

**RECOMMENDED PRACTICES
FOR
OCCUPATIONAL AND
PHYSICAL THERAPY SERVICES IN
ILLINOIS SCHOOLS**

2003

ILLINOIS STATE BOARD OF EDUCATION

TABLE OF CONTENTS

	<u>Page</u>
Purpose.....	1
Section I Overview of Occupational Therapy and Physical Therapy as a Related Service	2
Introduction	2
Statute Review.....	2
Differences between IDEA and Section 504.....	9
Description of Occupational Therapy and Physical Therapy Service Providers ...	10
Educational Relevance	13
Distinction between School-Based Therapy and Non-School-Based Therapy	15
Section II Determination of the Need for Therapy	16
Introduction	16
Identification of Students with Disabilities	16
Request for Assistance under Section 504.....	19
Referral, Assessment and Eligibility for Occupational Therapy and/or Physical Therapy	20
Section III Provision of Occupational Therapy and Physical Therapy in the Education Setting	29
Introduction	29
Implementation of Occupational and/or Physical Therapy.....	29
Documentation.....	33
Section IV Administrative Considerations	37
Introduction	37
Employment, Retention and Recruitment	37
Space, Equipment and Materials for Service Delivery.....	38
Workload Determination	39
Supervision and Management of Therapy Personnel.....	40
Continuing Education.....	41
Third Party Billing.....	41
References.....	42
Appendix.....	45

The Purpose of this Document

The purpose of this document is to present administrators, occupational and/or physical therapy personnel, educators, other professionals, and parents, with information regarding the provision of occupational and/or physical therapy in educational environments. This document is intended to serve as guidance so that each Local Educational Agency (LEA) employing therapists can establish or update their own procedures for providing these support services to students who must receive occupational and/or physical therapy.

Information provided herein is based upon standards of practice defined by the Illinois Occupational Therapy Practice Act, 225 ILCS 75/1 et seq., the Illinois Physical Therapy Practice Act, 225 ILCS 90/1 et seq., 23 Illinois Administrative Code Part 226, the American Occupational Therapy Association (AOTA), and the American Physical Therapy Association (APTA).

Inherent in this document are the following assumptions:

- Students with disabilities must be served in the least restrictive environment possible.
- The educational curriculum and educational needs of the student define the educational relevance of an activity.
- The educational environment is the location where a student's curriculum is implemented.
- While motor functioning may be assessed by professionals trained in various disciplines (e.g., occupational therapists, physical therapists, psychologists, early childhood teachers and physical education teachers), occupational therapists and physical therapists assess motor functioning and adaptive abilities from their unique perspectives as described in this document.
- Even though occupational therapy and physical therapy sometimes overlap, they are separate disciplines with separate entry-level educational experiences and separate licensure laws.
- Occupational therapy and physical therapy must both be available to students in the educational environment as needed. Equal availability of either service is assumed. (Iowa, 1996)

Administrators responsible for supervision of occupational therapy (OT) and physical therapy (PT) departments and therapists should have access to and be knowledgeable of the most current resources, particularly those listed below:

FEDERAL

Americans with Disabilities Act of 1990, 42 U.S.C. 12101 et seq., 28 C.F.R. Part 35 (Title II, Department of Justice), 29 C.F.R. Parts 1630, 1602 (Title I, EEOC).
Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq., 34 C.F.R. Part 300.
Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794, 34 C.F.R. Part 104.

STATE

Illinois Occupational Therapy Practice Act, 225 ILCS 75/1 et seq.
Illinois Physical Therapy Practice Act, 225 ILCS 90/1 et seq.
23 Illinois Administrative Code Part 226

PUBLICATIONS

American Journal of Occupational Therapy (AJOT)
OT Practice
Ethics in Physical Therapy
Guide to PT Practice
Pediatric Physical Therapy
PT Magazine

OTHER

American Occupational Therapy Association Guidelines for Occupational Therapy in the Schools
American Physical Therapy Association Guidelines for Physical Therapy in the Schools
Illinois Guidelines for Physical Therapy Practice in Educational Environments (Illinois Physical Therapy Association, 1994)
Illinois Physical Therapy Association for Illinois Learning Standards and Alternate Performance Indicators

Section I

OVERVIEW OF OCCUPATIONAL THERAPY AND PHYSICAL THERAPY AS A RELATED SERVICE

INTRODUCTION

Section I provides a chronological perspective of the laws and policy which created an atmosphere and, ultimately, a mandate for providing occupational therapy and physical therapy services in educational environments.

This section also defines the training, certification and licensure requirements for occupational therapists, certified occupational therapy assistants, physical therapists and physical therapy assistants.

Finally, this section looks at the educational relevance of occupational therapy and physical therapy. Common educational purposes for students to receive these therapies are listed. A distinction is made between therapies that are the responsibility of the educational system and those that are the role of non-educational-based clinical therapy.

LEGAL OVERVIEW

Prior to 1969, students in Illinois with disabilities or health impairments primarily received both their educational and therapeutic services in residential settings or community and private agencies. In 1969, Illinois enacted the first law that mandated services for students, essentially beginning formal special education services for children ages 3-21. Since that time, state and federal legislation have continued to affect the services for children with disabilities in educational settings.

1965 – Illinois House Bill 1407, approved July 21, 1965 (Enrolled Law 35 403) (currently at 105 ILCS 5/14-1.01 et seq.)

The State of Illinois passed this first statute providing for special education in 1965 requiring that all school districts provide special education for children with disabilities residing in their district after July 1, 1969.

1970 – The Elementary and Secondary Education Amendments of 1970 (ESEA) (P.L. 91-230) (currently at 20 U.S.C. 1400 et seq.)

The ESEA consolidated into one act a number of previously separate federal grant acts relating to children with disabilities.

1973 – Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112)

(currently at 29 U.S.C. § 794)

Section 504 initiated a national commitment to end discrimination on the basis of a person of any age having a disability. This law established a mandate to bring persons with disabilities into the mainstream of American life and established a White House Conference on Handicapped Individuals for the purpose of developing a plan of action to solve the problems of individuals with disabilities. The authority of Section 504 extends to any program or activity receiving federal financial assistance.

**1975 – The Education of All Handicapped Children Act (EHA) (P.L. 94-142)
(currently the Individual with Disabilities Education Act (IDEA) at 20 U.S.C. 1400 et seq.)**

The EHA offered federal financial assistance to states to provide special education services in educational settings. The federal requirements were similar to the services already in place in Illinois under Illinois House Bill 1407. However, the federal requirements added a complaint and due process procedure providing procedural protection for students receiving special education and related services. As a condition of federal financial assistance, this law initiated the requirement that states provide a free appropriate public education (FAPE) for children ages 5 through 18 in the least restrictive environment (LRE) no later than September 1, 1978 and that all states seeking federal financial assistance serve student populations ages 3 through 5 and 18 through 21 no later than September 1, 1980. The law also provided incentive money to states for early childhood programming (ages 3-5 years).

The EHA was the first law that made reference to occupational and physical therapy as "related services." The term "related services" is defined in the EHA (now IDEA) as

"transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, *physical and occupational therapy* [emphasis added], recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education, and includes the early identification and assessment of handicapped conditions in children."

1978 – State Board Policy on Special Education

In February 1978, the Illinois State Board of Education adopted a policy on special education addressing both the state and federal intent up to that period. The policy states:

The State Board of Education endorses the basic tenets of Public Law 94-142, the Education for All Handicapped Children Act of 1975, and states the components of that endorsement to be as follows:

1. A free, appropriate public education for every handicapped child in Illinois ages 3-18 by September 1978, ages 3-21 by September 1980.
2. A right-to-education policy for all children; education provided at no cost to parents when placed by the state education agency or local education agency.
3. Education in the least restrictive environment.

4. Guarantee of procedural safeguards, confidentiality of records, and nondiscriminatory (racially or culturally) testing.
5. Individualized education programs (IEP) for every identified handicapped child.
6. A comprehensive, articulated, personnel preparation program.
7. State Education Agency supervision of all educational programs for handicapped children offered within the State of Illinois.
8. Rights and guarantees applying to children in private or State agency schools as well as public schools.
9. An intensive and continuing search for handicapped children. (Illinois State Board of Education, 1990, p. 7)

**1986 – EHA Amendments (P.L. 99-457)
(IDEA, currently at 20 U.S.C. 1400 et seq.)**

This first of many reauthorizations of Public Law 94-142 reinforced requirements for the education of children with disabilities ages 3-21 and expanded the mandate to preschoolers with disabilities ages 0-3. Occupational therapy and physical therapy were required to be available for preschoolers for the 1990-91 school year. This federal law also established an early intervention state grant program for children birth through 2 years of age and their families. These amendments required, in certain cases in the 0-2 population, occupational therapy and physical therapy to be considered **primary** early intervention services provided based solely on the child's need regardless of what other medical or educational services are provided.

Since occupational therapists and physical therapists were now considered the primary early intervention therapists, they could now be named case managers on the Individualized Family Service Plan (IFSP) developed to determine specific child and family goals and services.

**1990 – Americans with Disabilities Act of 1990 (ADA) (P.L.101-336)
(currently at 42 U.S.C. 12101 et seq.)**

The ADA federal law expanded to all facets of society the Rehabilitation Act of 1973 and is considered the major civil rights act for persons with disabilities.

The purposes of the ADA are:

1. To provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;
2. To provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;
3. To ensure that the federal government plays a central role in enforcing the standards established in this Act on behalf of individuals with disabilities; and

4. To invoke the sweep of congressional authority, including the power to enforce the Fourteenth Amendment and to regulate commerce, in order to address the major areas of discrimination faced by people with disabilities.

The ADA definition of "a person with a disability" is comprehensive and has several components. Protection from discrimination is extended through the ADA to individuals who have a disability. Under the law, "'disability' means, with respect to an individual -

1. A physical or mental impairment that substantially limits one or more of the major life activities of such individual ("major life activities" include caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working);
2. A record of such an impairment; or
3. Being regarded as having such an impairment.

29 C.F.R. 1630.2(g)

These three categories are further defined as follows.

1, **“Physical or mental impairment means:**

- (1) **Any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitor-urinary, hemic and lymphatic, skin, and endocrine: or**
- (2) **Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.” 29 C.F.R. 1630.2(h)**

2. **A record of such an impairment**

To qualify under this provision, an individual must "have a history of, or have been classified as having, a physical or mental impairment that substantially limits one or more major life activities." 29 C.F.R. 1630.2(k)

This second aspect protects persons who have recovered from a physical or mental illness against discrimination that is based upon their history of mental health treatment. It also protects individuals misclassified as having a mental illness.

3. **Being “regarded as having such an impairment means:**

- (1) Has a physical or mental impairment that does not substantially limit major life activities but is treated by a covered entity as constituting such limitations;
- (2) Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or
- (3) Has none of the impairments defined ...but is treated by a covered entity as having a substantially limiting impairment.”

29 C.F.R. 1630.2(l)

This category is especially pertinent to individuals who have or have had mental health treatment, whether or not they are disabled by the illness. The stigma associated with mental illness often results in attitudinal barriers that hinder a person's ability to work or enjoy life. Concerns by employers regarding productivity, safety, insurance, liability,

attendance and acceptance by co-workers and customers have been identified as common barriers that frequently result in the exclusion of persons who have sought mental health care from the work force.

If a person is rejected from a job because of the myths, fears and stereotypes associated with mental illness, and no legitimate job-related reason can be articulated by the employer, that individual would be covered under this aspect. Furthermore, if an individual is qualified for the job, it is not necessary that he or she prove that an employer's concerns (e.g., that he or she will be accepted by others, or that insurance rates will not increase) are invalid.

The law states that the term "qualified individual with a disability" shall not include any employee or applicant who is currently engaging in the illegal use of drugs 29 C.F.R. 1630.3(a)

1990 – EHA Amendments (P.L.101-476)

This law changed the name of the EHA (P.L.94-142) to the Individuals with Disabilities Education Act (IDEA). The following is an overview of changes and additions:

1. Identified the use of the term "disabled" to replace "handicapped."
2. Added autism and traumatic brain injury to the list of disabilities that make a child eligible for special education.
3. Expanded the definition of instruction to encompass instruction in all settings, including the work place and training center.
4. Added rehabilitation counseling and social work as related services.
5. Added transition services to promote movement from school into appropriate activities and adult services agencies and required the inclusion of a transition plan in the IEP for a student aged 14½ to 21.
6. Defined assistive technology device as any equipment used to increase, maintain or improve the capabilities of individuals with disabilities and outlined what assistive technology services can include.
7. Defined "underrepresented" as minority, poor and limited-English-proficient individuals.
8. Required the U.S. Department of Education to conduct an inquiry into services for children with Attention Deficit Disorder (ADD).
9. Identified new priority areas for early education programming for children with severe disabilities, assistive technology, transition and programs for children with severe emotional disturbance.
10. Provided grants for training personnel in the use of assistive and instructional technology, research focusing on improvement of services for infants and toddlers and organization and dissemination of information on ADD.

11. Authorized improved access to assistive technology devices.
12. Required each state agency to be responsible for administering the early intervention program including informing parents of the availability of early intervention services and the extent to which primary referral services disseminate such information. It also added that the personnel development system must include training of primary referral sources about the basic components of the state's early intervention services.

The changes also offered expanded opportunities for occupational therapists and physical therapists to provide input in the areas of assistive technology and transition.

**1997 – IDEA Amendments (P.L. 105-17)
(regulations at 34 C.F.R. Part 300)**

The reauthorization of IDEA brought about several changes in the law including the following:

1. Allowed states to expand the definition of developmental delay to include children ages three through nine. (Illinois has retained the age range of three through five).
2. Allowed districts to spend only an amount proportionate to the federal funding per child on children with disabilities in private placements.
3. Allowed districts to provide services to children with disabilities on the premise of private schools as consistent with the law.
4. Allowed paraprofessionals and assistants who are appropriately trained and supervised to assist in provision of special education and related services.
5. Required that children with disabilities will be included in general state and district wide assessments with appropriate accommodations.
6. Prohibited a child from being determined to be a "child with a disability" based on lack of instruction in math or reading or limited English proficiency.
7. Required that the IEP of a child with a disability include a statement of how the child's disability affects involvement and progress in the general curriculum; or for preschoolers, how the disability affects participation in appropriate activities.
8. Required that, beginning at least one year before a child reaches age of majority, parents and the child with a disability must be informed of rights transferred on reaching age of majority (age 18 in Illinois).
9. Required the IEP team to include at least one regular education teacher at the child's grade level, if the child is or might be participating in regular education classes.
10. Required the IEP team to include a special education teacher.
11. Allowed districts to place a child with a disability in an interim alternative educational setting for not more than 45 days if:

- the child brings a weapon to school; or
 - the child possesses/uses/sells illegal drugs.
12. Required state education agencies to collect suspension and expulsion data to determine if significant discrepancies exist in comparison to non-disabled children.
 13. Allowed states to include "at risk infants and toddlers" in the definition of infant or toddler with a disability.
 14. Disallowed parentally-placed private school children, with a disability, the individual right to special education and related services under Part B.

Note: Although this document includes the most recent laws at publication, it is the reader's responsibility to be aware of subsequent changes as they occur.

DIFFERENCES BETWEEN IDEA AND SECTION 504

There are a number of differences between the two statutes which have distinct, but complementary objectives. Most importantly, Section 504 is intended to eliminate barriers that exclude persons with disabilities from participation, whereas IDEA is remedial, typically requiring the provision of programs and services in addition to those available to persons without disabilities.

The IDEA definition of free appropriate education is:

- "...special education and related services that—
- (a) Are provided at public expense, under public supervision and direction, and without charge;
 - (b) Meet the standards of the SEA [state education agency] and federal government;
 - (c) Include preschool, elementary school, or secondary school education in the State; and
 - (d) Are provided in conformity with an individualized education program (IEP) that meets the requirements of 34 CFR 300.340-300.500" (34 C.F.R. 300.13).

The significant difference between this definition and the Section 504 definition is that, under IDEA, special education and related services provided through an IEP are considered appropriate education. Section 504 recognizes that appropriate education might be provided through the provision of regular education or related aids and services without an IEP. Also, under IDEA related services may not be provided without special education. Section 504 may require the provision of related services including occupational therapy and physical therapy, to a student not eligible for special education.

Section 504 recognizes two very important possibilities:

1. A population of children with disabilities exists who are not eligible for special education under IDEA but who are still in need of protection against discrimination because of a disability as defined under Section 504; and

2. An obligation is imposed on recipients to provide services (evaluations, regular education, reasonable accommodations, related services and related aids) regardless of eligibility for special education under IDEA.

A second difference concerns "eligibility for special education" under IDEA as compared to the concept of "protection" under Section 504. IDEA applies to students with a disability that adversely affects educational performance necessitating special education and related services. The broader definition under Section 504 includes persons with disabilities not mentioned in IDEA or state education policies. Therefore, the obligation of school districts to provide appropriate education extends beyond the traditionally operated special education programs.

The following three concepts relate to the differences in eligibility policies between Section 504 and IDEA:

1. Many more individuals qualify for protection under Section 504 than under IDEA. For example, youngsters with AIDS or orthopedic impairments might be protected under Section 504 but not qualify as educationally disabled and requiring services under IDEA.

A district might be required to provide related services or other aid(s) under Section 504 in the absence of any provision of special education. A district might be compelled to use "general education" monies to support the related services costs of a student with a disability. Section 504 requires that schools not discriminate, and in some cases undertake actions that require additional expenditures, but provides no additional financial support.

2. The provision or availability of a special education system of services does not always suffice to meet the Section 504 requirements. A district can claim that any child with a disability would be provided FAPE through its special education program and still not be in compliance with Section 504.

(Portions reprinted from *Liaison Bulletin, A Publication of NASDSE, Inc., Vol. 17. No.8 Oct. 1991.*)

DESCRIPTION OF OCCUPATIONAL THERAPY AND PHYSICAL THERAPY SERVICE PROVIDERS

Licensing and types of therapy personnel

Occupational therapists (OTR), certified occupational therapy assistants (COTA), physical therapists (PT), and physical therapist assistants (PTA) are health care professionals distinctly trained and qualified to provide the unique services of occupational therapy and physical therapy. As such, these professionals practicing in Illinois must meet licensure requirements established by the Illinois Department of Professional Regulation, 320 West Washington, Springfield, Illinois 62786, telephone: 217/785-0800.

Occupational Therapy definitions

The following definitions are cited from the Illinois Occupational Therapy Practice Act (225 ILCS 75/2):

“Occupational therapy” means the therapeutic use of purposeful and meaningful occupations or goal-directed activities to evaluate and provide interventions for individuals and populations who have a disease or disorder, an impairment, an activity limitation, or a participation restriction that interferes with their ability to function independently in their daily life roles and to promote health and wellness. Occupational therapy intervention may include any of the following:

- (a) remediation or restoration of performance abilities that are limited due to impairment in biological, physiological, psychological, or neurological processes;
- (b) adaptation of task, process, or the environment or the teaching of compensatory techniques in order to enhance performance;
- (c) disability prevention methods and techniques that facilitate the development or safe application of performance skills; and
- (d) health promotion strategies and practices that enhance performance abilities.

“Registered Occupational Therapist” means a person licensed to practice occupational therapy as defined in this [the Illinois Occupational Therapy Practice] Act, and whose license is in good standing.

“Certified Occupational Therapy Assistant” means a person licensed to assist in the practice of occupational therapy under the supervision of a Registered Occupational Therapist, and to implement the occupational therapy treatment program as established by the Registered Occupational Therapist. Such program may include training in activities of daily living, the use of therapeutic activity including task oriented activity to enhance functional performance, and guidance in the selection and use of adaptive equipment.

Educational Background of the Occupational Therapist

The occupational therapist is a graduate of a baccalaureate or master’s level professional educational program approved by the Accreditation Council for Occupational Therapy Education (ACOTE). Programs of study include coursework in the natural, medical and human sciences including chemistry, physiology, human anatomy, kinesiology, orthopedics and medical and surgical conditions; human growth and development; the behavioral sciences such as psychology, sociology and psychiatry; and occupational therapy theory, skills and application. In addition to classroom instruction, six to nine months of clinical internship and experience are required in selected medical, educational and other community agencies. Following successful completion of academic instruction, clinical training and a national certification examination, the occupational therapist is certified to practice by the National Board of Certification in Occupational Therapy, Inc. (NBCOT) as a Registered Occupational Therapist using the initials “OTR” after the therapist’s name. In the state of Illinois, the initial “L” is added to signify the therapist is licensed appropriately by the Illinois Department of Professional Regulation; hence, OTR/L.

Educational Background of the Certified Occupational Therapy Assistant

The certified occupational therapy assistant has been granted a certificate by an institution of higher education approved by ACOTE. Course work emphasized technical principles and applications. Following two to four months of clinical fieldwork, which allows practice or roles and functions required at entry-level practice, the student assistant is eligible to take the national exam for “COTAs” and become certified through NBCOT. Upon registration with the American Occupational Therapy Association, the title “Certified Occupational Therapy Assistant,” abbreviated “COTA,” is used after the assistant’s name. Illinois licensure further adds the use of the initial “L”; hence “COTA/L”.

Physical Therapy Definitions

The following definitions are cited from the Illinois Physical Therapy Act (225 ILCS 90/1):

“Physical therapy” means the evaluation or treatment of a person by the use of the effective properties of physical measures and heat, cold, light, water, radiant energy, electricity, sound, and air; and the use of therapeutic massage, therapeutic exercise, mobilization, and the rehabilitative procedures with or without assistive devices for the purposes of preventing, correcting, or alleviating a physical or mental disability, or promoting physical fitness and well-being. Physical therapy includes, but is not limited to: (a) performance of specialized tests and measurements, (b) administration of specialized treatment procedures, (c) interpretation of referrals from physicians, dentists and podiatrists, (d) establishment and modification of physical therapy treatment programs, (e) administration of topical medication used in generally accepted physical therapy procedures when such medication is prescribed by the patient’s physician licensed to practice medicine in all its branches, the patient’s physician licensed to practice podiatric medicine or the patient’s dentist, and (f) supervision or teaching of physical therapy. Physical therapy does not include radiology, electrosurgery, chiropractic technique or determination of a differential diagnosis; provided, however, the limitation on determining a differential diagnosis shall not in any manner limit a physical therapist licensed under this Act from performing an evaluation pursuant to such license. Nothing in this Section shall limit a physical therapist from employing appropriate physical therapy techniques that he or she is educated and licensed to perform. A physical therapist shall refer to a licensed physician, dentist, or podiatrist any patient whose medical condition should, at the time of evaluation or treatment be determined to be beyond the scope of practice of the physical therapist.

“Physical Therapist” means a person who practices physical therapy and who has met all requirements as provided in this [the Illinois Physical Therapy] Act.

“Physical Therapist Assistant” means a person licensed to assist a physical therapist and who has met all requirements as provided in the Illinois Physical Therapy Practice Act and who works under the supervision of a licensed physical therapist to assist in implementing the physical therapy treatment program as established by the licensed physical therapist. The patient care activities provided by the physical therapist assistant shall not include the interpretation of referrals, evaluation procedures, the planning of, or major modifications of, patient programs.

Educational Background of the Physical Therapist

The physical therapist is a graduate of a physical therapy program with entry-level credentials, which include a bachelor's degree, master's degree or a doctor of physical therapy. The professional program must be approved by the Illinois Department of Professional Regulation. Coursework in physical therapy consists of study in the areas of natural sciences, which include physics, chemistry and mathematics; health sciences, which include human anatomy, physiology, kinesiology, psychology and pathology; clinical sciences, which include the principles and practices of physical therapy as well as medical and surgical conditions and clinical arts, which include the administration of evaluative and therapeutic procedures. In addition to coursework, several clinical internships over a four to six-month period must be completed. These clinical internships are completed in specialized institutions such as a hospital, rehabilitation center, private practice or an educational or community agency. After successful completion of coursework and clinical internships, the physical therapy student must pass a state licensure examination. The physical therapist is then licensed to practice in the state of Illinois as a "Physical Therapist" using the initials "PT" after the therapist's name.

Educational Background of the Physical Therapist Assistant

The physical therapist assistant is a health care worker who assists the physical therapist in the provision of physical therapy. The physical therapist assistant is a graduate of a physical therapist assistant associate degree program approved by the Illinois Department of Professional Regulation. Coursework emphasizes technical principals and application. The physical therapist assistant must complete several experiences over a three-month period to allow for practice of roles and functions required at entry-level practice. The student must then pass a state licensure examination. The physical therapist assistant is then licensed to practice in the state of Illinois as a "Physical Therapist Assistant" using the initials "PTA" after the assistant's name.

EDUCATIONAL RELEVANCE

School-based therapy is integrated into the school's educational program as a means to enhance functioning and attain educational objectives. Occupational therapists and physical therapists can provide support to the total educational system. They can assist with problem solving to eliminate barriers that hinder access to educational environments and assist with modifications and accommodations to support students in their regular education program. The school system also provides the therapy specified on the Section 504 plan or, as deemed necessary by the team, for achievement of a student's identified educational goals and objectives/ benchmarks.

When occupational therapy and physical therapy are provided as educational services, decisions regarding what type of therapy is provided, how it is provided and who is to provide it are directly tied to the student's overall educational program. All team members support the attainment of these educational goals. Thus, therapy and other related services become a means or method to attain educational goals and objectives/benchmarks, rather than the focus of separate therapy goals or objectives/benchmarks. School-based therapy is not intended to meet all the therapy needs of a student but is intended to meet needs of the student to promote success in the educational environment.

Through the ADA and Section 504, occupational therapy and physical therapy are provided to assist a student to access their general education program. Occupational therapy and physical therapy, in the educational setting, have traditionally been classified as “related services”. This therapy is provided to enhance the student’s ability to adapt to and function in educational settings. As members of multidisciplinary teams, occupational therapists and physical therapists also assist in determining appropriate programs for those students with disabilities. All therapy within the educational setting must have a relationship to educational performance while directly impacting the student’s ability to benefit from their educational experiences.

Occupational therapists and physical therapists in schools need to identify the educational significance of therapy provided to students. Educationally-related therapy needs remain broad and allow for varying interpretations at local levels dependent on individual student needs. The most common educational purposes for students to receive occupational therapy and/or physical therapy services within the school environment include:

1. Enhancing school mobility and participation in educational activities by increasing strength, accuracy and speed.
2. Ensuring easier total care by maintaining flexibility.
3. Improving manipulative skills for self-care and paper/pencil tasks through reach, grasp and dexterity.
4. Enhancing comfort, participation and attending by maintaining functional postures.
5. Increasing functional use of hands and visual regard by providing stable positions.
6. Ensuring independence in feeding and oral motor skills for safety and nourishment.
7. Maintaining functional movement by prevention of contractures and deformities.
8. Facilitating safety in the school environment by decreasing the possibility of injury to student’s self or others as he/she moves or performs skills/tasks.
9. Improving success for small muscle school tasks by increasing coordination of eye-hand movements.
10. Facilitating access to and mobility within school by assessing and changing the environment.
11. Increasing functional use of extremities through adapted equipment.
12. Enhancing ability to learn through sensorimotor activities that address motor planning, attending and behavior issues.
13. Arranging preparation for vocational needs.
14. Promoting competency and safety of educational staff in body mechanics, handling techniques, motor skills and classroom adaptations.
15. Facilitating student’s independence through access to assistive technology.

DISTINCTION BETWEEN SCHOOL-BASED THERAPY AND NON-SCHOOL-BASED THERAPY

The determination of when occupational therapy and physical therapy are educationally relevant is a complex issue. Several issues must be considered when determining the appropriate level of school-based and non-school-based therapy.

1. School-based therapy is a part of a student's total educational program. Therapy provided within the school setting has a different orientation than therapy provided in non-school settings. School-based therapists identify needs of the student and assist in providing strategies on how best to capitalize on abilities as well as minimizing the impact of the disabilities in the educational environment. Non-school-based therapists typically evaluate performance based only on a student's disabilities. The school-based therapist also evaluates a student to determine abilities as well as disabilities. The school-based therapist then determines the adverse effect these disabilities have on the student's performance in the educational and/or community-based instructional settings. Input is gathered from teachers, parents, students and other educational staff as to how these problems may influence performance areas within the educational environment.
2. School-based therapy involves "teaming", in which recommendations and decisions are made based on input from all team members in order to determine a student's total educational plan. Non-school-based therapists make unilateral recommendations based on their individual findings to determine their individual therapy plan.
3. The principal role of school-based therapists is to assist students in benefiting from their educational program. A general guideline is that therapy must contribute to the development, improvement or maintenance of the student's functional level within the educational environment. If a student needs occupational therapy and/or physical therapy to address problems, but the problems do not prevent him or her from benefiting from the educational program, school-based therapy should not be provided. Most non-school-based therapists do not have these criteria superimposed on their recommendations for intervention (Royeen, 1992).

Section II

DETERMINATION OF THE NEED FOR THERAPY

INTRODUCTION

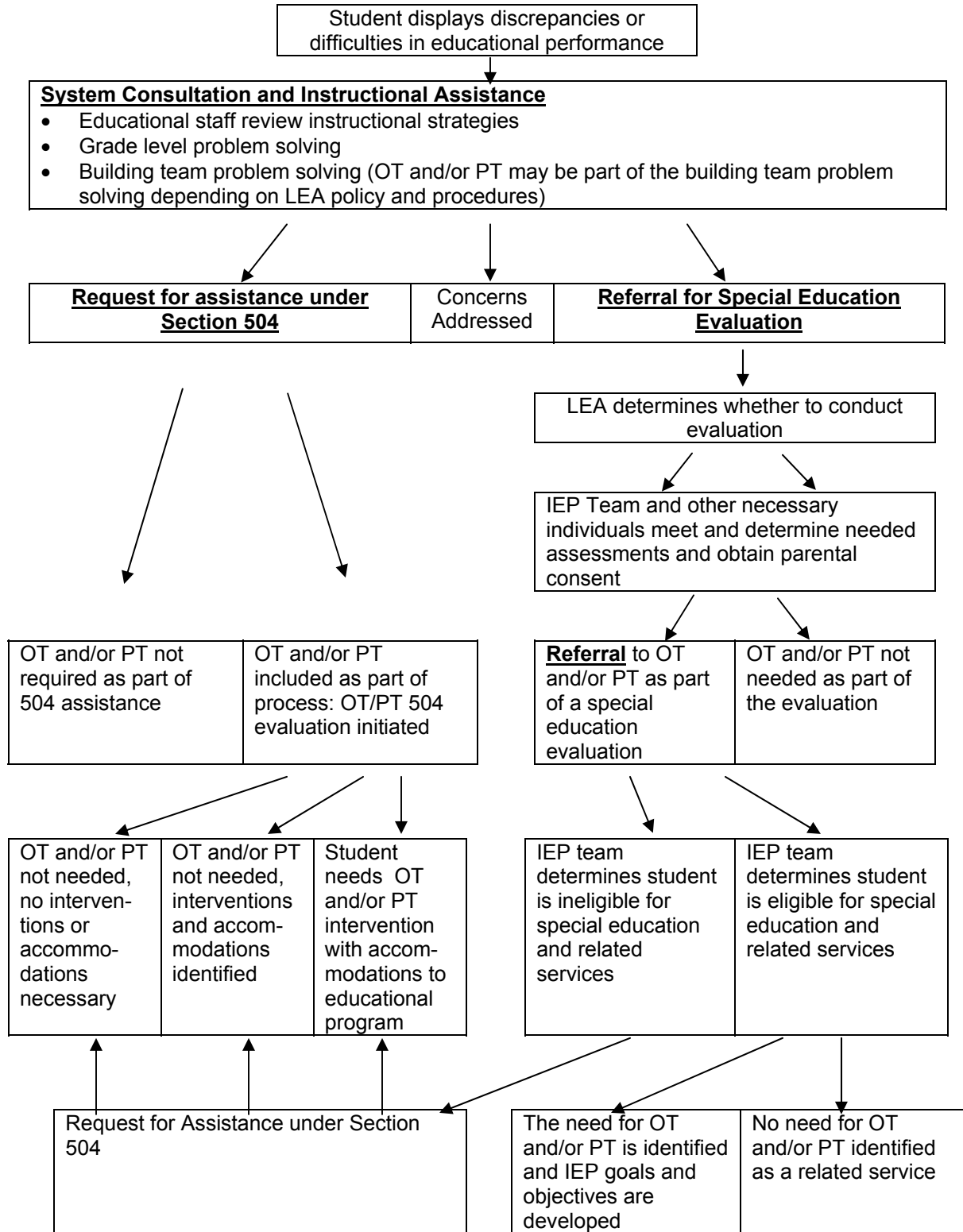
Section II provides information on the complete assessment process. Students with disabilities may be identified for occupational therapy and/or physical therapy by the LEA through Section 504 or IDEA. Eligibility for special education under IDEA and initiation of services under Section 504 are discussed. Section II concludes by reviewing factors a therapist should consider when making recommendations to the school team. Subjects in Section II include screening, the referral process under both IDEA and Section 504, the special education evaluation process, the therapy assessment process, assessment documentation, the staffing process, determination of eligibility for therapy and exit criteria.

IDENTIFICATION OF STUDENTS WITH DISABILITIES

Occupational therapists and physical therapists can support regular and special education programs whenever a student exhibits a discrepancy between actual and expected performance. When a teacher has exhausted his/her own resources to assist the student, he/she can go to other team members within the building for support. These can include grade level, building level, general education and special education teams. Occupational therapists and/or physical therapists participate in team problem solving and instructional assistance prior to referral for specialized evaluation. Recommendations by the occupational therapist and physical therapist for use in a student's general education environment need to be general in nature, relate to the classroom curriculum and be able to be provided to all students in that environment. These recommendations may be sufficient to meet the student's concerns and no further involvement is necessary. If the intervention strategies and techniques are not sufficient to meet the student's needs, an evaluation either as part of a Section 504 Plan or special education case study may be initiated. The recommendation for an evaluation is a team decision.

An occupational therapy or physical therapy evaluation may or may not be a part of a Section 504 evaluation or special education evaluation depending on an individual student's needs. A therapy evaluation may also be initiated after a special education evaluation is in progress when the team members determine that additional expertise is required to complete an understanding of the student's function. The recommendations from Section 504 therapy evaluations may state that therapy intervention may or may not be necessary to meet the student's needs. The special education evaluation determines whether or not a student is eligible for special education. If eligible for special education, the need for specialized therapy services may or may not be identified. If not eligible for special education, a request for assistance under Section 504 may be initiated and carried out as stated above. (See the chart on the following page.)

Occupational Therapy and Physical Therapy Identification of Students with Disabilities



System Consultation and Instructional Assistance

As part of a system consultation, observations of a sequence of an activity performed by all students is allowed without parental consent. The purpose of these therapist observations is to help a student maintain himself or herself in the current educational program. These observations must be conducted within the context of a typically occurring activity. The resulting therapist suggestions could be applied to all students in the program. Use of a method, an assessment or an activity typically used as part of an official evaluation requires parental permission.

Assessment for instructional purposes is not defined in 23 Illinois Administrative Code Part 226 because it is **not** a special education activity.

Assistance may be provided to individual students for **instructional** purposes, and each district or LEA must clearly differentiate this assistance from screening, referral and special education evaluation procedures. The function of instructional assistance activities is to maintain the student in his/her current environment. Assistance for instructional purposes is driven by the same parameters that guide classroom instruction. These parameters may: 1) include conducting skill or curriculum-based assessments, 2) be either intrusive or non-intrusive, 3) be child specific or group specific, 4) not be timeline driven and 5) be considered part of the routine LEA provision of services. As such, forms and terminology other than those used in special education must be utilized.

Ordinarily, norm-referenced measures are **precluded** when conducting an instructional assessment because the purpose of norms is to compare one student with other students for the intent of inclusion/exclusion rather than identifying beneficial instructional strategies. While norm-referenced measures are prohibited for instructional assessment, the LEA should have written procedures describing the use of non-intrusive procedures such as observation of the child, assessment of instruction materials used, consultation with the teacher or requesting agent or a conference with the child. While the consideration of these data may eventually assist the LEA to determine that a specific student requires a special education evaluation, the data must be originally collected and utilized with intent to improve instruction.

When the building team becomes involved to assist a student to succeed in his/her current educational environment, occupational therapy and/or physical therapy may also assist in the problem solving process. Either discipline may assist in determining strategies to enhance student function. Occupational therapy and physical therapy involvement in this problem solving process is dependent on the LEA policies and procedures.

Screening

Screening is the process of reviewing all children in a given group (such as all fifth graders in the district) with a set of criteria for the purpose of identifying individuals for evaluations who may be in need of special education.

School districts are responsible for seeking out and identifying all special education eligible children in the district between the ages of 3 and 21. Examples of utilizing screening procedures appropriately include:

- Screening children between the ages of 3 and 5. Therapists should participate in these screenings as they have special expertise in the identification of functional deficits in neurological, musculoskeletal and sensorimotor areas.
- Hearing and vision screenings at regular intervals.
- Ongoing review by teachers for referral of those children who exhibit difficulties that interfere with educational progress or adjustment to the educational setting.

Individual screening for the purposes of determining the need for evaluation by an occupational therapist or physical therapist is not an allowable component of this process.

REQUEST FOR ASSISTANCE UNDER SECTION 504

Under Section 504 regulations, occupational therapy and physical therapy assistance can be requested for a student who is not in special education. This request comes through a building team problem solving process or a request from the student's parent/guardian. During this process it is determined whether an assessment is required to assist in identifying appropriate accommodations or interventions. Ongoing review of the Section 504 Plan must be conducted at regular intervals according to LEA policy and procedures. Best practice suggests this plan should be reviewed at least annually.

To receive accommodations and/or interventions under Section 504 the following must be determined:

1. The student has a physical or mental impairment, has a record of such an impairment and/or is regarded as having such an impairment.
2. The impairment substantially limits one or more major life activities which adversely affects the student in the educational environment.

Local LEAs may define the above terminology and must have written procedures, which therapists should follow.

Accommodations may include direct therapy intervention, adaptive equipment, consultation interventions, environmental adaptations, parental consultation and instruction to staff. Interventions provided within LEAs in Illinois must enable students to benefit from their educational program. LEAs must have written procedures for implementing Section 504 and special education that clearly delineate the proper application of each, how they are similar and how they differ. Students' eligibility for therapy under Section 504 is then based on an assessment of the accommodations or intervention needed by the student in order for the student to effectively participate in major life activities as defined by the educational teams, rather than a function of the students' medical diagnosis.

Referral for Special Education

"Referral" is defined as, "a formal procedure, established by a school district which involves a request for a case study evaluation, (23 Illinois Administrative Code Section 226.75). Since the term *referral* is defined as a special education procedure, a different term(s) must be utilized to distinguish a *referral* from a "request for assistance" under Section 504 or some other instructional intervention strategy.

Referral procedures must be written, well-known to school personnel, provided to the general public and include the process by which the LEA determines the validity of the referral. The referral process is clearly a special education only process.

Referrals should provide specific information regarding a student's difficulties in the educational environment, his or her educational success, strategies attempted and their level of success and the accommodations attempted and their level of success. This information assists the team in determining if the referral requires a special education evaluation.

Evaluation

"Evaluation" is defined as, "a series of procedures designed to provide information about a child's suspected disability; the nature and extent of the problems that are or will be adversely affecting his/her educational development; and the type of intervention and assistance needed to alleviate these problems," (23 Illinois Administrative Code Section 226.75).

An evaluation must cover all domains that are relevant to the child under consideration. The IEP team and other necessary individuals, including occupational therapists and physical therapists if appropriate, determine the specific assessments needed for each referred child. A variety of assessment tools and strategies are used to gather relevant functional and developmental information about the student. These tools and strategies assist the IEP team in determining adverse effect on educational performance and need for specialized services. Written parental consent is required due to the individualization of the procedure on a specific student. Evaluation is clearly a special education only process.

The purpose of conducting the special education evaluation is to determine:

- Individual student's educational needs.
- The particular category of disability demonstrated by the student.
- Whether a student is eligible for special education.

The district may **NOT** conduct a partial evaluation in order to determine if a full evaluation is needed, or stop the process prior to its completion and discussion at an eligibility meeting, or initiate a re-evaluation without written parental consent.

Occupational therapy and/or physical therapy are brought into the evaluation process through procedures determined by the local educational agency (LEA). Written parental consent for specific occupational therapy and/or physical therapy assessment is required in the same context as written consent for other diagnostic procedures on state mandated forms.

REFERRAL, ASSESSMENT AND ELIGIBILITY FOR OCCUPATIONAL THERAPY AND/OR PHYSICAL THERAPY

Referral

Referral for occupational therapy and/or physical therapy assessment occurs through the team process. Referral can be made as part of or following an initiation of a special education evaluation or as part of a request for assistance under Section 504. Written parental consent for evaluation is required. According to the Illinois Occupational Therapy and Physical Therapy Practice Acts, a physician's prescription is required at the time of referral. LEAs may establish

more restrictive policies regarding procurement of prescriptions. The referral packet for occupational therapy and/or physical therapy assessment should include the following:

- Basic student demographic information;
- Reason for referral including student strengths, student needs and previously attempted strategies and performance outcomes relative to the educational setting;
- Medical records (requires written release of information);
- Pertinent therapy records (requires written release of information) and
- Educational records including the most current IEP, if applicable.

Assessment

Assessment refers to systematic and organized methods of collecting data. It is "...the complex and individually specific process of gathering information in order to identify areas of strengths and weaknesses and to interpret the findings for effective program planning" (Huber & King-Thomas, 1987, p. 3).

The purpose of assessment is to:

- Identify an individual student's functional capabilities and limitations within the school environment.
- Determine the extent to which the deficit areas are impacting a student's educational performance given the demands of the educational system.
- Provide insights into the reasons for student performance and factors that may be interfering with the learning process.
- Share information about the impact of a student's disability on both present and future functional capabilities.
- Enable a therapist to assist in determining accommodations.
- Enable a therapist to assist in goal identification.
- Provide baseline data to determine the effectiveness of intervention.

Assessment may encompass a variety of data collection methods, such as:

1. Review of school records: The therapy practitioner should consider frequent school changes, attendance, history of grades and test scores.
2. Examination of the student's work: The therapy practitioner should review work samples and portfolios and consider the work of the student's peers.
3. Review of pre-referral procedures: Documentation regarding strategies or modifications that have been attempted, with the outcomes, is reviewed and discussed with personnel involved.
4. Interviews: Through interviewing, the therapy practitioner obtains the parents', teacher's and student's perspectives on the student's strengths, needs and causes of problems.
5. Observation: Therapists should schedule child observations in the natural setting and at the time of day when the behavior is problematic. Methods for documenting observations include:

- a. Anecdotal records. Records of subjective data relating to the child, environment, or instruction style are maintained.
 - b. Event recording. Often a data collection sheet is used to record the frequency with which the problematic behavior occurs.
 - c. Duration recording. A data collection sheet can be used to record the amount of time the child spends engaged in the problematic behavior.
 - d. Time-sampling recording. This method uses a practical approach of recording the frequency of the problematic behavior during a specific time period.
 - e. Checklists and rating scales. Rating scales are often specific to performance areas, provide a Likert scale or yes/no format for judging performance and often lack evidence of formal investigation of reliability and validity.
6. Testing: Common assessment methods used are listed below.
- a. Criterion-referenced assessment. Criterion-referenced tools compare the child's performance to a specific criterion; therefore, these tests describe the child's mastery of specifically defined skills.
 - b. Norm-referenced assessment. In a norm-referenced test, the child's performance is compared to that of a representative group.
 - c. Ecological assessment. Ecological assessment refers to direct observation of students in a variety of environments to determine the influence of various environments on student performance.
 - d. Curriculum-based assessment. Curriculum-based assessment compares the child's performance in the current curriculum to that of other children in that class, school or district. These local norms provide information immediately relevant to instructional programming (Berdine and Meyer, 1987).
 - e. Dynamic assessment. Acquisition of assessment data includes interaction between the examiner and the child. The examiner may model tasks, provide prompts or cues or praise the child. Through dynamic assessment, the examiner assesses the child's ability to process information, respond to learning situations and problem-solve. Can the child learn and apply knowledge: Without assistance? With verbal or physical cues? With behavior modeling?
 - f. Outcome-based assessment. Specific outcomes for a student are identified, competencies needed to achieve these outcomes are analyzed by task and student strengths/needs related to these outcomes are documented.
 - g. Learning styles assessment. An assessment of a student's learning styles focuses on the elements that are critical to the child's learning such as the environment of the classroom (noisy, dark, light), types of teaching materials (visual, auditory, tactual) and types of thinking the child uses in problem solving

(trial and error, analysis). The final findings are incorporated into modifications of the child's educational setting (Frolek Clark & Coster, 1998).

Through the selection and administration of specific assessment tools and tests a therapist identifies the underlying deficits of student performance. It is important that a therapist choose assessment tools which can identify, as succinctly as possible, a student's current abilities and the potential for adaptation or remediation to allow full benefit from the educational program.

A critical step after observing a student and administering formal and informal assessments is the interpretation of findings. This interpretation process attempts to explain some of the discrepancies between a student's performance in school and the expectations that others have for that student. This is done by comparing the underlying components of neuromuscular, sensorimotor and psychological performance with the functional performance of daily living, mobility/transitional skills, positioning, social activities, play/leisure skills and educational/vocational skills. Both present and future curricular expectations should be considered.

It is the responsibility of a therapist to accurately reflect the results of the assessment process in order for the team to make an informed decision regarding the needs of the student. Of course, the final decision to support a student's needs and the total program for the student rests with the entire team and is determined at the multidisciplinary staffing.

Documentation of Assessment Results

School-based therapy practitioners must base their decisions on objective evaluation data and be able to support the effectiveness of intervention strategies provided for the student (Frolek Clark & Coster, 1998).

Reports should be clear, concise and in a format agreed upon by the local education agency. Reports should contain the results of specific assessment procedures as well as a summary of educational needs. Any recommendations regarding therapy needs as a part of the students' educational program should be made without reference to therapy levels, frequency or duration.

The following should be included in a written report:

- Identifying information;
- Reason for and date of referral;
- Pertinent medical/educational history;
- Date(s) and place(s) of assessment(s);
- Assessment methods including:
 - Description of standardized and formalized evaluation tools used and scores obtained,
 - Informal evaluative methods used and
 - Description of functional skills assessed;
- Interpretation of results, identifying strengths and deficit areas as they relate to the student's participation in activities within the educational environment;
- Identification of environmental and adaptive equipment needs and
- Summary of educational needs with an explanation of how these needs impact the student in the educational environment.

Eligibility Determination

A meeting is required to share assessment information with parents and other team members once the occupational therapy and/or physical therapy assessment is completed.

Participants in the meeting include:

- The parent(s),
- A representative of the district who is qualified to provide or supervise the provision of special education,
- Other persons having significant information regarding the student,
- Those persons who may be responsible for providing the special education program or service to the student,
- The student (where appropriate),
- Other individuals at the discretion of the parent or local district and
- General education teacher.

The purpose of this meeting is to:

- Establish a composite understanding of the student's learning characteristics, behaviors and sensory and motor skills;
- Determine the student's unique educational needs and the extent to which these needs can be met by the standard program and
- Determine eligibility for special education programs and/or services.

It is the responsibility of a therapist to interpret the assessment findings in a meaningful fashion to the other team members. It is important that the team understands the connections between the therapist's interpretation of the results and a student's present needs at school as well as future performance outcomes.

The occupational therapist and/or physical therapist, as part of the evaluation team, provide input, substantiated by assessment results, to determine eligibility based on exceptional characteristics. Should anyone on the team disagree with the eligibility determination, a dissenting report may be written.

IEP Development

A student becomes eligible for development of a written IEP based on student identification and evaluation processes followed by a team decision that a child has one or more of the 13 disabilities as defined by IDEA and 23 Illinois Administrative Code Part 226. The IEP is developed following determination by the team that 1) the child has a disability, 2) the disability adversely affects the child's educational performance and 3) as a result of that disability or a secondary disability, the child needs special education and related services in order to benefit from educational programming. The IEP team, which includes the student's parents, collaboratively determines the special education program for the child through development of the IEP. This team is also responsible for determining if occupational therapy and/or physical therapy are necessary to assist the child to access or to participate in the educational environment in attaining educational goals (APTA, 2000). A description of the IEP development process is outlined below.

IEP Planning

The IEP team is required to meet within 30 calendar days following the eligibility team's determination that a child requires special education in order to meet his/her specific education needs (34 C.F.R. 300.343(b)(2)). Participants in the development of the IEP are delineated in 34 CFR 300.344(a) and include: the parent(s) of the child, a regular education teacher, a special education provider, a representative of the LEA, an individual who can interpret the instructional implications of the evaluation results and other individuals who have knowledge or expertise regarding the child at the discretion of the parent or the LEA. The IEP meeting is arranged at a mutually agreeable time and place in order to allow participation by the parents and the IEP team from the educational agency (34 C.F.R. 300.345(a)(2)). It is through the IEP meeting that the written, legally binding commitment of educational resources is developed (APTA, 2000). The IEP must be written and implemented without delay following the meeting.

IEP Components

A sample format of the written IEP document is provided by the Illinois State Board of Education and frequently added to by the LEAs. As a result, the written IEP format often varies among different school districts in the state although the contents are comparable. As delineated at 34 C.F.R. 300.347, the legally required components of an IEP are:

- A statement of the child's present levels of educational performance;
- A statement of measureable annual goals, including benchmarks or short-term objectives;
- A statement of the special education and related services and supplementary aids and services to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided for the child;
- An explanation of the extent, if any, to which the child will not participate with nondisabled children in the regular class and in activities;
- A statement of any individual modifications in the administration of State or district-wide assessments of student achievement that are needed in order for the child to participate in the assessment; and, if necessary, a statement of why that assessment is not appropriate for the child, and how the child will be assessed;
- The projected date for the beginning of the services and modifications described, and the anticipated frequency, location, and duration of those services and modifications; and
- A statement of how the child's progress toward the annual goals described will be measured, and how the child's parents will be regularly informed, at least as often as parents are informed of their nondisabled children's progress.
- For each student with a disability, beginning at age 14 (or younger, if determined appropriate by the IEP team.) and updated annually, a statement of the transition service needs of the student under the applicable components of the student's IEP that focuses on the student's courses of study.
- For each student beginning at age 16 (or younger, if determined appropriate by the IEP team,) a statement of needed transition services for the student including, if appropriate, a statement of the interagency responsibilities or any needed linkages.

Development of IEP Goals

The IEP team members are responsible for collaborating to develop meaningful goals that are important for student learning. Prior to the development of specific goals and objectives/benchmarks for a student, it is necessary to identify the desired educational outcomes for the student. Defining future outcomes for the student may be more difficult when a student's present levels of performance vary significantly from that of same-age peers in the general curriculum. Collaboration of all team members, including the student's parent(s) and the student as appropriate, is necessary to define functional outcomes. A functional outcome describes an activity that the student is unable to do presently which would make a significant difference in the educational experience of the student and his/her family if they were able to do it. A functional task is an activity that the student is unable to do presently and must be done by another person if the child is not able to do it (Effgen, 1995). In order to be a functional outcome for a given student, the student must be capable of accomplishing that active behavior over a given time period. Developing goals then becomes a written expression of the desired outcome(s) that have been generated by the collaborative IEP team. Goals are generally written to describe a measurable behavior that can be accomplished within one year (34 C.F.R. 300.347 (a)(2)). When writing annual goals, the team must create goals that are functional, discipline-free, chronologically age-appropriate, meaningful to both the student and the student's family and reference the general curriculum (APTA, 2000). A meaningful goal is one that will make a significant difference in the life of the student and his/her ability to function in a variety of environments. If there were no curricular emphasis on the skills a student needs to improve, these areas would not be educationally relevant in this case.

Ideally, the student should have opportunities to practice the tasks/activities that comprise the goal on a daily basis and in more than one environment. King, McDougall et al. (1999) propose that functional goals of particular importance in the school environment can often be categorized into one of the following areas: communication, classroom productivity and mobility. Goals in these areas are likely to meet the future as well as the present needs of a student.

Measurable objectives/benchmarks must be developed after the IEP team has identified the desired outcomes for a student by expressing those outcomes as written (long-term) goals. Objectives/benchmarks contain a statement of the behavior to be achieved, the conditions under which it should be achieved and the criteria used to measure whether or not it has been attained (Effgen, 1995). Short-term instructional objectives/ benchmarks are based on a logical breakdown of the annual goal and should serve as milestones for measuring progress towards goal attainment.

After a student's outcomes have been identified, the team therapist and other members of the IEP team determine the following:

- The methods and strategies of intervention anticipated, given the type of skills to be learned.
- The level of expertise required to implement the methods and strategies. At this time, the decision is made whether or not to provide occupational therapy and/or physical therapy as part of the educational plan.
- The least restrictive environment in which the occupational therapy and/or physical therapy services will be delivered (Iowa, 1996).

The IEP team also determines the other professionals needed to assist the student in achieving the educational goals and objectives/benchmarks. In addition, decisions on program

modifications, supplementary aids and supports may be necessary to allow the student access to and participation in the educational environment. In determining the need for occupational therapy and/or physical therapy, the IEP team decides which team members have the expertise needed to assist the student and how much time will be required from that professional to enable the student to attain that goal (APTA, 2000). At the end of the IEP development process, the IEP team determines the most appropriate placement for the child based on the amount of combinations of service locations enumerated in the IEP, in accordance with the least restrictive environment provisions under IDEA and 23 Illinois Administrative Code Part 226.

Entrance Criteria

While some overlap does exist between occupational therapy and physical therapy based on environmental circumstances and student needs, the following performance areas/categories should be considered to determine whether a student requires one or both therapies.

Occupational Therapy

- Activities of Daily Living
- Educational & Vocational Activities
- Play or Leisure Activities

Physical Therapy

- Mobility/Movement
- Posture/Positioning
- Safety Accessing Environments

Based on the student's function in the above performance areas, all the following criteria should be considered to determine if the student's need requires the expertise of the therapist.

- There is a significant limitation in at least one performance area as listed above.
- The problem adversely affects the student's ability to benefit from his/her educational program.
- The potential for student improvement over time through intervention appears likely (change is unrelated to maturity).
- The unique expertise of a therapist is required to meet the student's identified needs or to assist the team in providing the educational program.

The final decision regarding the provision of occupational therapy and/or physical therapy as a related service is made by the whole team at an IEP meeting in accordance with 23 Illinois Administrative Code Part 226 or based on written Section 504 procedures determined by the LEA. Therapists are responsible for presenting intervention options to the team. A therapist needs to be prepared to discuss whether intervention is indicated as well as the advantages and disadvantages of each possible intervention plan.

Exit Criteria

Based on the student outcomes after intervention occurs in the above performance areas/categories, each of the following criteria should be considered to determine if the student no longer requires therapy.

- The expected therapy outcomes have been met and no additional outcomes are appropriate.
- The potential for further significant change as a result of therapy intervention appears unlikely.
- The identified limitation(s) no longer require(s) the unique expertise of the therapist.
- The problem ceases to be educationally relevant.
- Therapy is contraindicated due to change in medical or physical status, and psychological and/or social complications.

The team decision regarding the termination of occupational therapy and/or physical therapy as a related service is made by the whole team at an IEP meeting in accordance with 23 Illinois Administrative Code Part 226 or based on written Section 504 procedures determined by the LEA. Therapists are responsible for presenting advantages and disadvantages for termination of therapy intervention.

Section III

PROVISION OF OCCUPATIONAL THERAPY AND PHYSICAL THERAPY IN THE EDUCATION SETTING

INTRODUCTION

Section III presents information on how occupational therapy and physical therapy are included in the educational setting. Measuring student progress and transition planning are described and their educational relevance explained. Methods of therapy implementation, collaborative teaming and documentation are also outlined in this section.

IMPLEMENTATION OF OCCUPATIONAL AND/OR PHYSICAL THERAPY

During any school year, although the goals and objectives/benchmarks may or may not change, the intervention approaches may vary based on the educational environment and the needs of the student. These needs must be addressed when determining the therapist's caseloads. The judgment of the therapist as to how best to utilize his/her expertise during the school year may offer the opportunity for a variety of interactions between the therapist/student, therapist/team and the therapist/parent. To insure that the student will attain the goals and objectives/benchmarks the therapist needs flexibility to work individually with a student, meet with the team, make adaptations to facilitate student function, implement strategies in the classroom at different times and during a variety of content areas, and measure success in the educational environment. The therapist and team may determine that the student's goals and objectives/benchmarks should be addressed by an intense period of intervention or that the student's educational program requires a shortened intense period of intervention with the lessening of need for the therapist's expertise over time.

The models are typically categorized in two types: consultative (collaborating with team members) and direct (contact with student). Two conceptual models of intervention help explain the therapy system and should not be viewed as isolated entities. **Any student intervention should be collaborative regardless of whether it is a direct intervention approach or a consultative intervention approach.**

Consultative Intervention

Consultative intervention occurs when the therapist collaborates with the teacher, other staff, parents and, when appropriate, the student, regarding student-specific issues as identified in the student's IEP goals and objectives/benchmarks. While direct intervention with the student is needed to develop and monitor an appropriate consultative program, consultation is primarily problem solving with the educational team to determine appropriate expectations, environmental modifications, assistive technology and possible learning strategies for the student in naturally occurring environments. As part of the collaborative model the therapist uses direct intervention to model strategies for team members within the naturally occurring setting or to collect data for updating or revising consultative plans. Data collection may also occur in more isolated situations but should include student performance while the student is integrated in naturally occurring activities. An "integrated" approach, then, is important in facilitating collaboration regarding student needs, goal development and program planning. The therapist's unique expertise may also be needed for staff and parent training.

A viable consultative intervention model has three parts: building support, classroom support and communication, and documentation.

1. Building Support

Therapists participate in building meetings in order to:

- Assist staff in completing referral procedures;
- Provide information regarding typical student performance and/or expectations;
- Provide suggestions for general accommodations for all students;
- Develop appropriate recommendations and suggestions with team members in order to establish whether or not a student meets criteria for evaluation; and
- Provide inservice to building staff on skill development, diagnosis information, occupational and/or physical therapy intervention and entrance/exit criteria.

2. Classroom Support for Students Receiving Occupational Therapy and/or Physical Therapy

Therapists participate in team meetings in order to:

- Collaborate on adapting functional and meaningful activities typically occurring in the student's routine;
- Create opportunities for the student to practice new skills;
- Collaborate on problem solving strategies with other team members to encourage student participation and independence;
- Act as a resource to share information regarding physical, sensory and skill development, medical issues, etc.;
- Act as a liaison between outside agency and school personnel;
- Add to the team's holistic approach of all factors impacting the student in the school environment (lunchroom, playground, classrooms, art, music, PE, etc.);
- Gather information to respond to the team's issues and concerns and
- Collaborate with team members regarding program planning in order to enhance a student's performance and independence.

3. Communication and Documentation

Therapists need to:

- Collect data, including:
 - Monitoring progress towards IEP goals
 - Completing assessment checklists of student's functioning
 - Gathering work or data for portfolios
- Document and report interventions, including
 - Preparing student progress reports
 - Identifying team issues and concerns on student's participation
 - Developing follow-up plans
- Develop formal reports/plans from observations and assessments
- Develop and maintain relationships with all team members
- Develop instructional programs (emergency evacuation plan, positioning and transfer protocols, sensory diet, analyzing tasks to teach, etc.)

- Develop collaborative goals and objectives/benchmarks that integrate therapeutic intervention with the general education curriculum

Occupational therapy and physical therapy can each appear as a support service and be associated with specific goal(s) and objective(s)/benchmark(s) on the Section 504 Plan or IEP. Since, in the consultative model, the therapist is not the only individual responsible for carrying out the interventions related to the goal(s) and/or objective(s)/benchmark(s), at least one other instructional or support service provider is identified as a provider. The time the therapist will spend in collaborative consultation must appear on the Section 504 Plan and IEP.

Direct Intervention

When the therapist provides direct intervention, he or she works with a student in or out of the classroom on a frequent, consistent basis. Direct intervention is used when the student requires the unique and ongoing expertise/assessment of the therapist because the student's performance is insufficiently consistent for the techniques and strategies to be safely incorporated within the daily routine. For direct intervention to be successful, consultative intervention with the educational team is also necessary. Therapy may occur in an isolated environment due to the need for instruction free from distraction or the need for specialized equipment not found in the classroom setting. "Integrated" therapy may also occur within naturally occurring environments (classroom, gym, playground, etc.) and during activities that occur throughout school routines. Whether such therapy is delivered in an "integrated" setting or in isolated environments, it is provided face-to-face with the student by the therapist and is considered direct intervention.

The need for direct intervention is identified based on the priorities established by the educational team when developing the Section 504 Plan or IEP. There are critical learning periods that necessitate direct intervention by the occupational therapist or physical therapist to address student needs. Often, only a short interval of direct therapy is needed during a skill-building period. The emphasis of direct occupational therapy is usually for the acquisition of occupational performance skills, which include activities of daily living, educational and vocational activities and play and leisure activities needed for the student's participation in the environment. The emphasis of direct physical therapy is usually for the acquisition of motor or sensorimotor patterns needed for skill development or safe independent functional movement. During this period of direct therapy there is not an expectation these interventions will be delegated to others and carried out between therapy sessions.

The therapist using a direct intervention model:

- Works with a student individually or in small groups on isolated skill development outside of the normal routines and activities,
- Works individually or with a small group on tasks in naturally occurring environments and activities that occur throughout the daily routine to increase or generalize skills,
- Provides equipment and materials to support student in environment and
- Functions as a resource for students' accessibility to technology.

Collaborative Teaming

Collaboration is the dynamic process through which quality interventions are designed, implemented, modified and evaluated (AOTA, 1997). Components of collaboration include

mutual respect, cooperation, communication, sharing of expertise, coordination of intervention and interagency cooperation. Critical to student success is the therapist's ability to develop and sustain productive working relationships with the student, family, teachers and other professionals.

Occupational therapists and physical therapists who work in the educational environment participate in a variety of teams. Teams may take many forms and have varying membership depending on the team's purpose, including the Section 504 team, IEP Team, IFSP Team and building or district level teams. Various models of teams may be encountered as well, including multidisciplinary, interdisciplinary and transdisciplinary teams. The role of the therapist on any team is to collaborate. Collaboration occurs between and among team members, which include the student and family. Collaborative teams prioritize a student's educational needs then develop goals and a plan for meeting these needs. Therapists collaboratively anticipate future educational outcomes, are a resource for the team regarding the educational significance of a student's medical disability and assist with interagency coordination. The goal of team collaboration is to identify a holistic program for the student with agreed on priorities for intervention in order for the student to benefit from his or her educational program.

Measuring Student Progress

Using criteria established with team members, occupational therapists and physical therapists must objectively measure student progress resulting from interventions. Measuring student progress occurs throughout the year via one or more of the following: 1) building team meetings, 2) Section 504 plan meetings, 3) parent conferences, 4) report cards and 5) IEP meetings. The criteria utilized are often a function of time, distance, work samples, repetitions, and/or percentages or completion of trials. Progress Monitoring and Goal Attainment Scaling are examples of precise data collection systems (King & Clark)

Parents must be informed of their student's progress at least as frequently as progress is reported for nondisabled peers. Therapists and the educational team use data when considering goal revision. The team also uses the objective data regarding student progress to determine personnel and adaptations needed for a student's success in the educational environments.

Transition Planning

Transition planning is the process that occurs prior to the child moving from one intervention environment to another. There are two occasions when transition planning is mandated by law and regulations. The first relates to transition to preschool programs (34 C.F.R. 300.132; 34 C.F.R. 303.148) which occurs at least 90 days and, at the discretion of the parties, up to 6 months prior to the third birthday, when the child graduates from early intervention programming to school-age programming. Best practice suggests that transition planning initiated a year ahead is beneficial and may start with initial communication between early intervention providers and the school district.

The second occasion arises no later than the student's fourteenth birthday when initial planning must start for post-school activities (34 C.F.R. 300.29). At that point, it is important that the educational team communicate with community service providers in identifying needed post school services.

Transition planning should also occur at other pivotal times in the student's educational career. These occasions might include, but are not limited to, moving from 1) one type of special education programming to another, 2) special education to regular education, 3) one school building to another or 4) one school district to another.

As a student gets older the role of occupational therapy and physical therapy changes. Early intervention is very family-oriented and therapists have the opportunity for family-directed intervention. Intervention to school-aged children is child focused, with the possibility of family involvement. When the child becomes school aged it is necessary for school therapists to collaborate with early intervention therapists to facilitate the transition into school (AOTA, 2000).

Communication between the family and school/community intervention providers is the key. Transition can be a stressful time for students and families. Changing environments and therapists may cause anxiety for members of both teams. Understanding the needs of the families and students is essential. The occupational therapists and physical therapists should be present with a student in the new environment(s), assessing and employing strategies for intervention in these environments and consulting with staff and families regarding concerns, suggestions and expectations for the student in the new educational environment or in the community (McEwen, 2000).

DOCUMENTATION

General Guidelines

Documentation facilitates effective intervention, provides communication among team members and the family, justifies reimbursement, reflects the therapist's reasoning and stands as a legal record (McClain, 1991; AOTA, 1995). Poor documentation can have ethical, financial and legal consequences.

Educational Documentation

Within the educational system, procedures for the establishment and maintenance of educational records are developed by the LEA in accordance with the mandates of the Illinois School Student Records Act (105 ILCS 10/1 et seq.), 23 Illinois Administrative Code Part 375, and the Family Educational Rights and Privacy Act (34 C.F.R. Part 99). Student records refer to any written or recorded information maintained by the student's school district by which he or she may be individually identified. In Illinois two types of records exist:

- A. Student Permanent Record, which includes:
 - Basic identifying information,
 - Academic transcript,
 - Attendance record,
 - Health records and accident reports and,
 - Record of release of permanent record information.Optionally, the permanent record may also include honors and rewards received and information regarding participation in extracurricular activities.

- B. Student Temporary Record, which may include:
 - Family background information,
 - Section 504 Plan,

- Intelligence and aptitude scores,
- Educational assessment results,
- Special education evaluation results,
- Extracurricular participation, awards and honors,
- Special education IEPs,
- Teacher and anecdotal records,
- Disciplinary information,
- Records of release of information of temporary record information,
- Special information files,
- Therapy attendance records and
- Other information of clear relevance to the education of the student.

Information that is generated by the educational team, including therapists, becomes a part of the temporary record. This may include the referral for evaluation, the evaluation for eligibility, the IEP, initial status and progress reports, records of intervention and discharge reports. Guidelines for documentation of screening, evaluation and pre-referral activities are discussed in Section II. (See 23 Illinois Administrative Code Part 375.)

Components and Guidelines for Therapy Documentation

The steps in documenting the therapy process closely mirror federal requirements. These steps include conducting an evaluation, creating the intervention plan, providing intervention and reevaluation. IDEA allows for billing third party payers, including Medicaid, for therapy services provided as part of the IFSP or IEP. Documentation for reimbursement must follow the rules and regulations of the governing statutes and agency policies. Therapists must be accountable for intervention time as defined in the Section 504 Plan or IEP and for information regarding student progress. Each local education agency will determine the format and frequency of documentation. Each therapist should maintain a working file for each student containing the intervention plan, daily progress notes, data collection and other information as appropriate. Some therapists may consider this their personal file. The Illinois School Student Records Act (105 ILCS 10/1 et seq.), Family Educational Rights and Privacy Act (34 C.F.R. Part 99), and the Privacy Act of 1974 (5 U.S.C. § 552a) allow therapists to maintain these working files but also ensures parents access to ALL files, including personal files, when student identifiable information has been shared with another person. This should not deter therapists from keeping documentation. Rather, it should encourage therapists to improve accuracy in all reporting of student progress.

1. Physician Referral

Best practice for occupational therapists and physical therapists suggests that a therapist obtain a physician's referral prior to evaluation. The Illinois Occupational Therapist Practice Act specifies that an occupational therapist may evaluate a person but shall obtain a physician's referral prior to treatment by an occupational therapist. Renewal of prescriptions is the responsibility of the therapist, which may be delegated to clerical personnel. An annual renewal is required for all students with an IEP, as that treatment plan must be developed annually. Best practice in other settings suggests annual renewal of prescription is appropriate and supported by AOTA and APTA.

2. Intervention Plan

Using the evaluation data and the educational outcomes expected in conjunction with intervention, the occupational therapist and physical therapist should develop an intervention plan to guide the direction of therapeutic programming. This plan is not the same as the IEP, but rather reflects the strategies and methods used to address the educational goals. The therapist chooses the methods for determining the effectiveness of the intervention plan using data collection. Defined behavior, baseline performance data and ongoing data collection promote effective intervention and decision making. The format for this plan and the decision for where the plan should be maintained are left to the discretion of the LEA. (See Occupational Therapy Services for Children and Youth under the IDEA (AOTA 2000))

3. Intervention Contact or Treatment Note

The contact or treatment note is used to document intervention activities, e.g, working directly with the student, contacting the student's physician, adapting equipment or the environment, meeting with the team. This thereby reflects the appropriate use and commitment of resources specified in a student's IEP. Documentation of supervision and instruction to parents and paraprofessionals is also achieved through treatment notes. The frequency, format and location for maintenance of these notes are left up to the LEA. Content should include:

- Attendance and participation;
- Activities, techniques and modalities used (a checklist or brief statement is allowed);
- Equipment issued or fabricated and specific instructions for the use of the item; and
- Student's response to therapy, related back to the IEP.

Occupational therapists are referred to the AOTA document, *Elements of Clinical Documentation (Revision)* (1995), for further specifics on the elements of documentation specific to occupational therapy.

4. Progress Reports

IDEA requires that parents of students with disabilities "be regularly informed (through such means as periodic report cards) [of their children's progress] at least as often as parents are informed of their nondisabled children's progress" (34 C.F.R. 300.347(a)(7)(ii)). The LEA should determine the format of this report. The content must reflect progress toward the annual IEP goals and "the extent to which that progress is sufficient to enable the child to achieve the goals by the end of the year" (34 C.F.R. 300.347(a)(7)(ii)(B)). If the team feels that the student will not achieve a goal, the parents should be notified and an IEP meeting convened to consider goal revision.

5. Annual Review of Progress

A progress report is a written narrative summary of student progress that is provided to the educational team to document student response to any interventions implemented. Annual reports of progress are included as part of the student's annual IEP review and update. Therapists may integrate their report into the IEP or write a separate report. Regardless, content should include a summary of the interventions used to meet objectives, progress

toward goals, present level of performance and continued educational needs relative to therapy.

Should a need for therapy no longer exist, this can be included as a part of the annual review report. The therapist should include a history of therapy provided, summarize progress and performance on current IEP goals, and identify follow-up or transition needs. A form or format to summarize this information in the therapy working file is extremely beneficial.

6. Administrative Records

Supervisors of therapy practitioners working in school systems need to develop the type of administrative records necessary to manage therapy programs, document the continuous quality improvement of practice, review the effectiveness of intervention and determine fiscal accountability. Examples of records that can be used to provide this information include:

- A record of services provided to staff and students in general such as inservice provision, classroom instruction, resource matching.
- A record of each student referred, source of referral, and outcome.
- A record of student interventions to determine if services were provided as indicated on the Section 504 Plan or IEP.
- Weekly and monthly schedules to assist in locating itinerant therapists, as well as documenting time in collaboration with teachers and teams.
- Statistical records such as number of referrals, students receiving intervention and number discharged, to assist in determining staffing needs and patterns.

Section IV

ADMINISTRATIVE CONSIDERATIONS

INTRODUCTION

This section includes information on the following areas: employment, retention and recruitment; orientation; space, equipment and materials; caseload; supervision and management; continuing education; professional liability; and third party billing.

EMPLOYMENT, RETENTION AND RECRUITMENT

Employment Arrangements

Many alternatives exist for educational agencies to obtain occupational therapy and physical therapy personnel: direct employment, cooperative employment and contractual employment. Direct employment occurs when a LEA employs a therapist or a consortium of education agencies, i.e., a special education cooperative, shares employment of a therapist. A therapist may also be employed through contractual arrangements between an educational agency, a local hospital, a rehabilitation facility, a contract firm, or therapist in private practice. When employment is obtained through contractual arrangements, a written agreement must stipulate the term of the contract; service and documentation expectations; supervision; responsibilities of the purchaser and provider for resources, continuing education, travel, liability insurance, secretarial support and Occupational Safety and Health Administration (OSHA) requirements; fees for service and terms for cancellation by either party.

Recruitment Methods

It can be beneficial to advertise in national, state and regional professional publications, along with local advertising. Posting job announcements and agency information with university and technical training programs can attract new graduates. Names and addresses of accredited professional schools nationwide may be obtained from AOTA and APTA. An educational agency may mail job notices to licensed therapists by purchasing a listing from the Illinois Department of Professional Regulations. Another recruitment tool is to provide a pediatric affiliation or fieldwork rotation at an agency. Grants or low interest loans provided via contractual agreements with occupational and/or physical therapy students in return for service have the potential to assist filling staffing needs. Also, recruiting at job fairs, universities or at state and national conferences offers a forum to share job opportunities at an agency.

Orientation of New Staff

In order to provide services that are appropriate and consistent with the educational system, the contract and direct-hire occupational therapy and physical therapy staff must understand both the consortium of educational agency (i.e. cooperative) and local educational agency systems' policies and procedures. The following areas should be included in the orientation:

- Basic philosophy of occupational therapy and physical therapy in an educational environment
- Agency policies, procedures and guidelines handbooks

- State and federal laws and regulations
- Documentation requirements for assessment reports, Section 504 accommodation plans, IEP forms, intervention plans and monitoring of student progress
- Introductions to administrative, educational and support staff
- Opportunities for observation of and mentoring from experienced staff

Retention of Therapists

Retention and recruitment of therapists are of primary concern for administrators. Job security, good working conditions, salary, opportunity for career development, peer support, interesting and challenging work, a supportive communicative environment in which to work, autonomy and the opportunity to develop specialized skills are some of the important employment values for therapists in the marketplace. These issues require attention from educational managers to create committed and loyal therapists.

SPACE, EQUIPMENT AND MATERIALS FOR SERVICE DELIVERY

The value placed upon the work of an employee is supported by the provision of appropriate tools and an environment in which the job can be satisfactorily accomplished. The presence of appropriate space and resources is important to attract occupational therapists and physical therapists and to retain them in their positions. Most importantly, availability of space for providing student intervention, office space and proper equipment and therapy materials must also be provided to conduct successful student intervention. Funds should be available to the therapist for specialized equipment and materials including those needed for assessments or on a trial basis. Therapists and their assistants should be involved in deciding the type of equipment to be ordered. Commonly needed equipment includes the following:

- Positioning materials such as wedges, bolsters, adapted tables and chairs and standers;
- Therapeutic equipment such as walkers, crutches, ball, keyboard modifications, specialized writing devices, switches and toys;
- Self-care devices such as adaptive feeding tools, toileting equipment and grooming/dressing tools;
- Developmentally and age-appropriate learning materials;
- Assessment tools and standardized tests;
- Expendable materials such as test protocols and adaptive equipment such as Velcro, dycem, foam or strapping and
- Office equipment such as files, desks, computer access and resource books

Durable medical equipment and assistive technology devices, that appear on the IEP and are considered to be student specific and necessary to support the student's educational program must be procured through the LEA. The student's family and/or residential facility typically provides equipment that is not necessary for educational programming.

Constraints

Therapy expectations cannot be managed and meaningful outcomes obtained without suitable arrangements. School districts that would have students receive therapy in hallways or cafeterias generally suffer from the lack of privacy, proper equipment, potential distractions and are in violation of federal and state comparability requirements. The ability of therapists to

develop a strong professional identity as legitimate members of the educational team may also be hindered.

WORKLOAD DETERMINATION

Many variables affect the number of students a school-based therapist is able to service. These variables can be categorized into two distinct groups. The first group is driven by the Section 504 Plan/IEP minutes for those students receiving occupational and/or physical therapy and includes:

- Student intervention time
- Consultation time
- Team meeting time
- Documentation
- Planning
- Section 504/IEP meetings
- Re-evaluations
- Travel time
- Number of sites (travel time)

The second group includes new student identification and educational system support such as:

- New student referral meetings
- Assessment of new students
- Classroom/program consultation (for students currently not receiving occupational or physical therapy)
- Department meetings
- In-service training provided and attended
- Staff development

The amount of time devoted to each of these types of activities should to be determined based on LEA needs. Each therapist's workload is determined by the amount and type of these two different activities required and may change through the year depending on building/program needs. Once it is decided how much of the workload is given to each of these activities then caseload assignments can be made.

Time available for student intervention and new student assessment is limited by the hours students are in attendance. The percentage of the therapist's workday that is devoted to student intervention/assessment is roughly 65 percent of the student attendance hours. The other factors that influence a therapist's workload need to be taken into consideration when determining caseloads.

Travel Time/Number of Sites

Time required is based on distance between buildings and preparation required at each site. Time will vary between suburban and rural areas. In suburban areas allow approximately 30 minutes per site. In rural areas this amount of time may be significantly more. To determine the necessary amount of time in a particular area, it may be helpful to consult with the therapists traveling to these sites.

Assessments

All of the assessment activities need to be considered when allowing adequate time for assessments in the therapist's workload. This time roughly equates to one half day per assessment and up to an additional one half day per assessment for participating in each Section 504/IEP meeting.

SUPERVISION AND MANAGEMENT OF THERAPY PERSONNEL

Supervision and management of occupational and physical therapy services must be provided commensurate with the mandates and standards set forth by the Illinois Department of Professional Regulation, the Illinois State Board of Education and LEAs. Professional therapy practice is also governed by regulatory state and national agencies including APTA and AOTA.

In school settings, occupational therapy and physical therapy employees must receive technical assistance supervision provided by therapists of the same profession. Areas in which technical assistance is required are assessment, conducting appropriate student interventions, caseload management, consultation and professional development. Agencies that do not directly employ therapist supervisors can obtain technical assistance by contracting services from other LEAs, regional programs or clinical facilities. Occupational therapy and physical therapy employees may receive administrative supervision from other professionals.

The current Illinois Occupational Therapy Practice Act and the Illinois Physical Therapy Practice Act should be reviewed for complete information regarding supervision and licensure of occupational therapy and physical therapy staff, including therapists, assistants, student therapists and new graduates. The Illinois Department of Professional Regulation should be contacted regarding guidelines for foreign-trained therapists.

Supervision of an occupational therapy assistant is "...a process in which two or more persons participate in a joint effort to establish, maintain and elevate a level of performance and shall include the following criteria:

- 1) To maintain high standards of practice based on professional principles, supervision shall connote the physical presence of the supervisors and the assistant at regularly scheduled supervision sessions.
- 2) Supervision shall be provided in varying patterns as determined by the demands of the areas of patient/client service and the competency of the individual assistant. Such supervision shall be structured according to the assistant's qualifications, position, level of preparation, depth of experience and the environment within which he/she functions.
- 3) The supervisors shall be responsible for the standard of work performed by the assistant and shall have knowledge of the patients/clients and the problems being discussed.
- 4) A minimum guideline of formal supervision is as follows:
 - A) The occupational therapy assistant who has less than one year of work experience or who is entering new practice environments or developing new skills shall receive a minimum of 5% on-site face-to-face supervision from a registered occupational therapist per month. On-site supervision consists of

direct, face-to-face collaboration in which the supervisor must be on the premises. The remaining work hours must be supervised.

B) The occupational therapy assistant with more than one year of experience in his/her current practice shall have a minimum of 5% direct supervision from a registered occupational therapist per month. The 5% direct supervision shall consist of 2% direct, face-to-face collaboration. The remaining supervision shall be a combination of telephone or electronic communication or face-to-face consultation.

68 Illinois Administrative Code Sec. 1315.163(a), (2002).

It is the responsibility of the occupational therapy assistant to maintain on file at the job site signed documentation reflecting supervision activities. (68 Illinois Administrative Code Sec. 1315.163(b), (2002)

CONTINUING EDUCATION

Continuing education, defined as workshops, seminars, conferences and college courses, is an important issue for therapy professionals. Literature shows a trend among health professionals toward supporting continuing education. Some recognized benefits are staff development, recruitment and retention and program improvement. Agencies should develop guidelines for release time to allow therapists to attend courses and/or to determine a budget for continuing education. The Practice Acts define Continuing Education Unit (CEA) requirements for both disciplines.

THIRD PARTY BILLING

An agreement between the Illinois Department of Public Aid (IDPA) and the Illinois State Board of Education (ISBE) became effective in July, 1991 and was amended in December, 1994, permitting LEAs to bill Medicaid for eligible services including occupational therapy, physical therapy, audiology, speech and language, nursing, medical, psychological, social work and special transportation. IDPA and ISBE have developed a joint system for processing claims and payments. The LEA enrolls with the DPA as a Medicaid provider and separately signs an agreement with ISBE regarding certifying local tax dollars available for federal match, certification of staff providing the Medicaid services, submission of properly prepared invoices, maintenance of adequate documentation and use of funds. It is the responsibility of the therapist to document services provided, dates of service, procedure codes, duration of each session and diagnostic code. The LEA is responsible for the actual billing mechanism. There are varied issues and concerns regarding billing of educational therapy services through funding sources for medical services. Medicaid billing is continuously evolving in schools and it is important that readers continue to be educated regarding third party funding in relation to each LEA policy.

REFERENCES

- American Occupational Therapy Association. (2000). *Occupational therapy services for children and youth under the individuals with disabilities education act*. Bethesda, MD: Author.
- American Physical Therapy Association. (1996). *Evaluative criteria for accreditation of education programs for the preparation of physical therapists*. Alexandria, VA: Author.
- American Physical Therapy Association. (1990). *Physical therapy practice in educational environments: Policies and guidelines*. Alexandria, VA: Author.
- Assistance To The States for the Education of Children with Disabilities And The Early Intervention Program For Infants And Toddlers With Disabilities, 34 C.F.R. Part 300 (1999).
- Beresdorf, D. (1991). *Factors regarding retention of physical therapists*. Physical Therapy Forum. King of Prussia, PA: Advance for Physical Therapists.
- Bundy, A. (Ed.). (1991). *Making a difference: Occupational therapists and physical therapists in public schools*. Rockville, MD: American Occupational Therapy Association.
- Campbell, S. K. (Ed.). (1995). *The educational environment*. Physical Therapy for Children. Philadelphia, PA: W. B. Saunders Co.
- Chandler, B. (1989). *Fee for service in the public schools: Memo to state presidents*.
- Drnach, M. (2000). *A program for the delivery of physical therapy services in the educational setting*. Presented at the American Physical Therapy Association Conference. Indianapolis, IN.
- Frolek Clark, G., & Coster, W. J. (1998). *Occupational therapy: Making a difference in school system practice*. Bethesda, MD: American Occupational Therapy Association.
- Garrahy, Thibodaux, Hockman, & Caldwell. (1992). Continuing education requirements to maintain occupational therapy licensure. *The American Journal of Occupational Therapy*, 46(10).
- Giangreco, M. F. (1995). Related services decision making: A foundational component of effective education for students with disabilities. *Physical and Occupational Therapy Pediatric Journal*, 15.
- Huber, C. J., & King-Thomas, L. (1987) The assessment process in L. King-Thomas & B. J. Hacker (Eds.), *A therapists guide to pediatric assessment*, pp. 3-10. Boston: Little, Brown.
- 23 Illinois Administrative Code Part 226 (special education), (2002).
- Illinois Occupational Therapy Practice Act, 225 ILCS 75/1 et seq. (2002).

- Illinois Physical Therapy Association. (1989). *Supportive personnel. Physical Therapy in Illinois*. Oak Brook, IL.
- Illinois Physical Therapy Practice Act, 225 ILCS 90/1 et seq. (2002).
- Illinois State Board of Education. (1990). *Special education in Illinois: Reviewing the past, sharing the future 1969-70 to 1989-90*. Springfield, IL: Author.
- Illinois State Board of Education. (1991). *Third party billing/payments: Memorandum 91-78*. Springfield, IL: Author.
- Iowa Department of Education. (1996). *Iowa guidelines for educationally related occupational therapy services*. Des Moines, IA: Author.
- Karnes, H. L. (Coord.). (1992). *Federal laws and the provision of therapy services in the special education environment*. Healthcare Teleconference Resources.
- King, G. A., McDougal, J., Tucker, M. A., Gritzan, J., Malloy-Miller, T., Alambets, P. et al. (1999). An evaluation of functional, school-based therapy services for children with special needs. *Physical and Occupational Therapy Pediatric Journal*, 19.
- Langdon, H. J. & Langdon, L. L. (1993). *Initiating Occupational Therapy Programs within the Public School System: A Guide for Occupational Therapists and Public School Administrators*. Thorofare, NJ: Slack, Inc.
- McEwen, I. (Ed.). (2000). *Individual Education Program. Providing Physical Therapy Services under Parts B & C of the Individuals with Disabilities Education Act*. Alexandria, VA: American Physical Therapy Association.
- McEwen, I. & Shelden, M. L. (1995). Pediatric therapy in the 1990's: The demise of the educational vs. medical dichotomy. *Physical and Occupational Therapy Pediatric Journal*, 15.
- National Association of State Directors of Special Education. (1991). Section 504 of the rehabilitation act of 1973: Old problems and emerging issues for public schools. *Liaison Bulletin*, 17(8). National Association of State Directors of Special Education.
- National Mental Health Association. (1990). *A.D.A.: Americans with disabilities act of 1990 – public law 101-336*. Alexandria, VA: Author.
- New \$ for special education: medicaid and third party reimbursements*. (1989). Alexandria, VA: CPR Publishing Co.
- Northwestern Illinois Association. (1993). *NIA therapy division guidelines*. Geneva, IL: Author.
- Office of Special Education Programs. (2000). *Questions and answers on obligations of public agencies in serving children with disabilities placed by their parents at private schools*. (Memo). Office of Special Education Programs. Washington, D. C.: U. S. Government Printing Office.

Royeen, C. B. (1992). *Educationally related assessment and evaluation*. AOTA Self-Study Series: Classroom Applications for School Based Practice. Rockville, MD: American Occupational Therapy Association.

Silvergleit, I. T. (1992). The three r's of staffing: Recruitment, retention, and reactivation. *Administration and Management Special Interest Section Newsletter*, 8(3). American Occupational Therapy Association.

Tanta, K. C., Heistand, C., Adams, L., & Sparks, S. (2000). Transitioning young children to school-based services: perspectives from an early intervention program. *School System Special Interest Section Quarterly*, 7(1-4).

The new individuals with disabilities education act. (1991). Education of the Handicapped. Alexandria, VA: Capitol Publications Inc.

APPENDIX

Professional Publication Sources

Advance for Occupational Therapists
650 Park Avenue West
King of Prussia, PA 10406
(800)346-2889

Advance for Physical Therapists
650 Park Avenue West
King of Prussia, PA 10406
(800) 346-2889

American Physical Therapy Association
(APTA)
11 N. Fairfax Street
Alexandria, VA 22314-1488
(800)999-2782
website: www.apta.org

Illinois Occupational Therapy Association
(IOTA)
715 Lake Street
Oak Park, IL 60301
(708)386-9393

Illinois Department of Professional
Regulation
320 West Washington 3rd Floor
Springfield, IL 62786
(217)782-0458
website: www.dpr.state.il.us

OT Practice
4720 Montgomery Lane
Bethesda, MD 20814-3425
(301)652-2682

American Occupational Therapy
Association, Inc. (AOTA)
P.O. Box 31220
Bethesda, MD 20824-1220
(301)652-2682
website: www.aota.org

Illinois Physical Therapy Assoc.
(IPTA)
1010 Jorie Boulevard, Suite 134
Oak Brook, IL 60521
(630)571-1400
website: www.ipta.org

National Board for Certification in
Occupational Therapy, Inc.
(NBCOT)
800 S. Frederick Ave., Suite 200
Gaithersburg, MD 20877-4150
(301)990-7979
website: www.NBCOT.org

Original Draft Authors

Name

Mary Kolinsky, MS, OTR
Lynn Marshall, MS, Ed., OTR
Karen Nelson, M. Ed., PT
Phyllis Rowland, PT, PCS

District/Co-op

Northwestern Illinois Association
Northwestern Illinois Association
Northwestern Illinois Association
Northwestern Illinois Association

Revised Authors

Lisa Whiting, PT
Karla Brockman, PT
Bill Brown, OT
Tina Courtin, PT
Debbie Craig, PT
Robin Hentis, PT

Judy Katz, OT
Susan Kupczyk, OT
Cheryl Huber Lee, OT

Bessie Lewis, OT

Phyllis Rowland, PT, PCS
Molly Walters, OT

Southeastern Special Education Program
Kaskaskia Special Education District
Southeastern Special Education Program
Elgin School District #46
Indian Prairie School District #204
Belleville Area Special Services
Cooperative
Special Education District of Lake County
East DuPage Special Education District
School Association for Special Education
in DuPage
Belleville Area Special Services
Cooperative
Northern Illinois Association
Southeastern Special Education Program

SE\Guidelines-Occup & Phy Therapy bac