Maryland State Steering Committee for Occupational and Physical Therapy School-Based Programs

Occupational and Physical Therapy Early Intervention and School-Based Services in Maryland

A guide to practice

Prepared in collaboration with the Maryland State Department of Education, Division of Special Education/Early Intervention Services

REVISED **June 2014**

Rationale

This document was developed by the members of the Practice Subcommittee of the Maryland State Steering Committee for Occupational and Physical Therapy School-Based Programs in cooperation with the Maryland State Department of Education's Division of Special Education/Early Intervention Services as a replacement of the 1999 Maryland Guidelines for Occupational Therapy and Physical Therapy Services in Public Schools. This document has been reviewed by the members of the Maryland State Steering Committee for Occupational and Physical Therapy School-Based Programs along with professionals knowledgeable in school-based practice and early intervention. The purpose of this document is to provide a resource to occupational therapists, physical therapists, and special education administrators in Maryland.

Occupational and Physical Therapy Practice Subcommittee Members

Sarah Burton, OT, MS, FAOTA Subcommittee Chair, Prince George's County Public Schools

Stephen Buckley, OT, MS, Frederick County Public Schools

Sue Cecere, PT, MHS, Prince George's County Public Schools

Sue Cobb, PT, Prince George's County Public Schools

Denise Figueiredo, OT, Queen Anne's County Public Schools

Elizabeth George, OT, Baltimore County Public Schools

Katie Kierstead, PT, MS, Garrett County Public Schools

Occupational and Physical Therapy Practice Subcommittee Members (continued)

Donna Lesch, PT, MA, Montgomery County Public Schools

Joyce Mastrilli, OT, MS, Cecil County Public Schools

Kristy Vandervalk, OT, Frederick County Public Schools

Jodie Williams, OT, MS, Anne Arundel County Public Schools

2014 Update

Updates to the Guide have been made to reflect changes in COMAR and technical assistance information that has occurred since publication in December of 2008 with the addition of new subcommittee members:

Karen Greeley, DSc, PT, Baltimore County

Mary Anne Leginus, PT, MEd, Prince George's County

Christine Novick, PT, MEd, Montgomery County

Debra Shatrowsky, OT, Calvert County

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Reviewers

Susan Effgen, PT, PhD, Professor and Director, Rehabilitation Sciences Doctoral Program, University of Kentucky

Walter Frazier, Retired Principal and Educator, Anne Arundel County Public Schools

Barbara Hanft, MA, OTR, FAOTA, Developmental Consultant, Maryland

Leslie Jackson, MEd, OT, Project Director TMICC Easter Seals, Washington DC and former Director and Legislative Liaison for AOTA

Anita Mandis, Education Program Specialist, Division of Special Education/Early Intervention Services, MSDE

Mary Jane Rapport, PT, PhD, Professor and Assistant Director of PT Program, University of Colorado at Denver and Health Sciences Center

Donna Riley, Policy and Resource Specialist, Division of Special Education/Early Intervention Services, Maryland State Department of Education

Fran Sorin, Coordinator, Professional Development , Division of Special Education/Early Intervention Services, Maryland State Department of Education

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Paul Dunford, Branch Chief, Programmatic Support and Technical Assistance Branch, Division of Special Education/Early Intervention Services, Maryland State Department of Education

Brian Morrison, Section Chief, Policy and Data, Division of Special Education/Early Intervention Services, Maryland State Department of Education

Karla Marty, Section Chief, Accommodations and Assessment, Division of Special Education/Early Intervention Services, Maryland State Department of Education

Tom Stengel, PT, former Section Chief, Division of Special Education/Early Intervention Services, Maryland State Department of Education

Members of the Maryland State Steering Committee for Occupational and Physical Therapy School-Based Programs

Maryland State Steering Committee for Occupational & Physical Therapy School-Based Programs
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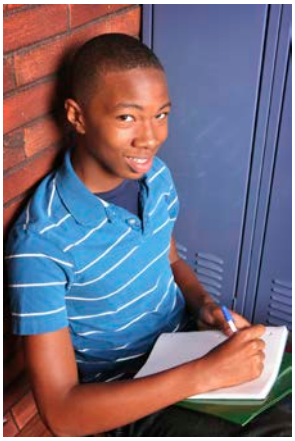

✓ KEY POINT

Those who work in Maryland public schools must be cognizant of the federal regulatory requirements [Individuals with Disabilities Education Improvement Act (IDEA), 20 U.S.C. §1400 et seq., implementing regulations at 34 CFR Part 300] and state regulatory requirements [Code of Maryland Regulations (COMAR) 13A.05.01], updated May 7, 2007, which govern their services in addition to the local school systems' and public agencies' policies and procedures that define the implementation of these services.

1.0 Introduction and Purpose

The purpose of this document is to provide school administrators and service providers with an understanding of the roles and responsibilities of occupational therapy (OT) and physical therapy (PT) in public schools and early intervention programs in Maryland. This is a working document of the Maryland State Steering Committee for OT/PT School-Based Programs (Practice Subcommittee). The Steering Committee provides a forum for OT/PT school-based and early intervention specialists and other stakeholders to meet and problem-solve regarding statewide issues in the assessment and implementation of OT/PT services in Maryland public schools and early intervention programs.

This document serves as a replacement to the Maryland Guidelines for Occupational Therapy and Physical Therapy Services in Public Schools (Occupational and Physical Therapy Five County Task Force, 1999). The first Guidelines were produced in 1990 by the Maryland Four County Task Force and supported by a Maryland State Department of Education (MSDE) grant. The first revision was in 1999. At that time, the Guidelines were reviewed by MSDE and distributed to the directors of special education throughout Maryland. The 1999 revision was also disseminated to occupational and physical therapists working in Maryland public schools at the October 1999 OT and PT School-Based State Conference. Since that time, the 1999 Guidelines have been made available to therapists, administrators, and other agencies upon request to the Five County Task Force.

This Guide was developed in accordance with federal and state laws to help school-based and early intervention teams make informed decisions that are also aligned with best practices related to OT and PT services (American Occupational Therapy

Association [AOTA], 2006a, 2006b; American Physical Therapy Association [APTA], 2003a, 2004). The sequence of the special education process was used to organize this document. In addition, this Guide was developed to enhance the clarity and consistency of implementation of OT and PT services throughout the state. Those who work in Maryland public schools must be cognizant of the federal regulatory requirements [Individuals with Disabilities Education Improvement Act (IDEA), 20 U.S.C. §1400 et seq., implementing regulations at 34 CFR Part 300] and state regulatory requirements [Code of Maryland Regulations (COMAR) 13A.05.01], updated May 7, 2007, which govern their services in addition to the local school systems' and public agencies' policies and procedures that define the implementation of these services.

2.0 Overview

The Individuals with Disabilities Education Improvement Act of 2004 (IDEA, 2004) is aligned with the Elementary and Secondary Education Act (ESEA) [20 U.S.C. §6301 et seq.], also known as the No Child Left Behind Act (NCLB, 2001). The purpose of IDEA 2004 is to ensure that children with disabilities have a free appropriate public education to meet their unique needs and prepare them for further education, employment, and independent living [IDEA 118 STAT.2651.SEC.601.(d)(1)(A)] [34 CFR §300.1.].

IDEA requires that as part of a comprehensive evaluation, a child is assessed in all areas related to the suspected disability, including if appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities which includes consideration of the need for OT and PT evaluation and services [34 CFR §300.304 (c)(4)].

The context in which therapy services are provided determines the focus, requirements, and expected outcomes. This Guide supports collaborative teaming, training, and an integrated service delivery approach. The roles of occupational therapists and physical therapists in school systems and early intervention programs support this approach as an avenue for ensuring that infants and toddlers receive early intervention services in the natural environment and that students receive special education instruction and related services in the least restrictive environment (LRE).

Section 504 of the Rehabilitation Act of 1973 is an anti-discrimination statute that protects both IDEA-eligible children and children who have disabilities but do not need special education services. A civil rights law, Section 504 ensures that

children with disabilities have equal access to education. Eligibility for Section 504 protections in schools is determined through a school team process. Any student thus identified or perceived as having a disability that substantially limits a major life activity, e.g., learning, caring for one's self, performing manual tasks, etc., is entitled to protection from exclusion from participation in, or denial of the benefits of district programs under Section 504. Section 504 procedures [34 CFR § 104.35(b)(1)-(3)] are similar to those set out in IDEA regulations [34 CFR § 300.532] (Gorn, 1998). Additional information on Section 504 can be found in Appendix C.

2.1 Occupational and Physical Therapy Practice Under IDEA and Section 504

Occupational and physical therapy are among the services that are available to children with disabilities under Parts B and C of IDEA 2004. Occupational and physical therapy practitioners, having skills and knowledge based on sound anatomical, physiological, and theoretical constructs, provide a unique service to children with disabilities and contribute specific expertise to the team responsible for meeting the child's educational or family service plan needs.

The IDEA Part B Code of Federal Regulations [34 CFR §300.34(c)(6)] defines occupational therapy as services provided by a qualified occupational therapist including:

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.

Additional information regarding Section 504 can be found at http://marylandlearninglinks.org/2771.

The IDEA Part C Code of Federal Regulations [34 CFR §303.13(b)(8)] defines occupational therapy as services to address the functional needs of an infant or toddler with a disability related to adaptive development, adaptive behavior, and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include:

Identification, assessment, and intervention;

Adaptation of the environment, and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and

Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

Physical therapy is defined as services provided by a qualified physical therapist [34 CFR §300.34(c)(9)] and [34 CFR §303.13(b)(9)].

Under **Part C**, services are provided through the Individualized Family Service Plan (IFSP) process. Therapy-related decisions for qualifying infants and toddlers are based on identified child and family outcomes. Therapists promote the child's awareness and interaction with the environment and the acquisition of motor skills and sensory processing abilities through intervention, parent coaching, support, and training. Therapists assist families in helping their children develop increased independence in mobility and activities of daily living, including play, and in preparation for entering school (MSDE, 2003).

Under **Part B**, services are provided through the Individualized Education Program (IEP) process. The IEP team determines the need for related services (related services is defined as

✓ KEY POINT

The effectiveness of OT and PT services is based on appropriate assessment and evaluation, measurable outcomes, and data-driven decisions. Following this best practice approach, young children and students with disabilities should have improved access and participation in their natural roles, routines, and environments.

transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education which includes physical and occupational therapy [34 CFR §300.34(a)]). During the development of a student's IEP, the IEP team identifies the professional expertise necessary for students to receive a free appropriate public education (FAPE) and make progress in the general education curriculum in the least restrictive environment. As appropriate, occupational and physical therapists may be part of the team that prepares students with disabilities for further education, employment, and independent living (LD Online, 2006).

Under **Section 504**, the school team develops a plan to support a general education student with a disability to ensure equal access to an appropriate education. The 504 Plan supports a student's accessibility in the general education setting through modifications and/or necessary accommodations. As part of the school team, occupational and physical therapists may contribute to this process, providing services as needed (Council of Educators for Students with Disabilities, 2003).

The profession of **occupational therapy** is built on the principle of affirming the importance of engaging in meaningful daily life activities or "occupations." Occupational therapists use their unique expertise to help infants and toddlers participate in appropriate activities in their natural environments and to help students benefit from special education instruction in order to make progress in the general education curriculum in the least restrictive environment. Occupational therapists work with children to improve performance for the completion of functional activities, help children to effectively engage in routine tasks and roles, and support families/caregivers/school staff with appropriate modifications or adaptations of materials and environments (AOTA, 2002, 2006a, 2006b).

✓ KEY POINT

The primary goal of OT and PT in public education is to enable children with disabilities to benefit from special education instruction in the least restrictive environment [34 CFR §300.34(a)]. This can be accomplished in multiple ways, including services to the child and on behalf of the child, such as support of the parent/teacher/caregiver and other team members working with the child.

The profession of **physical therapy** is built on the principle of preserving, developing, and promoting independent physical function. Physical therapists use their unique expertise to help infants and toddlers participate in appropriate activities in their natural environments and to help students benefit from special education instruction in order to make progress in the general education curriculum in the least restrictive environment. Physical therapists enable families/caregivers and school staff to further support the child's progress. Interventions, strategies, and adaptations focus on promoting functional mobility, positioning, and safe and efficient participation in daily activities and routines (APTA, 2003a, 2003b, 2004).

The effectiveness of OT and PT services is based on appropriate assessment and evaluation, measurable outcomes, and data-driven decisions. Following this best practice approach, young children and students with disabilities should have improved access and participation in their natural roles, routines, and environments.

2.2 Roles and Responsibilities of the Therapist

Occupational therapists and physical therapists have the professional and legal responsibility for providing early intervening services prior to referral for the IEP process (Section 4.1 of this document), conducting assessments that contribute to the comprehensive evaluation process, planning and implementing services, and documenting and monitoring the outcome of services provided. Therapists participate in and collaborate as part of a multidisciplinary team to properly identify and meet children's needs. Occupational and physical therapists can be one source for obtaining and interpreting medical information for families and staff and act as liaisons with the medical community, including suggesting referrals. In accordance with OT and PT practice, prior medical consultation may be necessary for the provision of some services. Therapists

are ethically bound not to provide services that are potentially harmful based on their professional judgment [COMAR 10.46.02.01; COMAR 10.38.03.02].

The primary goal of OT and PT in public education is to enable children with disabilities to benefit from early intervention services and special education instruction in the least restrictive environment [34 CFR §300.34(a)]. This can be accomplished in multiple ways, including services to the child and on behalf of the child, such as support of the parent/teacher/caregiver and other team members working with the child.

Occupational therapists, certified occupational therapy assistants (COTAs), physical therapists, and physical therapist assistants (PTAs) must have successfully completed an accredited program in their respective fields and must maintain specific licensure requirements, which include a specific number of continuing education credits per licensing cycle, in order to practice in the state of Maryland. COTAs and PTAs are legally authorized to carry out an established intervention program under the supervision of an occupational therapist or physical therapist, respectively. Specific requirements for supervision can be obtained from the licensure boards (Board of Occupational Therapy Practice, 2000; Board of Physical Therapy Examiners, n.d.). Services delivered by PTAs and COTAs satisfy the IEP service requirements provided this is specified in the IEP and would qualify for third party medical insurance reimbursement.

3.0 OT/PT for Infants and Toddlers (IDEA Part C)

Under Part C, occupational and physical therapy are a part of early intervention services provided to meet the developmental needs of Infants and Toddlers (Hanft, n.d.).

3.1 Screening

In early intervention, evaluation and assessment should not be confused with the process of screening. Screening includes procedures or activities to identify children who may need further evaluation in order to determine the existence of a delay in development or a particular disability. Screening involves the administration of appropriate instruments (reliable, valid, and designed for the purpose of screening) by qualified personnel in order to determine whether further comprehensive evaluation is warranted. In Maryland, numerous community partners may provide developmental screening including pediatricians, early childhood mental health consultants, early intervention, and Head Start staff. These screenings are provided prior to a referral to early intervention. If concerns are noted, this developmental screening may be the trigger for a referral to the Maryland Infants and Toddlers Program.

The 2011 revised federal regulations allow Local Infants and Toddlers Programs (LITPs) to implement optional screening policies and procedures as part of the evaluation process [34 CFR §303.320]. LITPs who choose to implement screening practices may elect to screen some or all children after referral. If the LITP elects to screen and concerns arise, an eligibility assessment must be completed and an Individual Family Service Plan (IFSP) must be developed.

Parent permission must be obtained before the LITP can screen a child [COMAR 13A.13.01.04.B(2)(c); 34 CFR §303.320(a)(1)(ii)]. In addition, parents may request a full evaluation and assessment at any time during the screening process, even if the results of the screening indicate no suspicion of a disability [COMAR 13A.13.01.04.B(5); 34 CFR §303.320(a)]. It is important to note that screening does not extend the 45-day timeline. If the results of the screening indicate that the child is suspected of having a disability or if a parent of a child who has passed his/her screening still requests a full evaluation and assessment, the evaluation, assessment, and initial IFSP must all be completed within 45 days of the referral [COMAR 13A.13.01.04.B(6); 34 CFR §303.310(a)].

3.2 Eligibility Evaluation

"Evaluation" under Part C means the procedure used by appropriate qualified personnel, which may include OT and/or PT as determined by the local agency, to determine a child's initial and continuing Infants and Toddlers Program eligibility. In conducting an evaluation, no single procedure may be used as the sole criterion for determining a child's eligibility. Eligibility can be based on the use of standardized criterion- and/or norm-referenced tests that are appropriate to the chronological age, developmental and/or functional level of the child, record review, parental interview, informed clinical opinion and/or observation indicating one of the following:

- A 25 percent delay, as measured and verified by appropriate diagnostic instruments and procedures, in one or more of the following developmental areas:
    - Cognitive development,
    - Physical development, including vision and hearing,
    - Communication development,

- Social or emotional development, and/or
- Adaptive development [COMAR 13A.13.01.03B(12)(a)

- Atypical development in any area:
  - Manifest atypical development or behavior, which is demonstrated by abnormal quality of performance and function in one or more of the above specified developmental areas or, interferes with current development, and is likely to result in subsequent delays (even when diagnostic instruments or procedures do not document a 25 percent delay) [COMAR 13A.13.01.03B(12)(b); or
- A diagnosed physical or mental condition that has a high probability of resulting in developmental delay, with examples of these conditions including chromosomal abnormalities, genetic or congenital disorders, severe sensory impairments, inborn errors of the nervous system, congenital infections, disorders secondary to exposure to toxic substances, including fetal alcohol syndrome, and severe attachment disorders [COMAR 13A.13.01.03B(12)(c).

3.3 Assessment

Assessment under Part C means the ongoing procedures used by appropriate qualified personnel throughout the period of a child's eligibility. Therapists, as part of a multidisciplinary team, assess the child's unique strengths and needs and develop a plan with families to address their priorities and concerns related to fostering the development and participation of the child in family and community life. This may include identifying the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.

In addition to data collected in the evaluation process, assessment in preparation for Individualized Family Service Plan

✓ KEY POINT

Child-based outcomes are expressed as functional skills for each child and are determined by the priorities of the family with input from the team members. The IFSP must also include family outcomes, which address the specific needs identified by the family in relationship to caring for the child.

(IFSP) development and/or modification may also include data from:

- Observations in natural environments,
- The identification of the child's needs in each of the developmental areas,
- Family-directed assessment of concerns, priorities, and resources based on an assessment tool and interviews with parents, caregivers, and other family members who elect to participate, [COMAR 13A.13.01.05F(1)(b).
- Reviews of medical and other reports, and
- Response to interventions and/or strategies

3.4 IFSP Development

The Individualized Family Service Plan (IFSP) is a document used to summarize the eligibility, assessment, and intervention plan for the eligible child and the child's family. It is based on the multidisciplinary evaluation and assessment of the child, in the context of the child's family, and focuses on the family's priorities, resources, and concerns [COMAR 13A.13.01.08].

Child-based outcomes are expressed as functional skills for each child and are determined by the priorities of the family with input from the team members. The IFSP must also include family outcomes, which address the specific needs identified by the family in relationship to caring for the child. Families and other team members collaboratively develop measurable criteria and strategies to address each outcome. The team then determines if the expertise of an OT and/or PT is needed to implement the plan.

For additional details regarding the evaluation, eligibility and IFSP development processes and procedures refer to: https://www.onlineiep.com/MD_IFSP/Help/Documents/IFSP_Manual.pdf, and

https://www.onlineiep.com/MD_IFSP/Help/Documents/IFSP_Directions.pdf

3.5 OT and PT Services Under Part C

The purpose of OT/PT service is to provide early intervention supports and services to young children and their families. Therapists assist families in promoting their children's physical, cognitive, communication, social/emotional, and adaptive development and participation in family/community life. The IFSP team considers the strengths and needs of the child and the priorities of the family in relationship to the child's ability to participate in natural environments, or in places where children without disabilities and their families spend their time, including home, school, daycare, and/or the community. Supports and services are activity-focused, providing the parent/caregivers with information and practical strategies they can incorporate into daily interactions and routines, which will foster their child's development and promote participation in typical activities for same-age peers. Under Part C, occupational and physical therapists can be the sole service provider for a given child and family. Occupational and physical therapists are members of the multidisciplinary team and participate in decision-making and planning about the child/family needs and how to appropriately meet those needs. They may also function as service coordinators.

Supportive services for the family should focus on:

- Assisting families to make informed decisions that will promote their child's development.
- Helping the IFSP team develop meaningful, functional, and practical outcomes.
- Identifying, with input from all team members, interventions and strategies that help the child and family achieve specific outcomes.

- Helping families to identify the natural environments in which they wish to see their children participate, and providing supports and services to promote this participation.
- Coaching and educating parents on how to care for their child and help their child achieve specific outcomes by understanding how the child participates in daily activities.
- Providing culturally competent intervention to the key adult caregivers who interact with the child in a variety of family-selected natural environments (i.e., a childcare setting).
- Ensuring ongoing, frequent assessment of the effectiveness of therapy interventions toward achieving desired outcomes within a specified period (Hanft & Pilkington, 2000) and participating in the Child Outcomes Summary (COS) process, as appropriate.
- Providing specific professional expertise to enhance the child's participation in the following areas:
    - Sensory motor processing
    - Visual motor skills
    - Self-help skills
    - Foundational fine and gross motor skills
    - Mobility skills
    - Posture and positioning
    - Recreational skills for age-appropriate play
- Providing professional expertise for:
    - Identifying the need for adaptive equipment
    - Identifying the need for assistive technology
    - Planning for Part C to Part B Transition

Refer to Section 3.6: OT/PT Early Intervention Standards of

✓ KEY POINT

Discontinuing the services of an OT or PT is appropriate when the expertise of an OT and/or PT is no longer required to implement the IFSP. An IFSP meeting with signed parental permission is necessary before making any changes to an IFSP. The parents have the right to accept or reject any individual service.

Practice in Compliance With IDEA, Part C, for additional information. Methodology may include a variety of therapeutic approaches. However, strategies must address the specific outcomes identified on the IFSP and should easily be implemented by families as part of their daily routines.

Discontinuing the services of an OT or PT is appropriate when the expertise of an OT and/or PT is no longer required to implement the IFSP. An IFSP meeting with signed parental permission is necessary before making any changes to an IFSP. The parents have the right to accept or reject any individual service.

For additional details regarding the evaluation, eligibility and IFSP development processes and procedures refer to:

https://www.onlineiep.com/MD_IFSP/Help/Documents/IFSP_Manual.pdf

https://www.onlineiep.com/MD_IFSP/Help/Documents/IFSP_ Directions.pdf

3.6 OT/PT Early Intervention Standards of Practice in Compliance With IDEA, Part C

The purpose of OT and PT services is to support child and family outcomes in the child's natural environment. Both OT and PT professional organizations recommend using a discipline-free model for outcomes; however, certain areas of concern are typically identified with specific disciplines. Through IFSP team discussion, the service provider is determined based on who has the necessary expertise to address the area(s) of concern. Services are provided according to IDEA, COMAR, the AOTA Practice Framework, and the Guide to Physical Therapy Practice. In certain circumstances, medical clearance may be needed for some strategies and/or interventions.

✓ KEY POINT

In certain circumstances, medical clearance may be needed for some strategies and/or interventions.

OT/PT Early Intervention Standards of Practice in Compliance With IDEA, Part C

I. Positioning/Posture (OT & PT)

Outcome	Barrier	Standard of Practice
Ability to participate in activities and/or routines as determined by family through appropriate positioning	Delayed skills and/or physical limitations Environmental barriers	**Assess** for adaptive equipment and make appropriate recommendations **Train** families on safe physical management of the child and appropriate equipment use **Assess** for environmental modifications or accommodations and make recommendations **Communicate** positioning strategies with family or caregivers **Communicate and coordinate** with outside medical providers and vendors **Direct intervention** to the extent that the child has the ability to make progress

II. Mobility (PT)

Outcome	Barrier	Standard of Practice
Ability to negotiate environments as determined by the family through the development of mobility skills	Delayed skills and/or physical limitations Environmental barriers	**Assess** functional mobility in multiple natural environments, inclusive of potential future placements **Determine need** for adaptive equipment, if appropriate **Direct intervention** to develop mobility skills to the extent possible **Train** family and other key caregivers

III. Foundational Gross Motor Skills (PT/OT)

Outcome	Barrier	Standard of Practice
Ability to participate in age-appropriate activities and routines as determined by family	Delayed skills and/or physical limitations	**Assess** for adaptive equipment and make appropriate recommendations **Train** families or caregivers in strategies, accommodations, or modifications **Direct intervention** (individual or group) to the extent that the child has the ability to make progress

IV. Foundational Fine Motor Skills (OT/PT)

Outcome	Barrier	Standard of Practice
Ability to participate in age-appropriate activities and routines as determined by family	Delayed skills and/or physical limitations	**Assess** for adaptive equipment and make appropriate recommendations **Train** families or caregivers in strategies, accommodations, or modifications for functional hand skills **Direct intervention** (individual or group) to the extent that the child has the ability to make progress

V. Self-Care (OT/PT)

Outcome	Barrier	Standard of Practice
Ability to participate in meal time, dressing and/or personal care activities	Delayed skills and/or physical limitations Environmental barriers	**Task analyze** routines and activities to develop strategies and modifications **Train** parents/caregivers **Direct intervention** to develop skills necessary to complete the task to the extent that the child has the ability to make progress

VI. Self-Management (OT/PT)

Outcome	Barrier	Standard of Practice
Ability to engage in age-appropriate play	Delayed skills and/or physical limitations Delayed motor planning and/or behavioral skills Environmental barriers	**Participate** with IFSP team to assess the interfering behaviors and develop intervention plans **Direct intervention** to develop necessary skills **Train** parents/caregivers

VII. Assistive Technology (OT/PT)

Outcome	Barrier	Standard of Practice
Ability to participate in family activities and routines through the use of assistive technology devices	Delayed skills and/or physical limitations Environmental barriers	**Participate** in team assessment process to include the child, environment, task, and tools (SETT) **Participate** in the recommendation of equipment for trial or acquisition **Train** child and family in use of adaptive equipment to access environment **Help** families coordinate with outside providers and vendors

VIII. Oral Motor/Feeding (OT)		
Outcome	**Barrier**	**Standard of Practice**
Ability to participate in mealtime and self-feeding activities as determined by the family	Delayed oral motor skills and/or physical limitations Intolerance or lack of awareness of various textures and consistencies Environmental barriers	**Participate** in the evaluation process to identify oral motor factors impacting the ability to manage secretions, food, and liquid intake **Recommend** to the IFSP team the need for additional medical tests or information beyond our scope of practice/expertise **Participate** in the development of a safe feeding plan **Direct intervention** to develop oral motor skills for feeding to the extent possible **Train** parents/caregivers in the implementation of strategies and techniques involved in the safe feeding plan

IX. Sensory (OT)		
Outcome	**Barrier**	**Standard of Practice**
Ability to interact or engage with family and peers within different environments as determined by the family	Delayed skills and/or physical limitations Inappropriate response to sensory information Environmental barrier	**Assess** child's response to sensory stimuli in the environment, the task, and social interactions, and the impact of that response on behaviors **Participate** in the development of appropriate strategies/environmental modifications that can be incorporated into the child's daily schedule **Provide training** to child, parents, and caregivers **Direct intervention** to support the development of adaptive responses and/or use of strategies within the natural environment

3.7 Transition From Early Intervention (Part C) to Preschool Services (Part B)

No later than 90 days and not more than nine months before a child's third (3rd) birthday (when a child is between the ages of 27 and 33 months), the early intervention program must hold a transition planning meeting (TPM) to discuss options for services when the child turns three. The local school system must participate in the meeting unless the family does not want to consider participation in preschool (Part B). With written parental consent as necessary, Part C therapists provide copies of existing information to the local school system representative and any other representatives from community services who may be present and considered appropriate. During the TPM, the following may occur:

- A review of progress toward achieving the transition outcomes on the IFSP identified when a child reaches age 2 or enters early intervention after age 2.
- A revision and/or update of transition outcomes, as needed.
- The development of a transition plan as part of the child's IFSP.
- Documentation of additions and/or revisions to the IFSP, as appropriate.
- Consideration of other community-based services, such as private/parochial preschool and/or daycare for all children who have been identified with a disability unless the parent does not want to consider these services.

Unless the family does not want to consider participation in Part B, a local school system must convene an IEP team meeting to determine eligibility for Part B.

- The IEP team reviews existing information provided by the Infants and Toddlers Program and any other sources and

✓ KEY POINT

Regardless of whether a child is transitioning to a Part B (preschool) or other community program, the input from the early intervention program occupational and/or physical therapist is important in the decision-making process.

determines if additional information is needed. Part B is responsible for completing any additional assessments (formal and informal).

- The need for additional assessments must be based on the child's needs as necessary to ensure a comprehensive evaluation for the determination of eligibility and services. Assessments selected should be based on the unique needs of the child.
- The local school system convenes the IEP meeting with the family and other required participants. The local Infants and Toddlers Program must be invited to participate. Parents must be afforded all Part B parental rights and procedural safeguards.
- The child with a 25 percent delay in one or more areas of development, as measured and verified by appropriate diagnostic instruments and procedures, may qualify as a student with a disability under the category of Developmental Delay (at the discretion of the local school system and through age 7). Children identified as having a diagnosed physical or mental condition that has a high probability of resulting in developmental delay or with atypical development may also qualify for the Developmental Delay code [COMAR 13A.05.01.03B(77)].
- All decisions in the IEP team meeting are documented on the IEP and notes, or other documents according to local procedures.

If a child is currently enrolled in a local Infants and Toddlers Program and are found eligible for preschool special education and related services, families have the choice to continue services through an IFSP or move to an IEP.

Regardless of whether a child is transitioning to an IEP or continuing on an IFSP until the beginning of the school year

following the child's fourth birthday [COMAR 13A.13.01.03B(28)(b)], the input from the early intervention program occupational and/or physical therapist is important in the decision-making process. Although legal requirements relating to transition do not address collaboration between therapists from the sending and receiving agencies, best practice studies in this area have identified collaboration, consideration of current IFSP and team support as positively contributing to the transition process. "Specific practices may take place between personnel at different agencies, such as sharing the child's information between sending and receiving programs [and] providers..." (Myers & Effgen, 2006).

When a child is found eligible for preschool special education and related services and the family chooses to begin services through an IEP, the IEP team meets to develop the IEP. IDEA 2004 requires that the IEP team consider the IFSP when developing a child's IEP. The IEP must be in place by the child's third birthday. When an eligible child over the age of 3, is continuing services through an IFSP, the IFSP must include an educational component that promotes school readiness and incorporates preliteracy, language, and numeracy skills.

The delivery of specialized instruction for the educational component is not limited to any particular professional or provider. A special educator may provide consultation and support to other IFSP team members regarding strategies for addressing the educational component within a variety of settings, including skill specific therapy sessions, in order to maximize opportunities for learning and foster generalization of readiness skills across environments and activities. A physical therapist, for example, can address numeracy as part of an activity such as alternating feet for going up steps by counting each step with the child. This approach emphasizes integration of knowledge and skills across domains and supports progress towards functional outcomes for each child.

4.0 OT/PT for Ages 3–21 (IDEA Part B)

Under Part B, occupational and physical therapy are considered related services, defined in federal law as "... such developmental, corrective, and other supportive services (including...physical and occupational therapy...) as may be required to assist a child with a disability to benefit from special education, and includes the early identification and assessment of disabling conditions in children" [34 CFR §300.34]

4.1 Early Intervening Services

Early intervening services are for the purpose of supporting students (K-12) who have not been identified as needing special education or related services, but who may need additional academic and/or behavioral support to succeed in the general education environment [USC §1413(f): 34 CFR § 300.226(a)]. The intent of early intervening services is to provide research- or evidence-based academic or behavioral interventions that may reduce the number of inappropriate or unnecessary referrals for special education. The school team must use specific, carefully-defined data collection to document responsiveness to these interventions. The data collected can be used to assist in the determination of whether referral to special education is warranted.

School-based teams may consult with occupational and physical therapists regarding suggested strategies for teams and students. This may include providing professional development for teachers, and/or participating in curriculum committees and in team brainstorming of strategies/techniques that might improve instructional outcomes (AOTA, 2007).

4.2 Evaluation

An evaluation is a comprehensive process conducted by the Individualized Education Program (IEP) team. Evaluation means procedures used in accordance with 34 CFR §§ 300.301-.311 to determine whether a child has a disability and the nature and extent of the special education and related services that the child needs. Evaluation includes the review of information from parents, existing data, and the results of assessment procedures used. This review shall occur at a meeting of the IEP team [COMAR 13A.05.01.06].

In interpreting evaluation data for the purpose of determining if a child is a child with a disability as defined in 34 CFR §300.8, and the educational needs of the child, each public agency must:

- Draw upon information from a variety of sources, including aptitude and achievement tests, parent input, teacher recommendations, as well as information about the child's physical condition, social or cultural background, and adaptive behavior; and
- Ensure that information obtained from all of these sources is documented and carefully considered.

The process of evaluation requires a synthesis of all available assessment information. The student's parents are an integral part of the evaluation process, including providing information about the student. Parents are members of the IEP team meeting held for the purpose of determining the educational needs of the student, including whether the team needs to conduct assessments in order to complete a comprehensive evaluation.

In completing assessments as a part of the evaluation process public agencies must ensure:

- *Nondiscrimination*: Testing and assessment materials and procedures used to assess a student's need for special

education and related services are selected and administered in a manner that is not racially or culturally discriminatory.

- *Assessment materials:*
    - Assessment and other evaluation materials used to assess a child are administered in the child's native language or other mode of communication and in a form most likely to yield accurate information regarding the child's academic achievement and functional performance; and
    - Assessment and other evaluation materials must be used for the purposes for which they are valid and reliable,
        - Must be administered in accordance with any instructions provided by the producer of the assessment, and
        - Are selected and administered so as best to ensure that if an assessment is administered to a child with impaired sensory, manual, or speaking skills, the results accurately reflect the child's aptitude or achievement level or whatever other factors the test purports to measure, rather than reflecting the child's impaired sensory, manual, or speaking skills (unless those skills are the factors that are to be measured).
- *Assessment Procedures:*
    - Administration of assessment and other evaluation materials is conducted by trained and knowledgeable personnel.
    - A student shall be assessed in all areas related to the suspected disability as appropriate, including:

- Academic performance;
- Communication;
- General intelligence;
- Health;
- Hearing;
- Motor abilities;
- Social, emotional, and behavioral status; and
- Vision.

- A variety of assessment tools and strategies shall be used to gather relevant functional, cognitive, developmental, behavioral, and physical information that directly assists the IEP team in enabling the student to be involved in and progress in the general curriculum.
- Technically sound instruments shall be used to assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors.
- Assessments and other evaluation materials include those tailored to assess specific areas of educational need and not merely those that are designed to provide a single general intelligence quotient [34 CFR §300.304].

The evaluation/re-evaluation under IDEA should include data on academic progress/achievement, as well as developmental and functional information, and be administered in such a way to yield accurate functional, developmental, and academic information about the student [34 CFR §300.304]. This is information on "what the child knows and can do academically, developmentally, and functionally." The evaluation/re-

✓ KEY POINT

In Part B, the IEP team, which includes the parents and the student (as appropriate), identifies the areas of concern, barriers, and supports necessary to achieve the functional outcomes needed to facilitate participation in the general education curriculum or, for preschool children, participation in age-appropriate activities; whereas in Part C, the IFSP team, which includes the parents and family, determines the functional outcomes selected for the child.

evaluation should assist in the determination of whether a child needs or continues to need special education and related services [34 CFR § 300.305].

For occupational and physical therapists, assessment may include:

- Observations in natural learning environments
- Ecological inventories and checklists
- Data from the following:
    - Interviews with teachers, parents, student, and other team members
    - Record reviews
    - Early intervening service outcomes
    - Work samples
    - Student performance of specific tasks, roles, and routines
    - Responses to educational or therapeutic interventions
- Standardized criterion- and/or norm-referenced tests that are appropriate, given the student's chronological age, educational and/or functional level

As outlined by the AOTA and APTA, best practice regarding school-based evaluation supports a top-down approach while ensuring alignment with federal and state laws. A top-down approach to evaluation and assessment examines the interrelationship between a child's performance and participation (Goldstein, Cohn, & Coster, 2004) in all natural learning environments. "A child's [need] is not defined by his/her deficits, but rather by the extent of his/her engagement in meaningful activities despite the limitation imposed by the disability" (Goldstein et al, p.115). Both the AOTA Practice

✓ KEY POINT

Both of these transfer situations require action as soon as possible and within the guidelines of the local school system or public agency.

Framework and the APTA Guide to Physical Therapist Practice promote use of the International Classification Framework (ICF), an enablement model, when developing strategies and interventions to achieve functional outcomes through a task-oriented approach, with the overall goal being enhanced participation in life's roles (World Health Organization, 2001). In Part B, the IEP team, which includes the parents and the student (as appropriate), identifies the areas of concern, barriers, and supports necessary to achieve the functional outcomes needed to facilitate participation in the general education curriculum or, for preschool children, participation in age-appropriate activities; whereas in Part C, the IFSP team, which includes the parents and family, determines the functional outcomes selected for the child.

Outside assessments and/or recommendations from medical facilities or private practices must be reviewed and considered by the IEP team; however, because they were completed in a clinical setting, the relevance of the results to student performance in the educational environment needs to be determined. It may be the responsibility of the OT or PT to interpret for the IEP team and parents the results of these outside assessments and their relationship to the student's ability to access and participate in general education curriculum.

Additional information regarding eligibility and determination of specific learning disabilities can be found in Code of Maryland Regulations (COMAR 13A.05.01.06). A link can be found on http://www.marylandpublicschools.org/MSDE/divisions/earlyinterv/Special_Ed_Info.htm?WBCMODE=Pr%25%25%253e%25

4.3 Transferring Students

If a student with a disability transfers to a new district in the same state, comparable services must be provided until the student's former IEP is adopted or the student's IEP is revised.

For students with a disability transferring from out of state, the receiving local school system or public agency must provide comparable services until such time as the local school system adopts the IEP or conducts an evaluation and/or revises the IEP. Both of these transfer situations require action as soon as possible and within the guidelines of the local school system or public agency.

4.4 OT/PT Contribution to IEP Development

Occupational and physical therapists, as appropriate, contribute to the development of an IEP for a student found eligible for special education. The OT/PT assessment findings are considered with other assessment data in order to determine present levels of academic achievement and functional performance that:

- Include strengths, weaknesses, and educational impact relative to academic achievement and functional performance which:
    - Can be identified through the evaluation/re-evaluation process.
    - May include response to intervention as it relates to the student's progress.
- Establish educationally relevant needs that are addressed through IEP team-established goals and objectives, supplementary aids and services, and/or accommodations/modifications.

Goals/objectives are developed by the IEP team, including the parents and students as appropriate, and should:

- Be based on the child's needs that result from his or her disability to enable the child to be involved in and make progress in achieving the performance standards in the Maryland College and Career- Ready Standards (CCRS)

- Support access to, participation and progress in the general curriculum.
- Enable the student to benefit from his/her educational program.
- Be tied to school-based activities and routines and be as discipline-free as possible.
- Be stated in measurable, observable terms, include criteria for evaluation, and be achievable within an IEP period.
- Address barriers that arise as a result of the child's disability, impacting educational progress, and that are amenable to change.
    - Impairments related to diagnoses may not be amenable to change.
    - Performance deficits may need to be addressed through supplementary aids and services.
- Avoid naming specific methodology and/or specific brands of equipment/materials.
- Address transition needs starting by age 14 or younger if determined to be appropriate.

4.5 Identifying the Need for OT and/or PT as a Related Service

Once the IEP team agrees on the present levels of the student's performance and IEP goals/objectives, the team then determines whether the unique expertise of an OT or PT is required for the student to be able to access, participate, and progress in the learning environment in preparation for success in his/her postsecondary life. Based on the individual needs of the student, the present levels of performance, goals and objectives, the IEP team with recommendations from the OT or PT team member(s) determines necessary related services. The following should be considered by the therapist when making recommendations:

- Supplementary aids, services, program modifications, and supports that require the expertise of the occupational or physical therapist
- The performance skills to be addressed
- The availability of others to implement the student's program (Iowa Department of Education, 2001)
- The level of expertise required to provide the services to a student and on behalf of a student

Examples of OT/PT Services on Behalf of Students

Educating and training other team members

- Explaining the potential impact of developmental, medical, and/or sensory motor problems on school performance
- Helping set realistic expectations for student performance in school
- Developing, demonstrating, training, and monitoring the effectiveness of strategies and intervention activities carried out by school personnel
- Instructing in skills for physical management of student
- Instructing in use and care of adapted and assistive devices
- Collaborating with school teams to support age-related and instructional-related transitions of children/students birth through 21
- Collaborating to develop the transition plan for students 14 and over
- Supporting the safe transportation of students
- Assisting with establishment of emergency evacuation plans for students
- Participating in IEP and other team meetings

✓ KEY POINT

Only after completion of the preceding steps does the IEP team in concert with the occupational and/or physical therapist specify on the IEP the nature, location, number and frequency of therapy sessions, including start and end dates of the OT/PT service and the least restrictive environment in which goals can be accomplished.

- "A member of the IEP team shall not be required to attend an IEP meeting, in whole or in part, if the parent of a child with a disability and the [local school system] agree that the attendance of such member is not necessary because the member's area of the curriculum or related services is not being modified or discussed at the meeting" [34 CFR §300.321(e)(1)].
- A member of the IEP team may be excused from attending the IEP meeting, in whole or part, when the meeting involves a modification to or discussion of the member's area of the curriculum or related services if:
  - The parent in writing and local school system consent to the excusal; and
  - The member submits in writing to the parent and IEP team input into the development of the IEP prior to the meeting [34 CFR §300.321(e)(2)].

Modifications to environment and curriculum

- Collaborating with IEP team(s) to develop modifications and/or accommodations to school activities and school environments
- Consulting with appropriate local school system personnel regarding building modifications for safety and accessibility
- Adapting equipment or materials for school use
- Evaluating postsecondary environments/activities as part of the transition process

Equipment and technology

- Participating with the IEP team in the consideration process in determining the appropriateness of assistive technology

and/or equipment for access and participation in the general curriculum

- Assisting families in equipment and technology decisions for use in the home and community
- Communication with medical professionals, local agencies, and vendors

More information about appropriate assistive technology can be found at http://marylandlearninglinks.org/955

Examples of OT/PT Services Provided to Students

- Implementing interventions and strategies to support a student's learning and participation in educational activities, routines, and environments when OT/PT expertise is required
- Exploring, recommending, developing and/or implementing student strategies and modifications to support access, participation and progress in the general curriculum and success in postsecondary settings. This may include:
    - Individualized seating, positioning or mobility equipment.
    - Exploring individualized modifications/ adaptations to school activities, routines, and environment to increase access, participation, and progress.
    - Training of school personnel in specific handling, self-care management or equipment use.
- Monitoring the effectiveness of the above and making changes to strategies and interventions based on data collection (Muhlenhaupt, 2003a)

Only after completion of the preceding steps does the IEP team in concert with the occupational and/or physical therapist

specify on the IEP the nature, location, number and frequency of therapy sessions, including start and end dates of the OT/PT service and the natural/least restrictive environments in which goals can be accomplished.

4.6 Best Practice in School-Based OT/PT

"Evidence-based practice is the use of the best available evidence, in conjunction with professional judgment and reasoning, to determine the most appropriate intervention for a given [student], given the outcomes to be achieved" (Jackson, 2005). Intervention must be based on peer-reviewed research to the extent practical and refer to instructionally-based practice (APTA, n.d.; IDEA, 2004).

Interventions:

- Are targeted toward individuals, groups, environmental factors, and programmatic needs.
- Require consultation, collaboration, and teamwork as essential components for effective implementation.
- Are provided in natural settings (such as schools, preschools, etc.) during daily routines and activities.
- Require the use of methodologies based on curriculum content and classroom materials that are most likely to achieve maximum contextual integration and replication.

Interventions are provided by related service providers to:

- Help children and youth develop appropriate skills to succeed in school, at home, in the community and contribute to successful postsecondary transitions.
- Help teachers meet their goals (e.g., effective classroom management, increased student achievement).
- Help schools meet their goals (e.g., safe learning environments, increased student achievement).

4.7 OT/PT School-Based Standards of Practice in Compliance With IDEA, Part B

OT and/or PT services provide support for access, participation, and progress in the student's educational program. Both OT and PT professional organizations recommend a discipline-free model for goals and objectives; however, certain areas of concern are typically identified with specific disciplines. Through IEP team discussion, the service provider is determined based on who has the necessary expertise to address the area(s) of concern. Services are provided according to IDEA, COMAR, the AOTA Occupational Therapy Practice Framework and the APTA Guide to Physical Therapist Practice. In certain circumstances, medical clearance may be needed for some strategies and/or interventions.

✓ KEY POINT

In certain circumstances, medical clearance may be needed for some strategies and/or interventions.

OT/PT School-Based Standards of Practice in Compliance With IDEA, Part B

I. Positioning/Posture (OT/PT)

Outcome	Barrier	Standard of Practice
Positioning necessary to attend to instruction and participate in all educational settings and routines	Delayed skills and/or physical limitations Environmental barriers	**Assess** for adaptive equipment and make appropriate recommendations **Train** classroom support personnel for safe physical management of the student and appropriate equipment use **Assess** for environmental modifications or accommodations and make recommendations **Communicate** positioning strategies with family or caregivers **Communicate and coordinate** with outside medical providers and vendors **Direct intervention** to the extent that the student has the ability to make progress

II. Balance (PT)

Outcome	Barrier	Standard of Practice
Development of static and dynamic balance to safely participate in educational activities as independently as possible	Delayed skills and/or physical limitations Environmental barriers	**Assess** balance deficits as they interfere with classroom instruction, self-care, and environmental mobility in all learning environments **Create** accommodations and modifications as necessary to support a safe environment for the student **Direct intervention** to the extent that the student has the ability to make progress **Educate** school staff with regard to inclusion and safety implications

III. Mobility (PT)

Outcome	Barrier	Standard of Practice
Development of: Safe ambulation and transfer skills Speed and endurance to keep pace with peers Wheelchair skills Environmental negotiation skills to include stairs, uneven terrain, curbs, and ramps	Delayed skills and/or physical limitations Environmental barriers Cognitive, behavioral, and attention issues that impact safety	**Assess** functional mobility in multiple learning environments, inclusive of potential postsecondary placements **Determine** need for adaptive equipment, if appropriate **Direct intervention** to develop mobility skills to the extent possible **Develop** home program and train student and/or family **Train** school support staff, including developing schedules for mobility skill practice

IV. Foundational Gross Motor Skills (PT/OT)

Outcome	Barrier	Standard of Practice
Ability to participate in a preschool motor group or physical education class with same-age peers	Delayed skills and/or physical limitations Environmental barriers and/or task demands	**Provide** strategies to PE teacher to include students **Direct intervention** (individual or group) to the extent that the student has the ability to make progress

V. Foundational Fine Motor Skills (OT/PT)

Outcome	Barrier	Standard of Practice
Ability to participate in age-appropriate fine motor activities that may include pre-readiness hand skills, management of classroom tools and manipulatives, and prevocational skills	Delayed skills and/or physical limitations Environmental barriers and/or task demands Intolerance to the sensory aspects of activities	**Assess, recommend, and acquire** adaptive equipment and make appropriate recommendations **Training** of school teams in strategies, accommodations, or modifications for functional hand skills **Communicate** strategies with family or caregivers **Direct intervention** (individual or group) to the extent that the student has the ability to make progress

VI. Self-Care (OT/PT)

Outcome	Barrier	Standard of Practice
Functional independence in the areas of meal time, dressing, and bathrooming within the learning environment	Delayed skills and/or physical limitations Environmental barriers and/or task demands Intolerance to the sensory aspects of activities	**Task analyze** routines and activities to develop strategies and modifications **Assess, recommend, and acquire** adaptive equipment as needed **Train** support personnel and parents/caregivers **Direct intervention** to develop skills necessary to complete the task

VII. Self-Management in the Learning Environment (OT/PT)

Outcome	Barrier	Standard of Practice
Facilitation of: - organizational skills or strategies to manage classroom materials, personal space, and belongings - appropriate work behaviors and coping strategies - skills to transition between activities and/or carry out daily school routines	Delayed skills and/or physical limitations Cognitive, behavioral, and attention issues Environmental barriers and/or task demands Intolerance to the sensory aspects of activities	**Participate** with school team to assess the purpose of the interfering behaviors and develop intervention plans **Task analyze** routines and activities relative to all learning environments to develop strategies and modifications **Direct intervention** to develop necessary skills **Train** staff and parents/caregivers **Work** with student to develop self-advocacy skills

VIII. Assistive Technology (OT/PT)

Outcome	Barrier	Standard of Practice
Utilization of assistive technology devices to access, participate in, or progress across learning environments	Delayed skills and/or physical limitations Cognitive, behavioral, and attention issues Environmental barriers and/or task demands Intolerance to the sensory aspects of activities	**Participation** in the team assessment process to include the student, environment, task, and tools (SETT) **Participate** in the recommendation of assistive devices for trial or acquisition **Provide** training to student and staff in use of appropriate technology to access instruction or environment **Communicate** strategies with family or caregivers **Communicate** and coordinate with outside providers and vendors

IX. Oral Motor/Feeding (OT)

Outcome	Barrier	Standard of Practice
Development of appropriate mealtime skills and behaviors	Delayed oral motor skills and/or physical limitations Cognitive, behavioral, and attention issues Environmental barriers and/or task demands Intolerance to the sensory or environmental aspects of mealtime Intolerance or lack of awareness of various textures and consistencies	**Participate** in the evaluation process to identify oral motor factors impacting the ability to manage secretions, food, and liquid intake. **Recommend** to the IEP team the need for additional medical tests or information beyond our scope of practice **Participate** in the development of a safe feeding plan **Direct intervention** to develop oral motor skills for feeding to the extent possible **Train** parents and support staff in the implementation of strategies and techniques involved in the safe feeding plan

X. Sensory (OT)

Outcome	Barrier	Standard of Practice
Facilitation of appropriate responses to sensory information for safe and successful participation in activities across learning environments	Cognitive, behavioral, and attention issues Environmental barriers and/or task demands Intolerance to the sensory or environmental aspects of learning environments	**Assess** student's response to sensory stimuli in the environment, the task, and social interactions, and the impact of that response on behaviors **Analyze** the student's routines, habits, and roles within learning environments **Participate** in the development of appropriate strategies/environmental modifications that can be incorporated into the student's daily schedule **Provide training** to student, parents, and educational staff including precautions as needed **Direct intervention** to support the development of adaptive responses and/or use of strategies within the natural environment

XI. Handwriting (OT)

Outcome	Barrier	Standard of Practice
Facilitation of the development of the underlying motor and/or sensory readiness skills needed to efficiently use written communication tools	Delayed fine motor skills and/or physical limitations Cognitive, behavioral, visual motor and attention issues Environmental barriers and/or task demands Intolerance to the sensory or environmental aspects of learning environments	**Assess** prerequisite fine and visual motor skills, ergonomic and environmental factors, and writing demands as they impact written communication **Determine** the need for adaptive equipment or materials and modifications to task or environment **Participate** in the decision-making process for use of assistive technology in the area of written communication **Educate** student and staff in strategies for improving legibility of written work **Direct intervention** to facilitate the development of prerequisite skills for handwriting to the extent that the student has the ability to make progress

✓ KEY POINT

Discontinuing services is warranted when the IEP/504 team determines that the child no longer requires the unique expertise of the occupational and/or physical therapist to achieve educational benefit under the IEP or 504 Plan.

5.0 Discontinuing OT/PT Services

5.1 Discontinuing Services Decisions

Discontinuing services is warranted when the IEP/504 team determines that the child no longer requires the unique expertise of the occupational and/or physical therapist to benefit from special education. There is no single method to make a final decision regarding the discontinuation of services.

5.2 Factors to Consider for Discontinuing Services

The following are factors supporting discontinuation of occupational and/or physical therapy services:

- The student has met the functional goals being addressed by the occupational or physical therapist.
- Deficits are no longer interfering with the child's ability to function adequately within his/her educational environment.
- Level of participation is within expectations for the student's educational program, and OT/PT service is not necessary in order for the student to progress.
- Rate of skill acquisition, potential for progress, and/or level of function are not likely to change with therapy intervention.
- The student has learned appropriate strategies to compensate for deficits.
- Strategies needed can be effectively implemented by the current educational team and do not require the training and expertise of an OT or PT.
- Classroom program, strategies, and/or routines have been established and are not in need of modification.

- Equipment and environmental modifications are in place and are effective, making OT or PT services unnecessary for the student to make progress.

6.0 Occupational and Physical Therapy Documentation

The following documentation guidelines are required for occupational and physical therapists in accordance with Board of Occupational Therapy Practice and Board of Physical Therapy Examiners regulations.

6.1 Occupational and Physical Therapy Assessment Reports

Specifics for OT and PT assessment reports are outlined in each profession's practice act (Board of Occupational Therapy Practice, 2000; Board of Physical Therapy Examiners, n.d.). Assessment reports for school-based practice should include:

- A statement indicating that the procedures used are valid for the intended purpose.
- A statement indicating whether assessment results are an accurate reflection of a student's current performance levels.
- A statement of the child's current health status based on a review of pertinent records and medical history.
- A statement which describes the child's levels of functioning in each developmental area and the dates of the evaluation and assessment procedures.
- A statement of criteria, including tests, evaluation materials, and informed clinical opinion.
- The signatures and titles of the qualified personnel who conducted the evaluation and assessment.

6.2 Documentation of OT and PT Services

Service documentation format may vary among the local school systems, but should include the following:

- Documentation for regularly scheduled or make-up services delivered to a student/child and on behalf of a student/child (Board of Occupational Therapy Practice, 2000; Board of Physical Therapy Examiners, n.d.) must include:
    - Date
    - Length of session
    - Location
    - Specific strategies used to address IEP goal/objectives/IFSP outcomes/strategies
    - Student/child performance/outcome of session
    - Record of attendance
    - Signature and credentials

  Documentation may also include:
    - Student/child behavior or response
    - Meetings/phone calls/outside contacts
    - Training for and/or consultation with other team members
    - Plan for future intervention/needs
- IEP progress reports (when OT and/or PT services are implemented), should contain contributions from occupational and physical therapists individually or in conjunction with other service providers. Each local school system will have its own procedures for the frequency of reporting progress based on the general education requirements.
- 504 Plan documentation must meet requirements as stated by the state licensing boards for OT and PT (Board of

Occupational Therapy Practice, 2000; Board of Physical Therapy Examiners, n.d.).

Additional information regarding the documentation of related services can be found in TA Bulletin # 21 at the link that follows: http://www.marylandpublicschools.org/MSDE/divisions/earlyinterv/Special_Ed_Info.htm?WBCMODE=Pr%25%25%253e%25

6.3 Data Collection

- Specific data must be collected for each outcome developed by the IFSP team and for each goal and objective developed by the IEP team.
- Data may be collected by the OT, PT, and/or other team members.
- Data may be recorded on daily notes and/or on separate data collection sheets.
- Current data should be reflected on IEP Present Levels of Academic Achievement and Functional Performance and Progress reports.
- Decisions regarding changes to intervention, service, and discontinuation of services should be based on data collected over the IFSP/IEP cycle and made by a child's IFSP team/IEP team.

7.0 Administrative Considerations

As with any service implemented to improve outcomes for children with disabilities, administrative support plays an essential role. It is the administrator who establishes a school's climate of inclusiveness and establishes expectations for the physical and academic learning environment for students. Inclusiveness also involves respect for the time and expertise of specialists and flexibility in scheduling to accommodate both staff and student needs.

7.1 Quality Assurance

Quality assurance is important for consistent service delivery and professionalism of staff. OT/PT licensure laws certify therapists as qualified in their respective fields. The following methods can be combined to promote maximum quality of OT/PT services:

- Maintaining licensure through relevant continuing education
- Professional development including:
    - Small group discussion, literature review, peer collaboration and documentation review, case studies
    - Association with professional organizations
    - Development of core competency skills
    - In-house presentations and trainings
    - Staff meetings to maintain knowledge of administrative procedures
- Observations
    - Opportunities for therapy staff to observe others

  - Opportunities to be observed to enhance both skills and knowledge

- Administrative supervision monitors compliance with general policies and regulations of the local school system and may be the responsibility of a school system administrator and/or the employing agency. Administrative supervision may include:
  - Direct observation
  - Record review in terms of compliance with state and local guidelines
  - Schedule maintenance
  - Performance evaluation based on accepted educational standards
    - May include feedback from other stakeholders (e.g., classroom teachers, peers, administrators, parents)
    - May include an assessment of the ability to communicate with parents and IFSP/IEP team members
- Professional supervision monitors competency in therapeutic intervention and associated functions and can only be provided by an experienced professional of the same discipline. Professional supervision may include:
  - Record review for compliance with OT/PT practice
  - Direct observation of therapists
  - Orientation and mentoring
  - Performance evaluation
    - Should include therapeutic intervention, documentation, assessment, IFSP/IEP development, work duties, organizational skills, communication,

work ethics, quality of work, job knowledge, collaboration, professional decision-making using evidence-based practices, and consideration of the learning environment

- May include feedback from other stakeholders (e.g., classroom teachers, peers, administrators, parents)

7.2 Workload

Workload is more than caseload and encompasses all of the activities performed by occupational therapists and/or physical therapists (Jackson, Polichino, & Potter, 2006). Workload recognizes the broad responsibilities of early intervention and school-based therapists and is defined as the time involved to:

- Provide early intervening services to students (Section 4.1 of this document).
- Administer initial assessments to students (refer to local school system timelines).
- Provide services to a child/student with a disability.
- Provide services on behalf of a child/student with a disability (Section 4.5 of this document).
- Provide make-up services when students/therapists are unavailable for specified IEP services (only exceptions are student absence and school closures).
- Plan for service provision, which includes team collaboration.
- Prepare documentation:
    - IFSP/IEP/504 Plan
    - Service documentation

  - Medical Assistance (MA) billing (including date, location, length of service, intervention, outcome, original signature)

- Provide services to the number of schools served within a geographic area.
- Travel between locations of service delivery.
- Attend meetings:
  - IFSP/IEP/504 Plan
  - Staff
  - Team
- Provide service coordination.
- Participate in and/or provide professional development.
- Participate in and/or provide supervision and mentoring of less experienced therapists, PTAs/COTAs and student therapists.
- Implement programmatic requirements.
- Complete other duties as assigned.
  - Therapists' attendance may be required at resolution sessions, mediations, and/or due process hearings. Therapists should refer to their local school system's Procedural Safeguards.

If there are questions related to workload, please follow your local procedures for seeking additional opportunities for input.

7.3 Workflow

- The concept of workflow describes a therapist's creation and implementation of a manageable schedule. It involves completion of many of the responsibilities listed previously and the challenges imposed by the time constraints of a typical school day and school calendar.

✓ KEY POINT

Occupational therapists and COTAs are bound by the Code of Ethics of the Maryland Board of Occupational Therapy Practice. Physical therapists and PTAs are bound by the Code of Ethics of the Board of Physical Therapy Examiners of Maryland. All therapists have access to these documents and are obligated to promote, support, and maintain the standards set forth within these codes. Violation of the Code of Ethics may result in legal action by the respective Board and potential loss of licensure (Swinth et al., 2003).

Challenges related to the flow of work may include:

- Inability to schedule during academic subjects, field trips, assemblies, related/creative arts, and mandated tests
- Length and number of meetings requiring therapists' attendance
- Weather-related schedule changes
- Student suspension due to behavior issues
- Therapist absence
- Addition of new students
- Participation in due process
- Coverage for staff shortages
- Compensatory services
- Other school duties

7.4 Work Environment

While it is recognized that OT/PT services should be provided in the local school system, it may be necessary to provide group or individual services in a separate, distraction-free environment to support the IEP. Each local school system will facilitate the implementation of the IEP by providing therapists with safe and appropriate space, location, supplies, materials, and equipment.

Each therapist should be provided with the space and tools necessary to complete his/her professional obligation. This may include:

- Computer access/email accounts
- Work station/desk
- Telephone access
- Mailbox
- Storage space

✓ KEY POINT

If the therapist is not in agreement with the team's decisions regarding OT and/or PT service, a written statement to that effect should be provided to the team regarding the perceived ethical dilemma (according to local documentation practices). Therapists should discuss concerns with their immediate supervisors.

- Pagers/cell phones/voice messaging
- Mileage reimbursement
- Continuing education funds

7.5 Ethics

Occupational therapists and COTAs are bound by the Code of Ethics of the Maryland Board of Occupational Therapy Practice. Physical therapists and PTAs are bound by the Code of Ethics of the Board of Physical Therapy Examiners of Maryland. All therapists have access to these documents and are obligated to promote, support, and maintain the standards set forth within these codes. Violation of the Code of Ethics may result in legal action by the respective Board and potential loss of licensure (Swinth et al., 2003).

Possible ethical dilemmas in school-based practice include:

- Changing service delivery based on an unmanageable caseload.
- Being pressured to provide services or service levels that are inappropriate based on professional judgment.
- Making caseload decisions without taking into consideration logistical issues related to providing services in the least restrictive environment.
- Providing services that are outside the scope of practice.
- Insufficient medical information to address precautions and safety issues related to service provision.
- Performance evaluations being completed by someone outside of one's professional field.
- Prioritizing student service based on third-party billing and payment.

If the therapist is not in agreement with the team's decisions regarding OT and/or PT service, a written statement to that

effect should be provided to the team regarding the perceived ethical dilemma (according to local documentation practices). Therapists should discuss concerns with their immediate supervisors.

8.0 Frequently Asked Questions for Therapists

How do I determine how much service to provide? And how often?

There is no simple answer to these questions. Occupational and physical therapy are related services to access, participate, and progress within the learning environment. IEP teams determine the necessary service based on individual student need. The IEP team discusses the best discipline to provide the services. Decisions regarding the amount of service should be made by the IEP team based on professional expertise of the therapist and evidence-based findings, where possible, and be clearly documented on the IEP. Please refer to sections concerning Part B Service Delivery (Section 4.0) and the Standards of Practice chart (Section 4.7).

What if I disagree with the team recommendations?

Please see Ethics (Section 7.5).

What if I don't have current medical information?

It is the responsibility of the OT and/or PT to obtain pertinent medical information when there are medical concerns in order to provide intervention in a safe and ethical manner. If a therapist is unable to obtain this information, he/she may refuse to provide a specific intervention until sufficient information regarding safety and/or precautions can be obtained. An IFSP/IEP team meeting should be convened to inform the team of the concern, develop an action plan, and modify the IFSP/IEP. Thorough documentation of the entire process including attempted contacts must be made. School health services must be consulted as well.

What do I do if I can't attend a meeting?

If you are a required member of the team and you have received excusal from attending a meeting, written input is still required if your area is being discussed. Refer to Identifying the Need for OT/PT (Section 4.5).

What is a reasonable caseload?

There is no easy answer to this question. Consideration must be given to all the roles and responsibilities of the therapist when determining a reasonable caseload. Refer to Workload (Section 7.2).

How do I explain to parents the difference between medical and educational service?

Medically based therapists direct their attention primarily to the medical needs of the child. School therapists direct their attention to enabling students to benefit from special education instruction in order to make progress in the general curriculum and to participate in appropriate activities [34 CFR §300.320] to the best of their abilities.

How do I help parents understand the considerations that determine the decision to discontinue services?

See Factors to Consider for Discontinuing Services (Section 5.2) and the Standards of Practice charts (Section 3.6 and Section 4.7).

How do I write educationally relevant goals and objectives?

Goals are developed as a part of the IEP process and should be discipline-free, activity based, and related to access, participation, and progress in the general education curriculum (Appendix B).

What are Early Intervening Services?

Refer to Early Intervening Services (Section 4.1)

What is the difference between an IEP and a 504 Plan?

A 504 Plan provides accommodations for a student with a disability who does not require special education. Refer to Appendix C on Section 504 and the Overview (Section 2.0). Under IDEA, an Individualized Education Program (IEP) refers to the plan developed for a student with a disability who requires special education, and related services.

Who conducts my performance evaluation?

Although this varies within each local school system, best practice indicates that evaluations should be completed by therapists of their respective disciplines whenever possible. See Quality Assurance (Section 7.1).

What assessment tools should I use?

The match between the child, the environment, and the task should be the focus of assessment. Refer to OT/PT Under IDEA Part C (Section 3.1, 3.2) and/or refer to OT/PT Under IDEA Part B (Section 4.0, 4.1, 4.2).

How do I tie goals and objectives to curriculum?

All goals and objectives should support access, participation, and progress in the general curriculum. OT/PT support may be implemented through accommodations and modifications rather than through goals and objectives.

What skills should I have to be an effective early intervention/school-based therapist?

Therapists should refer to their professional organizations, appropriate professional development, and relevant professional literature. Refer to Core Competencies for Licensed Therapists (Appendix A).

How does the OT Practice Framework relate to early intervention/school-based practice?

The OT Practice Framework: Domain and Process (AOTA, 2008) supports the International Classification of Functioning, Disability, and Health (ICF) (World Health Organization, 2001) constructs, which address participation, activities, environment and body constructs, and function. The OT Practice Framework provides a common practice platform for therapists to assess performance skills and performance patterns of children in their natural learning or school environment and to identify factors which influence performance. The OT Practice Framework also guides the implementation of child-centered and outcome-based intervention strategies that will support a child/student's participation and/or progress. Occupational therapists focus on the activity demands and the context in order to promote the child's access, participation, and progress in his or her natural or learning environment.

How does the Guide to PT Practice relate to early intervention/school-based practice?

Early intervention/school-based physical therapists may reference the Guide to Physical Therapist Practice (APTA, 2001) to facilitate their clinical decision making. By following the outlined patient/management framework, and using the five elements of care specified by the Guide (examination, evaluation, diagnosis, prognosis, and intervention), physical therapists are able to contribute to the writing and support of an IFSP/IEP/504 Plan that will meet the unique needs of the child/student and enable him/her access, participation, and progress in his/her early intervention/educational programs.

What can COTAs and PTAs do independently from the occupational and physical therapists?

COTAs and PTAs can be an integral part of school teams and can support the service delivery to and on behalf of children through intervention and consultation, which may include data collection

only when provided supervision by an occupational or physical therapist. State licensure regulations specify supervision requirements and limit the roles of COTAs and PTAs in regard to evaluations, interpretation of assessment results, and the implementation or modification of treatment plans.

How do I gather evidence to support my decisions?

Literature searches, clinical experience, and data collection provide the basis for evidence based decision-making. Refer to Data Collection (Section 6.3).

How do I show student progress if I only support modifications and/or accommodations and not goals?

Therapists should report progress under the educational/functional goals/objectives that relate to the accommodations/modifications that they are supporting.

How do I get started in school-based practice?

Competencies are a good reference for therapists considering school-based practice. Ask to shadow therapists and for support to attend school-related conferences. Ask whether your local school system has a mentoring program. There are many books and continuing education opportunities available through AOTA, APTA, and other professional organizations that can be helpful.

9.0 Frequently Asked Questions for Administrators

How do I evaluate a therapist?

Please see Quality Assurance (Section 7.1).

How do I support therapists in my school system?

Provide for mentoring and peer networking; offer continuing education opportunities; consider workload, workflow, and work environment; involve therapists in promoting professional development; understand ethical dilemmas and support decision-making. See Administrative Considerations (Section 7.0).

What if the therapist's professional judgment is not in agreement with team recommendations or administrative policies?

Please see Ethics (Section 7.5).

What is sensory integration and a sensory diet?

Sensory integration is a theory which describes the process of taking in sensory information and prioritizing and interpreting that information to make meaningful responses. Sensory integration is a theoretical frame of reference used to guide intervention for children who demonstrate impaired abilities in these areas. All occupational therapists have training in sensory integration theory and application of intervention to support approaches using this frame of reference; there is no specialty certification for using a sensory integration approach. Therapists working in the school must consider sensory issues as well as all other factors impacting performance. Sensory diets are part of the continuum of sensory integration and are often more

appropriate in the school or home environment. Sensory diets address a child's specific sensory regulation needs through environmental adaptations and activity supports.

Why might the occupational therapist object to teaching handwriting?

Learning to write should be an educational goal addressed by the classroom teacher. Poor handwriting skills by themselves do not constitute a disability for which a student should be identified as a student with a disability. Occupational therapists may collaborate with teachers and staff to recommend strategies to meet student needs within the general curriculum. It is imperative that the OT identify opportunities for these strategies to be effectively implemented throughout the school day. Evaluation includes information about how the fine motor and handwriting challenge is impacting important outcomes (e.g., work product, attention, and group participation). Occupational therapists are discouraged from providing direct services for the sole purpose of implementing a handwriting program (Dunn, 2000).

How many children can I expect a therapist to see?

Caseload is based on the number of hours of therapy services in conjunction with travel and other workload concerns. Refer to Workload (Section 7.2) and Workflow (Section 7.3).

How can a child have a diagnosis of Cerebral Palsy and not receive PT?

Services are not based on the diagnosis, but on the child's level of functioning in relationship to access, participation, and progress in the general education curriculum.

How does a child qualify for OT and/or PT services?

Children qualify through the evaluation, documentation of a disability, and IEP development process. Qualification is not based on a specific test score or discrepancy. Refer to OT/PT

Under Idea Part B (Section 4.0, 4.1, 4.2) and/or refer to Identifying the Need for OT and/or PT (Section 4.5).

What impact should outside evaluations have on decision-making for school-based occupational and physical therapists?

Refer to Evaluation (Section 4.2).

Where can administrators go for help or resources?

Consult the Maryland State Steering Committee for Occupational and Physical Therapy School-Based Programs as well as the AOTA (www.aota.org) and the APTA section on pediatrics (www.pediatricapta.org).

What is the role of the OT and/or PT with 504 Plans?

Children who qualify for a 504 Plan may be eligible for related services to support accommodations to access the general curriculum. Refer to Appendix C: OT/PT Services under Section 504.

What is the role of PT with physical education and transportation?

Occupational and/or physical therapists can provide collaborative consultation for participation in physical education.

For transportation, therapists may determine whether equipment is appropriate for safe transport. Physical therapists support transportation access.

How do state licensure regulations impact what our therapists can do in the schools?

Refer to Ethics (Section 7.5) and Roles and Responsibilities (Section 2.2).

What professional resources do occupational and physical therapists use to guide their practice decisions?

Occupational therapists may reference the OT Practice Framework. The OT Practice Framework: Domain and Process

(AOTA, 2008) supports the International Classification of Functioning, Disability, and Health (ICF) (World Health Organization, 2001) constructs, which address participation, activities, environment and body constructs, and function. The OT Practice Framework provides a common practice platform for therapists to assess performance skills and performance patterns of children in their school or natural learning environment and to identify factors that influence performance. The Practice Framework guides the implementation of child-centered and outcome-based intervention strategies that will support a child/student's participation and/or progress. Occupational therapists focus on the activity demands and the context in order to promote the child's access, participation, and progress in his or her natural or learning environment.

Physical therapists may reference the Guide to Physical Therapist Practice (APTA, 2001) to facilitate their clinical decision making. By following the outlined patient/management framework, the Guide provides a common practice platform by using the five elements of care (examination, evaluation, diagnosis, prognosis, and intervention). Physical therapists are able to contribute to the writing and support of an IEP/504 Plan that will meet the unique needs of the student and enable him/her access, participation, and progress in his/her educational programs.

How do occupational and physical therapists determine service amounts and frequencies?

There is no simple answer to this question. OT and PT are related services that a student may need in order to benefit from special education instruction.

The IEP team discusses the best discipline to provide the services. IEP team decisions regarding the amount of service should be based on professional expertise and evidence-based findings, where possible. Please refer to the sections concerning

OT/PT for Ages 3-21 (IDEA Part B) (Section 4.0) and the OT/PT Standards of Practice chart (Section 4.7).

What is the difference between a certified occupational therapy assistant (COTA) and an occupational therapist? Between a physical therapist assistant (PTA) and a physical therapist?

Occupational and physical therapists have a minimum of a bachelor's degree in OT or PT from an accredited educational facility. COTAs and PTAs have an associate's degree from an accredited educational facility. All of the above must meet state licensure regulations. Refer to Roles and Responsibilities of the Therapist (Section 2.2).

COTAs and PTAs can be an integral part of school teams and can support the service delivery to and on behalf of children through intervention and consultation, which may include data collection only when provided supervision by an occupational or physical therapist. State licensure regulations specify supervision requirements and limit the roles of COTAs and PTAs in regard to evaluations, interpretation of assessment results, and the implementation or modification of treatment plans.

Can a trained paraprofessional be used to substitute for a PTA or COTA?

No. There are certain activities related to PT and OT that can be carried out by paraprofessionals as well as other personnel; however, PTAs and COTAs are trained, licensed professionals that have specialized skills. Only services delivered by licensed personnel can satisfy the service requirements of an IEP and be billed.

How do you define the types of services to students?

Please refer to Identifying the Need for OT and/or PT as a Related Service (Section 4.5).

What is the role of the therapist in school-based practice?

Refer to Roles and Responsibilities of the Therapist (Section 2.2).

When should medical-based information or services be followed up by the school nurse rather than occupational and physical therapists?

School nurses have the responsibility to manage medical care for students in the educational environment, including the development of health care plans as appropriate. However, as medically trained professionals, occupational and physical therapists may be asked to interpret medical reports and information that are more specific to their area of practice for the parents and team.

Should a student's third party/Medical Assistance status influence related service decision-making?

No. This is a violation of IDEA, OT and PT COMAR regulations, and professional ethics. Refer to Sections 2.1 and 7.5.

Glossary

Accommodations: Identified strategies that may enable a student to make progress, access, participate and/or benefit from the general education curriculum. Accommodations are established by the IEP team and may require the support of related service personnel. As defined in COMAR 13A.05.01.03B(1), accommodations are practices and procedures which are in accordance with the Maryland Accommodations Manual that allow students with disabilities equitable access during instruction and assessment in the areas of presentation, response, setting, and scheduling.

Activity-focused intervention: Interventions, developed by an occupational and/or physical therapist, that provide structured practice and repetition of functional actions that are directed toward the learning of motor tasks that will increase a child's participation in daily routines (Valvano & Rapport, 2006).

Adaptations: Alterations made to tests, materials, and/or equipment to meet the unique needs of a student. These may require the support of related service personnel.

Assessment: According to COMAR, 13A.05.01.03B(3), assessment is the process of collecting data in accordance with 13A.05.01.05 to be used by the IEP team.

> Part B: Assessment is systematic and organized methods of data collection for making educational decisions. Assessments may consist of discipline-specific tools, checklists, observations and/or work sampling which may be used to contribute to a multidisciplinary evaluation to determine eligibility for special education and related services. Assessment data may be used to identify present levels of academic achievement and functional performance and needs, and assist in the development of appropriate goals and objectives,

modifications, and accommodations designed to assist the student in school.

Part C: Assessment means the ongoing procedures used by appropriate qualified personnel throughout the period of a child's eligibility to identify the child's unique strengths and needs and the services appropriate to meet those needs. Assessment is ongoing and used for program planning.

Barrier: A barrier is an obstacle in accessing and participating in any given educational activity or part of the school day as a result of a student's disability.

Best practice for OT/PT: An approach supported by contemporary theories of motor development and the ICF framework, and advocated by both the APTA and AOTA. Best practice includes but is not limited to: the use of peer-reviewed research, clinical experience, criterion-referenced assessments and ecological inventories to define present levels of educational performance and child/student needs, functional IFSP/IEP goals and objectives that are discipline-free and measurable, and data-driven decision making.

Caseload: The number of students with IFSPs or IEPs that an occupational or physical therapist supports with services to and/or on behalf of the student or child/family.

Child Outcomes Summary Process: In 2005, ECO created the Child Outcomes Summary Process as a way for states to summarize data on children with disabilities for federal reporting purposes. Maryland uses the Child Outcomes Summary (COS) as part of the IFSP process to document child functioning in three outcome areas. The three outcomes are: 1) develop positive social-emotional skills (including social relationships), 2) acquiring and using knowledge and skills, and 3) taking appropriate actions to meet needs. Child functioning in each of the three areas is rated on a scale of 1-7, with a rating of 7 meaning age appropriate functioning most of the time in most

settings, and 1 meaning child functioning would be described like that of a much younger child.

Collaborative model: Through consensus, the educational team identifies realistic outcomes for a student and identifies potential barriers to their achieving these outcomes. Following this discussion, the team recommends the implementation of program(s), practices, and services that will help the student achieve the stated outcomes or goals (Muhlenhaupt, 2003b).

Consultative model: Therapists use their expertise and education to discuss, demonstrate and teach educational staff and/or parents to implement strategies and develop practice activities/ routines for skill development and generalization (Lundy, 2006).

Criterion-referenced: An assessment that compares a child's performance to a specific criterion; it describes the child's mastery of specifically defined skills. An example of a criterion-referenced test is the Pediatric Evaluation of Disabilities Inventory (PEDI) or School Function Assessment (SFA) (Illinois State Board of Education, 2003).

Developmental approach: Following normally sequenced motor milestones with intervention targets identified from skills at the next higher level. Children (students) engage in exercises or structured play that will target specific skills. In school settings, this often requires the student/child to be "pulled out" and the skill worked on in isolation (as opposed to the functional approach) (Mahoney, Robinson, & Perales, 2004).

Discipline-free goals: Goals that are shared among educational team members and are child-centered. These are not speech, OT, or PT specific goals that focus on the remediation of a specific impairment; these are goals that focus on what the child/student needs to make progress or successfully access and/or participate in the general education curriculum.

Early intervening: For students K-12, with special emphasis on children K-3, who have not been identified as needing special education and related services but who need additional academic and behavior support to succeed in the general education environment. This may include educational and behavioral evaluation, services, and supports including scientifically based literacy instruction (U. S. Department of Education, 2005).

Early intervention: A collection of services provided by public and private agencies and designed by law (IDEA 2004, Part C) to support eligible children and their families in enhancing a child's potential growth and development from birth to age three (Maryland State Department of Education, n.d.).

Ecological assessment: Using an ecological inventory for data collection, the direct observation of students in a variety of environments to determine the influence of various environments on student performance (Illinois State Board of Education, 2003).

Ecological inventory: A list of activities, routines or skills required in specific environments.

Educationally relevant: Services to a student or on behalf of a student associated with enhancing access and/or participation in a general school activity or the general education curriculum. Educationally relevant OT and PT services are meant to meet the needs of the student to promote his/her success in the educational environment.

Enablement model: The mirror of the disablement model, the process begins with the student/child and restoring his/her role in society. It focuses on what a student/child can do in personally important contexts. The student/child is not defined by deficits but rather his/her engagement in daily activities and routines despite limitations (Goldstein, Cohn, & Coster, 2004).

Evaluation: According to COMAR 13A.05.01.03B(25), , evaluation is the process of reviewing information from parents,

existing data and results of assessment procedures used to determine whether a student has a disability and the nature and extent of the special education and related services a student needs.

> Part B: The Part B regulations only give general requirements for evaluation. Evaluation includes both eligibility determination and program planning in Part B. It is a systematic process of gathering and interpreting information that may be needed to resolve an educational problem or behavior of concern, or to support the fact that a disability is suspected (Iowa Department of Education, 2001).
>
> Part C: The procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility under this part consistent with the definition of "infants and toddlers" with disabilities including determining the status of the child in each of the developmental areas. Based on this definition, physical therapists, occupational therapists, and other team members "evaluate" to determine if the infant/toddler meets the individual state's eligibility criteria for early intervention (McEwen, 2000).

Evidence-based practice: Obtaining evidence from appropriate professional literature, evaluating it for validity and applicability, combining that with child/student data and clinical experience to make informed decisions (APTA, n.d.).

Free Appropriate Public Education (FAPE): IDEA ensures that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living. FAPE is provided at public expense under public supervision and direction and in conformity with the IEP [34 CFR §300.101].

Functional approach: The functional approach identifies motor problems within typical activities and routines in meaningful environments. It does not follow any particular sequence but rather focuses on what the child/student needs to do, to access and/or participate in natural settings important to them and their families. It involves an active role for the child and/or parent/caregiver/school team and repetitive practice of the problematic motor abilities within the context of a natural setting (Ketelaar, Vermeer, Hart, Beek, & Helders, 2001).

Goals: A goal is a statement that is chronologically age-appropriate, achievable, measurable and individually meaningful for the child's current and future environments (functional). Goals are not failed test items (McEwen, 2006).

Individualized Education Program (IEP): An individualized education program is a written statement for each child with a disability that is developed, reviewed, and revised in a meeting in accordance with federal regulations in §§ 34 CFR 300.320-300.324. The IEP must be tailored to the individual student's needs as identified through the evaluation process and help teachers and related service providers understand the student's needs that result from the disability and how the disability affects the child's ability to be involved in and make progress in the general education curriculum. In other words, the IEP should describe how the student learns, how the student best demonstrates that learning to participate and make progress in the general education curriculum, and what teachers and service providers will do to help the student more effectively access or participate in educational opportunities and achieve IEP goals.

Individualized Family Service Plan (IFSP): A document developed for a child ages birth to three years of age [COMAR 13A.13.01.03B(28)] with developmental delays and his/her family. The IFSP is a single, coordinated plan developed by a multidisciplinary team, including the parents. The plan includes the strengths and needs of the child; the family's resources,

priorities, and concerns relating to enhancing the development of the child; the measurable results or outcomes expected to be achieved for the child and the family; the specific services based on peer-reviewed research necessary to meet the unique needs of the child and the family; 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; and the steps to be taken to support the transition of the child to preschool or other appropriate services.

Extended Individualized Family Service Plan (IFSP): Maryland's Extended IFSP Option offers families the choice to remain on an IFSP beyond their child's third birthday, if their child is determined eligible for preschool special education and related services as a child with a disability. The extension of IFSP services beyond age 3 until the beginning of the school year following the child's fourth birthday [COMAR 13A.13.01.09C], incorporates the strength of the special education/preschool education program with the existing infants and toddlers family-centered model. The Extended IFSP Option moves Maryland toward its mission of creating a seamless birth through 5 early childhood intervention and preschool special education system of services.

Infants & Toddlers Program: The Maryland Infants and Toddlers Program (MITP) directs a family-centered system of early intervention services for young children with developmental delays and disabilities— and their families. By recognizing each family's concerns and priorities and focusing on each child's strengths and needs, the MITP assists families of children with special needs during the first four years of the child's developmental journey. Support, information, and coordinated services in community settings are what families tell us enhance their ability to manage the challenges and celebrate the gifts that each child has to offer.

The Maryland Infants and Toddlers Program provides monitoring and technical assistance to 24 Local Infants and Toddlers Programs (LITPs) throughout Maryland. These programs are composed of local departments of education, health, social services, and other public and private providers identified by each jurisdiction. LITPs constitute the service delivery component of the statewide early intervention system.

Through Local Infants and Toddlers Programs, services are offered throughout the State and are designed to enhance a child's potential for growth and development before he or she reaches school age. Services may include: audiology, physical therapy, occupational therapy, transportation, speech-language pathology, family training, special instruction, assistive technology, health services and home visits.

Integrated services: A way to expand therapeutic intervention by embedding it into everyday routines at home and at school. Specific discipline specific methods are infused into everyday routines and activities that occur in natural settings, such as home and school. Most often integrated services are transdisciplinary; discipline-specific skills and methods must be taught to other team members who regularly instruct the student or work with the child in various educational environments and activities (York, Rainforth, & Giangreco, 1990).

International Classification of Functioning Disability and Health (ICF): A model of disablement, the framework takes a broad view of health and focuses on how people live with their conditions. It describes the etiology of functioning and health, not only in association with underlying health conditions but also in association with personal and environmental factors. This framework rejects the view that the disability resides solely in the person and recognizes environmental factors as important and influencing contributors to disability and function (Jette, 2005).

Intervention: Based on in-depth problem-solving and evaluation/assessment, interventions are discipline-specific

therapeutic methods, strategies, modifications, and /or accommodations to meet a child's and/or student's needs.

Instructionally-based practice: An ongoing process that is learner centered and focuses on the mastery of content and learning objectives as well as the demonstration of competence and skill (Duke University Center for Aging and Human Development, 2000).

Least restrictive environment (LRE): To the maximum extent possible, children with disabilities are educated with children who are not disabled. Special classes, separate schooling, or other removal of children with disabilities from the regular education environment occurs only when the nature or severity of the disability of a child is such that the education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily [34 CFR §300.114].

Methodology: A technique or method, typically discipline-specific, used to develop skills.

Modification: A change in an activity or routine to allow a child/student success or the ability to participate in the best way possible. According to [COMAR 13A.05.01.03B(43), modifications means practices that change, lower, or reduce learning expectations in accordance with the Maryland Accommodations Manual.

http://www.marylandpublicschools.org/NR/rdonlyres/5F4F5041-02EE-4F3A-B495-5E4B3C850D3E/33557/2012MarylandAccommodationsManual.pdf

Monitoring model: Therapists may not provide direct intervention but maintain contact with the student/team to check a child/student's status and provide instruction as needed. This is useful for monitoring physical impairments that may deteriorate with time or equipment needs (Lundy, 2006).

Multidisciplinary team: A group of professionals with expertise from different disciplines who share information in the decision-making process.

Natural environment: Settings which are natural and normal for a child's same-age peers who have no disabilities. Typically these are key settings where a child and/or family spend much of their time (Hanft & Pilkington, 2000).

Norm-referenced: An assessment that compares the child's performance to that of a representative group. Age equivalents may be determined using this type of assessment. A Peabody Gross Motor Scales II is an example of a norm-referenced test (Illinois State Board of Education, 2003).

Objective: Objectives reflect the unique disciplinary knowledge and experience that therapists may use to help children/students achieve desired goals and outcomes. Objectives are related to the goal and are often less complex. They are the "steps" which may be more developmental or therapeutic in nature that will lead to the achievement of the overall goal.

Occupational Therapy Practice Framework: *The Occupational Therapy Practice Framework: Domain and Process, 2nd Edition* is an official document of the American Occupational Therapy Association (AOTA). Intended for internal and external audiences, it presents a summary of interrelated constructs that define and guide occupational therapy[1] practice. The Framework was developed to articulate occupational therapy's contribution to promoting the health and participation of people, organizations, and populations through engagement in occupation. It is not a taxonomy, theory, or model of occupational therapy and therefore must be used in conjunction with the knowledge and evidence relevant to occupation and occupational therapy (AOTA, 2008).

Outcome (as defined in Part C): A quality of life change that may enable a young child to socialize with siblings and peers,

move in his/her environment(s), manipulate toys, communicate needs and ideas, etc. (Hanft & Pilkington, 2000).

Problem-solving model: A process used to define problems, design interventions to target identified problems, collect data, and monitor progress. As an example, the Response to Intervention (RTI) model for identifying learning disabilities can incorporate the steps of the problem-solving model.

Related service: "Related service" means transportation, and such developmental, corrective, and other supportive services (including OT and PT) as may be needed to help a child with a disability benefit from special education. It includes early identification and assessment of disabling conditions of childhood [34 CFR §300.30].

Response to Intervention (RtI): " ... a multi-tiered approach to **general education** that focuses on helping *all* students, identifies students who are at risk for academic or behavioral concerns, and provides targeted instruction and intervention strategies for students whose rate of progress is behind the classroom norm" (Clark, Brouwer, Schmidt, & Alexander, 2008, p. 9).

Role-release: Putting newly acquired techniques into practice with consultation from the team member whose discipline is accountable for those practices.

School-based: Educationally-relevant OT and PT services delivered to eligible children/students ages 3–21 who are enrolled in special education or have 504 plans implemented in a school setting. Interventions are designed to improve the student's function and participation in the educational environment. School-based therapy is part of a student's overall educational program.

Screening: Screening involves the process of reviewing available data, observation of the child/student or the administration of an appropriate instrument (reliable, valid, and designed for the

purpose of screening) by qualified personnel in order to determine whether further comprehensive evaluation is warranted to document the existence of a delay in development or a particular disability.

Sensory-motor processing: The ability to receive, filter, and organize information through the body's senses. It facilitates the body's ability to use motor and sensory information to interact with the environment.

Service coordinator: The individual selected by an early intervention team and designated in an IFSP to coordinate and facilitate early intervention services and integrate the family into the process. Whether he/she is a service provider or veteran parent, the case manager must demonstrate understanding of the laws and nature of the process (Maryland State Department of Education, n.d.) [COMAR 13A.13.01.03B(59)].

Services on behalf of a student: These are services previously identified as "indirect" that may include but are not limited to: consultation and collaboration with school team members, training personnel, student-centered discussion with outside personnel involved in a student's case, adapting and acquiring materials and equipment, etc.

Services to a student: Face-to-face interaction between the child/student and therapist. This may be delivered individually, in a group or with another team member for training purposes.

Session: The time that is required of the therapist to complete service as designated in the IFSP/IEP to and on behalf of a child/student/team/family on any given day.

Strategy: An adapted OT/PT technique that can be incorporated into a classroom activity or naturally occurring routine.

Student/environment/task/tool (SETT) process: An ecological approach used when assessing the need for assistive technology.

Standardized assessment: Uniform procedures used to assess a child's/student's performance and compare it to others who have taken the same assessment. A child/student is assessed and scored in a consistent manner. Often these tests are also norm-referenced and used to establish age equivalencies for children's performance.

Top-down approach: This approach involves establishing what roles the child/student/family needs to perform or desires to do, what skills are needed to perform those roles, and what resources and/or services are needed to meet those needs/desires. The outcome of the top-down approach is the development of a skill.

Transdisciplinary model: This model is characterized by a sharing or transferring of information and skills across traditional disciplinary boundaries. There is a high degree of collaboration and joint decision-making among the team members (York, Rainforth, & Giangreco, 1990; Orelove & Sobsey, 1991).

Transition planning: A results-oriented process that is focused on improving the academic functional achievement of a child with a disability to facilitate the child's movement from school to post-school activities, including postsecondary education, vocational education, and/or integrated employment, which includes supported employment, continuing and adult education, adult services, independent living or community participation. It takes into account the individual child's needs by considering his/her strengths, preferences and interests and 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 [COMAR 13A.05.01.03B(80)].

Transitions: Key phases of change for all children, including moving from Part C to Part B, preschool to school, elementary to

middle, middle to high school, and high school to post-school activities.

Universal Design for Learning (UDL): UDL principles and guidelines are an approach for designing curriculum, shaping instruction, selecting instructional materials/technology, and developing assessments that provide greater access to learning for all students. UDL provides a blueprint for creating instructional goals, methods, materials, and assessments that work for everyone--not a single, one-size-fits-all solution, but rather flexible approaches that can be customized and adjusted for individual needs.

Additional information about UDL can be found at:
http://marylandlearninglinks.org/950
http://www.cast.org/udl/

Visual motor skills: Also known as eye-hand coordination, skills that are a result of the ability to use visual information to create fine motor movement.

Workload: Workload refers to all activities required and performed by early intervention and school-based occupational and/or physical therapists.

References

AOTA. (2008). Occupational therapy practice framework: Domain & process (2nd ed.). *American Journal of Occupational Therapy, 62,* 625-683.

AOTA. (2006a). *Occupational therapy for children: Birth to 3 years of age* [Fact sheet]. Retrieved March 27, 2007, from the AOTA Web site: http://www.aota.org/featured/area6/docs/Child0-3fact.pdf

AOTA. (2006b). *Occupational therapy in educational settings under the Individuals with Disabilities Education Act* [Fact sheet]. Retrieved March 16, 2007, from the AOTA Web site: http://www.aota.org/featured/area6/docs/ssfact.pdf

AOTA. (2007). *FAQ on response to intervention*. Bethesda, MD: Author.

APTA. (2001). *Guide to physical therapist practice (Rev. 2nd ed.)*. Alexandria, VA: Author.

APTA (Practice Committee of the Section on Pediatrics). (2003a). *Providing physical therapy in schools under IDEA*. Retrieved March 27, 2007, from the APTA Web site: http://www.pediatricapta.org/graphics/GuideFactSheet.pdf

APTA. (Practice Committee of the Section on Pediatrics). (2003b). *Using APTA's guide to physical therapist practice in pediatric settings*. Retrieved March 27, 2007, from the APTA Web site: http://www.pediatricapta.org/graphics/IDEA%20Part%20C.pdf

APTA. (Practice Committee of the Section on Pediatrics). (2004). *Early intervention: Physical therapy under IDEA*. Retrieved March 27, 2007, from the APTA Web site: http://www.pediatricapta.org/graphics/IDEA%20Part%20B.pdf

APTA. (Practice Committee of the Section on Pediatrics). (n.d.). *Evidence-based practice in pediatric physical therapy*. Retrieved March 27, 2007, from the APTA Web site: http://www.pediatricapta.org/graphics/Evidence-based%20Practice%20Fact%20Sheet.pdf

Board of Occupational Therapy Practice, Code of Maryland Regulations, § 10.04 (2000).

Board of Physical Therapy Examiners, Code of Maryland Regulations, § 10.38 (2006, April 24).

Board of Physical Therapy Examiners. (n.d.). *Frequently asked questions.* Retrieved March 27, 2007, from the Maryland Department of Health and Mental Hygiene Web site: http://www.dhmh.state.md.us/bphte/bdinfo/faq.htm

Clark, G. F. , Brouwer, A., Schmidt, C., & Alexander, M. (2008). Response to Intervention (RtI) Model: Using the print tool to develop a collaborative plan. *OT Practice, 13*(14), 9–13.

Comar 13A.13.01.02. (n.d.). Early intervention services to eligible infants and toddlers and their families. Definition 21. Retrieved March 27, 2007, from the Maryland Office of the Secretary of State Division of State Documents Web site: http://www.dsd.state.md.us/comar/13a/13a.13.01.02.htm

Comar 13A.13.01.06. (n.d.). Provision of a free, appropriate public education. Retrieved March 27, 2007, from the Maryland Office of the Secretary of State Division of State Documents Web site: http://www.dsd.state.md.us/comar/13a.1301.06.htm

Comar 13A.13.01.08. (n.d.). Early intervention services to eligible infants and toddlers and their families. Retrieved March 27, 2007, from the Maryland Office of the Secretary of State Division of State Documents Web site: http://www.dsd.state.md.us/comar/13a/13a.13.01.08.htm

Council for Exceptional Children. (2002). Understanding the differences between IDEA and Section 504. *Teaching Exceptional Children, 34*(3). Retrieved March 27, 2007, from the LD Online Web Site: http://www.ldonline.org/article/6086?theme=print

Council of Educators for Students with Disabilities. (2003). *504 overview*. Retrieved March 27, 2007, from: http://www.504idea.org/504resources.html

Department of Health and Mental Hygiene. (n.d.). Title 10. Subtitle 46 Board of Occupational Therapy Practice. Retrieved March 27, 2007, from the Maryland

Occupational Therapy Board Web site: http://mdotboard.org/21-55.pdf

Duke University Center for Aging and Human Development. (2000). *Resources for teaching and assessment.* Retrieved March 30, 2007, from http://www.geri.duke.edu/pepper/osteocurriculum/teachresource.pdf

Dunn, W. (2000). *Best practice in occupational therapy in community service with children and families.* Thorofare, NJ: Slack.

Goldstein, D. N., Cohn, E., & Coster, W. (2004, Summer). *Enhancing participation for children with disabilities: Application of the ICF enablement framework to pediatric physical therapist practice, 16*(2), 114-120.

Gorn, Susan. (1998). *What do I do when...The answer book on Section 504.* Horsham, PA: LRP Publications.

Hanft, B. E., and Pilkington, K. O. (2000). Therapy in natural environments: The means or end goal for early intervention? *Infants and Young Children, 12*(4), 1-13.

Hanft, B. E. (n.d.). *Early childhood tutorial* [Series of three Web-based modules]. Retrieved April 10, 2008 from the Maryland State Department of Education Web site: http://olms.cte.jhu.edu/olms/output/page.php?id=1214

Illinois State Board of Education. (2003). *Recommended practices for occupational and physical therapy in Illinois schools.* Retrieved March 30, 2007, from the Illinois State Board of Education Web site: http://www.isbe.state.il.us/SPEC-ED/pdfs/occupational_therapy.pdf

Individuals with Disabilities Education Improvement Act (IDEA) of 2004. Public Law 108-446, 20 U.S.C.

Iowa Department of Education. (2001, February). *Iowa guidelines for educationally related physical therapy services.*

Jackson, L. (2005, March 17). *What the new IDEA means to OT/PT.* Power Point presentation to the Practice Committee on August 25, 2005.

Jackson, L., Polichino, J., & Potter, K. (2006). Transforming caseload to workload in school-based and early

intervention occupational therapy services. *Practice Tips for Occupational Therapists and Occupational Therapy Assistants from the American Occupational Therapy Association*. Bethesda, MD: AOTA.

Jette, A. (2005, February). The changing language of disablement. *The Journal of the American Physical Therapy Association*, 1-3.

Ketelaar, M., Vermeer, A., Hart, H., Beek, E., & Helders, P. (2001). Effects of a functional therapy program on motor abilities of children with cerebral palsy. *Physical Therapy, 81*(9), 1534-1545.

Legal Aid Bureau. (2003, September 19). *Special education – The law in Maryland*. Retrieved March 27, 2007, from the People's Law Web site: http://www.peoples-law.org/education/spec-ed-law.htm#comar

LD Online. (2006). IDEA 2004. Retrieved March 27, 2007, from the LD Online Web site: http://www.ldonline.org/features/idea2004#purpose

Lundy, H. (2006, July). *Physical Therapy in the Educational Setting*. Temple, TX: Communicate and Negotiate, LLC.

Mahoney, G., Robinson, C., & Perales, F. (2004). Early motor intervention: The need for new treatment paradigms. *Infants and Young Children, 17*(4), 291-300.

Maryland Special Education Law and Policy Manual. (2001). Part II. Maryland regulatory provisions. [2000-2001 ed.]. Subtitle 05 Special Instructional Programs. .03 Definitions. 40 & 49. Matthew Bender: Charlottesville, VA

McEwen, I. (Ed.). (2000). Providing physical therapy services: Under Parts B & C of the Individuals with Disabilities Education Act (IDEA). Alexandria, VA: American Physical Therapy Association.

McEwen, I. (2006). *Educationally-Relevant PT Intervention* [PowerPoint slides]. From the course Providing School-Based Physical Therapy under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA), January 13-14, 2006.

Maryland State Department of Education. (2003). Divisions. Overview. Special Education and Early Intervention. Retrieved March 27, 2007, from the Maryland State

Department of Education Web site: http://www.marylandpublicschools.org/MSDE/divisions/earlyinterv/

Maryland State Department of Education. (2011). Early Intervention and Special Education web portal: http://marylandlearninglinks.org

Metzger, D. (2003). *Maryland infants and toddlers program and preschool special education services*. Retrieved October 14, 2008, from the Maryland State Department of Education Web site: http://www.marylandpublicschools.org/MSDE/divisions/earlyinterv/infant_toddlers/about/message.htm

Muhlenhaupt, M. (2003a). Evidence-based practice in the schools: How can we begin? *The Israel Journal of Occupational Therapy*, *12*(1), E19-E35.

Muhlenhaupt, M. (2003b, March). *Frequently Asked Questions about School-based OT and PT Practices.* Retrieved December 1, 2008, from the Kids OT Web site: http://www.kidsot.com/kidsotweb_files/SBOTQ&Acolor.pdf

Myers, C.T., & Effgen, S.K. (2006). Physical therapists' participation in early childhood transitions. *Pediatric Physical Therapy*, *18*, 182-189.

No Child Left Behind Act (NCLB) of 2001. Public Law 107-110, 20 U.S.C.

Occupational and Physical Therapy Five County Task Force. (1999). *Maryland guidelines for occupational therapy and physical therapy in public schools.* Baltimore: Maryland State Department of Education.

Office for Civil Rights. (2005, March 4). *Protecting students with disabilities. Frequently asked questions about Section 504 and the education of children with disabilities.* Retrieved March 27, 2007, from the U.S. Department of Education Web site: http://ed.gov/about/offices/list/ocr/504faq.html

Orelove, F., & Sobsey, D. (1991). *Educating children with multiple disabilities: A transdisciplinary approach (2nd edition)*. Baltimore: Brooks.

Swinth, Y., Chandler, B., Hanft, B., Jackson, L., & Shepherd, J. (2003, May). *Personnel issues in school-based occupational therapy: Supply and demand, preparation, certification and licensure.* Retrieved April 20, 2006, from www.coe.ufl.edu/copsse/docs/IB-1/1/IB-1.pdf.

U. S. Department of Education (1999, July). *Free appropriate public education for students with disabilities: Requirements under Section 504 of the Rehabilitation Act of 1973.* Retrieved March 27, 2007, from the U.S. Department of Education Web site: http://www.ed.gov/about/offices/list/ocr/docs/edlite-FAPE504.html

U. S. Department of Education. (2005). *IDEA-Reauthorizing Statute Early Intervening Services.* Retrieved June 13, 2008, from http://www.nichcy.org/reauth/tb-early-intervent.pdf

U. S. Department of Education. (2007). *Building the legacy: IDEA 2004.* Retrieved March 27, 2007, from the U.S. Department of Education Web site: http://idea.ed.gov/

Valvano, J. & Rapport, M. (2006). Activity-focused motor interventions for infants and young children with neurological conditions. *Infants and Young Children, 19* (4), 292-307.

Vermont Department of Education. (2001). *Guidelines for making decisions about I.E.P. services.* Retrieved March 16, 2007, from http://www.uvm.edu/~cdci/iepservices/pdfs/decision.pdf

World Health Organization. (2001). *International classification of functioning, disability and health (ICF).* Geneva, Switzerland: Author.

Wright, P.W.D. (2006, September 13). *The Individuals with Disabilities Education Improvement Act of 2004. Overview, explanation and comparison.* Retrieved March 27, 2007, from the Wrightslaw Web site: http://www.wrightslaw.com/

York, J., Rainforth, B. & Giangreco, M. (1990). Transdisciplinary teamwork and integrated therapy: Clarifying the misconceptions. *Pediatric Physical Therapy*, 73-78.

Resources

State and Federal Regulations

Individuals with Disabilities Education Improvement Act (IDEA) of 2004. Public Law 108-446, 20 U.S.C.

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

Maryland State Department of Education
Website: http://www.marylandpublicschools.org/msde
IEP Process Guide
On-line IEP

Maryland Board of Occupational Therapy Practice
Website: www.mdotboard.org

Maryland Board of Physical Therapy Examiners
Website: www.dhmh.state.md.us/bphte/

Code of Maryland Regulations (COMAR), Division of State Documents
Website: www.dsd.state.md.us/comar/

School-Based Practice Resources

Effgen, S.K. (2005). Service delivery settings: Schools. In S. K. Effgen, *Meeting the physical therapy needs of children* (pp. 377-396). Philadelphia: F. A. Davis Co.

Effgen, S.K. (2006). The educational environment. In: Campbell, S., Palisano, R., & Vander Linder, D. *Physical therapy for children, 3rd edition*. (pp. 377-396). Philadelphia, PA: Saunders Elsevier.

Effgen, S.K., Chiarello, L., & Milbourne, S. A. (2007). Updated competencies for physical therapists working in school. *Pediatric Physical Therapy*, *19*, 266-274.

Giangreco, M. F., & Edelman, S. W. (1996, December). How to make decisions about related service delivery in schools. *School System: Special Interest Section Quarterly*, *3*(4), 7-8.

Gombash, L. (1998). *PT assistant in the schools.* San Antonio, TX: Therapy Skill Builders.

Jackson, L. (2006). *The new IDEA: An occupational therapy toolkit* [CD-ROM]. Bethesda, MD: American Occupational Therapy Association.

Jackson, L. (2007). *Occupational therapy services for children and youth under IDEA* (3rd ed.). Bethesda, MD: American Occupational Therapy Association.

Jackson, L., Swinth, Y., & Clark, G. F. (2006). *Role of the occupational therapist under IDEA fact sheet*. Bethesda, MD: American Occupational Therapy Association.

LD Online. (2006). IDEA 2004. Retrieved March 27, 2007, from the LD Online Web site: http://www.ldonline.org/features/idea2004#purpose

McEwen, I. (Ed.). (2000). *Providing physical therapy services: Under Parts B & C of the Individuals with Disabilities Education Act (IDEA)*. Alexandria, VA: American Physical Therapy Association.

Council for Exceptional Children
Website: www.cec.sped.org

National Dissemination Center for Children
Website: www.nichcy.org

Early Intervention

Chiarello, L., & Effgen, S.K. (2006, Summer). Updated competencies for physical therapists working in Early Intervention. *Pediatric Physical Therapy*, *18*(2), 148-158.

Dunst, C.J., Hamby, D., Trivette, C.M., Raab, M., & Bruder, M.B. (2000). Everyday family and community life and children's naturally occurring learning opportunities. *Journal of Early Intervention, 23,* 151-164.

Hanft, B. E. (n.d.). *Early childhood tutorial* [Series of three Web-based modules]. Retrieved July 17, 2007, from the Maryland State Department of Education Web site: http://olms.cte.jhu.edu/olms/output/page.php?id=1214

Hanft, B. & Pilkington, K. (2000). Therapy in natural environments: The means or end goal for early intervention? *Infants and Young Children, 12*(4), 1-13.

Kleinert, J.O. & Effgen, S.K. (2005). Service delivery settings: Early intervention. In S.K. Effgen. *Meeting the physical therapy needs of children* (pp. 361-376). Philadelphia: F.A. Davis Co.

Valvano, J. & Rapport, M. (2006). Activity-focused motor interventions for infants and young children with neurological conditions. *Infants and Young Children, 19*(4), 292-307.

Evidence-Based Practice

Canadian Association of Occupational Therapists (CAOT). (1999). Joint position statement on evidence-based occupational therapy (1999). Retrieved March 27, 2007, from the CAOT Web site: http://www.caot.ca/default.asp?pageID=156

Jewell, D.V. (2008). Guide to evidence-based physical therapy practice. Sudbury, MA: Jones & Bartlett.

American Occupational Therapy Association, Inc.
Evidence Briefs Series
Website: www.aota.org

American Physical Therapy Association
Open Door and Hooked on Evidence (for APTA members)
Website: http://www.apta.org

Center of Personnel Studies in Special Education
Website: www.copsse.org

PubMed (Service of U.S. National Library of Medicine & National Institutes of Health)
Website: www.pubmed.com

Centre for Childhood Disability Research (McMaster University)
Website: www.canchild.ca

Appendices

Appendix A: Core Competencies for Licensed Therapists

Updated Competencies for Physical Therapists Working in Early Intervention

Chiarello, L. & Effgen, S. (2006). Updated competencies for physical therapists working in early intervention. *Pediatric Physical Therapy*, *18*, 151-154.

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Early-Intervention Competency Areas

Content Area A: The context of therapy in early intervention settings

1. Demonstrate knowledge of local, state, and federal laws, rules, and regulations regarding service delivery
    a. discuss the implications of PL 94–142, PL 99–457, PL 105–17, and PL 108–446 and their reauthorizations
    b. apply the guidelines of federal, state and local regulations
    c. identify and use information sources for federal, state, and local legislation and regulation changes
    d. discuss and demonstrate professional behavior regarding ethical and legal responsibilities
    e. discuss professional competencies as defined by professional organizations and state regulations
    f. advocate to support family and child entitlements

2. Demonstrate knowledge of family systems theory, recognize the central importance of the family, and be able to provide family centered services
    a. identify and discuss how the following factors may affect a child's and family's experience with an early intervention program:
        i. cultural
        ii. socioeconomic
        iii. ethical
        iv. historical
        v. personal values

    b. conduct a family interview using active listening skills to gather information on: family's knowledge, strengths, concerns, and priorities regarding their
        i. child
        ii. family lifestyle and beliefs
        iii. services and outcomes desired

c. respect the family and acknowledge that the family is the most significant member of the team
d. advocate that children are best understood in the contexts of family, culture, and community

3. Recognize the impact of a child with special needs on a family unit throughout the family life cycle
    a. describe a typical daily routine and activities that families may encounter
    b. implement basic strategies to support the family unit, including the parents, parent-child relationships, and sibling subsystems

4. Support the parents' primary roles as mother and father to the child
    a. assist the family in identifying and developing:
        i. internal and external resources
        ii. a social support network
        iii. advocacy skills
    b. advocate the right of parents to be decision makers in the early intervention process
    c. provide parents with the information and options needed for informed decisions
    d. respect parents' choices and goals for their children

5. Collaborate and encourage family involvement with the early-intervention process
    a. implement, a range of family-oriented services based on the family's identified resources, priorities, and concerns
    b. provide information on family oriented conferences and support groups in the community
    c. demonstrate people first and family friendly communication and interaction skills
    d. communicate effectively with parents about curriculum and the child's progress

Content Area B: Wellness and prevention in early intervention settings

1. Promote public awareness of early-intervention services
    a. disseminate information about the availability, criteria for eligibility, and methods of referral
    b. collect and use data from multiple sources for child-find systems

2. Design and implement a screening program to identify infants and toddlers at risk for developmental delay
    a. demonstrate knowledge of genetic and cultural differences in standards of growth and development
    b. identify the etiology, signs and symptoms, and classifications of common pediatric disabilities
    c. identify established biological and environmental factors that affect children's development and learning
    d. demonstrate understanding of developmental consequences of maternal health and nutrition, social supports, and stress

3. Select, administer, and interpret a variety of screening instruments and standardized measurement tools
   Apply knowledge of:
   a. child development from cognitive, adaptive, motor, social-emotional, and communication perspectives
   b. the interrelationship among developmental areas
   c. the range of normal variations of development
   d. the difference between delayed and atypical development

4. Promote child safety by educating caregivers on:
   a. child development
   b. environmental and toy hazards and safety measures
   c. accident prevention
   d. recognition of child neglect and abuse

Content Area C: Coordinated care in early intervention settings

1. Form a partnership and work collaboratively with other team members, especially the child's family
   a. refer and coordinate services among family, other professionals, community agencies, day care programs
   b. demonstrate effective and appropriate interpersonal communication skills
   c. implement strategies for team development and management
   d. develop mechanism for ongoing team coordination
   e. function as an interdisciplinary or transdisciplinary team member
   f. if applicable, serve as a service coordinator

2. Function as a consultant
   a. identify the administrative and interpersonal factors that influence the effectiveness of a consultant
   b. provide technical assistance to other early intervention team members, community agencies, and medical facilities

3. Supervise personnel and professional students
   a. monitor the implementation of therapy recommendations by other team members
   b. establish a student clinical affiliation
   c. formally and informally teach/train therapy staff

Content Area D: Evaluation and assessment in the early intervention setting

1. Individualize the evaluation and assessment for child, team, and family needs
   a. offer flexible scheduling
   b. provide options for multiple settings
   c. solicit input on the process
   d. establish consensus of content including domains of child development and family routines

2. Evaluate family strengths, resources, concerns, and priorities
    a. conduct family interview
    b. select and administer supplemental family surveys

3. Selectively gather, interpret, and report information from available medical/developmental records

4. Evaluate and assess child abilities and strengths including
    a. functional ability including activities of daily living, play, and gross motor, fine motor, perceptual motor, and oral motor skills
    b. musculoskeletal status
    c. neuromotor status
    d. sensory status
    e. cardiopulmonary status

5. Use valid, reliable, and nondiscriminatory examination instruments and procedures for
    a. identification and eligibility
    b. diagnostic evaluation
    c. individual program planning
    d. documentation of child progress, family outcomes, and program impact

6. Function as a team leader and/or member in a multidisciplinary, interdisciplinary, or transdisciplinary assessment through
    a. organization
    b. time management
    c. timeliness
    d. constructive feedback
    e. consensus building
    f. wrap-up

Content Area E: Planning

1. Actively participate in the development of the Individualized Family Service Plan
    a. accurately interpret and communicate examination findings to the family and other team members
    b. discuss and integrate examination findings from family and other team members
    c. solicit from family their goals of the early intervention process
    d. Prioritize needs identified during examination according to:
        i. family preference and goals
        ii. environmental demand
        iii. future environmental demands
        iv. resources
        v. developmental level
        vi. past history
    e. collaboratively establish IFSP outcomes that are meaningful to the child and family

f. communicate options for strategies, programs and services to family
g. establish consensus on strategies, programs and services

2. Integrate an interdisciplinary understanding of the home, child care, medical and social community of the child and family into the IFSP:
   a. inquire about family routines and activities
   b. establish contact and with permission consult with child care / preschool providers
   c. establish collaborative relationship with any relevant medical personnel
   d. inquire about community resources from local interagency coordinating council
   e. gather family information on community activities, programs, services, and resources

3. Develop mechanism for ongoing coordination and collaboration regarding the IFSP
   a. implementation of the IFSP
   b. update or modify IFSP
   c. transition planning and implementation of the transition plan
   d. interagency activities

Content Area F: Intervention

1. Develop and implement appropriate intervention programs and strategies that address or incorporate:
   a. self-care, mobility, learning and play
   b. values of the family and child's culture
   c. developmentally and individually appropriate activities
   d. environmental adaptations in the home and community
   e. information and strategies from multiple disciplines
   f. medical care of infants and toddlers
   g. methods of behavior support and management

2. Assist families in accessing services that promote full inclusion of child and family into the community
   a. provide services in the child's natural environments
   b. communicate with, and educate, family/caregivers, teachers, and others regarding intervention strategies
   c. implement small group parent-child and peer activities when appropriate for a particular community setting
   d. link current intervention plan with the next educational setting

3. Integrate therapy intervention strategies into home and community settings:
   a. support and facilitate family child interaction as primary context for learning and development
   b. use daily routines including child care activities such as feeding, bathing, dressing, and playing
   c. use parent and child mediated activities during intervention

d. modify intervention strategies according to changes in the child's interests, functional level, medical status, or family needs

Content Area G: Documentation issues in early-intervention settings

1. Produce useful written documentation by:
   a. using commonly understood and meaningful terms
   b. maintaining timely and consistent records
   c. concisely summarizing relevant information
   d. sharing records with family and other team members

2. Demonstrate the ability to write the IFSP document, including:
   a. current developmental and functional status of the child
   b. long-and short-term child and family objectives that are meaningful, functional and measurable
   c. objective means of monitoring progress
   d. description of the early intervention and community services
   e. justification for frequency, intensity, location, and service delivery

3. Document to convey information to family, other team members, and funding agencies, including:
   a. summary of intervention session
   b. child's response
   c. ideas for daily activities and routines
   d. plans for new intervention strategies and resources

4. Collaboratively monitor and modify child's intervention plan
   a. establish a mechanism for ongoing communication with family and other team members
   b. record summary of communications with family and other team members
   c. establish a plan for re-evaluation
   d. schedule pre-established team meetings to review child's progress

5. Evaluate and document the effectiveness of therapy intervention strategies and therapeutic procedures
   a. establish baseline of child's developmental and functional status
   b. collect ongoing data on the child's progress toward stated IFSP outcomes
   c. summarize data to determine child's progress
   d. make recommendations for modifications of IFSP

Content Area H: Administration issues in early intervention settings

1. Function as an administrator:
   a. identify the philosophy, goals, structure and function, and administrative needs of the early intervention program and therapy services
   b. apply knowledge of other disciplines' roles and functions for program planning and policy formation

c. develop and implement criteria and procedures for job descriptions, recruitment, staff selection, supervision, and performance appraisals
d. develop therapy policies and procedures
e. direct therapy services and delegate appropriate responsibilities
f. establish appropriate and manageable caseloads
g. meet deadlines in order to be able to provide services in a timely and efficient manner
h. identify and develop appropriate referral mechanisms
i. develop procedures for documenting service in accordance with Codes of Ethics, funding agency policies, and federal, state, and local regulations

2. Demonstrate the ability to assist and support the professional development of early intervention personnel
   a. identify and access intramural and extramural funding sources and resources
      i. community
      ii. state
      iii. national
   b. provide onsite in-service training
   c. establish intra-agency mentoring program
   d. implement individualized professional development plan

3. Demonstrate leadership abilities in promoting effective team processes
   a. facilitate regularly scheduled staff meetings
   b. implement mentor program
   c. provide opportunity for staff in-service trainings
   d. selectively delegate responsibilities
   e. allocate time for team collaboration
   f. mediate team differences

Content Area I: Research in early intervention settings

1. Demonstrate knowledge of current research relating to infant development, medical care, and developmental intervention for infants and toddlers
   a. conduct a literature review using such reference materials as Index Medicus, or
   b. other data base sources
   c. seek assistance from experienced researchers in interpreting published research
   d. critically evaluate published research

2. Apply knowledge of research to the selection of therapy intervention strategies, service delivery systems, and therapeutic procedures in early intervention
   a. use objective criteria for evaluation
   b. justify rationale for clinical decision making
   c. expand clinical cases into single-subject studies

3. Partake in program evaluation and clinical research activities with the appropriate supervision
   a. identify topics in early intervention in which research efforts are needed

b. secure resources to support clinical research
c. implement clinical research projects
d. disseminate research findings

Updated Licensure Competencies for Physical Therapists Working in Schools

Effgen, S., Chiarello, L., & Milbourne, S. (2007). Updated competencies for physical therapists working in schools. *Pediatric Physical Therapy, 19*, 269-271.

Competencies for School-Based [Physical] Therapists

Content Area 1: The Context of Therapy Practice in Schools

1. Knowledge of the structure, global goals, and responsibilities of the public education system, including special education
   a. diagram the functional and supervisory organization of the education system served by the therapist
   b. identify the goals and outcomes of the educational curriculum from preschool through high school
   c. demonstrate an understanding of the eventual goals of independent living and working
   d. apply knowledge of the outcomes-based education curriculum

2. Knowledge of federal (for example IDEA, Rehabilitation Act of 1973, & ADA), state, and local laws and regulations that affect the delivery of services to students with disabilities
   a. discuss the implications of the laws (national, state and local)
   b. apply the guidelines of federal, state, and local regulations
   c. identify and use information sources for federal, state, and local legislation and regulation changes
   d. discuss and demonstrate professional behavior regarding ethical and legal responsibilities
   e. discuss professional competencies as defined by professional organizations and state regulations
   f. advocate to support services related to educational entitlements

3. Knowledge of the theoretical and functional orientation of a variety of professionals serving students within the educational system
   a. initiate dialogue with colleagues to exchange professional perspectives
   b. disseminate information about the availability of therapy services, criteria for eligibility, and methods of referral
   c. describe evaluations and interventions commonly used by psychologists, diagnostic educators, classroom teachers, speech and language pathologist, adaptive physical educators, nurses, physical therapists, occupational therapists, and professionals in other education and health-related disciplines

4. Assist students in accessing community organizations, resources and activities
   a. demonstrate awareness of cultural and social differences that relate to family and student participation in the education program
   b. in collaboration with the educational team, develop a plan for transition into community activities or adult services
   c. identify the need to make appropriate student referrals to community therapy and recreational services when school services are not able to meet all of the child's needs
   d. include the family in the educational process
   e. serve as a resource to family and other team members for information and appropriate community resources (medical, educational, financial, social, recreational, and legal)

Content Area 2: Wellness and Prevention in Schools

1. Implement school wide screening program with school nurse, physical education teacher, and teachers
   a. apply knowledge of risk factors affecting growth, development, and learning
   a. identify the etiology, signs, symptoms, and classifications of common pediatric disabilities
   b. identify established biological and environmental factors that affect children's development and learning
   c. select, administer, and interpret a variety of screening instruments and standardized measurement tools

2. Promote child safety and wellness using knowledge of environmental safety measures
   a. maintain CPR certification
   b. institute an environmental hazards and accident prevention plan
   c. recognize child neglect and abuse

Content Area 3: Team Collaboration

1. Form partnerships and work collaboratively with other team members, especially the teacher to promote an effective plan of care
   a. demonstrate effective communication and interpersonal skills
   b. refer and coordinate services among family, school professionals, medical service providers, and community agencies
   c. implement strategies for team development and management
   d. develop mechanism for ongoing team coordination

2. Function as a consultant
   a. identify the administrative and interpersonal factors that influence the effectiveness of a consultant

b. implement effective consultative strategies
c. provide technical assistance to other school team members, community agencies, and medical providers

3. Educate school personnel and family to promote the inclusion of the student within the educational experience
   a. assist school administrators with development of policy and procedures
   b. provide orientation to teachers and classroom aides
   c. conduct in-service sessions
   d. develop informational resources

4. Supervise personnel and professional students
   a. apply effective strategies of supervision
   b. monitor the implementation of therapy recommendations by other team members
   c. establish a student clinical affiliation
   d. formally and informally teach or train therapy staff

5. Serve as an advocate for students, families, and school
   a. attend public hearings
   b. serve on task force or decision making committees
   c. provide necessary information to support student rights
   d. actively participate in IEP process

Content Area 4: Examination and Evaluation in Schools

1. Identify strengths and needs of student
   a. interview student, family, teachers, and other relevant school personnel
   b. gather information from medical personnel and records
   c. observe student in a variety of educational settings

2. Collaboratively determine examination and evaluation process
   a. designate appropriate professional disciplines
   b. identify environments and student activities and routines
   c. select instruments
   d. establish format for conducting examination
   e. inform and prepare the student

3. Determine student's ability to participate in meaningful school activities by examining and evaluating
   a. level of participation and necessary assistance and adaptations through formal naturalistic observations
   b. functional abilities including: gross motor, fine motor, perceptual motor, cognitive, social/emotional, and ADL
   c. impairments related to functional ability including: musculoskeletal status, neuromotor organization, sensory function, and cardiopulmonary status

4. Utilize valid, reliable, cost-effective, and nondiscriminatory instruments for
   a. identification and eligibility
   b. diagnostic purposes
   c. individual program planning
   d. documentation of progress

Content Area 5: Planning

1. Actively participate in the development of the Individualized Education Plan
   a. determine eligibility related to a student's educational program
   b. accurately interpret and communicate examination findings collaboratively with family, student, and other team members
   c. discuss prognosis of student performance related to curricular expectations
   d. discuss and prioritize outcomes related to student's educational needs based on current and future environmental demands and student and family preferences and goals
   e. offer appropriate recommendations for student placement and personnel needs in the least restrictive educational setting with intent to serve children in inclusive environments
   f. in collaboration with the team, determine how therapy can contribute to the development of an individualized educational program (IEP) including
      i. meaningful student outcomes
      ii. functional and measurable goals and objectives
      iii. therapy service recommendations
      iv. specific intervention methods and strategies
      v. determination of frequency, intensity, and duration
   g. develop mechanism for ongoing coordination and collaboration regarding the IEP
      i. implementation of the IEP
      ii. updating or modifying the IEP
      iii. transition planning and implementation of the transition plan
      iv. interagency activities

Content Area 6: Intervention

1. Adapt environments to facilitate student access to and participation in student activities
   a. recommend adaptive equipment, assistive technology, and environmental adaptations
   b. monitor adaptive equipment, assistive technology, and environmental adaptations
   c. be able to instruct student and other team members in the appropriate use of adaptive equipment and assistive technology
   d. identify sources for obtaining, maintaining, repairing, and financing adaptive equipment, assistive technology, and environmental adaptations

2. Use various types and methods of service provision for individualized student interventions:
   a. direct, individual, group, integrated, consultative, monitoring, and collaborative approaches
   b. develop generic instruction plans and intervention plans that select and sequence strategies to meet the objectives listed on the student's IEP

3. Promote skill acquisition, fluency, and generalization to enhance overall development, learning, and student participation
   a. use creative problem-solving strategies to meet the student's needs
   b. explain the basic motor learning theories, and relate them to therapy education programs
   c. address neuromuscular, musculoskeletal, sensory processing, and cardiopulmonary functions that support motor, social, emotional, cognitive, and language skills

4. Embed therapy interventions into the context of student activities and routines
   a. implement appropriate positioning, mobility, environmental, and ADL strategies into curriculum, classroom schedule and routines
   b. develop a matrix integrating objectives, routines and activities, and strategies

Content Area 7: Documentation

1. Produce useful written documentation by:
   a. writing reports in commonly understood and meaningful terms
   b. maintaining timely and consistent records
   c. concisely summarizing relevant information
   d. sharing records with family and other team members

2. Collaboratively monitor and modify student's IEP
   a. establish a mechanism for and record ongoing communication with family and other team members
   b. establish a plan of action for re-evaluation
   c. schedule pre-established team meetings to review student progress over the course of the school year

3. Evaluate and document the effectiveness of therapy programs
   a. establish baseline of student's level of participation and functional status
   b. collect ongoing data on the student's progress toward stated IEP outcomes
   c. summarize data to determine student's progress

Content Area 8: Administrative Issues in Schools

1. Demonstrate flexibility, priority setting, and effective time management strategies

2. Obtain resources and data necessary to justify establishing a new therapy program or altering an existing program

3. Serve as a leader
   a. integrate knowledge of education, health, and social trends that impact therapy services
   b. identify and educate others on the overall roles, responsibilities, and functions of therapy services
   c. identify and differentiate characteristics of alternative approaches for resolving needs of therapy services
   d. identify the administrative needs of the therapy service within the school setting
   e. serve as a role model to other therapists regarding professional responsibilities

4. Serve as a manager
   a. develop and analyze job descriptions for therapists
   b. implement a recruitment, orientation, mentorship, and professional development program for therapists and staff
   c. develop and implement policies and procedures to guide therapy services
   d. establish therapy caseloads and staffing needs
   e. evaluate the performance of therapy personnel
   f. plan and implement a therapy quality assurance plan and program evaluation
   g. participate in the assessment of school facilities and educational activities
   h. makes recommendations, especially related to ensuring accessibility to and reasonable accommodations in school environments
   i. identify and use appropriate school, home, community, state, and national resources, especially funding sources
   j. demonstrate the ability to plan and manage a budget for the therapy component of services

Content Area 9: Research

1. Demonstrate knowledge of current research relating to child development, medical care, educational practices, and implications for therapy
   a. conduct a literature review
   b. seek assistance for experienced researchers in interpreting published research
   c. critically evaluate published research

2. Apply knowledge of research to the selection of therapy intervention strategies, service delivery systems, and therapeutic procedures
   a. use objective criteria for evaluation
   b. justify rationale for clinical decision making
   c. expand clinical treatment cases into single-subject studies

3. Partake in program evaluation and clinical research activities with the appropriate supervision
   a. identify research topics
   b. secure resources to support clinical research
   c. implement clinical research projects
   d. disseminate research findings

Appendix B: IEP Development

Therapist Guide to Maryland Statewide Online IEP Documentation

General Tips

- The IEP document includes decisions made during the IEP team meeting; the IEP is finalized during the IEP team meeting. The form includes space to document discussion and the basis for the decisions.

- The IEP document may contain information from other IEP team meetings (those convened to discuss behavior, manifestation, academic progress, parental concerns, etc.) under the appropriate Present Levels section.

- If your LOCAL SCHOOL SYSTEM is using the Maryland Online IEP, the following documents are very helpful in the development of an IEP, and are accessible in the online IEP tool ; The Maryland Statewide IEP Process Guide, *The Maryland Online IEP Users Guide*, along with Wizards to help complete several of the IEP sections.

- It is important to complete **discussion and documentation** in each area of the IEP as appropriate.

- If the LEA uses the Maryland Online IEP system, there is a Prior Written Notice (PWN) form available as part of the tool that can be used to document considerations and decisions made during the IEP meeting. If your school system does not use the Maryland Online IEP tool, these decisions still must be documented.

- COMAR 13A.05.01.03B(9) effective July 1, 2012, at least five (5) business days before a scheduled IEP team meeting or other multidisciplinary education team meeting, school systems must provide parents with an accessible copy of each assessment report, data chart, draft IEP, or other document(s) the team plans to discuss at the meeting. Parents have the opportunity to notify the appropriate school personnel that they do not want to receive the document(s) required to be provided.

- No later than five (5) business days after a scheduled IEP or other multidisciplinary education team meeting, appropriate school personnel are to provide parents an accessible copy of the completed IEP.

Identifying Information, Evaluation & Eligibility, Student Participation Data on District/Statewide Assessments

Student and School Information

A county-level Maryland Online IEP Administrator must enter a student into the system. A Student's identifying information must be entered in order to save changes to the IEP.

Initial Evaluation/Eligibility Data

- **This section should be used by the IEP Team for the initial IEP ONLY**. An Initial IEP is the first IEP ever — for a student transferring in from another district with a Maryland IEP, use "Continued Eligibility" Data. If all special education services are discontinued, and the student then later qualifies for special education, you would choose Initial Evaluation/Eligibility Data.
- When identifying and discussing areas impacted by a suspected disability (initial evaluation section), the IEP team considers each of the following areas:
    1. Academic — be specific, such as reading comprehension, phonemic awareness, math calculations, math fluency, etc.
    2. Functional
    3. Developmental
    4. Physical
    5. Sensory
    6. Social or behavioral issues

Continued Eligibility Data

- Choose this heading for **all** IEPs after the initial IEP year. Ensure that all of the above areas are also considered by the IEP team during re-evaluation.
- The following information MUST be included in the discussion and documentation boxes in the evaluation report; document in this section the basis for decisions made by IEP team regarding evaluation and eligibility:
    1. A description of the actions proposed or refused
    2. An explanation of why the public agency proposes or refuses to take the action

3. A description of the options the public agency considered and the reason(s) the options were rejected
4. A description of each assessment procedure, test, record, or report the public agency uses as a basis for proposal or refusal
5. A description of any other factors relevant to the proposed or refused action

Student Participation on District/Statewide Assessments and Graduation Information

- The IEP team must document the basis for decision if identified for the alternate assessment based on alternate academic achievement standards with a statement such as: "The student is not able to successfully complete the standards outlined in the Maryland College and Career-Ready Standards given proper implementation of special education services."
- The IEP team must include a statement under graduation information such as: "Local School System requirements are the same as the State requirements" after the designation of whether student is pursuing a diploma or certificate.

IEP PROCESS
Categories of Academic and Functional Areas Assessed

If the IEP team identifies a need:

- An OT/PT would choose a Category and an Area, identify student needs, clearly link to an existing goal, embedded goal, supplementary aid, or service based on student need.
- Provide documentation in all categories that are affected by the student's disability.
- Present levels may be included under more than one category.
- The OT/PT should document present levels *consistently across the document* so the information moves to the goal page for that area.
- Some suggested choices/examples for relevant areas are included in the chart on the following page.

Suggested Choices/Examples for Relevant Areas

ACADEMIC	-Written Language Mechanics -Pre-Writing -Other	Report performance related to pre-writing and/or handwriting concerns that will be addressed through instruction, intervention, accommodations, and/or modifications
BEHAVIORAL	-Social-Emotional/ Behavioral -Social Interaction Skills -Self-Management -Other	Report performance related to sensory processing and self-regulation or for self-advocacy issues; may use for organizational skills
HEALTH	-Health/Medical -Hearing -Vision -Orientation & Mobility -Other	Report performance re: sensory loss due to a medical condition; pressure relief program (see example below) if needed to access or participate in the educational program. Document feeding issues that may contribute to nutrition.
PHYSICAL	-Fine Motor -Gross Motor -Independent Living – Feeding -Independent Community Living – Recreation & Leisure -Independent Community Living – Toileting -Independent Community Living – Dressing & Grooming -Other	Report motor skills and self-care skills AS THEY IMPACT performance in natural learning environments or an educational program May use “other” for categories such as “Functional Mobility” or “Independent Living Skills– Pre-Vocational”

OT/PT Examples

Examples of Categories Used by OTs/PTs

- For a student with autism, an OT could report under **Academic** to embed written work, **Behavioral** for Self-Management Skills, and **Physical** for Independent Community Living – Recreation & Leisure Skills.
- For a student with orthopedic impairments, a PT could report under **Physical** "Other" and type in "Functional Mobility."
- For a student who is unable to weight bear and is medically fragile, an OT/PT could provide instruction on proper lifting and equipment to use for pressure relief or alternative positioning for health maintenance and report under **Health** and then "Health/Medical" or "Other."
- For a student who is unable to participate in snack/lunch due to swallowing or aspiration concerns, an OT/PT could contribute to the development of the safe mealtime plan in conjunction with outside medical consultation.

IEP PROCESS
Documenting Academic and Functional Areas Assessed

Tips for Summary of Assessment Findings

- **Under sources of data**, include the date of administration.
- **If a student received OT or PT on the current IEP, information for review by the IEP team is provided, and an OT or PT must complete the Present Levels even if the IEP team is recommending to discontinue services.** If services are discontinued by the IEP team, the present levels should accurately reflect that the student can access, progress, and participate in his/her educational program (despite weaknesses and/or with instructional supports).
- **Consider the following to structure your summary:**
  The summary MUST start with the date and end with your name and credentials.
  (Discipline) Date
  Summary of Assessment Findings and/or Observations
  Strengths and Supports
  Areas of Educational Concern and Barriers
  Instructional Implications for Participation in General Education
  Name and Credentials (License number always for PTs, optional for OTs)

Summary of Assessment Findings and/or Observations

- Provide a narrative summary of performance using a variety of sources including assessments, classroom observations, portfolios, running records, PARENT INPUT, and input from the general education teacher. (Source information is entered in the next area.)
- Include curriculum-based assessments and teacher-made tests as appropriate.
- Use ONLY the most recent assessment data.
- Consider the following when documenting your summary (from the School Function Assessment):
    - Mobility — endurance, timeliness relative to peers, stairs, safety awareness
    - Maintaining and/or changing positions, including the ability to sit for the length of a classroom activity
    - Recreational movement — include playground/recess and PE
    - Manipulation with movement — carrying classroom materials, personal materials
    - Set up and cleanup of classroom tasks
    - Eating and drinking
    - Hygiene
    - Clothing management
    - Computer and other equipment use
    - Responses to sensory experiences
    - Peer interactions
    - Personal care awareness
    - Task behavior/completion
    - Compliance with social conventions and classroom routines

- If the IEP Team determines that OT/PT is no longer needed, the discussion and decision must be documented in the prior written notice. (Check with OT/PT Practice Regulations regarding documentation of discontinuation of therapy service).

OT/PT Examples

Examples of Summary of Assessment Findings and/or Observations

Discuss progress (or lack of progress) towards the goals if appropriate. If goals have not been achieved, explain the impact on performance.

- Sally has mastered her goals to access all areas of the building using her manual chair. We are now addressing safety in using her manual chair to navigate in the community.

- John has not made progress on his goal to write using an efficient grasp. Despite consistent practic**e with a strengthening program and use of a pencil grip, John doe**s not demonstrate improvements in underlying muscle strength necessary to maintain an efficient grasp. John's immature grasp continues to cause him to write more slowly and fatigue quickly. It is unlikely, due to his medical condition, that he will make further progress in this area.

You may include test findings and interpretations, significant changes in test results or lack of change, AS RELEVANT TO CURRENT PERFORMANCE.

- OT: John was administered the Beery VMI on (date). His score of 75 is below average . During testing he had difficulty copying forms with diagonals and multiple components. He has difficulty with the same skills when observed in the classroom copying notes and diagrams from near and far models.
- OT: John was administered the Beery VMI on (date). His score of 75 which is below average . During testing, it was noted that he was impulsive, worked quickly, and did not attend to details or to prompts to slow down and work carefully. It appears that his low test score is a reflection of his documented difficulties with attention, rather than his visual motor abilities. When observed during writing tasks, he is able to form letters correctly, on the line, and in the space provided given no distractions.
- OT: Sally was administered the Beery VMI on (date). Her score of 92 was in the average range. She has made significant improvements in visual motor skill since the Beery VMI was last administered on 1/1/06 with a score of 75. She is now able to copy with better than 90% accuracy from near and far models to complete classroom writing assignments.
- PT: John was administered the PDMS-II on (date). He scored below his 25% chronological age; however, in the classroom environment his functional mobility skills are at the same level as his peers.
- PT: Sally was assessed using the MOVE assessment on (date). Her skills range between Level I and Level II; her greatest area of improvement was in area of transitioning from sitting to

standing and standing to sitting when comparing her performance to 1/1/07's MOVE assessment. She is now able to stand up and sit down from her own classroom chair independently.

OT/PT Examples

Examples of Strengths and Supports

Include interventions/modifications utilized and responses to these interventions.

- John has used a portable word processor to complete extended writing tasks (any assignment greater than 1 paragraph response) during the 2nd and 3rd quarter. This has been effective, as he is now completing writing tasks with acceptable quality within the teacher's assigned time frame.
- A portable word processor was available in the classroom and Sally was encouraged to use this to complete extended writing tasks. She has been instructed in how to use the device and demonstrated proficiency at doing so; however, she refuses to use it within the classroom. Sally has stated that she prefers to write so she doesn't "look different."
- A mobile prone stander was used in the chemistry lab in order for Josh to participate in experiments with his peers.
- A daily walking program implemented by the IEP team has enabled Mohammad to walk to the cafeteria daily with his peers.

Indicate HOW the strengths and needs affect the student's ability to access, participate, or make progress in the general education curriculum and in age-appropriate activities and routines.

- Mary's balance deficits impact her ability to participate without the assistance of an adult in all areas requiring mobility in her educational program. This includes the cafeteria and her ability to socialize with same-aged non-disabled peers on the playground during recess.
- Caleb's upper extremity spasticity impacts his ability to manage his lunch tray independently. The use of a peer buddy enables Caleb to go through the lunch line making choices in a timely fashion with same-aged non-disabled peers.

Identify what the student currently knows and can do.

- Mary can walk from the bus to her classroom using a posterior walker within five minutes of her peers. She can navigate the school building and can get in and out of her desk with supervision only.
- Caleb can choose from a group of food items by saying the word or handing the correct Picture Communication Symbol (PCS) to the cafeteria worker to designate what food item he desires.

Areas of Concern and Barriers:

Define any barriers to access, progress, and/or participation. (Refer to Part B Table, page 36.)

- Is the barrier internal to the student (e.g., tone, visual motor impairment, cognitive limitation), is the barrier external (i.e., the task or environment), or is it a combination?
- Is the barrier amenable to change (goal versus supplementary aids and services)?
- Include barriers as reported by parents/care givers and other team members.

Instructional Implications for Participation in General Education:

Consider:

- How do the strengths and concerns affect the student's ability to access, progress, or participate in his/her educational program (K-12) or natural learning environments (ECC)?
- To what extent is this child meeting expectations with regard to classroom demands?
- Is the student's participation limited? During what part of the day? Why?
- What types of activities/tasks are problematic?
- To what extent is the child included in or restricted from participating in the activities and routines typical of this age or grade level?
- What are the factors that give rise to the barriers or limitations?
- What contextual factors could be altered to increase participation?
- How can the barriers be overcome? (This will help define your intervention.)

Name and Credentials

(License number always for PTs, optional for OTs)

OT SERVICE or PT SERVICE SHOULD NOT BE LISTED AS A SUPPORT, BARRIER, OR NEED.

PT Example

Example of COMPLETED Present Level

PT: Date and Service Provider's Name

Summary of Assessment Findings and/or Observations: Sally is a first-grader with cerebral palsy (orthopedically impaired). She walks independently with bilateral Lofstrand crutches for unlimited distances; she requires early dismissal from class (7 minutes) to reach the bus at the end of the school day in a timely fashion. She is cognizant of her limitations and walks at the end of the line when moving throughout the school building for safety reasons. She is unable to carry objects within the classroom when using her crutches but can walk with her backpack on when entering and leaving the school building.

She is able to ascend and descend the stairs using the railing and a marking time pattern with adult supervision if she is at the end of the line with her classmates. She can stand from a classroom chair and maintain her balance for periods of time long enough (3 minutes) to participate in some instructional activities such as music, circle, etc. Sally is able to transfer in and out of all chairs and up/down from the floor with the use of a stable object within the classroom. She is able to sit at a regular desk and chair for all instruction as long as her feet are supported. She is able to get on and off the cafeteria benches independently and sit with support at her feet for the lunch period (20 minutes). She is independent with self-care and eating and drinking.

Strengths and Supports: During lunch, she requires a buddy to assist her with her tray and food set up on the lunch table. On the playground Sally requires adult assistance to support her balance deficits and difficulty with managing the uneven terrain. She has endurance to ambulate with Lofstrand crutches throughout the school day. Sally has an independent nature and prefers to do activities without supports whenever possible.

Areas of Concern and Barriers: Sally's leg spasticity as a result of cerebral palsy impacts her ability to move her legs in a reciprocal manner, slowing her pace relative to her peers and compromising her balance. Sally is unable to keep pace with her peers while walking within the school environment and when participating in gross motor activities. Sally has difficulty walking on the sand on the playground and transitioning from the different surfaces of the playground using her crutches. She is unable to socialize with peers during this time because of her inability to access the playground in a safe manner without adult assistance during recess.

Instructional Implications for Participation in General Education: Due to the impact of her cerebral palsy on functional mobility, Sally needs environment accommodations (early dismissal, end of online transit) for safety reasons and activities to improve her balance and mobility to support her increasing level of independence while at school.

Signature and License Number

If using the Maryland Online IEP you will note these tool features:

IMPACT: Yes

Radio Button: Specific Goal

OT Example

Example of COMPLETED Present Level

OT: Date and Service Provider's Name

Summary of Assessment Findings and/or Observations: Joe uses a right dynamic tripod grasp during all writing tasks. He stabilizes the writing page with his left hand. He writes in the space provided and uses the left margin. Joe needs reminders to space between words and to skip lines to help with writing legibility. His writing is better than 80% legible. He completes modified assignments within teacher time frames. Joe is learning to sign his name in cursive. He now holds the scissors correctly and can accurately cut pictures from magazines using learned strategies for shadow cutting first, then cutting for detail. He is able to use a ruler, stencil, hole punch, stapler, and paper clips.

Strengths and Supports: Current accommodations to reduce length of written assignments, supplement written answers with verbal responses, provide copy of notes that Joe can highlight, and allow Joe to type final draft on classroom computer have been effective to reduce fatigue and improve efficiency. Joe is able to complete classroom projects that require him to cut, color, glue, and use multi-media art supplies if he is provided with a visual model of the expected end product.

Areas of Concern and Barriers: Joe continues to form many letters with bottom to top formation, but is unlikely to change this habit at this time. He uses excessive pressure when writing and continues to complain of fatigue for longer writing assignments. Joe has difficulty keeping pace with peers to take notes, copy from near or far model, or complete more than one paragraph of original writing.

Instructional Implications for Participation in General Education: Joe's functional fine motor performance is within expectations for his age/grade. His learning disability contributes to difficulties with processing information and pacing. With current accommodations, Joe's needs in the area of written work production and efficient task completion are being met in the general education classroom.

Signature

If using the Maryland Online IEP you will note these tool features:

IMPACT: Yes

RADIO BUTTON: Supplementary Aids/Services

IEP PROCESS
Academic and Functional Areas Assessed

Sources

- These are the specific assessments that are currently available in the Maryland Online IEP relevant to OT and PT.

  Examples:
  Battelle Developmental Inventory
  Observation
  School Function Assessment
  Test of Visual Motor Skills
  Test of Visual Perceptual Skills
  Other

- You can select multiple sources.
- If you select **Other** provide either a specific test name (e.g. Sensory Profile, Gross Motor Performance Measure) or state whether it was a "Record Review," "Parent Interview," "OT Assessment," or "PT assessment" if you did not administer a specific test. You can enter multiple sources under **Other**.

Level of Performance (also prints as "Instructional Grade Level")

- Identify the instructional grade level or level of performance. This appears on the completed IEP as Instructional Grade Level for the Academic area and as Level of Performance for the Behavioral, Health, and Physical Areas.
- You may enter below grade level, on grade level, or above grade level if a specific instructional level is not available based on available assessment information. "Age equivalent" scores that you may have from standardized testing may not be representative of a student's performance. **Does this area impact the student's academic achievement and/or functional performance?**
- Select YES or NO in response to this question.

If using the Maryland Online IEP you will note these tool features:

- If you select "yes" you have 4 choices, but *may only select one of the following*:
    - Specific goal to address
    - Supplementary aids and services
    - Embedded IEP goals (will not prompt later in any other goal area)
    - Service
- If you write a goal to address this area of need, select "Specific Goal" — the information from present levels will then carry over for you to view while writing your goal.
- If you provide service in the form of modifications, adaptive equipment, training, or other "supplementary" services on behalf of the student, select "Supplementary Aids and Services."
- If you plan to "embed" in another goal area, select this option. The present level will not link to a specific goal if this option is chosen.

OT/PT Example

Examples of EMBEDDED Goals

Goal in the area of Adaptive:

Caleb will walk through the lunch line with his peer buddy choosing two food items using PCS symbols.

- ❖ Will walk 50 feet without loss of balance (embedded PT goal)
- ❖ When given two PCS symbols, will match the correct symbol to the food item 100% of the time (embedded academic goal)
- ❖ Caleb will grasp PCS, hand and release to cafeteria worker (embedded OT goal).

If you choose "service," only OT/OTA or PT/PTA can provide. Examples:

- Student with Down syndrome is monitored for gross motor development periodically through reassessment
- Monitoring sensory strategies for a student identified with autism who has sensory regulation difficulties

If other IEP team members enter information in this area, the IEP team should select "Yes" if any one team member notes that there will be an impact for the student. Just be sure that your entry is clearly labeled with date, discipline, and your name/credentials so you can refer back to your specific entry if there is any question when you get to the services page.

IEP PROCESS
Academic and Functional Areas Assessed
Area Discussion

What is the parental input regarding the student's educational program?

- The IEP team must provide documentation of parental input in the development of the IEP.
- Consider the input of parents to enhance the education of their child. This may be a good opportunity to discuss future plans for a student: What are your long-term goals or dreams for your child? What do you want your child to be able to do? Identify what motivates the student from a parent's perspective? Consider discussion about postsecondary transitions.
- May include information from student or parent interviews that you may have used during the assessment process.
- The IEP team must briefly summarize the contents of the procedural safeguards at the meeting.

What are the student's strengths, interest areas, significant personal attributes, and personal accomplishments? (Include preferences and interests for post-school outcomes, if appropriate.)

- Document the areas of strength for the student when compared to peers; document areas of motivation, interest, and/or learning style.

How does the student's disability affect his/her involvement in the general education curriculum?

- Answer this question for school-age students. For preschool students, record N/A and skip to the next question.
- Document how the student's disability specifically **impacts** his/her involvement and progress in the general curriculum. If there is a concern, what is the impact on the student's participation and progress in a particular area?

For preschool age children, how does their disability affect participation in appropriate activities?

- Document how the student's disability affects his/her involvement in age-appropriate activities.

Educational Impact Statement:

- The impact statement is intended to be completed at the IEP meeting as a team. Therapists should be prepared to contribute to the discussion.
- Impact statements explain how the disability affects the students' involvement in the general education curriculum.
- Effective use of the impact statement helps to clarify the purpose of your service, frame your service, and set the stage for maintaining, increasing, decreasing or discontinuing service.
- Its use will help define how the student's disability affects his/her ability to access, participate in, and/or make progress in the general education curriculum.
- Statements should be written in terms of functionality and indicate increased independence or decreased need for previous level of support.
- It is very important to be sure that the IEP team includes input from the OT/PT if the child has identified needs.
- This is the only section in the IEP document to identify if there are secondary disabilities.

When Contributing to Impact Statements, OTs and PTs may use the following suggestions:

Student A's disability in the areas of: (fill in one or more of these areas)

- Written Language Mechanics
- Pre-Writing
- Social-Emotional/Behavioral
- Social Interaction Skills
- Self-Management
- Fine Motor
- Gross Motor
- Independent Living – Feeding
- Independent Community Living – Recreation & Leisure
- Independent Community Living – Toileting

- Independent Community Living – Dressing & Grooming

causes him/her to have difficulty with: (choose one or more)

- functional mobility
- gross motor skills
- fine motor skills
- age-appropriate activities or routines
- social interaction skills
- self-care activities or routines

This impacts his/her performance in: (list educational and functional activities across learning environments and WHY)

Guiding Questions for Impact Statements:

In contributing to the IEP team impact statement, the therapist might consider some of the following questions:

- How is this child's access and/or participation being affected given the present levels of performance and needs?
- In what part of the child's day (recess, PE, cafeteria, etc.) are there difficulties?
- What type of difficulties are they?
- How extensive are those difficulties...do they carry over into other environments?
- What types of activities/tasks are problematic?
- To what extent is the child either included in or restricted from participating in the activities and routines typical of this age or grade level?
- To what extent is this child meeting expectations with regard to classroom demands?
- What are the student's strengths or limitations in performing specific activities that are required to accomplish major classroom activities?
- How do the student's impairments impact the performance of daily tasks and activities?

If you have a need listed in the impact statement, there should clearly be a goal and/or supplementary aid/service to address that need in the child's/student's IEP.

Guiding Questions for Impact Statements:

In contributing to the IEP team impact statement, the therapist might consider some of the following questions:

- How is this child's access and/or participation being affected given the present levels of performance and needs?
- In what part of the child's day (recess, PE, cafeteria, etc.) are there difficulties?
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- What types of activities/tasks are problematic?
- To what extent is the child either included in or restricted from participating in the activities and routines typical of this age or grade level?
- To what extent is this child meeting expectations with regard to classroom demands?
- What are the student's strengths or limitations in performing specific activities that are required to accomplish major classroom activities?
- How do the student's impairments impact the performance of daily tasks and activities?

If you have a need listed in the impact statement, there should clearly be a goal and/or supplementary aid/service to address that need in the child's/student's IEP.

OT/PT Examples

Examples of Impact Statement with OT/PT Input

John's disability of Orthopedic Impairments in the areas of gross motor, fine motor, and self-care causes him to have difficulty with functional mobility, functional writing tasks, and dressing and grooming skills. This impacts his academic performance for writing tasks and functional performance during the school day because he requires specialized instruction and adaptive equipment to access his classes and to make progress in the general education curriculum.

IEP PROCESS
Special Considerations and Accommodations
Special Consideration

Communication:

If yes, describe the specific needs (e.g. amplification devices, sign language) and indicate how needs will be addressed (through a particular IEP goal, supplemental service, etc.). If there are no special needs, indicate that it was considered, but no special communication needs exist.

Assistive Technology (AT):

AT is defined as: ANY device or service that the student needs to access the educational program, or to participate in or make progress in the educational program AND this device and/or service has been used with the student and there is evidence that it works for the student.

If the team determines that there is sufficient data/evidence to support use of an AT device or service, your basis for decision might say:

> "The IEP team determined that the student requires _____ (the AT device and/or service) in order to increase his functional communication skills."

If the student has needs, include documentation from an AT report or other sources, as appropriate.

- When choosing how AT devices need to be addressed, choose either Supplementary

Aids or Instructional/Testing Accommodations.

- When choosing how AT services need to be addressed, choose either Supplementary Aids, Related Services, or Instructional/Testing Accommodations.

Discussion: For each, you will note the report or observation that supports the use of the device. You will also restate the basis for the decision in either the Supplementary Aids or Testing Accommodations section.

OT/PT Examples

Examples of Assistive Technology Discussion

- ❖ Josh requires a mobile prone stander to access materials during chemistry lab.
- ❖ John requires a slant board to copy notes from the board or projection screen.
- ❖ John requires a portable word processor for extended writing tasks.
- ❖ Samantha requires a modified chair with head and foot rest and side arms for postural support.
- ❖ Juan requires a visual schedule used daily to successfully transition between tasks and to help him to be available for learning.
- ❖ Bianca requires adaptive equipment to participate in physical education and to support her during all seated classroom instruction.

IEP PROCESS
Special Considerations and Accommodations
Instructional and Testing Accommodations

Refer to the Maryland Accommodations Manual issued July 2, 2012 for guidance in Selecting, Administering, and Evaluating the Use of Accommodations for Instruction and Assessment, http://goo.gl/eZLZBw. Accommodations guidelines for national assessments (e.g., PARCC, NCSC) may vary from those in the Maryland Accommodations Manual. Please contact your local school system for additional information.

- There must be evidence to support that these accommodations are necessary to reduce or even eliminate the effects of a student's disability and that they have been implemented during classroom instruction and assessment and enabled the student to participate more fully or better demonstrate their knowledge and skills.

- Accommodations MUST be used in BOTH instruction and testing prior to being used for a statewide assessment.
- Under discussion to support decision, include a statement of rationale and any further description.

OT/PT Examples

Examples of Discussion for Instructional/Testing Accommodations

- ❖ Sue's visual impairment prevents her from reading material that is not large print.
- ❖ Joey needs to work at a study carrel during instruction and testing to reduce visual distractions.
- ❖ Sierra's learning disability prevents her from writing extended assignments with legible handwriting. She is able to complete extended writing tasks (more than one paragraph) given use of a portable word processor. (Team decision making regarding access to accommodations during state/national assessments should be aligned with accommodations guidance.)

IEP PROCESS
Special Considerations and Accommodations Supplementary Aids, Services, Program Modifications and Supports

Service Nature

- Select appropriate service nature or "other."
- Use the "Clarify location and manner" area to provide specifics.
- If the primary recipient of the intervention or strategy you are going to provide is someone other than the student, it is considered services on behalf of the student and is specified on this page.
- Services on behalf of the student will typically be considered supplementary services, and should be indicated in this section.
- Service to the student will be documented on the related service page.
- If you are the Primary Provider, you are responsible for collecting the data on this service.
- If OT and/or PT are selected, only a licensed OT/OTA or PT/PTA can provide this service.

OT/PT Examples

Examples of Supplementary Aids/Services Provided by OT/PT

- A student is in need of positioning throughout the school day. The PT will be providing instruction on handling, lifting, and equipment use. The primary recipient of this service will be the members of the IEP team who provide direct services to the student.
- You have tried a slant board with the student. It is effective to allow participation in the educational program when copying from the board or screen. The student needs to use this daily, with a reminder to use it.
- The student is transitioning to a new program. You will need to train the team re: the student's disability and how to facilitate transitions during day to day activities/routines.
- The student uses a weighted vest at specific times each day. You monitor the effectiveness of using the vest to increase availability for learning.

Anticipated Frequency

- You must indicate the anticipated frequency that the supplementary aid/service will be used.
- Often this is daily (adapted equipment, positioning devices, academic modifications), but choose what is most appropriate.

Begin Date and End Date

The dates may vary from the IEP dates depending on the student's needs and the instructional program.

Primary Provider

Other Provider

- If the supplementary aid/service is used by the student daily, designate the member (s) of the "IEP team or Service Provider" who is the most appropriate choice as the Primary Provider. OTs or PTs are more commonly designated as the Other Provider.
- If an OT or PT is providing training and/or consultation to the staff and not working with the student on a daily basis as the "supplementary service," an OT or PT would be designated as the Primary Provider.

Clarify the location and manner in which Supplementary Aids, Services, Program Modifications and Supports to, or on behalf of, the student will be provided.

- Provide a detailed description of service delivery.
- Meetings with the IEP team to discuss specific supplementary aids and services may be included as part of your service on behalf of the student.
- Supplementary aids and services should be based on data that supports their effectiveness prior to documenting on the IEP.

OT/PT Examples

Examples of Supplementary Aids, Services, Program Modifications and Supports

- ❖ The OT will collaborate with the IEP team quarterly to monitor progress in implementation of the mealtime plan of care.
- ❖ The OT will meet with the classroom teacher 2 times per month to review the daily schedule for sensory strategies to determine if any adjustments are needed.
- ❖ The OT will meet with the special education teacher monthly to provide, adapt, construct, modify, and monitor use of equipment for positioning during all educational activities and to assess and modify the environment for safety and function.
- ❖ The PT will provide lifting and handling training to the IEP team once every quarter.
- ❖ The PT will review data collection on mobility practice sessions monthly with the student's dedicated aid and make changes accordingly.

Discussion to Support Decision

Describe WHY you have listed the specific service/support.

> Example: The IEP team agrees that due to Johnny's needs in the areas of fine motor performance, these specialized services on behalf of the student are necessary for him to participate and make progress in his educational program.

IEP PROCESS
Special Considerations and Accommodations
Extended School Year

Therapists should contribute to the IEP team decision-making about eligibility for ESY services.

For Part B students (ages 3–21) who have an IEP, ESY is for current goals (not new goals).

ESY can be provided to those children who are transitioning from Part C to B based on emerging skills even if the IEP is new and there is no data in relationship to the goals. The decision would be based on the expertise of the OT and or PT.

IEP PROCESS
Special Considerations and Accommodations
Transition

OTs and PTs contribute to the transition discussion as appropriate.

Activities to support a desired transition outcome can become goals and/or objectives for an IEP and may require OT and PT services.

The transition outcome must be measurable.

Example: Joe will work at a supported employment facility upon completion of his high school certificate.

IEP PROCESS
Goals

How will the parent be notified regarding progress on goals? How often??

Indicate the parent will be notified "in writing" and at the frequency as determined by the LOCAL SCHOOL SYSTEM.

If using the Maryland Online IEP you will note these tool features:

Category

Area

Description of area affected by disability

The Category and Area should match Present Levels.

Goal

- Measurable annual goals, along with accompanying short-term objectives MUST align with the present levels of academic achievement and functional performance.
- Goals should be activity-based and meaningful to the student and team, and be able to stand alone.
- Objectives are the benchmarks to meet the goal.
- Goals should contain qualities of being SMART:
    - **S**pecific and descriptive
    - **M**easurable
    - **A**ttainable
    - **R**ealistic and relevant
    - **T**ime limited (one year)

If using the Maryland Online IEP you will note these tool features:

- For guidance in developing SMART goals, click the "Student Compass — Goal Wizard" on the Maryland Online IEP.

By = End Date

- **End dates for goals are required.**
- If the goal will remain for the duration of the IEP, the end date should be the day before the next annual review. You should have a reasonable expectation for the goal to be MASTERED by this date.
- The end date can be less than one year if the team has determined a definitive termination date. This might occur for an ESY goal, a goal related to a specific class that is only one semester, or a goal related to a specific program that is time limited.

Evaluation (how will you measure progress)

Informal Procedures

Classroom Based Assessment

Observation Record

Standardized Assessment

Portfolio Assessment

Other: specify

With (criteria for measuring)

% accuracy

% increase

__ out of __ trials

% decrease

other: specify

- If you choose % increase, decrease, or accuracy, you will need to have a very clear baseline in the present levels.

Objectives

- Objectives are BENCHMARKS to meet the goal. You will report progress on the GOAL NOT OBJECTIVES.
- Objectives describe meaningful intermediate outcomes between the student's current performance level and the measurable annual goal. Think "task analysis" when writing objectives.

- Consider the time limits of your IEP and Goal. If the Goal is to be met in 1 year, the objectives should be steps to meet that goal.
- Objectives do not require evaluation criteria, but may be included in the body of the objective.

PT Examples

Example Goals for PT

❖ **Goal:** Student A will walk to and from his classroom from the bus drop off carrying his backpack without assistance from an adult.

By: One year from now

Evaluation Method: Observation Record

With: **Other**: On a daily basis within 5 minutes of his peers

ESY Goal: yes or no

Objectives:

1. Student A will stand and put on backpack and/or coat 100% of observed trials without falling and without adult assistance.
2. Student A will participate in recess by traversing uneven terrain and accessing low, stable playground equipment without falling more than 2x on any given day.
3. Student A will walk short distances within the classroom (20-30 ft.) carrying objects weighing no more than 5 pounds, 100% of observed trials, without falling.

❖ **Goal:** Student B will participate in her self-care at school or in the community by increasing her standing time from 1 minute to 3 minutes in order to have her clothing managed by one adult.

By: One year from now

Evaluation Method: Observation Record

With: 100% accuracy

ESY Goal: yes or no

Objectives:

1. Student B will hold railing with either hand to support herself in standing 100% of observed trials.

2. Student B will rise from a chair and bear weight on both feet when supported at the trunk by one adult upon command, 100% of observed trials.
3. Student B will lower herself to a sitting position by holding onto a railing and flexing her knees on command with support at the trunk by one adult, 100% of observed trials.

OT Examples

Example Goals for OT

- **Goal:** Student A will use a variety of classroom tools (scissors, glue, stencils) to complete classroom tasks/projects from requiring intermittent physical assistance to using tools independently.

  By: One year from now

  Evaluation Method: Observation Record

  With: Other: Within teacher time frames, 3 of 4 times

  ESY Goal: No

  Objectives:

  1. Student A will cut out simple geometric shapes, staying within ¼ inch of line, 4 of 5 times.
  2. Student A will stabilize stencil with her left hand while tracing 4 designs without the stencil shifting, 4 of 5 times.
  3. Student A will open and squeeze glue to make one dot in each corner of a square, 4 of 5 times.

- **Goal:** Student B will remain on task to participate in a structured small group activity, following a preparatory sensory motor activity.

  By: One year from now

  Evaluation Method: Observation Record

  With: For 10 minutes, 3 of 4 opportunities

  ESY Goal: Yes

  Objectives:

  1. Student B will select a preparatory activity from a list of three, 4 out of 5 times.

2. Student B will remain on task to participate in a 1:1 task for 10 minutes following a preparatory sensory activity.
3. Student B will participate with 1 peer in a cooperative task for 10 minutes following a preparatory sensory activity.

Other tips on writing goals

- If you are utilizing an embedded strategy for your goals and objectives it is important to assess children using multiple measures containing meaningful skills that are activity-based and result in broad functions instead of specific behaviors. Ecological inventories geared toward specific environments may be helpful.
- In natural environments, outcomes are distinguished from therapeutic objectives. Outcomes are written as functional goals, which enable children to participate with their peers.
    - What do you want the student to do?
    - Where do you want them to do it?
    - Under what conditions should it be done?
    - What is the specific degree of success desired by a specific timeline?
- Annual goals should contain "Who" and "What" with descriptive conditions, such as levels of assistance and measurement.
- Goals should not be based on failed test items.
- Goals are DATA-DRIVEN. You must be able to collect and use meaningful data to document access, progress, and participation.
- Goals should support the general education curriculum. You can refer to the Maryland College and Career-Ready Standards.

IEP PROCESS
Services

Questions to ask to yourself and to discuss with the IEP team when establishing the need for OT and/or PT as a related service:

- Will the lack of service interfere with the student's progress, access and/or participation in the general education curriculum this year?
- Could someone else address the proposed strategies/interventions appropriately?
- Has the student been making progress and benefiting from his/her educational plan without the service?
- Will the student continue to make progress and access/participate in the general curriculum without the service?

Category

Service Nature

When deciding if a service is to or on behalf of, ask yourself: "Who is the primary recipient of my intervention or strategy?" If your answer is the student, it is a service to the student and is listed as a related service.

Location

Inside General Education

Outside General Education

- PLEASE REMEMBER — the IEP team is NOT yet discussing the placement/program!
- Choose inside general education if it is appropriate to provide your services in the general education classroom or program.
- Choose outside general education if you are planning to pull the student out for service 1:1 or in a small group outside the general education program, or during a time in which you anticipate they will be in a group without any typical peers.
- You may need to choose "inside" for some sessions and enter a second service line for "outside" for other sessions. (See examples following.)

Description

Number of Sessions

Length of Time (appropriate to the service and clearly stated in the IEP)

Frequency (the number of days or sessions that a service will be provided)

Total Service Time

- A session is an episode of skilled service provided by an OT or PT practitioner. Each calendar day of service is considered a session.
- The IEP team determines the number of sessions and the length of time for each session required to meet the IEP goals.
- Frequency of service provision typically should be 'weekly' or 'monthly' so that families and service providers have a clear understanding of how often the student will receive the service.
- Setting a frequency of service provision as a number of sessions per year, requires a stated rationale for this decision which must be clearly justified and documented in the statement of service delivery.
- The total service time out of the general education classroom is calculated automatically in the Maryland Online IEP and is used in determining LRE/placement/program.

Service Date

Begin Date

End Date

- End dates are now required for all services. The end date will typically be one year from the start date unless there are special circumstances (example: a semester course).

Service Provider

Primary Provider

Other Provider

- If you have chosen OT or PT as the Service Nature, then you are the Primary Provider and there is not an 'Other Provider'.

Summary of Service

Discussion of Service Delivery

- Use to describe service for ALL students — similar to previous "statement of service delivery"

- Describe where services will be rendered and how.
- Use to provide clarity to your service regarding purpose, environment, activities, etc.
- Do NOT include documentation/progress reports/writing the IEP as part of your service time.

ESY Service

Repeat of all fields, specific to ESY

- Please review ESY criteria and, if you determine that services are warranted during ESY, you will need to explain and then repeat all of the above fields specific to ESY services.

General Points about Services

- You may have services listed on the Supplementary Aids/Services page AND the Related Services page
- The number of sessions and frequency do not have to be the same for all services.
- You may have services listed twice on the related services page if you are providing services both INSIDE and OUTSIDE of general education.

PT Examples

Examples of PT Services

❖ A student whose need is the development of functional mobility skills for access

- When the student is pulled from class to work on stair skills, enter on the services page, "outside of general ed.," documenting frequency and session length.
- If you are working within the classroom or hallways during natural transitions on walking shorter distances without a device, record "inside of general ed." On the services page, document session frequency and duration.
- If this student needs practice on walking with the assistive device with his/her dedicated aid enter on supplementary aids page. Service nature description might be "functional mobility practice." Record how often and the provider (IEP team). Frequency might be daily, provider would be IEP team; PT might be "other."

- Using the discussion box, and without writing 2 separate lines of service you could document that service to the student might take place outside (or inside) the classroom on occasion.
- *The 2 different services do not need to match in terms of frequency.*

❖ A student whose primary need is appropriate positioning for classroom instruction

- When the student is placed in equipment and equipment is adjusted for fit, modifications are made to support the student better, etc., the student is the primary recipient of your strategies and/or intervention. Document as a Related Service.
- When training school staff in the use of the equipment, how to position the student appropriately, and where to use the equipment (for what instructional area), the primary recipient of your service is the IEP team or classroom teacher. Document on "supplementary aids and services" page.

OT Examples

Examples of OT Services

❖ A student with difficulties with sensory regulation and written work production

- If you meet with the teacher once a month to review the classroom strategies, schedule, breaks, rewards, and cues, this is entered on the Supplementary Service page.
- If you pull the student out of class 2 times a month to teach new strategies and work on skill development, this is "Outside General Education" on the Related Services page.
- If you work with the student directly in the classroom with typical peers to insure the student can successfully carry over the strategies and skills we have worked on, this is "Inside General Education" on the Related Services page.
- *The 3 services do not need to match in terms of frequency or duration. You should have a unique discussion of the service for each entry. These must be entered this way to correctly reflect the services you are providing, as your services contribute directly to the LRE calculation.*

Appendix C: OT/PT Services Under Section 504

Section 504 requires that school districts provide a free appropriate public education to qualified students in their jurisdictions who have a physical or mental impairment that substantially limits one or more major life activities. These students may not qualify for special education under the IEP process. Under Section 504, these children can be provided with accommodations and services to help them access the general education curriculum. In some cases, these accommodations and services can include OT/PT.

The 504 Committee reviews documentation and team findings to determine the need for a 504 Plan (U. S. Department of Education, 1999; Council for Exceptional Children, 2002). When instructions in the use of the accommodations require ongoing OT and/or PT intervention/support to access and participate in the general education curriculum, the consideration of an IEP rather than a 504 Plan is warranted.

Evaluation

A 504 evaluation may contain the same components as the Part B evaluation.

Refer to Section 4.0: OT/PT for Ages 3-21 (IDEA Part B); Section 4.1: Early Intervening Services; Section 4.2: Evaluation.

OT/PT Contribution to the 504 Plan

Occupational and physical therapists can support the 504 team by providing input to the plan, and may include strategies, modifications, and/or adaptations to the student's environment where difficulties are or may be encountered to gain equal access and participation in the general education environment. Modifications and adaptations are written into the 504 Plan; goals and objectives are not. Services to the student and on behalf of the student are provided as needed to implement the 504 Plan. (For specifics regarding each discipline's area of expertise, see Section 4.7: OT/PT School-Based Standards of Practice in Compliance with IDEA, Part B.) It is recommended that the team reconvene annually or as needed to review the 504 Plan.

Appendix D: Lifting and Transferring Students/Children in a School or Other Setting

This appendix was developed by the Maryland Steering Committee for Occupational and Physical Therapy School-Based Programs to support Occupational and Physical Therapy Early Intervention and School-Based Services in Maryland: A Guide to Practice (Section 4.0).

The foundations of this tool were the Guidelines for Nursing Homes: Ergonomics for the Prevention of Musculoskeletal Disorders (U.S. Department of Labor, Occupational Safety and Health Administration, 2009), Strategies to Improve Patient and Health Care Provider Safety in Patient Handling and Movement Tasks (American Physical Therapy Association, Association of Rehabilitation Nurses, and the Veterans Health Administration, 2003), and Safe Patient Handling and Movement Algorithms (VISN 8 Patient Safety Center, 2006). It should be noted that the OSHA Guidelines are advisory and recommendations "should be adapted to the needs and resources of each individual work place of employment" (OSHA, p. 8).

School-based teams assist a diverse group of students with complex needs to access and participate in their educational programs. In some instances, these students require physical assistance and adaptive techniques/equipment to support safe physical management in the school environment. This appendix was created as a reference for occupational and physical therapists in school systems in Maryland who lend their expertise in this area to school teams.

PURPOSE:

1. Promote safety of students during lifting and repositioning tasks
2. Promote safety of caregivers during lifting and repositioning of students
3. Promote optimal functional status and independence for students with physical challenges
4. Promote communication among team members regarding safe lifting and repositioning of students
5. Increase statewide awareness of the principles related to safe lifting and repositioning of students

6. Provide tools for team decision-making as it relates to lifting and repositioning of students

STEPS IN THE PROCESS:

1. Needs Analysis
2. Sample Decision-Making Algorithms
   a. Transferring Student between Wheelchair and Changing Table
   b. Transferring Student from Chair to Chair, Chair to Toilet
   c. Transferring Student from Floor to Chair
   d. Repositioning on Changing Table: Rolling to One Side or Scooting
3. Training
4. Documentation

Step One: Needs Analysis

Strategies for safe lifting and repositioning should be determined by the needs of the student, the staff, and environmental factors. Consider the following factors when developing a comprehensive plan for student and staff safety:

Student Characteristics

- Size and weight
- Weight bearing capability (with and without orthoses)
- Level of assistance required
- Upper extremity function
- Lower extremity function
- Postural stability and control
- Level of comprehension
- Level of cooperation
- Medical conditions that may influence the choice of methods for lifting or repositioning
- Presence of IEP goals and/or supplemental aids and services for increasing independence in transferring
- Consistency of performance

Staff Characteristics

- Presence of lifting restrictions
- Physical characteristics of staff members
- Capability to initiate and follow directions

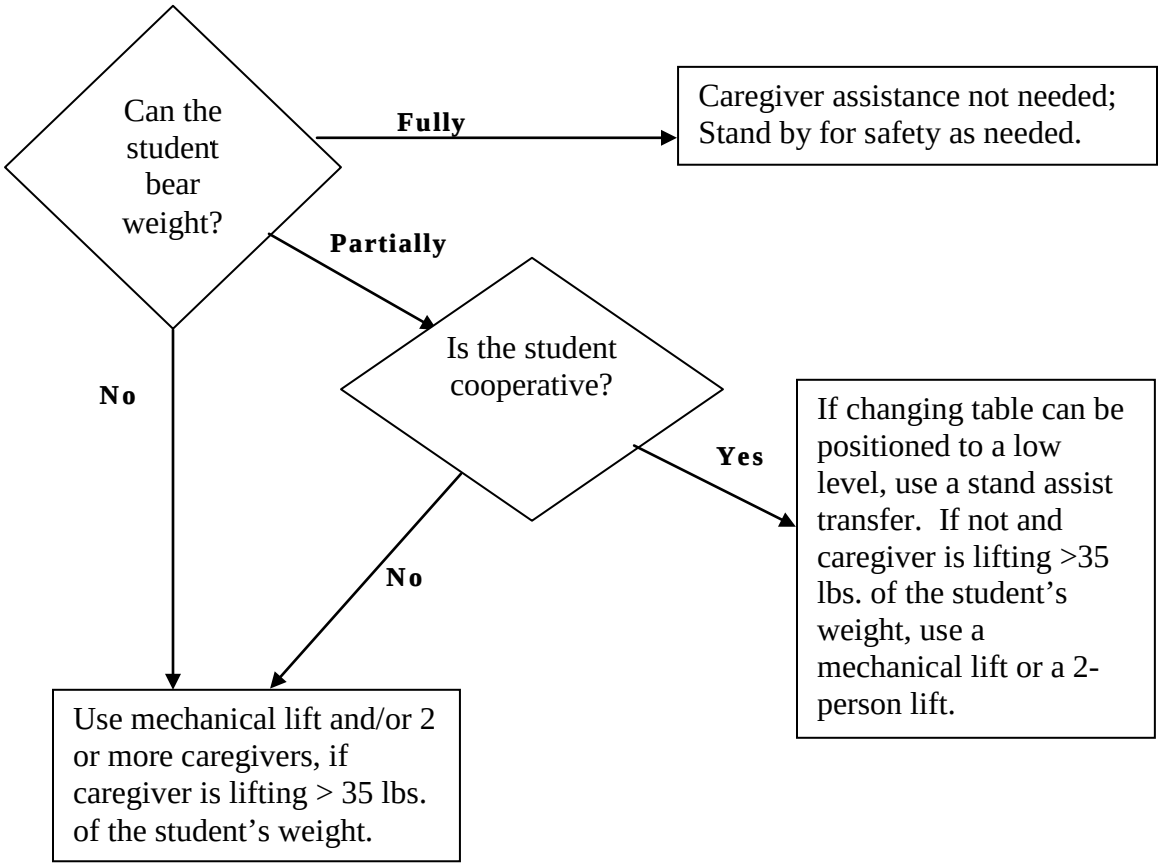
Environmental Factors

- Anticipated frequency of lifts and/or repositioning
- Space where task will occur (presence of guard rails, adequate room for staff members and/or equipment, flooring)
- Characteristics of available or needed equipment
- Time constraints
- Alternative sites for task (i.e. field trips)
- Need for building modifications
- Number of qualified staff available when movement of the student is needed

Step Two: Decision-Making Algorithms

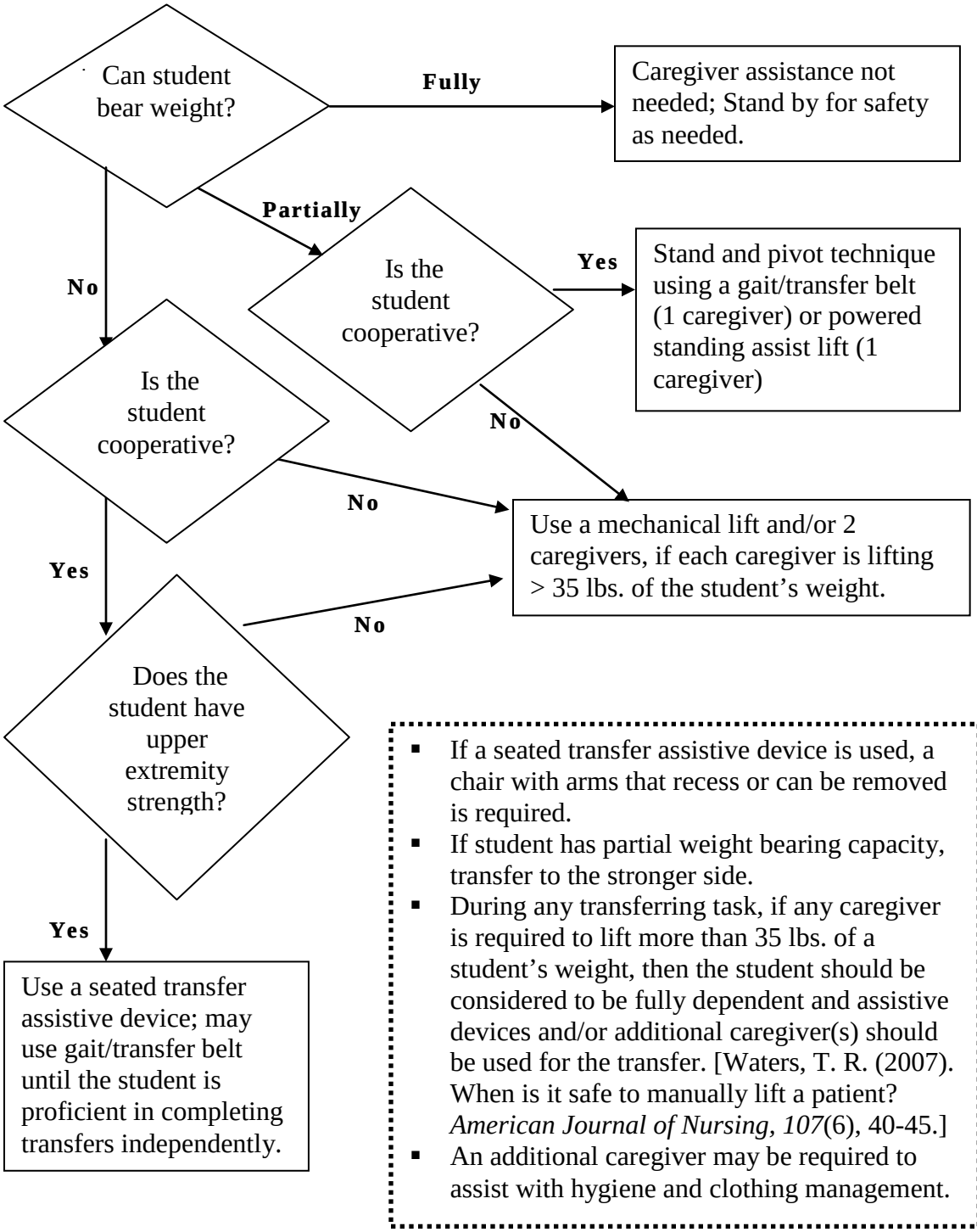
Having given consideration to student, staff, and environmental factors, the following algorithms can be used to aid in decision-making for student and staff safety.

a. Transferring Student Between Wheelchair and Changing Table



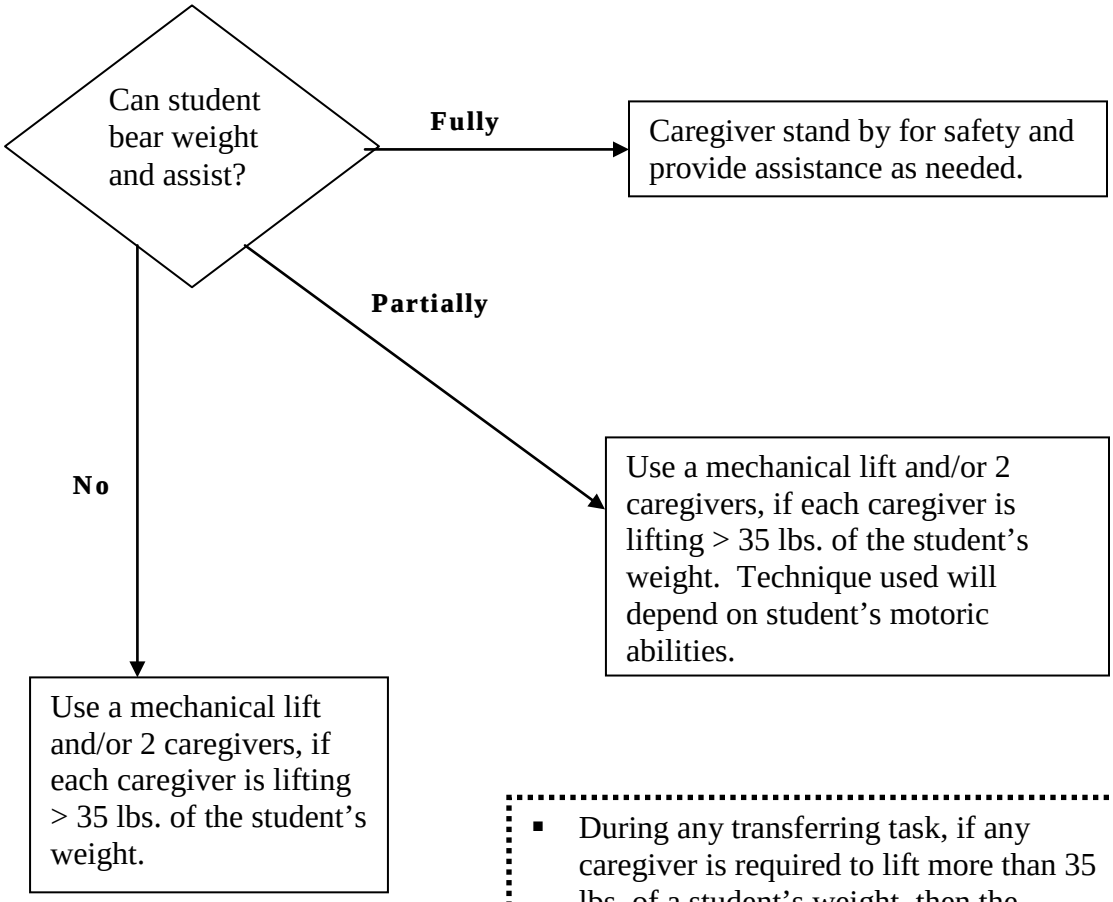
- Adjustable height changing tables would be ideal.
- During any transferring task, if any caregiver is required to lift more than 35 lbs. of a student's weight, then the student should be considered to be fully dependent and assistive devices and/or additional staff should be used for the transfer. [Waters, T. R. (2007). When is it safe to manually lift a patient? *American Journal of Nursing, 107*(6), 40-45.]

b. Transferring from Chair to Chair, Chair to Toilet



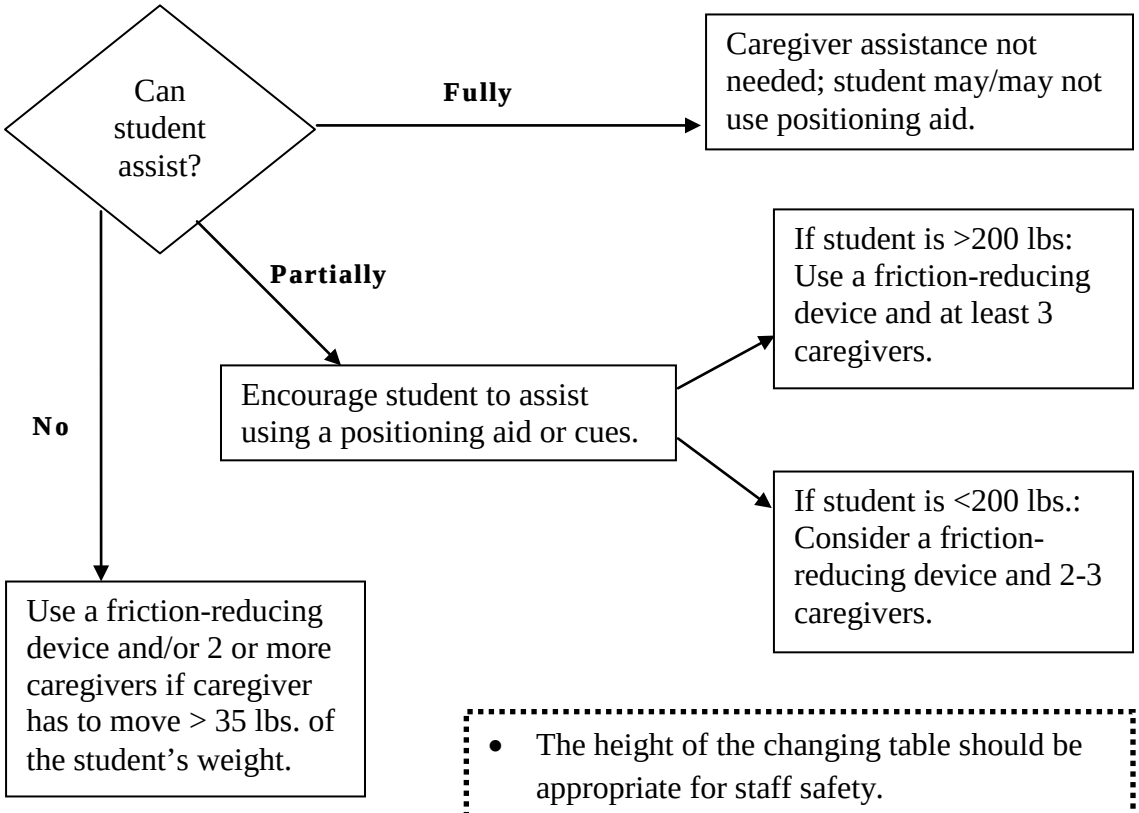
- If a seated transfer assistive device is used, a chair with arms that recess or can be removed is required.
- If student has partial weight bearing capacity, transfer to the stronger side.
- During any transferring task, if any caregiver is required to lift more than 35 lbs. of a student's weight, then the student should be considered to be fully dependent and assistive devices and/or additional caregiver(s) should be used for the transfer. [Waters, T. R. (2007). When is it safe to manually lift a patient? *American Journal of Nursing, 107*(6), 40-45.]
- An additional caregiver may be required to assist with hygiene and clothing management.

c. Transferring Student from Floor to Chair



- During any transferring task, if any caregiver is required to lift more than 35 lbs. of a student's weight, then the student should be considered to be fully dependent and assistive devices and/or additional caregiver(s) should be used for the transfer. [Waters, T. R. (2007). When is it safe to manually lift a patient? *American Journal of Nursing, 107*(6), 40-45.]
- **Depending on a student's level of comprehension and cooperation, techniques may need to be modified.**

d. Repositioning Student on Changing Table: Rolling to One Side or Scooting



- The height of the changing table should be appropriate for staff safety.
- If the student can assist moving toward the head of the table, ask the student to bend their knees and push on the count of three.
- During any transferring task, if any caregiver is required to lift more than 35 lbs. of a student's weight, then the student should be considered to be fully dependent and assistive devices and/or additional caregiver(s) should be used for the transfer. [Waters, T. R. (2007). When is it safe to manually lift a patient? *American Journal of Nursing, 107*(6), 40-45.]

Step Three: Training

The following components should be considered in developing training for safe student/child lifting and transfer training.

1. **Identify guidelines for safe lifting and transferring of students by determining who will analyze student/staff/environment needs and develop a plan for safe movement.**

   This person or team should:

   a. Identify all the transfers the student needs to complete at school; consider special classes, community outings, transfers to equipment such as gait trainers and standers,

   b. Consider student characteristics, staff characteristics and environmental factors,

   c. Determine the type of lift, assistance, and/or equipment needed for identified transfers, and

   d. Identify how to document this information.

2. **Identify qualified and competent trainers.**

   a. For general body mechanics and lifting principles, trainers could be physical and/or occupational therapists, as well as health care or human resource staff who have training in this area.

   b. For training on lifting and transfers of students, trainers should be physical and/or occupational therapists who are knowledgeable about general body mechanics, lifting and transfers, adult learning strategies, and school policies and procedures as they relate to student lifting and transfers.

   c. For training on equipment, such as mechanical lifts, trainers could be physical therapists, occupational therapists, Durable Medical Equipment providers, and/or manufacturer representatives.

3. Identify designated trainees (staff in need of training).

a. Consider identifying "lifting teams."

b. Identify back-up personnel that need to be trained to provide coverage when a lifting team member is not present and the substitute is not trained.

c. Trainees could include but are not limited to paraeducators, personal care assistants, special education teachers, regular education teachers, physical education teachers, health room staff, therapists.

4. Identify resources needed to support training.

a. Release time for trainers and trainees

b. Space for training

c. Materials for training

i. Equipment (wheelchairs, changing table, mechanical lift, adapted commode seat)

ii. Handouts

iii. Audio-visual equipment for videos or PowerPoint

5. Identify content of training.

a. Overview of physical disabilities:

i. Impact of tone, weakness in various parts of the body, orthotics, and lack of sensation on transfer procedures

ii. Features of equipment used by students with physical disabilities

iii. Impact of student cognition and behavior

b. Basic posture and body mechanics

c. Reinforce importance of appropriate clothing and footwear

d. Basic principles of lifting heavy objects

e. Basic principles for moving students:

i. Plan the lift or transfer

ii. Prepare the student

iii. Encourage independence

6. Identify methods to develop and maintain competency over time, ensure effectiveness of student movement plans, and document training.

a. Consider role playing/practice with staff or mannequins during general training.

b. Model/coach/supervise lifts and transfers for student/child specific training.

c. Ongoing collaboration and monitoring of the effectiveness of student movement plans.

d. Establish plan for follow-up training (student's needs change, staff change, determine need for and frequency of routine re-training).

Step Four: Documentation

Purpose:

To document that a staff member has attended training to perform the task of lifting and transferring of a student.

Information that should be documented:

- Date
- Subject and information covered (e.g. body mechanics, two person transfer, use of Hoyer lift)
- Printed name/title and signature of instructor
- Printed name of staff member/title who received training and signature
- Include a plan for re-checking of skills as needed
- Indicate initial or follow up training

Location of Documentation:

A copy should be kept for the therapist's records and a copy should be sent to the designated administrator per jurisdiction.

Training in lifting and or transfer techniques to be used for a specific student is typically documented within the student's log or service notes. In special circumstances, additional documentation may be indicated.

REFERENCES

American Physical Therapy Association, Association of Rehabilitation Nurses, and the Veterans Health Administration. (2004). *Strategies to improve patient and health care provider safety in patient handling and movement tasks.* Retrieved September 14, 2010, from http://www.rehabnurse.org/pdf/whitepaper.pdf.

U.S. Department of Labor, Occupational Safety and Health Administration. (2009). Guidelines for nursing homes: Ergonomics for the prevention of musculoskeletal disorders (OSHA Publication No. 3182-3R). Retrieved September 12, 2010, from http://www.osha.gov/ergonomics/ guidelines/nursinghome/index.html.

VISN 8 Patient Safety Center. (Revised 2006, August 23). Safe patient handling and movement algorithms. Retrieved on September 15, 2010, from www.orosha.org/grants/resident_handling//apendicies.html.

Waters, T. R. (2007). When is it safe to manually lift a patient? *American Journal of Nursing, 107*(8), 53-59.

RESOURCES

Baptiste, A, McCleery, M, Matz, M, Evitt, C. (2008, January-February). Evaluation of sling use for patient safety, *Rehabilitation Nursing*.

Bureau of Labor Statistics. (2006). Occupational injuries, illnesses, and fatalities among nursing, psychiatric, and home health aides, 1995- 2004. Retrieved August 2, 2008, from http://www.bls.gov/opub/cwc/sh20060628ar01p1.htm.

Collins, J., Bell, J., Grönqvist, R., Courtney, T., Lombardi, D., Sorock, G., Chang, W., Wolf, L., Chiou, S., Evanoff, B., Wellman, H., Matz, M., & Nelson, A. (in press). Slip, trip and fall (STF) prevention in health care workers, *Contemporary Ergonomics.*

Collins, J. W., Wolf, L., Bell, J, & Evanoff, B. (2004). An evaluation of a "best practices" musculoskeletal injury prevention program in nursing homes. *Injury Prevention*, 10, 206-211.

DeCastro, A.B. (2004). Handle with care: The American Nurses Association's campaign to address work-related musculoskeletal disorders. *Online Journal of Issues in Nursing, 9*(3). Retrieved August 2, 2008, from http://www.nursingworld.org/MainMenu Categories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume92004/ Number3September30/HandleWithCare.aspx.

Engst, C., Chhokar, R., Miller, A., Tate, R.B., Yassi, A. (2005) Effectiveness of overhead lifting devices in reducing the risk of injury to care staff in extended care facilities. *Ergonomics, 48*(2), 187-199.

Evanoff, B., Wolf, L., Aton, E., Canos, J., & Collins, J. (2003). Reduction in injury rates in nursing personnel through introduction of mechanical lifts in the workplace. *American Journal of Industrial Medicine, 44,* 451-457.

Foley, M.E., Keepnews, D., & Worthington, K. (2001) Identifying and using tools for reducing risks to patient and health care workers: A nursing perspective. *The Join Commission Journal on Quality Improvement,* 27(9):494-9.

Garg, A., & Owen, B. (1994). Prevention of back injuries in healthcare workers. *International Journal of Industrial Ergonomics, 14,* 315-331.

Hignett, S., Crumpton, E., Ruszala, S., Alexander, P., Fray, M., & Fletcher,B. (2003). *Evidence-based patient handling: tasks, equipment, and interventions.* New York: Routledge.

Hignett, S. (2005). Determining the space needed to operate a mobile and an overhead patient hoist. *Professional Nurse, 20*(7):39-42.

Kirton, H. (2008, March). *Helping make 1:1 care mean 1:1 care!* Poster session presented at the 8th Annual Safe Patient Handling and Movement Conference, Tampa, Florida.

Marras, W. S., Davis, K. G., Kirking, B. C., & Bertsche, P. K. (1999). A comprehensive analysis of low back disorder risk and spinal loading during the transferring and repositioning of patients using different techniques. *Ergonomics, 42*(7), 904-926.

Marras, W. (2008, March). *Trade-offs in Patient Handling Risk: Pushing and Pulling.* Poster session presented at the 8th Annual Safe Patient Handling and Movement Conference, Tampa, Florida.

Motacki, K, Nelson, A. (2009) *The illustrated guide to safe patient handling and movement*. New York: Springer.

Matz, M. (2006). After-action reviews. In Nelson, A.L. (Ed), *Handle with Care: Safe Patient Handling and Movement.* New York: Springer Publishing Company.

Matz, M. (2008, June). Safe patient handling & movement: Evidence-based patient care ergonomic strategies and technology. Paper presented at the American Industrial Hygiene Association Conference and Exposition, Healthcare Ergonomics Roundtable, Minneapolis, Minnesota.

Moreno, J. (2003, January). Limit Liability with Lift Programs. *Provider,* 41-42.

Nelson, A. L. (Ed.). (2001). *Patient care ergonomics resource guide: Safe patient handling and movement.* Tampa, FL: Veterans Administration Patient Safety Center of Inquiry.

Nelson, A., Owen, C., Lloyd, J., Fragala, G., Matz, M., Amato, M., Boers, J., Moss-Cureton, S., Ramsey, G. & Lentz, K. (2003). Algorithms for safe patient handling and movement. *American Journal of Nursing, 103*(3), 32-34.

Nelson, A. L., Lloyd, J., Menzel, N., & Gross, C. (2003a). Preventing nursing back injuries: redesigning patient handling tasks. *Journal of the American Association of Occupational Health Nurses, 51*(3), 126-134.

Nelson, A. L., Fragala, G., & Menzel, N. (2003b). Myths and facts about back injuries in nursing. *American Journal of Nursing, 103*(2), 32-40.

Nelson, A.L., Tracey C.A., Baxter, M.L., Nathenson, P., Rosarios, M., Rockefeller, K., Joffe, M., Harwood, K.J., Whipple, K., & Hoang, L. (2005, April). Improving patient and health care provider safety: Task force develops recommendations on patient handling. *Physical Therapy Magazine*, 48-52.

Nelson, AL, Matz, M, Chen, F., Siddharthan, K., Lloyd, J., Fragala, G. (2006). Development and evaluation of a multifaceted ergonomics program to prevent injuries associated with patient handling tasks. *Journal of International Nursing Studies*, 43, 717-733.

Nelson, A.L. (Ed) (2006). *Safe Patient Handling and Movement: A Guide for Nurses and Other Health Care Providers.* New York: Springer Publishing Company.

Nelson, A.L., Baptiste, A.S., Matz, M, & Fragala, G. (2007). Evidence-based interventions for patient care ergonomics. In P. Carayon (Ed.), *Handbook of human factors and ergonomics in health care and patient safety* (pp. 323-345). Mahwah, New Jersey: Erlbaum.

Nelson, AL, Collins, J., Waters, T., Siddharthan, K., Matz, M. (2008). Link between safe patient handling and quality of care. *Rehabilitation Nursing, 33* (1), 33-41.

Teisman, H., Nelson, A., Charney, W., Fragala, G., & Siddharthan, K. (2003). Effectiveness of a ceiling-mounted patient lift system in reducing occupational injuries in long-term care nurses. *Journal of Healthcare Safety. 1*(1), 34-40.

ORGANIZATIONAL RESOURCES

American Nurses Association
http://www.nursingworld.org/osh

American Physical Therapy Association
http://www.apta.org/AM/PrinterTemplate.cfm?Section=Home&CONTENTID=18516&TEMPLATE=CM/HTMLDisplay.cfm

Veterans Health Association Patient Safety Center
http://www.visn8.med.va.gov/patientsafetycenter/

National Institutes for Occupational Safety and Health
http://www.cdc.gov/niosh/topics/ergonomics

Occupational Safety and Health Administration (OSHA)
http://www.osha.gov/SLTC/ergonomics/index.html

Washington State Department of Labor and Industries
http://www.lni.wa.gov/safety/Topics/Ergonomics/default.asp

LIFTING WORK GROUP MEMBERS

Maribeth Wilkins, PT, Chairperson, Calvert County Public Schools

Dorothy Lynn Borgmann, PT, Maryland School for the Blind

Patricia Brooks, PT, Howard County Public Schools

Judith Davidson, PT, Anne Arundel County Public Schools

Karen Greeley, PT, DScPT, Baltimore County Public Schools

Donna Lesch, PT, Montgomery County Public Schools

Lisa Spencer, Risk Management Officer, Maryland Association of Boards of Education

Appendix E: Safe and Successful Mealtime Practices

INTRODUCTION

This appendix was developed by the Maryland Steering Committee for Occupational and Physical Therapy School-Based Programs to support Occupational and Physical Therapy Early Intervention and School-Based Services in Maryland: A Guide to Practice (Section 4.0) and to support the further understanding of the MSDE Technical Assistance Bulletin # 28(TAB 28) located at: http://goo.gl/kDjcKq.

Integral to all children's development is their ability to take nutrients for growth and well-being and to participate in mealtime activities to develop independent self-management skills for eating and/or for social engagement. From the early stages in life, the ability of the parent/caregiver to bond with and engage their child in feeding and mealtime activities is significant. With normal mealtime skill development, children progress in all aspects of learning to swallow, chew, self-feed, explore and self-select food preferences, and develop culturally appropriate interaction skills to engage with others during mealtime activities.

Children who demonstrate developmental, behavioral, and/or medical impairments are sometimes compromised in their ability to develop feeding skills needed to participate in mealtime activities. Children with disabilities may have physical, medical, social/emotional, and/or cognitive concerns that impact their ability to develop skills for participation in mealtime activities. This presents challenges to the child's ability to participate in mealtime and snacks, which are considered important parts of the day. Mealtime provides not only essential nutritional opportunities, but also opportunities for social, language, and cognitive development.

When mealtime skill development is compromised by complex feeding, swallowing and/or behavioral problems there is the potential for significant medical risks for the student and potential liability for the feeder, educational team, and school system. Therefore, safe feeding intervention is a priority for the child and for the staff involved in implementing a safe feeding plan for nutritional benefit and participation. Consideration by the team developing the Individualized Family Service Plan (IFSP) or the Individualized Education Program (IEP) is necessary in order to develop and abide by mutually agreed interventions to address the child's

unique mealtime needs. Priority must be given to the child's safety and well-being. Addressing mealtime skill development, if identified as a need, should be IFSP/IEP team driven utilizing the expertise of its stakeholders, which may include the occupational therapist, speech pathologist, nurse, psychologist, educator, parent, physical therapist, nutritionist and/or medical community as appropriate. Team members must collaborate when developing and implementing safe feeding plans and/or mealtime skill activities that support nutritional well being and participation in the natural learning or least restrictive environments. Occupational therapists and/or speech-language pathologists often take lead roles in the assessment of feeding difficulties and contribute to the decision-making process of the IFSP/IEP team in identifying intervention strategies specific to the child and strategies that support the team in implementing feeding/mealtime plans.

Addressing these issues requires communication and collaboration among all stakeholders, including school and early intervention personnel, families, and the medical community as well as a clearly-defined process and procedure to include all the complexities mentioned. Occupational therapists and speech pathologists, along with nurses, physical therapists, and educational staff are often among the participants in the evaluation and implementation of feeding plans for our children/students with disabilities.

In the educational setting, federal and local requirements ensure that all children have nutritional meals to support their availability for learning. Children identified with a disability through the early intervention or special education process, which requires early intervention services or special education instruction including accommodations, may also have needs related to nutritional and mealtime skill development.

Determining educational relevance, defining professional roles, determining core competencies, assuring adequate staff training, and implementing medical recommendations safely in the home, school, and/or community setting are among some of the factors that early intervention providers and school staff are facing. This appendix was developed to provide a basic guide for therapists to assist IFSP and IEP teams, including administrators, in addressing feeding and/or swallowing issues successfully. It is not intended to be an all-encompassing resource for children with complex feeding issues.

Case law and court decisions support application of law in management of feeding difficulties in schools. Examples of case law that help clarify dysphagia (swallowing disorder) management in schools include:

- Cedar Rapids v. Garrett, 526 U.S. 883 (1984)
- Irving Independent School Dist. V. Tatro, 468 U.S. 883 (1984)
- Board of Educ. Of Henrick Hudson Central School Dist. v. Rowley, 458 U.S. 176, 192 (1982)
  - City of Warwick v. Rhode Island Dept. of Educ., No. PC 98-3189, 2000 WL 1879897 (R.I.Super., 2000)
  - Tanya v. Cincinnati Bd. of Educ., 100 Ohio App. 3d 52, 651 N.E. 2d 1373 (1995)

All children must be safe and adequately hydrated and nourished while eating in order to participate in and fully access the natural learning or least restrictive environment. Supporting families through early intervention services promotes engagement in safe mealtime activities. Development of efficient and safe mealtime skills enables students to actively participate in their school day so no child is denied a free and appropriate public education (FAPE)(ASHA, 2007).

The purpose of this addendum is to:

1. Promote safety and success of children/students during mealtimes
2. Assure safety and limit liability of educational and/or related service staff during mealtimes
3. Promote functional participation and/or independence for children/students with mealtime concerns
4. Promote communication and collaboration among team members to support strategies and intervention plans for mealtime activities
5. Increase statewide awareness of the principles related to safe and successful mealtime experiences
6. Provide a process for IFSP/IEP team decision making as it relates to early intervention/educational relevance for safe and successful mealtime participation as it applies to each local school system, the public agency and natural learning environment (see Glossary for definition of natural learning environment)

STEPS IN THE PROCESS:

1. Determining Need
2. Making Decisions - Sample Decision-Making Algorithms
3. Training
4. Documenting

STEP ONE: Determining Need

To determine a child's needs in mealtime skills and/or participation in mealtime activities the Top Down Assessment Approach outlined in the Guide for IFSP and IEP development should be implemented. Questions related to expectations, concerns, and specific performance skills or

routines must be factors considered in the context of the child/student, family, and staff within the natural learning or least restrictive environments. Identifying mealtime needs and outcome expectations contribute to the decision-making process for determining need for service. The following factors should be considered:

Child Specific Characteristics:

Development of oral motor structures
Oral motor control
Sensory issues
Positioning
    Head and neck control
    Trunk control
    Upper and lower extremity function
Pulmonary function
Cognitive function
Behavior
Medical diagnoses/history
Dietary restrictions/allergies
Food preferences
Cultural considerations
Current nutritional intake

Staff Considerations:

Level of competency and experience
Ability to recognize the signs and symptoms of aspiration/distress
Basic first aid training
Ability to follow feeding plan/protocol
Recognize signs of distress or change in behavior for child and recognize when to stop feeding
Ability to document and collect data

Environmental Factors:

Consider the differences between home and alternate environments
Sensory and or physical environment
Social implications
Equipment/seating needs
Availability of adaptive feeding equipment
Contingency plan for emergencies

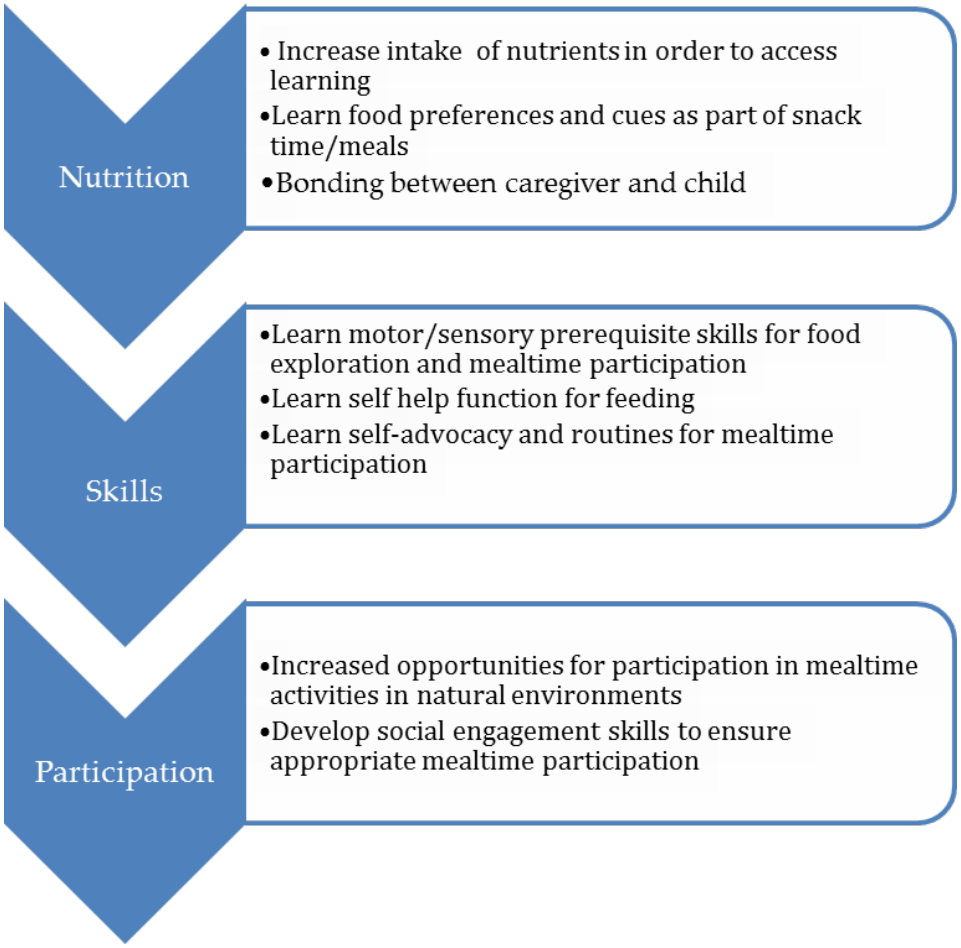
Time considerations

Number of qualified staff available during mealtimes

STEP TWO: Making Decisions to support participation in mealtime activities and safe feeding activities

The decision-making process to determine a child's or student's needs in mealtime skills and/or participation for mealtime activities should follow the Top Down Assessment Approach outlined in the Guide for IFSP and IEP development. Safety, nutrition, and skills to promote mealtime participation within the natural learning or least restrictive environment must be considered in looking at the early intervention/educational relevance for service decision and developing a mealtime plan.

The Normal Progression of Mealtime Development and Participation Includes:



Barriers Impacting Mealtime Development and Participation

Tier I: **Nutrition** Involving Medical and/or Behavioral Concerns:

Given medical clearance, children with significant medical and/or behavioral conditions that compromise nutritional benefit and/or participation in the natural learning or least restrictive environment must be provided with opportunities for nutrition. Children with problems involving swallowing demonstrate risk factors for aspiration and therefore safe feeding issues must be addressed in order not to compromise the child or the person responsible for providing nutrition.

Tier II: **Skills** Involving Motor and/or Sensory Development Concerns:

In order for children with sensory, physical, and/or developmental management concerns to successfully participate in mealtime activities, they must be provided accommodations to access mealtime activities in the natural or least restrictive learning environment. Determining the need for specific intervention is based on the assessment process considering the child's/student's physical limitations, cognitive capabilities, and/or tolerance to sensory stimulation, and parent/team support.

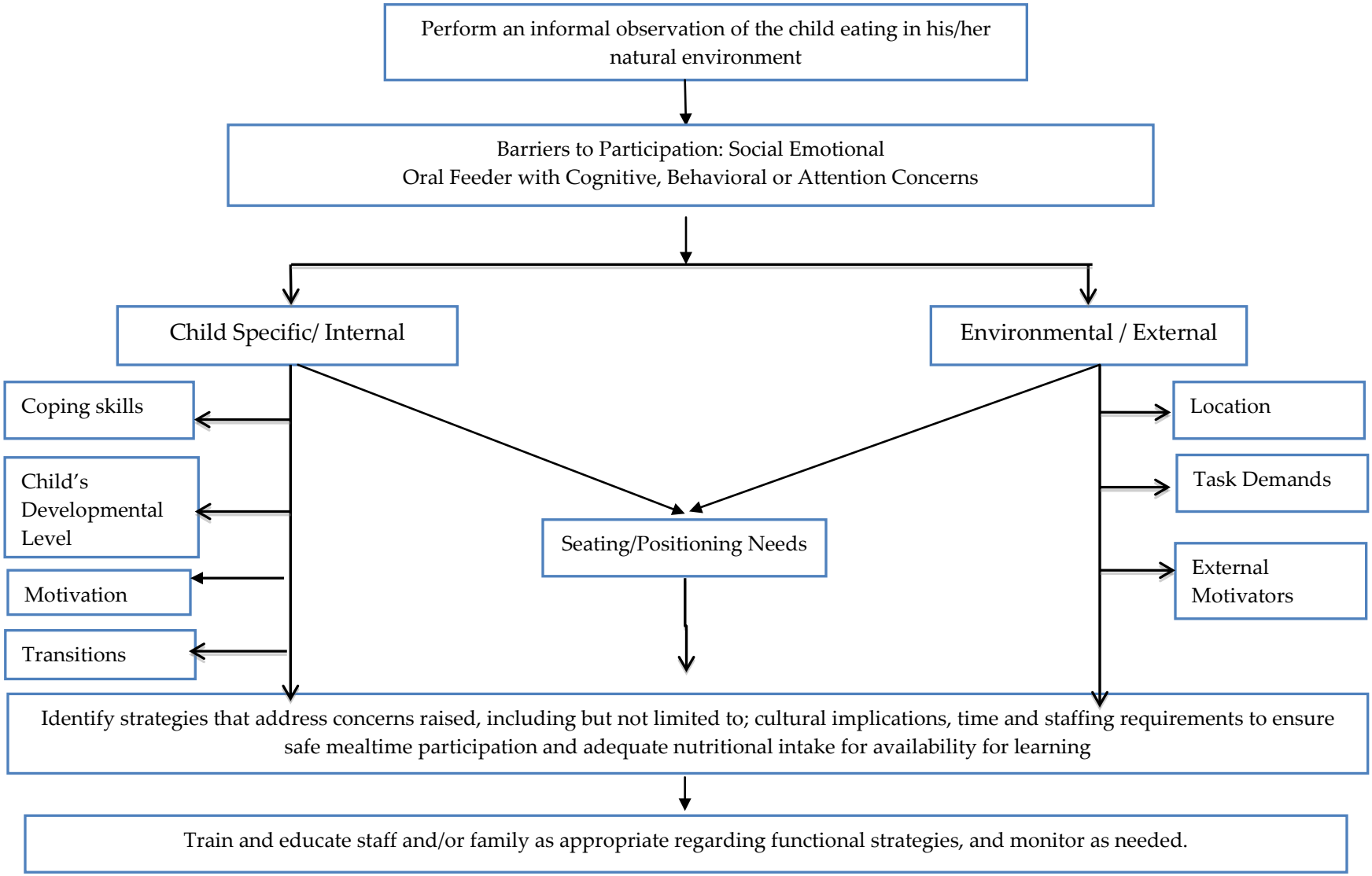
Tier III: **Participation** Involving Physical, Environmental, Behavioral Concerns:

Children who have difficulty engaging in mealtime routines or activities due to environmental or physical barriers, food intolerances, and/or behavioral difficulties should be provided with intervention plans. These plans should support opportunities for social interaction with peers/caregivers, self-advocacy skills for functional independence, and mealtime routines.

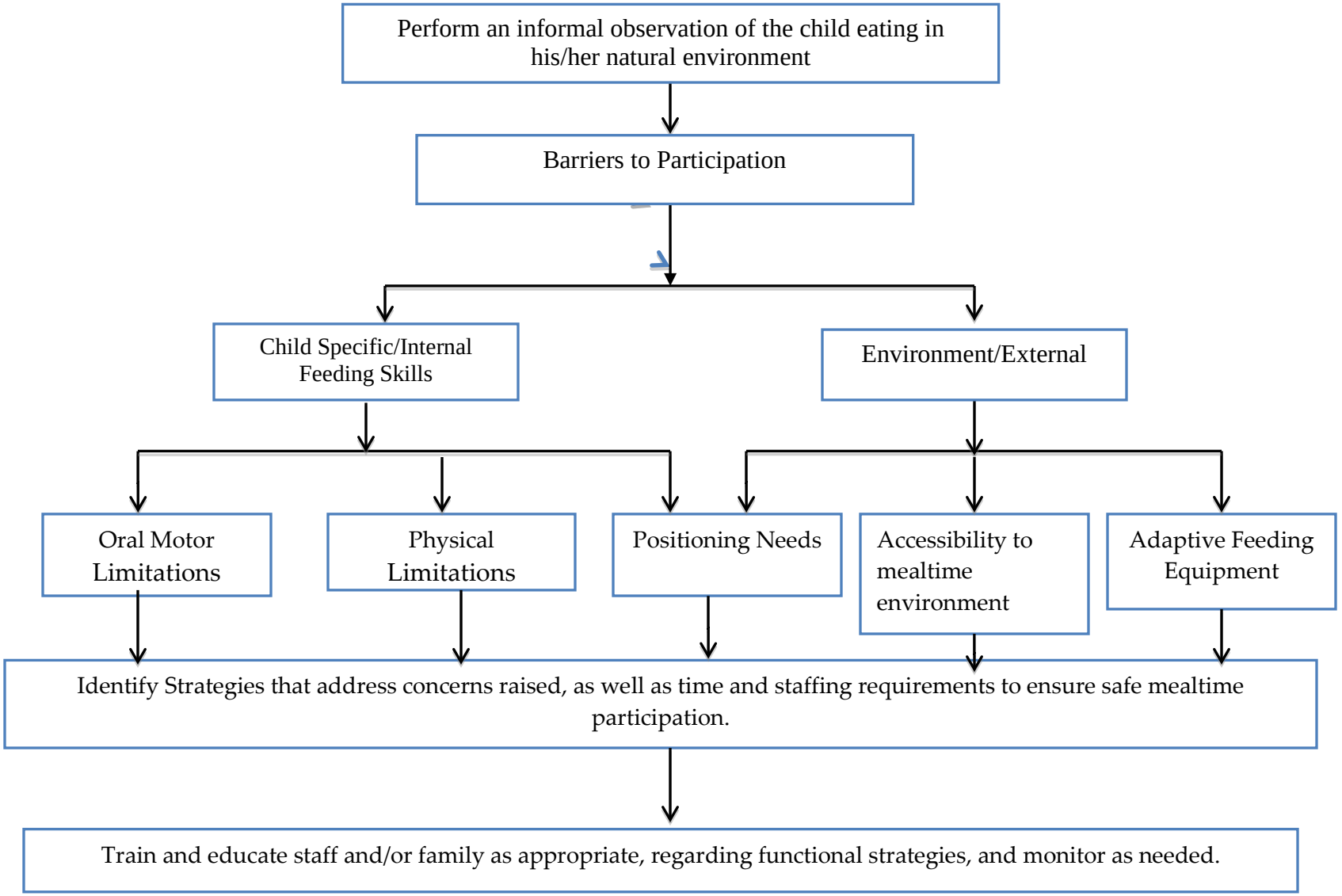
Making Decisions: Schematic Guide (Algorithms)

The following schematics are provided to address the team process for making decisions and determining educational relevance to support children/students with disabilities in mealtime participation and safe feeding.

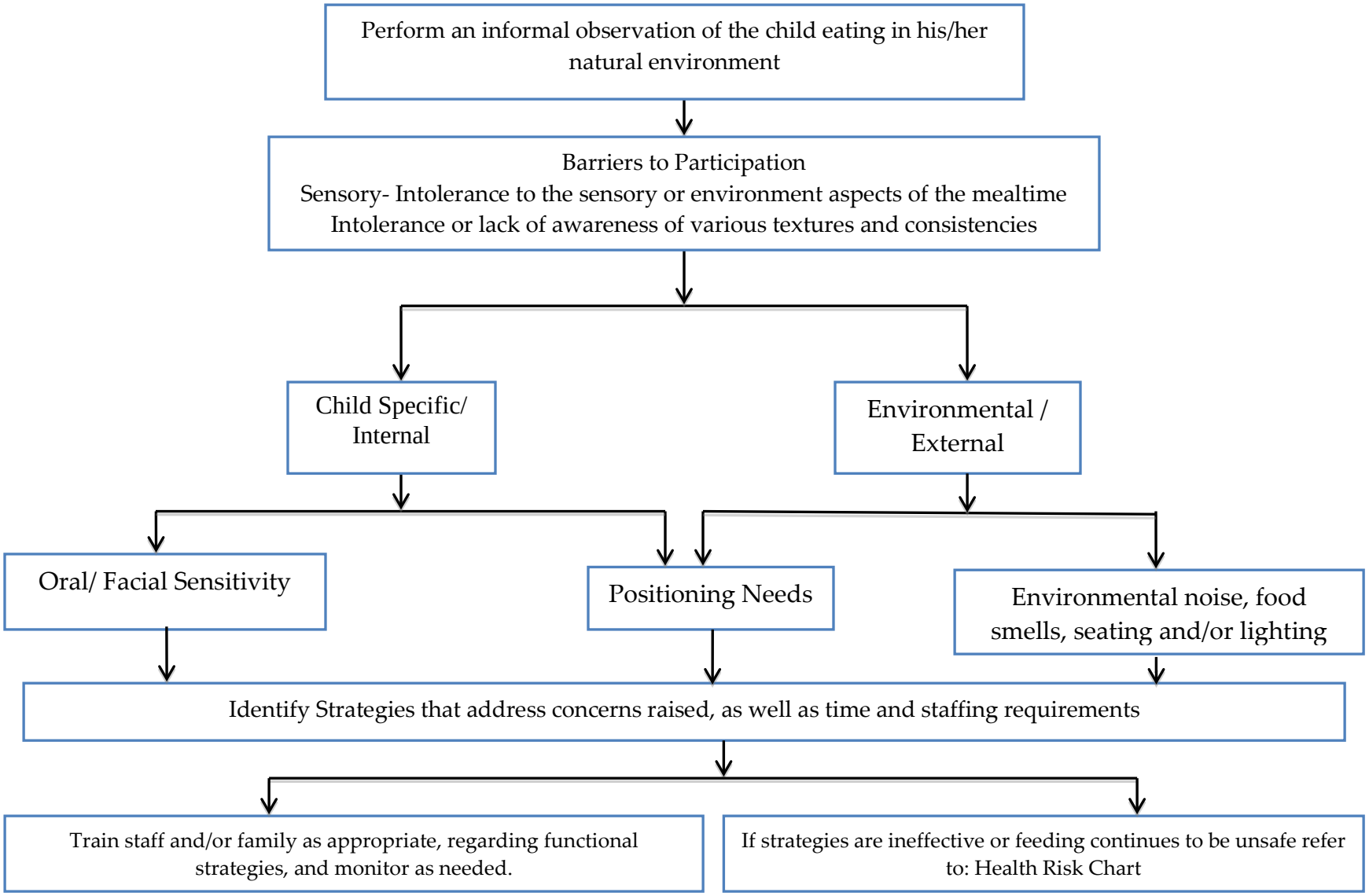
Mealtime concern was raised: Cognitive, Behavioral or Attention Concerns



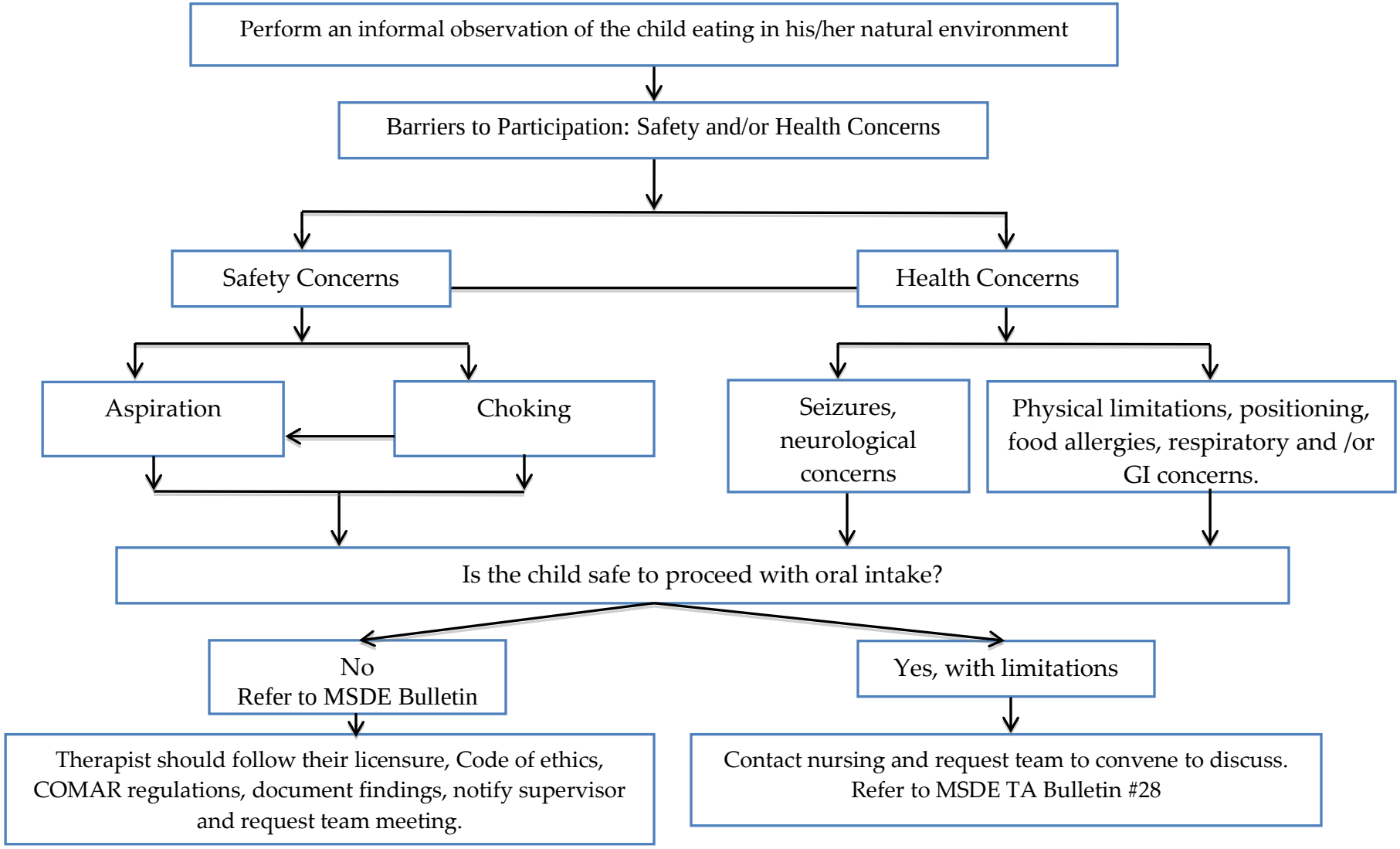
Mealtime concerns raised: Motor Skills



Mealtime concerns raised: Sensory



Mealtime concern was raised: Health Concerns



Making Decisions about the Implementation of the Mealtime Plan

Based on IFSP outcomes or IEP goals, objectives, supplemental aids and services, the IFSP or IEP team determines appropriate service providers. This decision should include a discussion to determine the expertise required to achieve desired outcomes.

STEP THREE: TRAINING

Purpose:

The purpose of training is to promote safety and success of children and students during mealtimes and to promote communication and collaboration among team members to support strategies and intervention plans for mealtime activities. In addition, appropriate training assures safety and limits liability of educational or related service staff during mealtimes.

Following clinical observations, review of assessments and analysis of student, staff, and environmental needs, designated members of the IFSP/IEP team which may include but are not limited to caregiver(s); school based occupational therapist(s), speech and language pathologist(s), school nurse(s), feeding specialist(s), and/or outside medical/educational professional(s) will collaborate to determine designated trainees and training requirements.

The designated individual(s) should:

1. Identify all the mealtime experiences that the student participates in to include but not limited to natural learning environments
2. Gather information related to mealtime experiences throughout the day
3. Obtain pertinent medical information
4. Consider child characteristics, staff characteristics, and environmental factors,
5. Determine the specialized mealtime procedures and equipment needed for mealtime
6. Document this information

Based on the above information the team identifies potential trainers, designated trainees (staff in need of training), and resources needed to support training. As appropriate, considerations should be made for:

1. Release time for trainers and trainees
2. Space for training
3. Materials for training
4. Equipment (positioning, feeding, communication)
5. Handouts and/or presentation materials

As needed, identify content of training to include, but not limited to, an overview of:

1. Pertinent physical and medical history, including diagnoses, allergies, and current status
2. Basic first aid
3. Signs and symptoms of aspiration (see Glossary)
4. Positioning
5. Food textures and consistency of liquids
6. Communication needs
7. Adaptive equipment needs
8. Feeding procedures
9. Precautions
10. Emergency protocol

Identify methods as needed to develop and maintain competency over time, ensure effectiveness of mealtime strategies/plan of care, and document training, including but not limited to:

1. Trainer to model/train/supervise implementation of mealtime strategies/plan of care for specific children/students.
2. Trainee to safely demonstrate techniques in presence of trainer.
3. The designated trainer will collaborate and monitor the effectiveness of mealtime strategies/plan of care.
4. The designated trainer will consider experiential opportunities to increase knowledge base and awareness of trainees.
5. The designated trainer will establish plan for follow-up training (student's needs change, staff change, determine need for and frequency of routine re-training).

STEP FOUR: DOCUMENTATION OF TRAINING

Purpose:

The purpose is to document that a staff member/trainee has received training, achieved competency, and demonstrates the ongoing ability to implement safe mealtime strategies in order to promote safety and success of children/students during mealtimes and assure safety and limit liability of educational and/or related service staff during mealtimes.

Once competency is demonstrated, the following should be documented:

1. Date
2. Student's name
3. Subject and information covered (mealtime strategies/plan of care)

4. Printed name/title and signature of trainer
5. Printed name of trainee/title who received training and signature
6. Include a plan for rechecking of skills as needed
7. Indicate initial or follow up training

Distribution of Competency Documentation:

1. Trainee's records
2. Trainer's records
3. Student's confidential record
4. Designated administrator, as determined by the responsible local school system or public agency.

GLOSSARY

Aspiration: penetration of food, liquid or foreign object into the airway below the true vocal folds.

Aspiration –Signs and Symptoms

- Coughing during and/or after meals
- Choking
- Throat clearing
- Wet/gurgling voice after swallowing
- Fever
- Chills
- Respiratory changes or chest congestion
- Leakage of food or saliva from mouth or tracheotomy
- Excess secretions
- Shortness of breath

Dysphagia: A swallowing disorder. The signs and symptoms of dysphagia may involve the mouth, pharynx, larynx, and/or esophagus.

Feeding Disorder: This refers to disordered placement of food in the mouth; difficulty in food manipulation prior to initiation of the swallow, including mastication; and the oral stage of the swallow when the bolus is propelled backward by the tongue. In pediatrics, this term may be used to describe a failure to develop or demonstrate developmentally appropriate eating and drinking behaviors.

Food Aversion: A food aversion is characterized by the child's consistent refusal to eat certain foods with specific tastes, textures, temperatures, or smells for at least 1 month. The child's reactions to aversive foods range from grimacing or spitting out the food to gagging and vomiting. After an aversive reaction, the child refuses to continue eating the food and frequently generalizes and refuses other foods with a similar color, appearance, or smell (Chatoor, 2009).

Functional Swallow: A swallow that may be abnormal or altered but does not result in aspiration or reduced swallowing efficiency. This type of swallow does ensure maintenance of adequate nutrition and hydration.

Independence: Lack of requirement or reliance on another; adequate resources to accomplish everyday tasks (Jacobs, 1999).

Mealtime participation: The process of taking part in mealtime activities which may include eating/feeding with family and peers, choice making and social interaction.

Natural learning environment: Settings which are natural and or normal for a child's same age peer. Typically these are key settings where a child and or family spend much of their time (Hanft & Pilkington, 2000). In Part C, the natural learning environment might include home and or community settings. In Part B the natural learning environment may include but is not limited to school or school related activities such as community outings or job sampling settings.

Nutrition: The process of nourishing or being nourished; the processes by which an organism assimilates food and uses it for growth and maintenance (Miriam-Webster, 2012).

Safety: According to Miriam-Webster (2012) safety is to be free from harm or risk. As related to mealtime participation children will receive adequate nutrition, without medical complication or social stigma.

Self-Feeding: This refers to the arm and hand coordination required to bring food from plate to mouth.

Silent aspiration: When a child does not cough in response to aspiration and may appear to swallow safely.

Slow Swallowing: This is noted to occur when the child appears to require an unusual amount of time to move food or liquid back in the oral cavity for swallowing, reflecting a slow oral transit time. Food may pool or be stored in the front of the mouth or in the back of the mouth between the dorsum of the tongue and the soft palate.

Oral motor concerns: Challenges with the muscles or structures of the mouth or mouth movements that interfere with eating.

REFERENCES

American Occupational Therapy Association. (2008). Occupational therapy practice Framework: Domain and process (2nd ed.). *American Journal of Occupational Therapy, 62,* 625-683.

American Speech-Language-Hearing Association. (2007). Guidelines for speech-language pathologists providing swallowing and feeding services in schools. Retrieved November 17, 2011 from: http://www.asha.org/docs/html/GL2007-00276.html

Chatoor, I. (2009, January). Sensory food aversions in infants and toddlers. Retrieved January 25, 2012 from: http://main.zerotothree.org/site/DocServer/293_Chatoorv.pdf?docID=7961

Connecticut State Department of Education. (2008). Guidelines for feeding and swallowing programs in schools. Retrieved November 17, 2011 from: http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Special/Feeding_and_Swallowing.pdf

Hanft, B. E., and Pilkington, K.O. (2000) Therapy in natural environments: The means or the end goal for early intervention? *Infants and Young Children, 12(4), 1-13.*

Jacobs, K. (1999). Quick reference dictionary for occupational therapy. Thorofare, NJ: Slack.

Maryland State Department of Education.(2011, July). Feeding and swallowing policies and procedures. Division of Special Education/Early Intervention Services, Technical Assistance Bulletin 28.

Maryland State Steering Committee for Occupational and Physical Therapy School-Based Programs.(2008, December). Occupational and physical therapy early intervention and school-based services in Maryland: A guide to practice. Baltimore: Maryland State Department of Education.

Miriam-Webster. (2012). Dictionary. Retrieved January 20, 2012 from: http://www.merriam-webster.com/dictionary/safety.

Wisconsin Department of Health Services.(2009, July).Wisconsin feeding assistant training manual. Retrieved November 17, 2011 from: http://www.dhs.wisconsin.gov/publications/p0/p00097.pdf

SAFE MEALTIME WORK GROUP MEMBERS:

Elizabeth George, OT, Chairperson, Baltimore County Public Schools
Emy Ahn, OT, Maryland School for the Blind
Sarah Burton, OT, FAOTA, Prince Georges County Public Schools
Elizabeth Cohen, OT, Howard County Public Schools
Robin Failli, SLP, Anne Arundel County Public Schools
Jayne Heck Hackley, OT, Baltimore County Public Schools
Kira Layng, OT, Anne Arundel County Public Schools
Jodie Williams, OT, Anne Arundel County Public Schools

Thanks for their assistance with this process and review of this appendix to:

Lisa Spencer, Risk Management Officer, Maryland Association of Boards of Education
Lisa Melody, Manager: Speech/Language Services Anne Arundel County Public Schools

Appendix F: Occupational and Physical Therapy Evaluation/Assessment as Components of a Comprehensive Evaluation

INTRODUCTION:

This appendix was developed by the MD State Steering Committee for OT and PT School-based Programs to support Occupational and Physical Therapy Early Intervention and School-Based Services in Maryland: A Guide to Practice.

As outlined by the American Occupational Therapy Association (AOTA) and the American Physical Therapy Association (APTA), best practice regarding school-based evaluation supports a top-down approach while ensuring alignment with federal and state laws. A top-down approach to assessment examines the interrelationship between a child's performance and participation (Goldstein, Cohn, & Coster, 2004) in all natural learning environments. "A child's [need] is not defined by his/her deficits, but rather by the extent of his/her engagement in meaningful activities despite the limitation imposed by the disability" (Goldstein et al, p.115) (Section 4.2, page 25)

The foundations of the assessment process are based on the Occupational Therapy Practice Framework, the Guide to Physical Therapy Practice and the International Classification of Function (ICF). Through the assessment process, barriers and supports necessary to achieve functional outcomes and participation are identified. This appendix includes schematics to describe the assessment process for both Early Intervention and School-Based services and therapists.

EVALUATION AND ASSESSMENT FOR PART C (Infants & Toddlers):

Evaluation and assessment (34 CFR 303.3221) for early intervention services are considered processes that have different purposes under Part C. For each child referred to the program a comprehensive, multidisciplinary evaluation of developmental levels in all areas is required, along with a family-directed identification of the needs of each child's family to appropriately assist in the development of the child. "Evaluation" means the procedures used by qualified personnel to

determine a child's initial and continuing eligibility (34 CFR 303.321). No single procedure may be used as sole criterion for determining a child's disability. Procedures include administering an evaluation instrument, taking the child's history, identifying the child's level of functioning in each developmental area, gathering information from other sources such as family members and reviewing medical and other records.

"Assessment means the ongoing procedures used by appropriate qualified personnel throughout the period of a child's eligibility under this part to identify - (i) the child's unique strengths and needs and the services appropriate to meet those needs; and (ii) 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 with a disability" (34 CFR 303.321).

Information from the evaluation, family assessment, child outcomes summary, informed clinical opinion and other sources, is used to develop an IFSP that includes child and family outcomes and early intervention services. Ongoing assessment guides parent coaching and direct services to support child and family outcomes.

EVALUATION for PART B: The OT/PT Contribution Using the TOP-DOWN Approach to Assessment

Evaluation (34 CFR 300.303(b)(1))means procedures, with parental consent, used to determine whether the student has a disability and the nature and extent of the special education and related services the child/student needs. The IEP team through a collaborative process reviews concerns from teachers, parents, and other school team members as appropriate, as well as existing data and evaluation results and determines if the student has a disability and is eligible for special education services. The IEP team determines how the disability affects participation in appropriate activities, or how the child's identified needs affect the child's involvement and progress in the general curriculum. The IDEA stipulates that a reevaluation may not occur more than once a year unless agreed upon by both the parents and the public agency members of the IEP team (34 CFR 300.303(b)(1). At a minimum, a reevaluation occurs at least once every three years unless the parent and the public agency agree that a reevaluation is unnecessary (34 CFR 300.303(b)(2).

Occupational Therapists (OTs) and Physical Therapists (PTs) may provide an assessment to contribute to the comprehensive evaluation of the child. A top-down assessment process is used by OT and PT practitioners and each should adhere to the respective practice frameworks of their

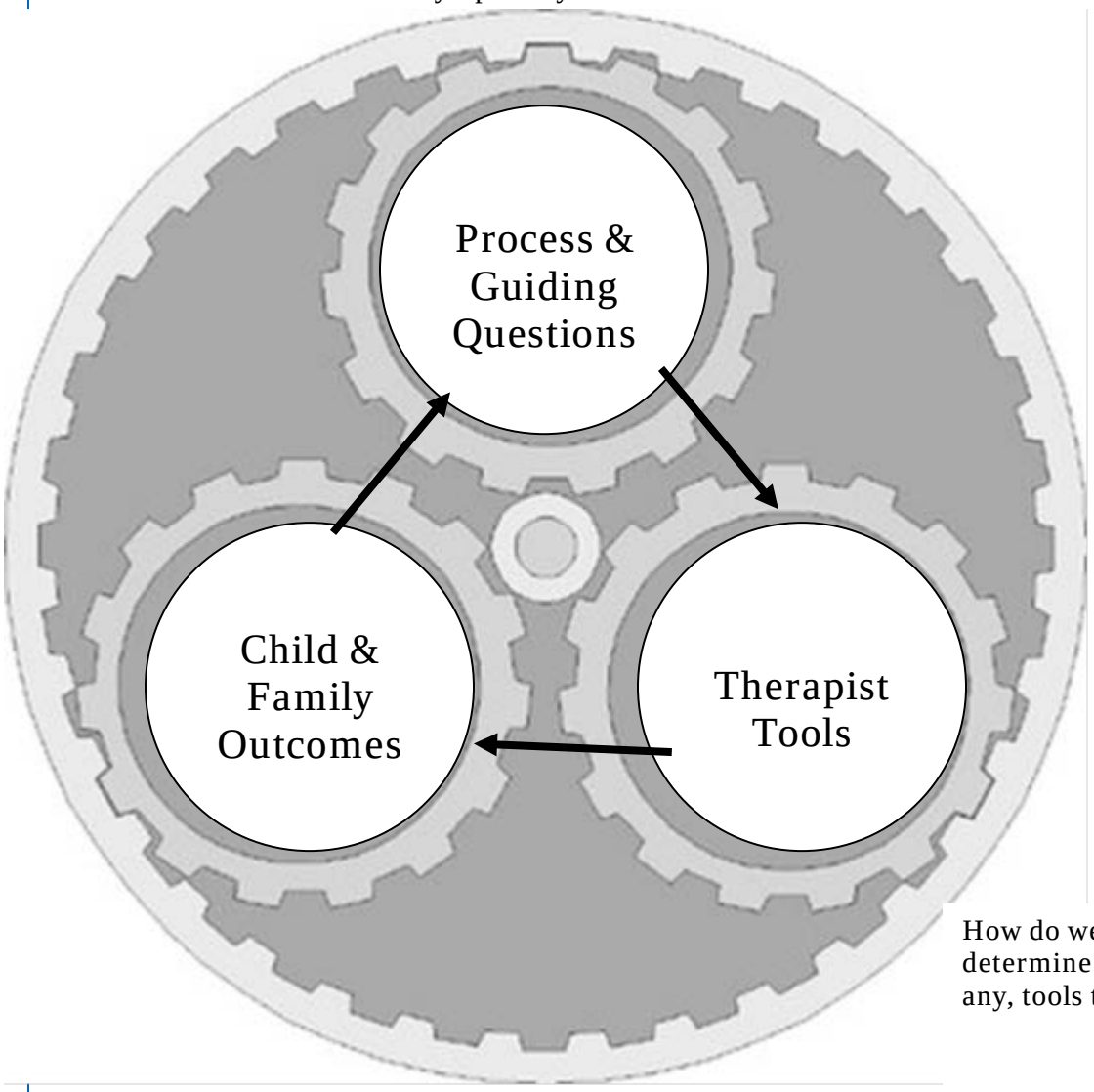
professions: The Occupational Therapy Practice Framework: Domain and Process (AOTA 2008) and the Guide to Physical Therapist Practice (APTA 2001). Within the scopes of practice, the OT or PT gathers data to address the child's ability to participate in and gain access to the general curriculum in various contexts of the child's day. School-based OT and PT assessments with parental consent are an ongoing dynamic process that uses information gathered from a variety of sources and may include but are not limited to observation, interview, review of data collected, and test results.

SCHEMATICS:

The following diagrams represent the process for OT and PT assessments as a component of a comprehensive evaluation for both Part C and Part B of the IDEA. Each step of the process is demonstrated schematically using arrows designed to capture the dynamic nature of the assessment process.

OT/PT Components of the Evaluation and Assessment Process for Part C (IFSP)

Is the child eligible for early intervention services?
What are the child's and family's strengths?
What are the barriers to participation in natural environments?
What are the family's priority outcomes?

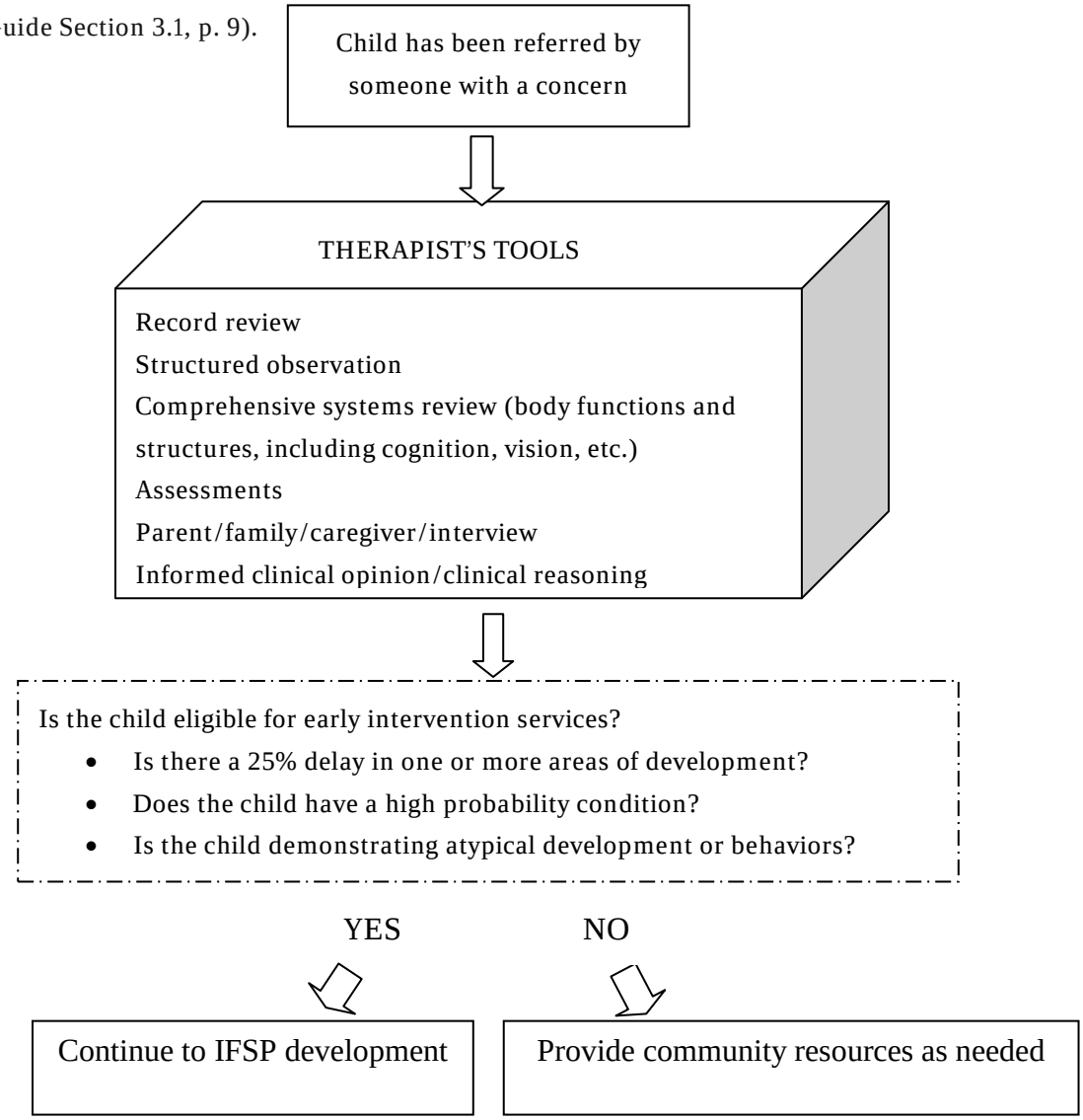


How do we determine what, if any, tools to use?

How do we translate assessment findings to meet the needs of the child and family?

OT/PT Evaluation Components in Initial and Continuing Eligibility

Evaluation under Part C means the procedure used by appropriate qualified personnel, which may include OT and/or PT as determined by the local lead agency, to determine a child's initial and continuing eligibility for early intervention services. A meeting must be conducted at least on a semi-annual basis to evaluate the IFSP for a child and the child's family, and, as appropriate, to revise its provisions. The results of any current evaluations and other information available from the ongoing assessment of the child and family must be used in determining what services are needed and will be provided and included in the child outcome summary (COS) (§303.342) (Guide Section 3.1, p. 9).



IFSP Development

The Individualized Family Service Plan (IFSP) is a document used to summarize the eligibility, assessment, and intervention plan for the eligible child and the child's family. It is based on the multidisciplinary evaluation and assessment of the child, in the context of the child's family, and focuses on the family's priorities, resources, and concerns [COMAR 13A.13.01.07]. Child-based outcomes are expressed as functional skills for each child and are determined by the priorities of the family with input from the IFSP team members. The IFSP must also include family outcomes, which address the specific needs identified by the family in relationship to caring for the child. Families and other team members collaboratively develop measurable criteria and strategies to address each outcome. **The IFSP team then determines if the expertise of an OT and/or PT is needed to implement the plan.**

Child has been determined eligible for early intervention services

GUIDING QUESTIONS FOR CONSIDERATION WHEN DEVELOPING THE IFSP CHILD AND FAMILY OUTCOMES.
(Keep in mind the three early childhood outcomes: developing positive social-emotional skills, acquiring and using knowledge and skills, and taking appropriate action to meet needs.) :

- What are the specific family/caregiver concerns?
- What are the child's strengths?
- What are the family's/caregiver's strengths?
- What family/caregiver routines and activities are going well?
- What are the perceived barriers to child development and participation in the daily routines of the family?
- What are the child's needs?
- What are the desired outcomes for the child and family?
- What formal and informal resources are available to the family?
- What other resources are needed to assist the family and child with participating in daily routines and community activities?
- What, if any, additional information is necessary to establish a baseline from which to measure response to intervention?

THERAPIST'S TOOLS

Review eligibility results with family/caregiver
Family interview
Routines-based assessment
Observation of activities in natural environments
Informed clinical opinion

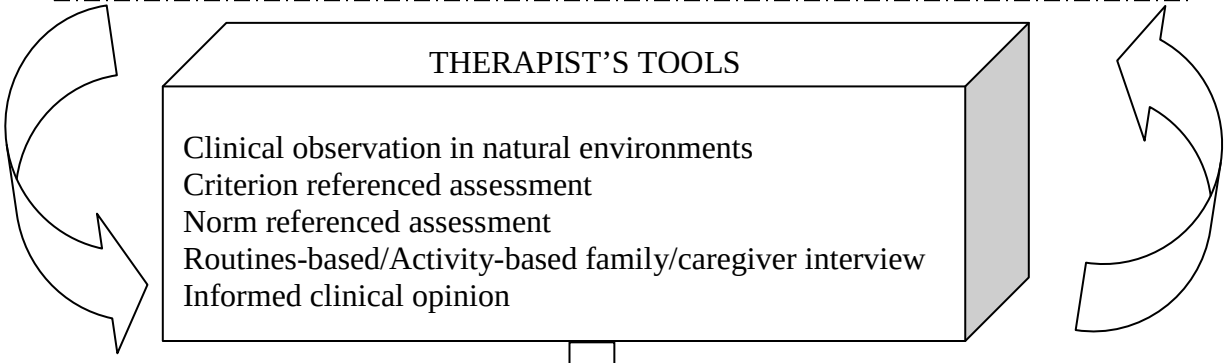
Develop and Implement the IFSP
Participate and contribute to the Child Outcomes Summary (COS) process.

On-going OT/PT Top-Down Assessment Component & Periodic IFSP Review

A review of the IFSP for a child and the child's family must be conducted on a semi-annual basis, or more frequently if conditions warrant, or if the family requests such a review. The purpose of the periodic review is to determine the degree to which progress toward achieving the outcomes is being made and whether modification or revision of the outcomes or services is necessary (§303.342-343) (Guide Section 3.2).

GUIDING QUESTIONS:

- What routines/strategies/activities are working well for the child and family/caregiver?
- What new routines/strategies/activities would the family like to establish?
- What are the perceived barriers to the child's development and participation in the daily routines of the family/caregiver?
- What is the response to intervention?
- What new strengths has the child acquired?
- What new strengths has the family/caregiver acquired?
- What are the child's current needs?
- Have the desired outcomes for the child and family/caregiver changed?
- What formal and informal resources are available to the family?
- What other resources are needed to assist the family/caregiver and child with participating in daily routines and community activities?



Based on my assessment, what are my recommendations to the team?

- Continue IFSP
- Revise IFSP

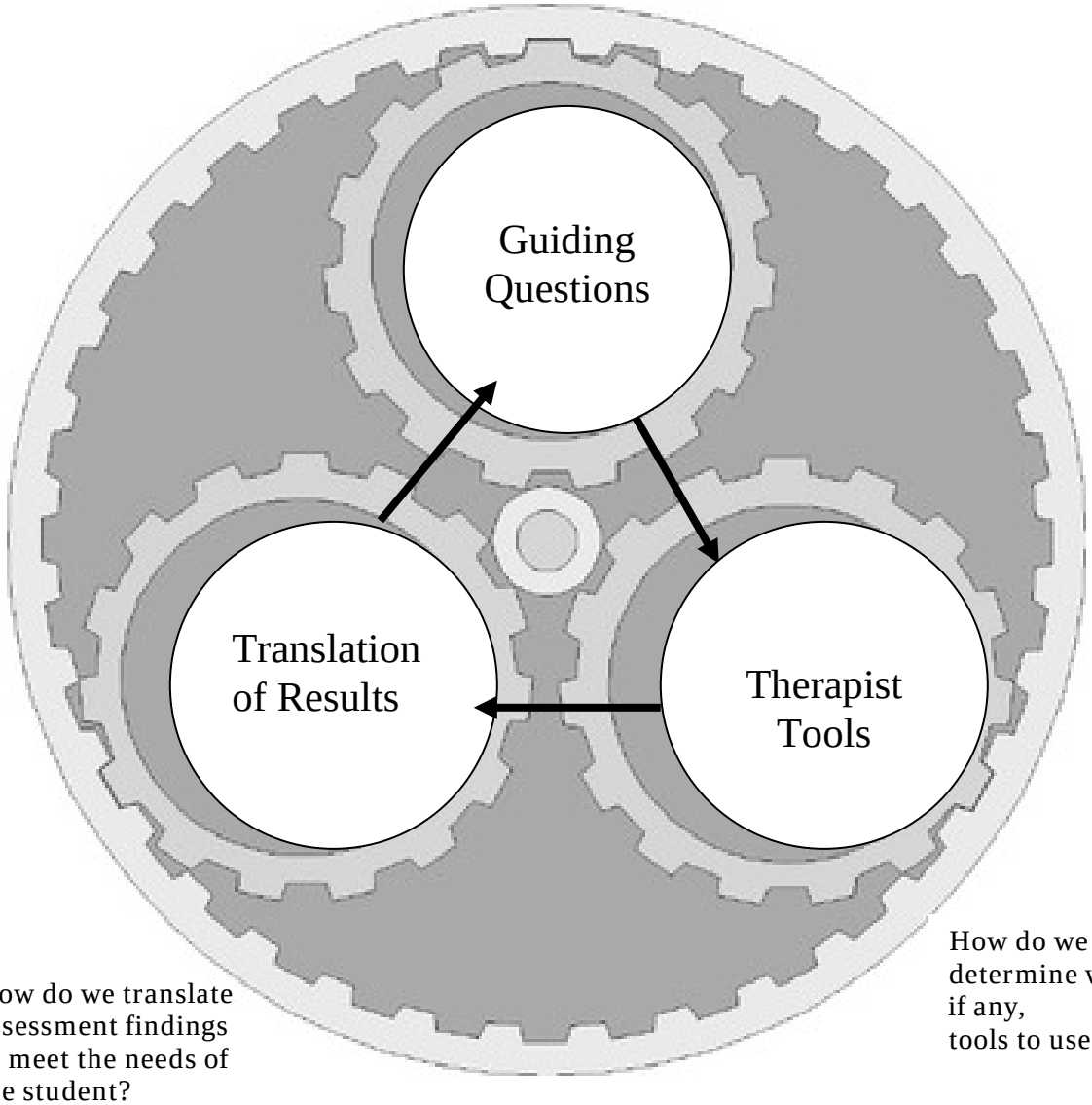
A Top-Down Assessment Process for Part B (IEP)
OT/PT Components of Ongoing and Dynamic Assessment

What are the priority outcomes related to the student's access and participation in the educational program?

What are the student's strengths?

What are the student's unique needs?

What are the barriers to access and participation?

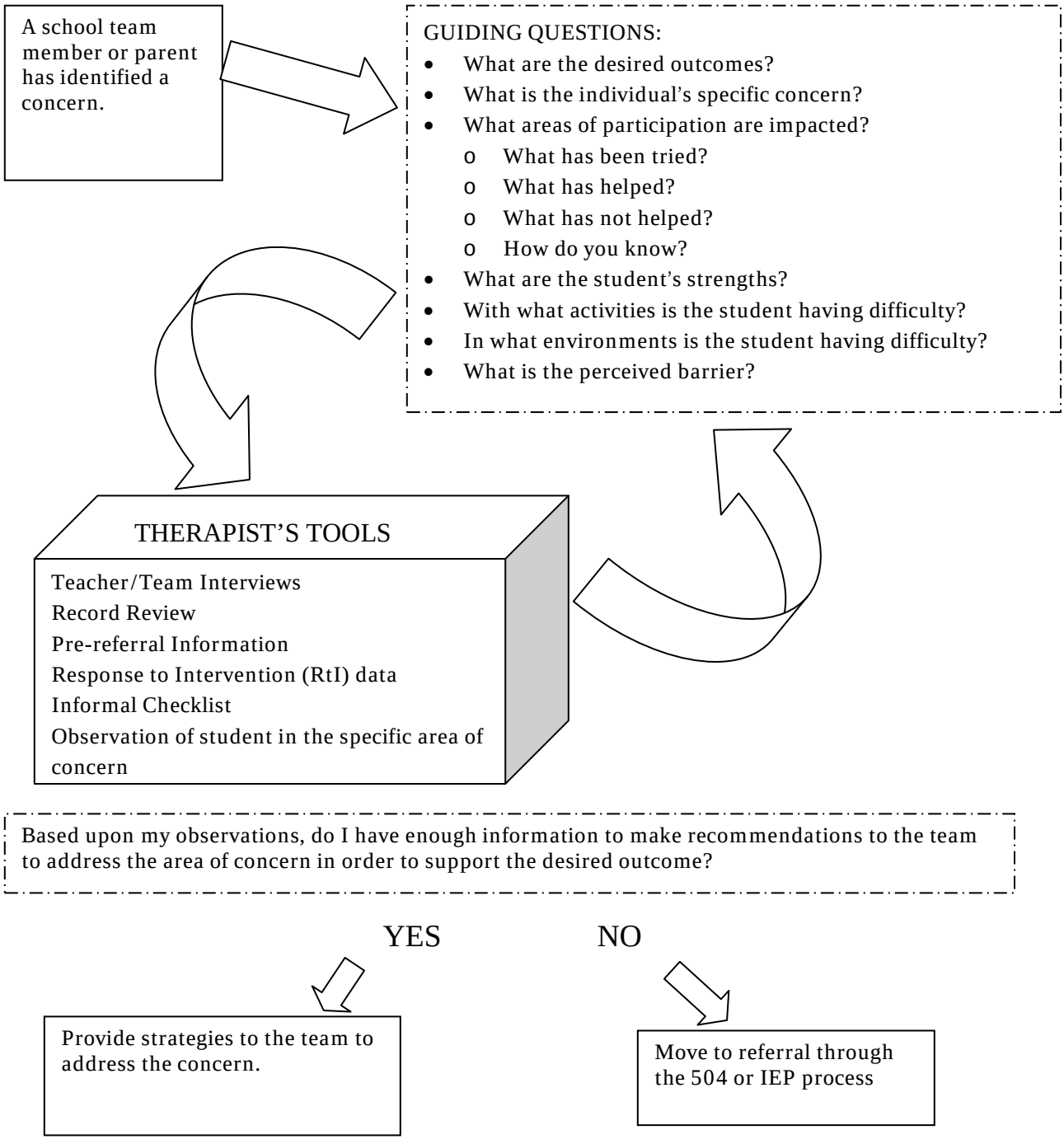


How do we translate assessment findings to meet the needs of the student?

How do we determine what, if any, tools to use?

An OT/PT Top-Down Assessment Process for Part B (IEP) *Early Intervening Services*

In some districts, OTs/PTs may participate in a Response to Intervention (RtI) or another similar process for the purpose of supporting students (K-12) who have not been identified as needing special education or related services, but who may need additional academic and/or behavioral support to succeed in the general education environment. These services are identified as Early Intervening Services by the American Occupational Therapy Association and the American Physical Therapy Association. [USC §1413(f): 34 CFR § 300.226(a)] (Guide to Practice, p. 21). The schematic on the following page is an example of how OT/PTs contribute to the process.


A school team member or parent has identified a concern.
GUIDING QUESTIONS:
What are the desired outcomes?
What is the individual's specific concern?
What areas of participation are impacted?
What has been tried?
What has helped?
What has not helped?
How do you know?
What are the student's strengths?
With what activities is the student having difficulty?
In what environments is the student having difficulty?
What is the perceived barrier?
THERAPIST'S TOOLS
Teacher/Team Interviews
Record Review
Pre-referral Information
Response to Intervention (RtI) data
Informal Checklist
Observation of student in the specific area of concern
Based upon my observations, do I have enough information to make recommendations to the team to address the area of concern in order to support the desired outcome?
YES
NO
Provide strategies to the team to address the concern.
Move to referral through the 504 or IEP process

A Top-Down Assessment Process for Part B (IEP) *OT/PT Assessment Component – Observing the Student*

NOTE: Parental consent is required for 504 or IEP Assessments.

As outlined by the AOTA and APTA, best practice regarding school-based evaluation supports a top-down approach while ensuring alignment with federal and state laws. (Guide to Practice, p. 25) Refer to Sections 4.2 Evaluation and 4.7 School-Based Standard of Practice in Compliance with IDEA, Part B. See the process on the following page.

Student has been referred through the 504 or IEP Process

GUIDING QUESTIONS:

- Observe Student throughout School Routines and Activities
  - Body structures and functions relative to activity (e.g., posture/positioning balance, mobility)
  - Understand student's personal factors and how they impact performance (e.g., motivation, response to sensory stimulation, cognition)
- Observe in Multiple Environments
  - In what environment(s) is the child having difficulty/success?
  - What is the classroom set-up?
  - What supports are in place? (e.g., type of placement, number of adults in classroom, accessibility, assistive technology)
- Observe in Multiple Activities or Tasks
  - What is the curriculum/classroom expectation? (e.g., self-management in the learning environment, handwriting)
  - What is the student doing or not doing? (e.g., foundational fine and gross motor skills, self-care)
- What are the barriers to successful access or participation?

THERAPIST'S TOOLS

Ecological inventories
Structured/Clinical observation
Activity analysis
Occupational Role Performance
Task demands
Interaction and participation with school activities and routines
Systems review

Based on your assessment observations, can you identify the barrier(s) to successful access or involvement in the general education curriculum?
Do I need additional information to make decisions based upon my observations?
Do I have enough data to support my findings?

Provide strategies to team to address the concern.

YES

NO

Proceed to *Determining the Need for Additional Assessments*

A Top-Down Assessment Process for Part B (IEP)
OT/PT Component- Determining the Need for Additional Assessments

Clinical reasoning for further assessment may need to take into consideration the anticipated outcome for the student and further examination of perceived barriers.

GUIDING QUESTIONS:

- Why do I need additional assessments?
  - To contribute to team decision-making
  - To establish age equivalence or performance level
  - To establish the need for additional interventions or accommodations
  - To tease out or confirm something noticed in an observation
  - To validate observations or rule out a specific causal factor
  - To determine a baseline
  - To monitor progress
  - To monitor effectiveness of intervention
  - To mark or show developmental change
  - To determine strengths and needs for accommodations
- What assessment tools align with the barriers that interfere with this child/student's involvement in the general education curriculum? Clinical observations should guide this decision-making.

Criterion referenced assessments
Norm referenced assessments
Developmental vs. functional assessments
Performance/Skill assessments
Motor assessments
Sensory-based assessments
Behavioral assessments
Adaptive skill assessments
Assessment of Participation/Engagement

In Part B, the IEP team, which includes the parents and the student (as appropriate), identifies the areas of concern, barriers, and supports necessary to achieve the functional outcomes needed to facilitate involvement and progress in the general education curriculum or, for preschool children, participation in age-appropriate activities (Guide to Practice, p.26).

Once the IEP team agrees on the present levels of the student's performance and IEP goals/objectives, the IEP team then determines whether the unique expertise of an OT or PT is required for the student to be able to access, participate, and progress in the learning environment in preparation for success in his/her postsecondary life (Guide to Practice, p.28).

Request for Reader Feedback

If you have questions, suggestions, or comments regarding this Guide, please forward them to:

Maryland State Department of Education

Division of Special Education/Early Intervention Services

200 W. Baltimore Street

Baltimore, Maryland 21201-2595

Fax: 410-333-0298

Email: ot.pt.steeringcomittee@gmail.com

Occupational and Physical Therapy Early Intervention and School-Based Services in Maryland:
A guide to practice

If you have questions about the contents of this document, please email ot.pt.steering.committee@gmail.com to speak with a representative of the Maryland State Steering Committee for Occupational and Physical Therapy School-Based Programs.

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Lillian M. Lowery, Ed.D.,
State Superintendent of Schools

Dr. Charlene M. Dukes
President, Maryland State Board of Education

Martin J. O'Malley
Governor

Maryland State Department of Education
Division of Special Education and Early Intervention Services
200 West Baltimore Street
Baltimore, Maryland 21201
410-767-0238
1-888-246-0016
410-333-8165 (Fax)
410-333-6442 (TTY)

MarylandPublicSchools.org