2CD%2C the responsibility for special education research shifted to the Institute of Education Sciences within the Department of Education from the Office of Special Education Programs. There are programs and funding sources that OTs and PTs may become involved in to obtain funding and training opportunities (Doll, 2010). See appendix 10.2 for program details.

Personnel

The local educational agency or special education local plan area (SELPA) is responsible for hiring or contracting with school-based OTs and PTs and for identifying funding sources for personnel. There are several methods for an agency to provide OT and PT services. The agency may employ therapists, or it may enter into a contract with

a nonpublic agency to provide the therapy staff. Resources for contracting include local hospitals, private clinics, or staffing agencies. Individual therapists may also work as independent contractors. Some school districts rely on the county or the SELPA to hire therapists to provide services for the children in the district. Local educational agency options depend upon the needs of the population in the agency and the availability of therapists in the area. Regardless of the staffing option selected, the therapist and the agency should agree on the philosophy and goals of the education system (APTA 1990). OTs and PTs are trained to work with diverse populations, including children with special needs. OTs and PTs who have limited experience will require additional training and mentoring. It is important to consider a candidate's experience and knowledge working in the educational setting when a leadership position or a vacancy as a sole practitioner is being filled.

Human Resources

Districts that choose to hire employees do so using according to internal policies directed by human resources offices. State regulations do not dictate the employment categories for hiring OTs or PTs. Occupational therapists and physical therapists are licensed but do not have a credential from the California Commission on Teacher Credentialing. Examples of employment categories in the educational setting are certificated non-credentialed, classified, and classified management. The LEA determines which category is most appropriate for its employees. See chapter 2 for functions of the school therapist.

Recruitment

Recruiting therapists is facilitated when the salaries and benefits offered are competitive with the current market. Online advertising for applicants (www.EdJoin.org) is most effective, as well as professional newsletters, journals, local newspapers. Posting job openings on the LEA and county web sites is helpful.

The Comprehensive System of Personnel Development (CSPD) is a practical guide that is intended to maintain an adequate supply of competent providers of special education, related service, and early intervention in urban, suburban, rural, and remote locations to serve children with special needs in compliance with IDEA and NCLB legislation. The CSPD is a vehicle for personnel development and for increasing the supply of therapists to work in the educational system by mobilizing local, regional, and state resources. During periods of shortages of OTs and PTs, a variety of strategies are needed to recruit and retain therapists. Appendix 10.3 documents considerations for recruiting and retaining therapists.

Nonpublic Agencies

When districts contract with outside agencies or individuals, the California Department of Education strongly advises contracting with those that have a nonpublic agency certification. To obtain a nonpublic agency certification, the agency or individual submits

an application with a fee. This process provides for a background and qualifications check, tuberculosis clearance, review of safety standards of privately owned agencies, and other important information. Applications can be requested from the nonpublic agency section of the California Department of Education Web site (www.cde.ca.gov).

Reimbursement

In California, the federal Medicaid agreement with the State Department of Health Services and the Department of Education has implemented an optional program to allow qualified LEAs to obtain state funds for Medi-Cal health services, including OT and PT services. For more information: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/california.html and http://www.medi-cal.ca.gov/

For LEAs to receive Medi-Cal reimbursement:

- A child must be Medi-Cal eligible,
- The service must be covered by Medi-Cal,
- The service must be medically necessary with a physician's prescription, and
- The service provider must have the required license or other credential/qualification.

OTs, PTs, and PTAs are licensed and COTAs are certified by the California *Business and Professions Code.* (A practitioner's license or certification can be verified by going to www.bot.ca.gov and www.ptb.ca.gov.)

Therapy Space and Equipment

As related service providers, OTs and PTs help children develop the skills they need to participate in the least restrictive environment. OT and PT services often take place in the natural setting of the classroom, playground, or lunchroom. Space and equipment requirements are determined by the child's need and the model of practice selected to address these needs.

Meeting the educational and therapeutic needs of some children may require space outside the classroom in a specialized environment/therapy room. Many school districts have been creative in developing appropriate therapeutic environments in locations such as classrooms, offices, warehouses, or assembly rooms. Sharing of space and equipment might be possible on some campuses. For example, when the Resource Specialist Program room, speech room, or gymnasium is used only a few days a week, it may be easily transformed into a therapy room, if storage space is provided for equipment.

The physical space for a specially designed therapy room must be large enough to allow spontaneous play and freedom of whole-body movement in all planes, as well as accommodate a variety of enriching equipment. Some school districts install suspended equipment attached to ceiling support beams. This setup requires the expertise of someone knowledgeable of safety requirements for load and force of the equipment

upon movement. Maintenance checks need to be scheduled regularly on all equipment. Appendixes 10.4 and 10.5 provide a list of equipment and supplies for OT and PT in the classroom as well as for an enriched therapy room environment.

OT and PT services require unique assessment, intervention, and documentation supplies. Many school districts develop lists of standard OT and PT materials, including consumable supplies, which may or may not typically be found in educational settings. Consultation often includes the use of supplies and materials that are meant to be used by teachers and other members of the education team for supporting the child's success.

In summary, quality OT and PT services in the educational setting require attention to funding, personnel, space, equipment, supplies, and fiscal responsibilities.

Appendix 10.1
Examples of Factors to Consider for OT and PT Department Needs Assessment

Demographics (Number of children with OT, PT, and other special needs)	• In each school • In each grade • In special education category
Programs and services	• District priorities, policy, and procedures • Existing school district programs to meet special needs • Current therapy services provided or needed or both, including frequency, duration, location, and cost • Number of assessments and discharges per year • Time needed to complete documentation requirements, • including upcoming IFSPs and IEPs • Type and extent of therapist role in future program development, exploration of service delivery models, RtI2 prevention services, pilot programs, parent/staff workshops, classroom groups, grant writing • Travel time between school sites and child transportation • OT and PT internal policy, procedures, forms needed
Environment	• Classroom and playground space • Availability of space for providing therapy services outside the classroom, as well as space for an intensive therapy room intervention
Supplies and equipment	• Assessment tools • OT and PT supplies and equipment • Computer hardware and software
Personnel	• Services provided by or shared with other agencies (e.g., private community-based OT and PT clinics, regional centers, California Children Services, etc.) • Therapist potential caseload and workload • Availability of support personnel (e.g., clerical, maintenance, custodial, paraprofessionals) • Comparison of salary and benefits • Recruitment of therapists • Staff orientation and ongoing staff training • University collaboration: fieldwork students • Community resources

Appendix 10.2
IDEA Part D Programs and Funding Sources

As a response to IDEA 2004, Part D, the responsibility for special education research shifted to the Institute of Education Sciences (IES) within the Department of Education from the Office of Special Education Programs (OSEP). OTs and PTs may become involved with the following programs and funding sources to gain access to funding and training opportunities.

Related services personnel are included in the following Part D programs:

- **State Personnel Preparation and Professional Development Grant Program**—supports training for special education and early intervention personnel (USC §§ 653, 654);
- **Personnel Development to Improve Services and Results for Children with Disabilities Program**—grants to universities to help prepare individuals to work in school and early intervention settings, including preparation at the doctoral level for leadership roles (USC § 662);
- **Technical Assistance, Demonstration Projects, Dissemination of Information, and Implementation of Scientifically Based Research Activities**—a network of projects and information clearinghouses that develop and disseminate information to states, parents, providers, administrators, and others on issues related to IDEA implementation (USC § 663);
- **A New Interim Educational Settings, Behavioral Supports, and Systemic School Interventions Grant Program** intended to help teachers, related services personnel, and administrators better identify, intervene, and educate students who have behavioral difficulties (USC § 665).
- **A National Center for Special Education Research** was established within IES to sponsor research to both improve services provided under the IDEA and to "expand knowledge and understanding of the needs of infants, toddlers and children with disabilities in order to improve…developmental, educational, and transitional results. . . ." One general duty is to "identify scientifically based related services and interventions that promote participation and progress in the general education curriculum and general education settings" (Title II, § 177(a)(4)).

Appendix 10.3
Considerations for Therapist Recruitment and Retention

Incentives	• Competitive salary and benefits • Sign-on bonus • Relocation fees • Educational stipends in return for years of service • Loan forgiveness programs • Professional development (in-house, continuing education, post-professional degrees, advanced training) • Professional association memberships
Daily support	• Professional mentorship • Therapy supplies (permanent and consumable) • Computer access (available daily to record information and fulfill documentation requirements)
Educational strategies	• Provide internship opportunities for OT, PT, OTA, and PTA students. • Recruit at university job fairs (local, state, national). • Develop recruitment materials.

Appendix 10.4
Suggested School-Based Equipment and Supplies to Support Motor Development in a Classroom

Gross motor development	• Balance beam • Balls of various sizes, textures, and colors • Beanbag chairs • Beanbags • Hula hoops • Jump rope • Large building blocks • Mat • Padded wedge • Parachute • Rings • Scooter boards • Spot markers or cones • Therapy ball • Tunnels • Various bats, scoops, and rackets
Fine motor development	• Alternative seating and therapy balls • Board games • Clay and play dough • Clothing fastener board/vest • Fine motor manipulative toys • Handwriting program and materials • Inflatable seat cushions • Markers, crayons, pencils • Slant boards • Small building blocks • Small chalkboards and whiteboards • Various pencil grips • Various scissors
Sensorimotor development	• Blankets • Fidget tools and toys • Large and small pillows • Jump ropes • Music and musical instruments • Parachute • Rocking boards and rocking chairs • Shaving foam, finger paint, art media • Sit and Spin wheel • Textured materials, balls, and toys • Trampoline • Tunnels • Vibrators • Weighted vests, beanbags, lap pad • Weighted pencils

Appendix 10.5
Suggested Equipment and Supplies for an Enriched Therapy Room Environment

- Back support brace
- Balance beam, rocker board
- Balls of various colors, sizes, textures and weights
- Barrels and crawling tunnels
- Bats, scoops, rackets
- Bean bag chairs, pillows, blankets
- Bean bags, various targets for throwing
- Bolsters (various sizes)
- Building blocks (various sizes)
- Chalkboard, whiteboard, easels, slant boards
- Clay, play dough, rice, tactile media
- Cones and spot markers
- Eating utensils and supplies
- Evaluation kits
- Fidget tools, weighted blankets and vests, massagers, therapy band and tubing
- Fine motor manipulative, markers, paper, various scissor, pencil grips, crayons
- Floor mats under all suspended equipment (minimum 8 inches thick)
- Hula hoops and rings
- Inflatable chair cushions
- Jump ropes and pull handles
- Mirrors (various sizes)
- Music and musical instruments
- Parachute
- Rolling cart for transporting supplies and equipment
- Scooter boards and ramp
- Small floor mats
- Small stairs, ladder, climbing structure
- Suspended equipment (hammock, platform swing, inner tubes, bolster swing, trapeze, sling swing)
- Suspension hardware (three or more rotational devices, height adjustable chains/ropes, safety hooks, bungee cord attachment, glider)
- Table and chairs in appropriate sizes to accommodate students for testing and desktop activities
- Therapy balls and chair balls
- Tools to repair, fabricate, or modify equipment
- Various riding toys, trampoline, ball pit, small tent, tactile table
- Wedges (various sizes)
- Whistles, oral-motor tools/toys

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Physical Therapy Board of California. www.ptbc.ca.gov

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Chapter 11
Management of Therapy in the Educational Setting

This chapter identifies factors involved in the comprehensive management of OT and PT in the educational setting. It gives an overview of workload versus caseload, departmental documentation, the importance of confidentiality of records, staff supervision, program procedures, and program evaluation.

Workload

The term, “workload” includes all activities performed by the therapist during his/her workday and is usually directly related to the amount of time a therapist works per week (e.g., full time or part time). Workload includes prevention and intervention activities, as well as support activities such as documentation and treatment planning. Since the term “caseload” includes only the number of children being served according to the IEP or IFSP, it is not an effective or accurate measure of therapist productivity (AOTA 2006).

The following activities are part of an OT or PT workload in addition to direct therapy with a child:

- Conferences with parents and staff
- Consultation
- Data collection
- Documentation
- Intervention planning
- Ordering of equipment and inventory
- Parent training and information
- Peer review
- Prevention and special program development and implementation
- Professional development
- Scheduling
- Screening and assessments
- Setup, clean-up, and maintenance of equipment
- Staff in-service training
- Student Success Team follow-up
- Studies and evaluation (research)
- Supervision of therapy staff
- Team meetings (staff, IEP, etc.)
- Technical assistance
- Technology development
- Travel time between sites

Determining Workload and Caseload

No specific federal or state guidelines exist for determining caseload for OT and PT school-based services. Many variables influence the determination of the appropriate number of children assigned to a therapist. Considerations include the identified responsibilities of the therapist, the degree of disability related to the population served, the type and amount of assessment and intervention required, the type of equipment and setup time required, and the amount of travel time between schools. Additionally, the use of a PTA or a COTA will affect the caseload a therapist can handle.

Supervision of assistants will need to be taken into consideration as part of the therapist's workload. In addition to supervision of the assistant, responsibilities of the therapist may include keeping records; attending meetings; ordering equipment; scheduling; consulting with parents and staff; conducting peer reviews, in-service training, needs assessments, screenings and assessments; and providing therapy. These factors are applicable for determining the therapist workload. The maximum number of children on caseload is directly related to the model of service and intervention required for each child.

Tools to Determine Workload

A variety of tools are available to assist in monitoring therapist workload, including treatment rosters, permanent and weekly schedules, and the Workload Management Form (WMF). See appendixes 11.1 and 11.2 for examples and definitions of terms on the form.

Treatment rosters may include the number of children served, frequency and duration, dates of benchmarks (goals), pending assessments and IEPs. This tool is helpful for therapists to record important dates for each child in their caseload. Review of the treatment roster may help administrators monitor therapist workload and determine whether changes are necessary.

Schedules provide an overview of therapists' use of time and reflect a therapist's caseload and location on a given day (local schools, administration offices, etc.). The schedule should also document the frequency, duration, location, and service delivery model (e.g., individual or group). Schedules typically include both periodic activities, such as IEP meetings, and assessments as well as regularly scheduled treatment sessions.

The WMF is a tool that provides a monthly overview of a therapist's time spent in prevention and special education activities. The WMF, together with a review of the schedule and roster, can provide an overview of the therapist's use of time. The administrator can then determine whether the caseload requires adjustment in order to provide quality services. Hours worked per week by each therapist may vary and should be considered for workload. Typical activities that involve child-driven services include

intervention, assessment and report writing, documentation of, and participation in team meetings.

Most LEAs determine a target for an appropriate caseload (e.g., number of children) as well as the amount of IFSP/IEP designated time (e.g., amount of service hours per week, month, etc.). For example, one full-time therapist might provide 25 hours of individual, small group, and/or consultation per week to a caseload of 45 children, at a single site (i.e., no driving time). The remaining time in the week might be spent in meetings, documentation, and assessments. Another full-time therapist who must drive to multiple school sites each week might provide 15 hours of services to an individual, a small group, or consultation each week to a caseload of 50 children. Again, the remaining time in the week would be spent in meetings, documentation, and assessments.

Since caseloads often increase as the year progresses, it is beneficial to have room for growth at the beginning of the school year. It is possible to project for future growth by looking at enrollment information, special education data, and, if applicable, the number of new school sites and programs.

Documentation Considerations

Maintaining accurate and up-to-date documentation is essential for fulfilling professional and legal responsibilities in any therapy setting. Documentation needs to be consistent with the employer's requirements as well as the requirements of the Association of Physical Therapy Assistants, Physical Therapy Board, Association of Occupational Therapy Assistants, and California Board of Occupational Therapy. Many procedures and documents require specific timelines and formats. It is necessary for the OT and PT supervisor, director, coordinator, and others to work closely with the administrators of the LEA to develop efficient procedures that meet federal requirements and OT and PT professional practice standards.

Documentation and professional communication by the therapist is aided by computerized formats, checklists, flowcharts, fill-in-the-blank forms, All acronyms and abbreviations that are known, understood, and accepted in the LEA and practice standards of OT and PT can be included in therapy records after they have been initially defined. All documentation produced by a therapist should include the date the record was completed and the therapist's official legible signature, followed by the appropriate professional credentials. All documentation written by an OTA or PTA or therapy fieldwork student must be reviewed and co-signed by the supervising therapist within the proper timelines. Corrections to official documents are made by drawing a line through the error and initialing above the correction. Cover ups such as "white out" are prohibited. To complete therapy records empty spaces are to be acknowledged (line drawn through or Not Applicable, N/A). This eliminates any question as to the therapists' intent to complete the record and prevents falsifying information added after the record has been completed and signed.

Confidentiality of Records

Confidentiality of all child records is a priority and should be maintained consistent with the Family Educational Right to Privacy Act. (FERPA http://www2.ed.gov/policy/gen/reg/ferpa/index.html

All documents and records pertaining to the child are considered confidential, and a copy placed in the child's permanent file. Authorized individuals can have access to confidential information as specified by the local school district. Any record that has identifiable data about the child, including documents generated by a school employee or outside agency, is considered confidential.

The definition of "educational records" under federal law is nearly identical to the definition of "pupil records" under state law and regulations. Such records are defined as any information or item that is:

(1) recorded in any way, regardless of the physical form in which it is maintained; (2) directly related to an identifiable pupil; and (3) maintained by a school district or required to be maintained by a district employee in the performance of his or her duties. E-mail that contains comments traceable to a particular child and that are maintained on the district's computer servers may be considered pupil records.

A consent form for release of information must be signed by the parent or guardian to allow child information to be shared between entities via telephone, e-mail, mail, fax, or other means. OTs and PTs who are contracted with the LEA may have access to child records as would district staff, consistent with the Family Educational Right to Privacy Act (FERPA) Confidential files must be stored in a locked file cabinet, preferably where the child receives therapy. Special procedures must be established for the transport and storage of confidential documents in a personal vehicle or home office. Child records shall be maintained for a period of no less than seven years following dismissal from services and in accordance with the LEA requirements (BPC §§ 2570.185 and 2620.7).

Supervision of Assistants and Aides

The OT and PT are responsible for all aspects of therapy service delivery and are accountable for the safety and effectiveness of the service delivery process. Ultimately, it is the responsibility of the supervising OT (AOTA, 2009) or PT to determine which responsibilities to delegate and when delegation is appropriate. Tasks are delegated based on the competence of the assistant. The OT or PT needs to clearly communicate roles, responsibilities, and expectations to the OTA or PTA and make sure that the assistants understand their roles. Supervision is a mutual responsibility of the supervisor and the assistant. Refer to appendixes 11.3 through 11.5 for further details. OTAs and PTAs are responsible for demonstrating the skills to perform the tasks delegated to them. While the OT or PT is responsible for determining which elements of a treatment plan may be assigned to the OTA or PTA, the assistant must be knowledgeable about his or her legal scope of work as well as level of competence and must be able to self-reflect on his or her current level of competence.

Although not mandatory, it is highly recommended that the assigned OT or PT be from the same organization (e.g., school district, nonpublic agency, etc.) as the OTA or PTA. Therapy assistants progress along a continuum from entry level to advanced level depending on work experience and professional development beyond program degree requirements. Appendix 11-4 describes the expectations for supervision of OTAs.

For the purpose of understanding roles and expectations, an educational or instructional aide is considered an unlicensed individual who is able to perform routine tasks, such as assisting with classroom programs, mobility, or dressing, that does not replace, but may complement, expert intervention with a child.

In general, an educational aide works under the supervision of the classroom teacher and provides support to the classroom program. However, if an aide provides specific occupational or physical therapy interventions under the direction of an OT or PT, that aide has now assumed the role of an OT Aide or PT Aide and the therapist must provide continuous and immediate supervision and document appropriately.

Program Evaluation

Monitoring of OT and PT services is necessary to ensure that the provision of therapy adheres to federal and state requirements, LEA policy and procedures and is appropriate to the needs of children served. Program evaluation includes a review of the following features:

- Adherence to timelines for referral, assessment, and IEPs
- Appropriate procedures for communication between the therapists, educational personnel, and family
- Caseload and workload levels
- Documentation of therapy intervention and program management
- Effectiveness of professional development
- Personnel Evaluation
- Program consistency across geographical, cultural, and socioeconomic lines
- Quality and consistency of service delivery
- Referral and intervention data
- Space and equipment

Tracking Data for Modifications to the Therapy Program

Statistical tracking of therapy outcomes will be necessary to justify program expansion or additional staffing. A computerized method to track statistical data is recommended as variables can easily be modified. Data may include:

- Length of time child has received therapy
- Number of children discontinued from service
- Number of children referred, date of referral, referral source, and reason for referral
- Number of evaluations and consultations completed
- Rationale for provision or denial of service
- Specific data on age, grade, eligibility, or campus

Program Handbook

Service providers should be given a program handbook with written descriptions of requirements for the school district and clear expectations. The handbook should contain the internal policies and practices of the LEA and can be produced in an electronic or paper version. The therapy handbook is a useful reference for administrators and therapy staff. In addition, therapy staff should have access to the policy and procedure manual of the LEA and the special education department handbook. Appendix 11.6 contains an example of a table of contents for an OT and PT handbook.

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Time Codes
15 min. = .25
30 min. = .50
45 min. = .75
60 min. = 1.0
***Round to nearest fourth of a percent**

Appendix 11.1

Sample Workload Management Form

Therapist Name: _____ Month/Year: _____

Employee Number: _____Assigned Location: _____

DAILY DATA

Day of Week	**M**	**T**	**W**	**T**	**F**		**M**	**T**	**W**	**T**	**F**		**M**	**T**	**W**	**T**	**F**		**M**	**T**	**W**	**T**	**F**		**M**	**T**	**W**	**T**	**F**	
Date of Service																														
I. PREVENTION AND PRE-REFERRAL	**M**	**T**	**W**	**T**	**F**		**M**	**T**	**W**	**T**	**F**		**M**	**T**	**W**	**T**	**F**		**M**	**T**	**W**	**T**	**F**		**M**	**T**	**W**	**T**	**F**	**TOTALS**
Consultation																														
Screening																														
Intervention																														
Total hours																														
II. SPECIAL EDUCATION	**M**	**T**	**W**	**T**	**F**		**M**	**T**	**W**	**T**	**F**		**M**	**T**	**W**	**T**	**F**		**M**	**T**	**W**	**T**	**F**		**M**	**T**	**W**	**T**	**F**	**TOTALS**
Screening (Number. of children not on workload or workload)																														
Screening (hours/day)																														
Assessments (# per day)																														
Assessments (hours/day)																														
IEP meeting (# per day)																														
IEP meeting (hours/day)																														
Meeting totals																														
Total hours																														
III. 504 ACTIVITIES	**M**	**T**	**W**	**T**	**F**		**M**	**T**	**W**	**T**	**F**		**M**	**T**	**W**	**T**	**F**		**M**	**T**	**W**	**T**	**F**		**M**	**T**	**W**	**T**	**F**	**TOTALS**
Number of meetings																														
Hours of meetings																														
Time spent in making 504 accommodations																														
Total hours																														

WEEKLY DATA		**MONTHLY DATA**	
A: Total treatment hours (per week)		**Pending assessments**	
B: Regularly assigned treatment hours (per week)		**Schools on caseload**	**Schools on workload**
C: Compensatory hours (per week)		**Children on caseload**	**Children on workload**
D: Stay-put treatment hours (per week)			

Source: Los Angeles Unified School District 2008

Appendix 11.2
Workload Management Form Definitions of Terms

DAILY DATA Section I: Prevention and Pre-Referral Practices for General Education Children (having no IEP; no special education eligibility)

Tier I: Universal Screening and Program Enrichment—increases teacher knowledge including: development and child's function in school

- *In-services*—provide general guidelines for typical motor development and suggestions for building skills in classroom
- *Activities*—demonstrated by therapist to be implemented by classroom staff
- *Ideas* – strategies for setting up the classroom for child success
- *Environmental accommodations*—for the child to gain access to the curriculum, classroom, and campus

Tier II: Targeted Groups—conducted only in natural environment; no pullout or child-specific activities

- *Observe* child in natural environment.
- *Consult* with parents, teachers, school staff regarding concerns about the child.
- *Review data* from teacher regarding outcomes of classroom accommodations from Tier I (consultation).
- *Screening and group activities*, as deemed appropriate
    - After screening, possible outcomes:
        - Provide information regarding child's motor abilities to access
        - Refer to SST
        - Recommendations for targeted intervention or program accommodations for teacher/parent to complete

Tier III: Child-Specific Intervention—focus on specific motor skills required for the child to gain access to the educational program

- *Follow-up consultation and monitoring* focusing on specific motor skills for child access
- *SST meeting participation*—Monitor recommended supports and accommodations and adjust as needed
- *Refer to special education* if the child continues to struggle with skills after accommodations and time designated by SST.

Section II: Special Education Data

Screening (children in special education but *not* on caseload)
Assessment
IEP meetings

Section III: 504 Activities
Number of meetings attended per day
Length (in hours) of meetings attended per day
Time spent in preparing 504 accommodations

WEEKLY DATA
A: Total Treatment Hours – Total treatment hours for the week
B: Regular Treatment Hours – Regular treatment hours for the week – services from signed/agreed upon IEPs
C: Compensatory Treatment Hours – Compensatory treatment hours for the week
D: Stay-Put Treatment Hours – Stay-put treatment hours for the week

MONTHLY DATA
Pending Assessments – Number of pending assessments per month based on workload
Schools on Workload – Number of schools per month on workload
Schools on Caseload – Number of schools per month on caseload
Children on Workload – Number of children served per month on workload
Children on Caseload – Number of children assigned per month on caseload

Source: Los Angeles Unified School District 2008.

Appendix 11.3
Supervision of Occupational Therapy Assistants

The following information is derived from the California *Business and Professions Code sections 2570.13 and 2570.20.*

Supervision of an OT assistant means that the responsible OT shall be responsible at all times for all OT services provided to the client. Documentation of the supervision shall include:

- documentation of direct client care by the supervising OT,
- documentation of the review of the clients medical or treatment record and services or
- a signature from the OT supervisor on the OT assistants on each client's record

As part of the responsible OT's appropriate supervision, he or she shall conduct at least weekly review and inspection of all aspects of OT services by the OT assistant.

(1) The supervising OT has the continuing responsibility to follow the progress of each patient, provide direct care to the patient, and to ensure that the OT assistant does not function autonomously.

(2) An OT shall not supervise more OT assistants, at any one time, than can be appropriately supervised in the opinion of the board. Two OT assistants shall be the maximum number of OT assistants supervised by an OT at any one time, but the board may permit the supervision of a greater number by an OTs if, in the opinion of the board, there would be adequate supervision and the public's health and safety would be served. In no case shall the total number of OT assistants exceed twice the number of OTs regularly employed by a facility at any one time.

Selected References

American Occupational Therapy Association, Commission on Practice. 2009. *Guidelines for supervision, roles, and responsibilities during the delivery of occupational therapy services.* Bethesda, MD: American Occupational Therapy Association.

Appendix 11.4
Expectations for Occupational Therapy Assistants

	Entry	Intermediate	Advanced
Evaluation			
Initiates the evaluation questions in clarifying the child's current performance in the areas of concern; documents the modifications or the attempts that have been made to solve the problem.	A	A	A
Evaluates the child to determine significance of the discrepancy between the child's performance and expected developmental performance. Identifies possible interfering factors. Collects information from multiple settings and sources regarding the child's performance using various methods, which may include observation; record review; interview of parent, caregiver, teacher, and pertinent others; and communication with other agencies. Determines child's current functional abilities in performance areas, components, and in contexts compared with expected development.	A	A	A
Using evaluation methods (observation, child's products, and assessment tools) that focus on the initial problem, provides input that can be used to develop intervention strategies and that considers the child's performance in the educational setting using the ecological model.	A	A	A
Synthesizes and summarizes information in a report to document referral, interpret evaluation results, describe current level of the child's performance, and provide recommendations and strategies relating to the initial evaluation question(s).	A	A	A
Program Planning			
Participates in the IEP process through oral or written communication or both.	A	A	A
Attends IEP meetings in which no change in services is proposed to current levels of performance and goals.	A	I	I
With educational team, determines child's needs, develops goals related to academic and nonacademic performance, and recommends OT service delivery when educationally necessary.	A	A	A
With other members of the team, develops activities that reflect the child's needs in the educational setting.	A	A	A
Develops OT intervention plan.	A	A	A
Determines skills the child needs to possess for OT services to be terminated.	A	A	A
Intervention			
Plans for and delivers OT services according to the frequency and duration listed on the IEP.	A	A	A
Develops and implements a plan of data collection to provide objective basis for making decisions (ongoing evaluation).	A	A	I
Provides intervention that considers child's performance within contextual aspects (temporal and environmental).	A	A	A
Alters intervention plan as indicated by child's performance (documents in record).	A	A	A
Implements the use of and adapts basic technology solutions as needed (slant boards, pencil grips, classroom tools).	A	I	I
Contributes information in meetings, conferences, and informal interactions.	A	I	I
Determines need for reevaluation.	A	A	A
Provides appropriate training and supervision to classroom staff and non-OT personnel who supply activities in the daily educational routine.	A	I	I
Critically analyzes and applies current research related to school practice.	A	A	A
Conducts studies to determine effectiveness of OT services in early intervention.	A	A	A
Identifies and addresses ethical issues that may develop.	I	I	I
Documents child's performance in treatment, phone calls, meetings, etc., in child's OT record.	I	I	I
After establishing service competency, administers standardized assessments assigned by the supervising therapist.	A	A	I
Tracks child's record to determine when reviews are scheduled.	I	I	I
Demonstrates awareness of legislation and current trends in school and early intervention.	I	I	I
Participates in consumer or advocacy activities related to school and early intervention practice on an individual, community, state, or national basis.	I	I	I

Key: A= Assists I= Independently performs

Appendix 11.5
Regulations for the Physical Therapy Examining Committee

Business and Professions Code Section *1398.44 Adequate Supervision Defined*

A licensed PT shall at all times be responsible for all PT services provided by the PT assistant. The supervising PT has continuing responsibility to follow the progress of each patient, provide direct care to the patient and to assure that the PT assistant does not function autonomously. Adequate supervision shall include all of the following:

(a) The supervising PT shall be readily available in person or by telecommunication to the PT assistant at all times while the PT assistant is a treating patient. The supervising PT shall provide periodic on site supervision and observation of the assigned patient care rendered by the PT assistant.

(b) The supervising PT shall initially evaluate each patient and document in the patient record, along with his or her signature, the evaluation and when the patient is to be reevaluated.

(c) The supervising PT shall formulate and document in each patient's record, along with his or her signature, the treatment program goals and plan based upon the evaluation and any other information available to the supervising PT. This information shall be communicated verbally, or in writing by the supervising PT to the PT assistant prior to initiation of treatment by the PT assistant. The supervising PT shall determine which elements of the treatment plan may be assigned to the PT assistant. Assignment of these responsibilities must be commensurate with the qualifications, including experience, education and training, of the PT assistant.

(d) The supervising PT shall reevaluate the patient as previously determined, or more often if necessary, and modify the treatment, goals and plan as needed. The reevaluation shall include treatment to the patient by the supervising PT. The reevaluation shall be documented and signed by the supervising PT in the patient's record and shall reflect the patient's progress toward the treatment goals and when the next reevaluation shall be performed.

(e) The PT assistant shall document each treatment in the patient record, along with his or her signature. The PT assistant shall document in the patient record and notify the supervising PT of any change in the patient's condition not consistent with planned progress or treatment goals. The change in condition necessitates a reevaluation by a supervising PT before further treatment by the PT assistant.

(f) Within seven (7) days of the care being provided by the PT assistant, the supervising PT shall review, cosign and date all documentation by the PT assistant or conduct a weekly case conference and document it in the patient record. Cosigning by the supervising PT indicates that the supervising PT has read the documentation, and

unless the supervising PT indicates otherwise, he or she is in agreement with the contents of the documentation.

(g) There shall be a regularly scheduled and documented case conference between the supervising PT and PT assistant regarding the patient. The frequency of the conferences is to be determined by the supervising PT based on the needs of the patient, the supervisory needs of the PT assistant and shall be at least every thirty calendar days.

(h) The supervising PT shall establish a discharge plan. At the time of discharge, or within 7 (seven) days thereafter, a supervising PT shall document in the patient's record, along with his or her signature, the patient's response to treatment in the form of a reevaluation or discharge summary.

Note: Authority cited: Sections 2615, 2655.1 and 2655.92, *Business and Professions Code.* Reference: Section 2655.92, *Business and Professions Code.*

Note: A new definition is currently proposed pending a vote by the Legislature (http://www.ptb.ca.gov/laws_regs/prop_regs/language.pdf).

History:

(1.) Repealer of subsection (f) filed 6-29-83, Register 83, No. 27.

(2.) Amendment of section and Note filed 9-18-93, operative pursuant to *Government Code* section 11343.4(d), Register 96, No. 38.

Appendix 11.6
Sample OT and PT Handbook Table of Contents

Philosophy	• District mission and vision • Department values and beliefs
Personnel	• District organizational chart • Job descriptions, duties and roles • Time off (absences, vacation, leaves, etc.) • Orientation procedures • Professional expectations • Dress code
Program and services	• Program descriptions • District calendars • Staff assignments and schedules • School schedules • Policy for making up missed therapy sessions
Case management documentation	• IFSP/IEP forms and instructions for use • Documentation for treatment sessions • Attendance records • Prescriptions • Child record maintenance • Steps to process a referral assessment • Content and format of the initial, the triennial, and discharge summary report • Collaboration and consultation • Home programs
Communication	• District and school contact Information • Release of information • Confidentiality requirements
Equipment	• Maintenance • Purchasing • Use of Low-Incidence Funds • Assistive technology • Lending policies
Procedures	• Emergencies and safety procedures • Universal precautions • Timecards and payroll • Transportation • Mileage • Professional development
Related agencies	• Contact information • Referral procedures
Resources	• Evidence-based practices • Continuing education opportunities

Glossary

Access is the opportunity to engage in educational curriculum, programs, and activities.

Adaptive development means the acquisition of skills that are required to meet environmental demands. Adaptive development includes, but is not limited to, activities of self-care, such as dressing, eating, toileting, self-direction, environmental problem solving, and attention arousal (17 CCR 52000(34).

Adequate Yearly Progress (AYP) is a statewide accountability system mandated by the No Child Left Behind Act of 2001, which requires each state to ensure that all schools and districts make adequate yearly progress.

Annual review is a yearly review, for a child with an IEP, to determine progress made on past IEP goals, the child's present needs, and goals, placement, and services for the next year.

Assistive Technology Services (AT) is any service that directly assists an individual with a disability in the selection, acquisition, or the use of an assistive technology device (20 USC 1401(2)).

Assistive technology device is any item, equipment, or product system that is used to increase, maintain, or improve the functional capabilities of a child with disabilities, not including medical devices that are surgically implanted (20 USC 1401(1)).

Best practice is a collection of exemplary principles and actions, supported by current professional research and philosophy, used to deliver services at the highest standard.

Built environment refers to the human-made surroundings that provide the setting for human activity, ranging from the large-scale civic surroundings to the personal places.

California Children's Services (CCS) is a division of California Medical Services, (CMS), an agency of the State Department of Health. CCS provides OT and PT services as part of the medical services provided to children who qualify based on medical diagnosis and functional need.

Certified Occupational Therapy Assistant (COTA) is a person who is certified by the California Board of Occupational Therapy (CBOT) and provides OT services under the supervision of a licensed occupational therapist.

Clinical skilled observations are part of the assessment process or ongoing monitoring of intervention. The observations are seen and interpreted by a trained professional.

Collaboration is working cooperatively, with frequent communication, in a team approach to address student need.

Competitive employment means work (i) in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting; and (ii) for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled (Rehabilitation Act, 1998, sections 7(11) and 7(35)(a), 29 USC 705(11) and 709(c).

Complaint procedures are initiated by a written signed statement alleging that a local public agency has violated a federal or state law or regulation.

Confidentiality is maintaining a person's right to privacy as stated by law.

Consent is voluntary permission expressed in writing for a certain activity to be carried out and is given after a parent or guardian is fully informed of all relevant information related to the activity being sought consent for.

County Office of Education (COE) means the office of the county superintendent of schools.

Criterion-referenced assessment is an assessment that has established standards of performance (often related to age or expectations of a developmental level) that the child is measured against.

Critical appraisal is evaluating current research articles expressly determining quantitative and qualitative values of the research.

Data collection is written documentation of some action or response, often used to establish a baseline or to measure progress.

Designated Instruction and Services (DIS) means related services.

Documentation is written record of assessments, services, and communications.

Dual eligibility is used in early intervention services designating that a child is eligible to receive services through both the local educational agency and the regional center. The responsibility of each agency is defined in *Government Code* Section 95014 (c).

Due process hearing is the process for resolving disagreements between a local public agency and a parent regarding IEP and IFSP issues including, but not limited to, eligibility, placement, and services.

Free Appropriate Public Education (FAPE) means special education and related services provided in conformity with the IEP, at public expense, and under public supervision and direction (20 USC 1401(9)).

Early intervening services are services provided to a child in general education that is struggling but has not been identified as qualifying for special education. Early intervening services are part of RtI_2 and precede assessment for special education. The state may use a portion of federal funds for IDEA to provide the services.

Early intervention services are designed to meet developmental need of infant and toddlers with disabilities under IDEA Part C and are documented on the IFSP.

Educational Framework for Child Success (EFCS) is an expansion of the Ecological Model of Student Performance that focuses on child success in the educational context.

Educationally necessary OT and PT related services are services specified on an IEP as needed in order for a child to benefit from his or her special education program.

Established risk refers to infants and toddlers with conditions of known etiology or conditions, including low-incidence disabilities, having a high probability of leading to developmental delays (GC 95014(2); 17 CCR 52022(b)).

Complaint procedures are initiated by a written signed statement alleging that a local public agency has violated a federal or state law or regulation. www.oah.dgs.ca.gov/

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High risk refers to infants and toddlers who have a combination of biomedical risk factors placing the infant or toddler at “high risk” of substantial developmental delays (GC 95014(3)).

Independent Education Evaluation (IEE) may be provided at public expense when parents disagree with a school district's evaluation. The parent is entitled to only one IEE each time the district conducts an evaluation. (The school district, however, may choose to defend its own assessment in due process rather than provide an IEE (34 CFR 300.502)).

Individuals with Disabilities Education Act (IDEA) is the federal educational law of 1997 (which amended PL 94-142 and PL 101-476 and included updated regulations) that delineated and governed special education services.

Individuals with Disabilities Education Improvement Act (IDEiA) is the federal educational law (which updated IDEA 1997 and includes updated regulations) that delineates and governs special education services. IDEIA, however, is commonly referred to as IDEA or IDEA 2004.

IDEA Part A refers to the first part of IDEA, which addresses general provisions and refers to the use of high-quality personnel who have the necessary knowledge and skills to effectively teach children with disabilities and intervene with them.

IDEA Part B refers to the second part of IDEA, which specifies assistance for education of all children with disabilities (i.e., special education and services for children three to twenty-one years of age).

IDEA Part C refers to the third part of IDEA, which specifies the program and services for infant and toddlers with disabilities, at one time called Part H.

IDEA Part D refers to the fourth part of IDEA, which includes national activities to improve the education of all children with disabilities. It covers professional development, personnel preparation, parent training and information centers, technical assistance, dissemination of information, and special education research.

IEP team refers to all the members, including the parents, who meet and/or provide services to the special education child as part of a free and appropriate educational program. The IEP meeting is where the IEP is discussed and formulated (34 CFR 300.23).

Individualized Education Program (IEP) is a working document for the special education child that documents eligibility for services, the level of present functioning by the child, appropriate goals, objectives, services, and service providers as well as other specific details. When the IEP is signed, which signifies acceptance by the parent or legal guardian, the IEP becomes the legal document that satisfies the requirement that special services be provided for the child with special needs (34 CFR 300.22).

Individualized Family Service Plan (IFSP) is a written plan for providing early intervention services to a child, eligible under Part C, and the child’s family. It must be reviewed every six months and updated yearly. It must include information about t (34 CFR 300.24).

Medically necessary occupational therapy or physical therapy services are those services directed at achieving or preventing further loss of functional skills or reducing the incidence and severity of physical disability (2 CCR 60300(n)).

Multidisciplinary team means two or more professionals from different disciplines, and the parent, who participate in provision of integrated and coordinated services (17 CCR 52000(34)).

Natural environment carries the concept of least restrictive environment for those children under age three. Natural environments include home and community settings in which children without disabilities participate (20 USC 1432(4)(G)).

Needing related services means that an assessment shows the need for a service related to special education for a child identified as a special education student.

No Child Left Behind (NCLB) Act of 2001 is a federal program to ensure that all children have a fair, equal and significant opportunity to obtain a high-quality education and reach proficiency on state academic achievement standards and academic assessments.

Nonpublic Agency (NPA) or Nonpublic School (NPS) is a nonsectarian agency or school that has applied, met state criteria, and paid fees to be recognized as a provider of special education or related services or both.

Occupational Therapy (OT), as outlined in the Occupational Therapy Practice Act, *Business and Professions Code* Section 2570.2(k), means therapeutic use of purposeful and meaningful goal-directed activities (occupations), which engage the individual's body and mind in meaningful, organized, and self-directed actions that maximize independence, prevent or minimize disability, and maintain health.

Physical Therapy (PT), according to the American Physical Therapy Association, Physical Therapy Scope of Practice, means services provided under the direction and supervision of the PT and includes examining (history, system review, and tests and measures) individuals with impairments, functional limitations, and disability or other health-related conditions for diagnosis, prognosis, and intervention; alleviating impairments and functional limitations and disability, including the maintenance of fitness, health, and quality of life in all populations and engaging in consultation, education, and research.

Physical Therapist Assistant (PTA) is a person who meets the legal qualifications and provides PT services under the supervision of a licensed PT.

Postsecondary education is the period of education after high school.

Private assessment is an assessment obtained privately without authorization from the school district.

Qualifying for special education means a child shows eligibility consistent with one or more of the federally identified 13 categories defining special education.

Regional center is a diagnostic, counseling, and service coordination center for persons with developmental disabilities and their families. It is a contractor of the Department of Developmental Services (17 CCR 52000(43)).

Related service is defined as a service that may be required in order for a child to benefit from his/her special education program. OT and PT are defined in both federal regulation and state regulations as related services (34 CFR 300.34).

Relevant practice question is the question developed and proposed to start a literature search on evidence-based practices.

Response to Instruction and Intervention (RtI$_2$) is a general education approach based on providing scientific, research-based interventions for a child struggling in general education. In RtI$_2$ the child's response is documented before referral to special education.

Scientifically based research is "….(A) research that involves the application of rigorous, systematic, and objective procedures to obtain reliable and valid knowledge relevant to education activities and programs; and (B) includes research that (i) employs systematic, empirical methods that draw on observations or experiment; (ii) involves rigorous data analyses that are adequate to test the stated hypotheses and justify the general conclusions drawn, (iii) relies on measurements or observational methods that provide reliable and valid data across evaluators and observers, across multiple measurements and observations, and across studies by the same or different investigators; (iv) is evaluated using experimental or quasiexperimental designs in which individuals, entities, programs, or activities are assigned to different conditions and with appropriate controls to evaluate the effects of the condition of interest, with a preference for random-assignment experiments, or other designs to the extent that those designs contain within-condition or across condition controls; (v) ensures that experimental studies are presented in sufficient detail and clarity to allow for replication or, at a minimum, offer the opportunity to build systematically on their findings; and (vi) has been accepted by a peer-reviewed journal or approved by a panel of independent experts through a comparably rigorous, objective, and scientific review (20 USC 7801(37)).

Screening to determine the appropriate instructional strategies for curriculum implementation is not considered to be an assessment for eligibility for special education and related services. This would be part of early intervening services, which occur, before referral to special education.

Section 504, of the Rehabilitation Act of 1973 and Amendments of 1992, is the civil rights law prohibiting discrimination against handicapped children for the use of public services. The term "504 accommodations" refers to the measures to accommodate the child's disability written into a 504 Plan, which becomes part of the child's general education program

Special Education Local Planning Area (SELPA) provides special educational services to children in the designated area. A SELPA may include more than one local educational agency.

Standardized assessment (also called norm-referenced assessment) is an assessment that ranks the child's performance based on normative population test results; thus average performance and performance outside the average range can be determined.

State standards are a collection of established target learning outcomes, based on NCLB, that provide information and guidelines for each grade level to ensure quality education and child achievement.

Student Success Team (SST) is a part of the general education program. Referral to an SST precedes a referral to special education. A team of different professionals and parents help problem-solve issues and monitor progress of a student struggling in the school environment.

Supplementary aids and services are those aids, services, and other supports provided in general education and other education-related settings to enable children with disabilities to be educated with nondisabled children (20 USC 1401 (33)).

Transition or transition services refers to a time period when a child is getting ready to enter a new phase or life role and the services directed toward that period. In the educational system, when a child in the early intervention program is going to turn three or is being discharged from all early intervention services, the IFSP team must create a transition plan (17 CCR 52112).

When a special education child is sixteen years old or younger, if appropriate, the term "transition services" refers to a coordinated set of activities for a child with a disability that is designed to be within a results-oriented process, that is focused on improving the academic and functional achievement of the child with a disability to facilitate the child's movement from school to post-school activities, including postsecondary education, vocational education, integrated employment (including supported employment). The child must have an individualized transition plan (ITP) for entering adulthood when the services provided by the public school are no longer available (20 USC 1401(34)).

Trans-disciplinary team is a team of different professionals who work together in assessing the child and often report findings in one integrated report so that team decisions can be made.

Triennial review is a process conducted every three years to determine whether the child continues to be eligible for special education services.

Frequently Asked Questions

1. Who may provide OT and/or PT?
Only a licensed OT or PT including certified OTAs and licensed PTAs under the supervision of an OT or PT, respectively, may provide therapy. Other educational professionals and paraprofessionals, such as instructional assistants may, at the discretion of the OT or PT, carry on the recommended activities following training by the OT or PT. Consultation and monitoring by an OT or PT is necessary under all circumstances. For additional information, see appendix 5.1.

2. When is a referral for an OT or PT assessment appropriate?
A referral for OT and/or PT is appropriate when a child is not able to participate in the educational curriculum at the expected level of ability, when modifications and accommodations have not been effective, and when the areas of concern are in the domain of OT and/or PT practice. For additional information, see appendix 7.4, "Sample OT and PT Referral Form."

3. Does an assessment to determine the need for OT or PT need to be completed by a licensed OT or PT?
Yes. No other service provider possesses the same licensing, qualifications, educational background, or training. *Note:* A PT may conduct an assessment in accordance with the referral without a specific medical diagnosis. Although a referral for PT can come from any source, a PT cannot perform treatment intervention without a diagnosis from a physician or other duly licensed practitioner. For additional information, see Chapter 5.

4. May a district require an adapted physical education (APE) teacher to do an assessment before an OT or PT evaluation is considered?
No. A District may not require an APE assessment or APE services before considering an assessment by an OT or PT.

5. If it has been determined by a physician or an outside agency that a child may benefit from OT or PT, is the LEA responsible for providing these services?
No. However, an IFSP/IEP meeting should be held to review the outside report and determine if additional supports and/or services are necessary for the child to benefit from his/her educational program. Whenever OT and PT services are considered, those professionals with the qualifications should attend the IFSP/IEP meeting. An IFSP/IEP team in the LEA must determine whether a child requires occupational therapy or physical therapy in order to benefit from the instructional program. The LEA is not responsible for OT and/or PT unless it can be demonstrated that the child has an educationally related need that only OT or PT or both can address.

6. Do OT and/or PT assessments alone, determine that the child meets eligibility as an individual with exceptional needs?
No. The need for OT and/or PT alone does not make a child (based on the eligibility criteria) qualified to be considered an individual with exceptional needs. The IEP team determines eligibility for special education on the basis of assessments in all areas of a suspected of disability (5 CCR § 3030).

7. When does a child receive OT and/or PT as a related service?
The IEP team determines that OT or PT or both services are included as a related service when assessment results show an educational need that only OT or PT or both can address. A child's diagnosis or disability alone does not indicate a need for therapy. However, the team considers the potential impact of the disability on the child's education.

8. How are the amount and mode of therapy service provision determined in an IFSP/IEP?
If the child is determined eligible as an individual with exceptional needs, goals are developed. The IFSP/IEP team determines which team member(s) has the expertise to achieve desired outcomes. If it is determined that OT or PT is appropriate to meet the identified goal, the OT and/or PT, based on professional frameworks, determines the methodology, intensity, and frequency of therapy required for the child to meet the identified IFSP/IEP goal(s). OT or PT or both services may include direct services (individual or small group) and/or a consultation to the IEP team.

9. Are there any regulations prohibiting a school district from providing OT and/or PT services to a child without special education eligibility?
No. There are no federal mandates prohibiting the provision of OT or PT services to a child without special education eligibility. Each LEA makes a determination to provide OT or PT based on the child's needs. OT and PT are provided as a related service under IDEA 2004. Some school districts provide OT and/or PT as an accommodation under Section 504 of the Rehabilitation Act of 1973 and develop a 504 Plan.

10. What does IDEA 2004 require regarding the least restrictive environment as it relates to the provision of OT and PT services in public schools?
IDEA 2004, Part B, requires "that to the maximum extent appropriate, children with disabilities…are educated with children who are not disabled" (34 CFR § 300.114(A)(2)(i)). There is a requirement to educate special needs children with children who are not disabled to the maximum extent possible. The "least restrictive environment" clause in the law was aimed at preventing a school from segregating students with disabilities from the general student body. The IDEA explicitly states that mainstreaming is not appropriate "when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily" (20 USC § 1412(5)(B)). The goal and intent of OT and PT as related services is to support a child's ability to participate and be successful in the least restrictive environment. Services are provided in a setting that best meets this goal.

11. What is the intent and meaning of the term "natural environment" in IDEA 2004 Part C?

"To the maximum extent appropriate, early intervention services are provided in natural environments, including the home, and community settings in which children without disabilities participate (34 CFR § 303.12(b))." The IFSP must contain "A statement of the natural environments in which early intervention services will appropriately be provided, including a justification of the extent, if any, to which the services will not be provided in a natural environment;" (20 USC § 1436(d)(5)). By definition, natural environments mean settings that are natural or normal for the child's age peers who have no disabilities" (34 CFR § 303.18). This includes a variety of settings, including but not limited to, homes, community parks, and recreation family program settings, community toddler preschool and early intervention programs, baby gyms, and playgrounds.

12. If a child is receiving medically necessary therapy from CCS, may he or she also receive therapy from the LEA?

Yes, a child may receive OT and PT from an outside agency such as CCS and still qualify for OT and PT as a related service through the LEA if therapy is educationally necessary (2 CCR § 60325(e) and (f)).

13. Why does an LEA determine whether therapy is educationally necessary or medically necessary?

The federal regulations do not differentiate between medically necessary and educationally necessary therapy. The law mandates that a referral to the LEA for an assessment of gross and fine motor skills shall be considered by either the LEA or by CCS, depending on the information contained in the referral and the pupil's documented physical deficit pursuant to Section 7572 of the *Government Code.* In California, CCS is obligated to provide therapy under the Interagency Responsibilities for Providing Services to Handicapped Children for children who are determined to be medically in need of therapy services and meet CCS criteria (2 CCR § 60310). Children may have medical *and* educational needs related to OT and PT services. Educational needs are determined at the IFSP or IEP meeting. Medically necessary therapy is determined by CCS, and a determination must be made by the LEA as to whether additional educationally related OT or PT is also necessary. If therapy is needed for the child to benefit from his education, it is the responsibility of the LEA to provide it.

14. How do children with mental health needs obtain services in the public school setting?

Children with mental health needs may obtain services through the early intervening services such as Response to Intervention approaches in general education as well as through the special education process. Referrals for mental health services are made by the school psychologist. There are two eligibility requirements that must be met for children to receive mental health services at school. The child must be eligible for special education, and the child must need mental health services in order to benefit from special education.

15. Is it necessary that each child who has been assessed and determined to need help in gross and fine motor skills development receive occupational therapy, physical therapy, or adapted physical education from a specialist?
No, not every child with gross motor and fine motor needs will require special services. The IFSP or IEP team makes the determination of the appropriate strategies and services based upon the identified needs of the child. In some cases, the general education or special education program can meet the child's needs. In other cases, children will need direct services or consultation (or both).

16. How do OT and PT goals relate to a child's future educational outcomes?
OTs and PTs collaborate with the IEP team to improve a child's performance and participation at school, help to build confidence and self-determination to go to college, find competitive employment, and live an independent, satisfying life. OTs and PTs support the development of the underlying foundational skills (body functions and structures) that influence learning and behavior. Therapists also scaffold a child's participation in educational activities to address meaningful and relevant educational outcomes.

17. What is the responsibility of the OT and PT in providing services in an Extended School Year?
Extended School Year (ESY) services are defined as special education and related services that are provided to a child with a disability beyond the normal school year in accordance with the child's IEP and as a necessary part of a free appropriate public education (34 CFR § 300.309(b)). The determination of whether a child requires an extended school year and OT and/or PT during an extended school year is made on an individual basis.

18. What should a school district do if the child's parents present recommendations for OT, PT, or AT from an outside evaluator and ask the school district to pay for services or purchase technology, but the rest of the IEP team does not believe the recommended services/devices are needed?
The school district must develop an appropriate educational program for the child and must indicate in the child's IEP the nature and amount of services required by the child to receive a FAPE (free appropriate public education). The child's IEP must be developed at the meeting with the parents, school personnel, and others as needed. If the IEP team determines that the child requires OT, PT, or AT, the child's IEP must include a statement identifying the nature and amount of such services needed by that child (McEwen 2000).

The school district is not required to implement all the recommendations provided by the independent evaluator, but: "If the parent obtains an independent educational evaluation at private expense, the results of the evaluation must be considered by the public agency, if it meets agency criteria, in any decision made with respect to provision of FAPE to the child" (34 CFR § 300.502(c)(1).

If the IEP team can show, on an individual basis, by using IDEA Part B procedures for evaluation, IEP development, and placement, that the child does not require the recommended OT, PT, or AT to receive FAPE, then the district does not have to provide the requested service. However, the IEP team should document that it discussed the independent evaluator's report and recommendations. The IEP team should also document why the services recommended are not necessary to provide the child with FAPE (McEwen 2000).

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