GUIDELINES FOR PROVIDING

Occupational Therapy

in

NORTH CAROLINA PUBLIC SCHOOLS

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DEPARTMENT OF PUBLIC INSTRUCTION June St. Clair Atkinson, Ed.D., *State Superintendent*
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EXCEPTIONAL CHILDREN DIVISION
Mary N. Watson, *Director* | mwatson@dpi.state.nc.us
6356 Mail Service Center, Raleigh, North Carolina 27699-6356 | (919) 807-3969 | Fax (919) 807-3243

INTRODUCTION

North Carolina has a strong tradition of providing guidance, consultation, and technical assistance to school-based occupational therapy practitioners and administrators as Local Education Agencies (LEA) have sought to implement best practice in occupational therapy services to students with disabilities. With the enactment of Public Law (PL) 94-142, which provided the foundation for the education of children with disabilities, North Carolina legislators and North Carolina Department of Public (NCDPI) leaders recognized the need for specific expertise in the provision of related services, like occupational therapy. As such, Jane Davis Rourk began serving the state as the Occupational Therapy Consultant to NCDPI in 1978. Ms. Rourk provided expert guidance until 2007 and was the only state-level occupational therapy specialist in American public education for many years. She was a national leader in school-based practice and led the development of both the American Occupational Therapy Association (1989) and NCDPI guidelines (1992) for occupational therapy services in public schools. This manual and NCDPI's ongoing provision of related services consultation build on that tradition.

The value of occupational therapy in public education continues to grow. Increasingly, interventions and strategies occupational therapy practitioners use with students with disabilities are being found effective with all children. Occupational therapy practitioners are informing an emerging understanding of the dynamic relationship between learner, educational content, instruction, activity demands, and environment. As public education shifts from a focus on "fixing" the student to the quality of research-based instruction, occupational therapy practitioners are solicited for their strengths in problem-solving, activity analysis, and critical and flexible thinking. This manual seeks to clarify roles and scope of practice for occupational therapy practitioners in light of these advances in education and the profession.

The 2011 edition of the *Guidelines for Occupational Therapy in North Carolina Public Schools* is intended to be, a working, growing, largely web-based document. The Guidelines will be routinely updated to keep practitioners and Individualized Education Program (IEP) teams current with federal and state policies changes and emerging research which inform school-based practice. The content is not state policy, but a guide for planning, implementing, and evaluating the quality of occupational therapy services, programs, and personnel. Questions or comments about the guidelines can be directed to Guidelines editor, Lauren Holahan, Occupational Therapy and Medicaid Consultant to NCDPI, at lauren_holahan@med.unc.edu or (919)843-4466.

Blue underlined text throughout the document are hyperlinks you can access by clicking Ctrl and clicking on the hyperlink. Many of these documents are also retrievable at the *Occupational Therapy in North Carolina Schools* website: http://www.med.unc.edu/ahs/ocsci/nc-school-based-ot-site

Appreciation is expressed for the leadership of:
Mary Watson, Director, NCDPI Exceptional Children Division
Laura Snyder, Assistant Director, NCDPI Exceptional Children Division
Virginia Dickie, Director, University of North Carolina-Chapel Hill Division of Occupational Science

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Lenore Champion, M.S., OTR/L
Lead Occupational Therapist, Durham Public Schools

Denise Donica, DHS, OTR/L
Assistant Professor, East Carolina University Occupational Therapy Department

Cindy Hancock, M.S., OTR/L
Lead Occupational Therapist, New Hanover County Schools

Ruth Humphry, Ph.D. OTR/L, FAOTA
Professor, Coordinator of Ph.D. curriculum in Occupational Science, UNC-CH Division of Occupational Science

Sue Porr, M.S., M.Ed., OTR/L
Lead Occupational Therapist, Lee County Schools

Sandra Schefkind, M.S., OTR/L
AOTA Pediatric Coordinator

Laura Snyder
Assistant Director, Exceptional Children Division, NC Department of Public Instruction

William Trant
Executive Director, Special Education and Related Services, New Hanover County Schools

Linn Wakeford, M.S., OTR/L
Assistant Professor, UNC-CH Division of Occupational Science

Tom Winton
Section Chief, Exceptional Children Division, NC Department of Public Instruction

TABLE OF CONTENTS

Chapter 1

TERMS OF ENGAGEMENT

Laws and Regulations

School-based occupational therapy practitioners must understand the legal and legislative foundations for therapeutic services in preschool, elementary, and secondary school. The following information provides a general overview of federal laws and regulations that govern related services.

Individuals with Disabilities Education Improvement Act (IDEA 2004)

IDEA is the primary federal law mandating and governing special education and early intervention for children with disabilities. The correlating federal regulations are entitled '*Assistance to States for the Education of Children with Disabilities and Preschool Grants for Children with Disabilities.'* The Education for All Handicapped Children Act (Public Law 94-142) was signed into law in 1975. In 1990, this law was revised and renamed as the Individuals with Disabilities Education Act (Public Law 101-476). IDEA was reauthorized in 1997 and 2004, with the most updated regulations published on August 14, 2006. Though IDEA's purpose has always been to ensure access to education for students with disabilities, the most recent reauthorization of the law, IDEA 2004, has an increased emphasis on outcomes and educational achievement (Jackson, 2007).

IDEA is an education law ensuring that students with disabilities receive a free appropriate public education (FAPE) in the least restrictive environment (LRE). IDEA defines FAPE as special education and related services provided at public expense to meet the standards of the state education agency (SEA), and are in compliance with the student's Individualized Education Program (IEP). Thus, FAPE is child-specific and varies based on the child's needs (IDEA, Sec. 300.101-3).

Part B of IDEA provides for special education services for students with disabilities ages 3 through 21. Occupational therapy is mandated by Part B as one of many related services to special education for eligible students "as may be required to assist a child with a disability to benefit from special education, and includes the early identification and assessment of disabling conditions in children" (IDEA, Sec. 602.26).

Part C of IDEA outlines The Program for Infants and Toddlers with Disabilities. Under Part C, early intervention services children with disabilities ages birth through age 2 years, who may later receive services under Part B.

Additionally, under IDEA, educational and related services must be provided in an appropriate and least restrictive environment. IDEA defines LRE as an environment in which students with disabilities are educated with their typically developing peers to the maximum extent appropriate. IDEA requires that students only be placed outside of the regular educational environment if, given modifications and supplementary aides, the child would be unable to achieve satisfactorily in the regular education setting (IDEA, Sec. 300.114).

North Carolina Laws and Regulations

North Carolina General Statute Chapter 115C: Elementary and Secondary Education, Article 9 –Education of Children with Disabilities: This is North Carolina's state law which implements IDEA 2004.

Policies Governing Services for Children with Disabilities: This is North Carolina's state regulation implementing the federal regulations.

Section 504 of the Rehabilitation Act of 1973

Most children with disabilities served in the school setting are served under IDEA, with a smaller percentage served under Section 504 of the Rehabilitation Act of 1973 (often referred to as Section 504)(Jackson, 2007). Section 504 is a civil rights law which prohibits government and private organizations receiving federal funds from discriminating against the participation of individuals with disabilities. Related to the school-aged population, this legislation covers facilities and organizations such as child care centers, schools, recreation programs, libraries, and clinics. Similar to IDEA, Section 504 requires that schools provide students with disabilities with a free appropriate education.

Unlike IDEA, Section 504 does not include strict eligibility requirements, rather it defines eligibility under the categories of short- and long-term disabilities. Thus, a student may not be eligible for services under IDEA but still qualify for the nondiscrimination provisions under Section 504. For example, a student with diabetes might have a 504 Plan outlining access to appropriately trained staff, medical supplies, and modified meal/snack schedule, but would not need special education services. Students eligible for services under Section 504 have a 504 Plan, which determines the services needed to meet the student's needs.

Though occupational therapy is not specifically mentioned in the act, in rare cases, OT services may be needed to ensure a student with a disability is not excluded from participation in regular education activities. Like IDEA, Section 504 emphasizes maximizing the time students with disabilities spend being educated in classrooms with their typically developing peers (Virginia Department of Education, 2004).

Further discussion of occupational therapy's contribution to 504 plans can be found in Chapter 3.

Americans with Disabilities Act of 1990

The Americans with Disabilities Act of 1990 (ADA) mandated the elimination of discrimination against individuals with disabilities in school, employment, public services, public accommodations, and transportation and applies equally to individuals of all ages (ADA, Sec. 12101). Under ADA, students with disabilities might be eligible for occupational and/or physical therapy services as a reasonable accommodation to assist them in participating and learning in school.

Family Educational Rights and Privacy Act

The Family Educational Rights and Privacy Act (FERPA, 34 *CFR* Part 99) protects the privacy of student education records and applies to all schools receiving funds from the U.S. Department of Education. A student's educational record, health record, including immunization records, school nurse records, and special education records, are "education records" subject to FERPA. Under FERPA, intervention records, by definition, are not available to anyone other than professionals providing intervention to the student, or to physicians or other appropriate professionals identified by parents and eligible students (students over the age of 18 or having attended school beyond the high school level). However, this does not prevent a school or LEA from

allowing a parent to inspect and review intervention notes. If the LEA chooses to allow parent review of intervention notes, though, such records are no longer excluded from the definition of "education records" and are subject to all other FERPA requirements. Also under FERPA, parents and eligible students have the right to review the student's educational record and request revision of incorrect information. Furthermore, FERPA requires written permission from a parent or eligible student to share personally identifiable student information to parties other than:

- School officials with legitimate educational interest;
- Schools to which a student is transferring;
- Specified officials for audit or evaluation purposes;
- Appropriate parties in connection with financial aid to a student;
- Organizations conducting certain studies for or on behalf of the school;
- Accrediting organizations;
- To comply with a judicial order or lawfully issued subpoena;
- Appropriate officials in cases of health and safety emergencies; and
- State and local authorities, within a juvenile justice system, pursuant to specific State law

Each year, schools must inform parents and eligible students of their rights under FERPA (U.S. Department of Education, 2008a).

FERPA intersects with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in that HIPAA generally does not apply to schools, because the school either:

(1) is not a HIPAA covered entity, or

(2) is a HIPAA covered entity but maintains health information only on students in records that are by definition "education records" under FERPA and, therefore, is not subject to the HIPAA Privacy Rule.

Medicaid

Medicaid began in 1965 as a component of Title XIX of the Social Security Act to ensure medical services to United States citizens living in poverty. In 1982, the Department of Health and Human Services Health Care Finance Administration (HCFA) determined any service included in an IEP was the financial responsibility of that school district. In 1986, the General Accounting Office made recommendations to changing the law to allow Medicaid to pay for medical services that are provided by public schools. To address issues of funding services mandated under IDEA, Congress enacted the Medicare Catastrophic Coverage Act of 1988, P.L. 100-360. This legislation changed the financial relationship between IDEA and Medicaid. Whereas generally Medicaid is the payor of last resort, this legislation reversed this and made Medicaid the payor of first resort in those states that have school services included in their state Medicaid plan.

Under this legislation, federal Medicaid funds are available to pay for health services that are provided to students (from 3-21 years old) as a component of their FAPE under IDEA, Part B. There are four limits to schools accessing these funds:

- Individual state Medicaid plans must cover the services
- Services must be included in the student's IEP
- The student must be eligible for Medicaid
- Services rendered must be medically necessary

If these conditions are met, schools can recover costs from Medicaid for speech pathology and audiology, psychological services, physical and occupational therapy, nursing, and medical counseling and services (Medicaid Catastrophic Coverage Act, P.L. 100-360). For specific North Carolina LEA Medicaid Policy see: http://www.ncdhhs.gov/dma/mp/8h.pdf

Definitions

Individualized Education Program (IEP)

The term individualized education program or IEP means a written statement for each child with a disability that is developed, reviewed, and revised in a meeting in accordance with NC 1503-4.1 through NC 1503-5.1, and that must include:

- *A statement of the child's present levels of academic achievement and functional performance, including:*
  - *How the child's disability affects the child's involvement and progress in the general education curriculum (i.e., the same curriculum as for nondisabled children); or*
  - *For preschool children, as appropriate, how the disability affects the child's participation in appropriate activities;*
- *A statement of measurable annual goals, including academic and functional goals designed to meet the child's needs that result from the child's disability to enable the child to be involved in and make progress in the general education curriculum*
- *For children with disabilities who take alternate assessments aligned to alternate achievement standards, a description of benchmarks or short-term objectives*
- *A description of how the child's progress toward meeting the annual goals will be measured; and, that periodic reports on the progress the child is making toward meeting the annual goals will be provided concurrent with the issuance of report cards*
- *A statement of the special education and related services and supplementary aids and services, based on peer-reviewed research to the extent practicable, to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided to enable the child to:*
  - *advance appropriately toward attaining the annual goals;*
  - *be involved in and make progress in the general education curriculum*
  - *participate in extracurricular and other nonacademic activities*
  - *be educated and participate with other children with disabilities and nondisabled children*
- *An explanation of the extent, if any, to which the child will not participate with nondisabled children in the regular class and extracurricular activities*
- *A statement of any individual appropriate accommodations that are necessary to measure the academic achievement and functional performance of the child on State and district-wide assessments*
- *If the IEP Team determines that the child must take an alternate assessment instead of a particular regular State or district-wide assessment of student achievement, a statement of why*
  - *The child cannot participate in the regular assessment*
  - *The particular alternate assessment selected is appropriate for the child*
- *The projected date for the beginning of the services and modifications described in this section, and the anticipated frequency, location, and duration of those services and modifications*

- *Transition services*
    - *Beginning not later than the first IEP to be in effect when the child turns 14, or younger if determined appropriate by the IEP Team, and updated annually thereafter, the IEP must include a statement of initial transition components including the child's needs, preferences and interests, and course(s) of study (such as advanced placement classes or a vocational education program.*
    - *Beginning not later than the first IEP to be in effect when the child turns 16, or younger if determined appropriate by the IEP Team, and updated annually, thereafter, the IEP must include:*
        - *Appropriate measurable postsecondary goals based upon age-appropriate transition assessments related to training, education, employment, and, where appropriate, independent living skills; and*
        - *The transition services needed to assist the child in reaching those goals, including if appropriate, a statement of interagency responsibilities or any needed linkages.*

Policies Governing Services for Children with Disabilities, NCDPI, 2008, **NC 1503-4.1**

Related Service

Related services means transportation and such developmental, corrective, and other supportive services that are required to assist a child with a disability to benefit from special education. Related services include, but are not limited to, speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. Related services also include school health services and school nurse services, social work services in schools and parent counseling and training.

Policies Governing Services for Children with Disabilities, NCDPI, 2008, **NC 1500-2.28(a)**

The term related service is also used in IDEA 2004. Under No Child Left Behind (NCLB, 2001) these same personnel are referred to as Pupil Service Personnel.

Supplementary Aids and Services

Supplementary aids and services means aids, services, and other supports that are provided in regular education classes, other education-related settings, and in extra-curricular and non-academic settings, to enable children with disabilities to be educated with nondisabled children to the maximum extent appropriate in accordance with the least restrictive environment requirements. Occupational therapy practitioners may provide supplementary aids and services.

Policies Governing Services for Children with Disabilities, NCDPI, 2008, **NC 1500-2.36**

Occupational Therapy

Occupational therapy is a student-centered continuum of services provided by a licensed occupational therapist or a licensed and supervised occupational therapy assistant. Occupational therapy services assist a student to engage in meaningful and/or necessary occupations that allow that student to participate in and benefit from his or her educational program. These occupations may include student role/interaction skills, learning academics and process skills, personal care, play and recreation, written communication, and community integration and work. Occupational therapy services may include:

(i) Screening, evaluation, intervention, and documentation;

(ii) Assistance with occupational performance when participation is impaired;

(iii) Modification of environments (both human and physical) and tasks, and selection, design, and fabrication of assistive devices and other assistive technology to facilitate development, promote the acquisition of functional skills and engagement in meaningful occupations;
(iv) Integration of occupational therapy interventions into a student's educational program to assist the student in participation and acquisition of goals;
(v) Collaboration with appropriate individuals to meet student's needs including transition planning; and
(vi) Provision of education and information to families and school personnel to assist with planning and problem solving.

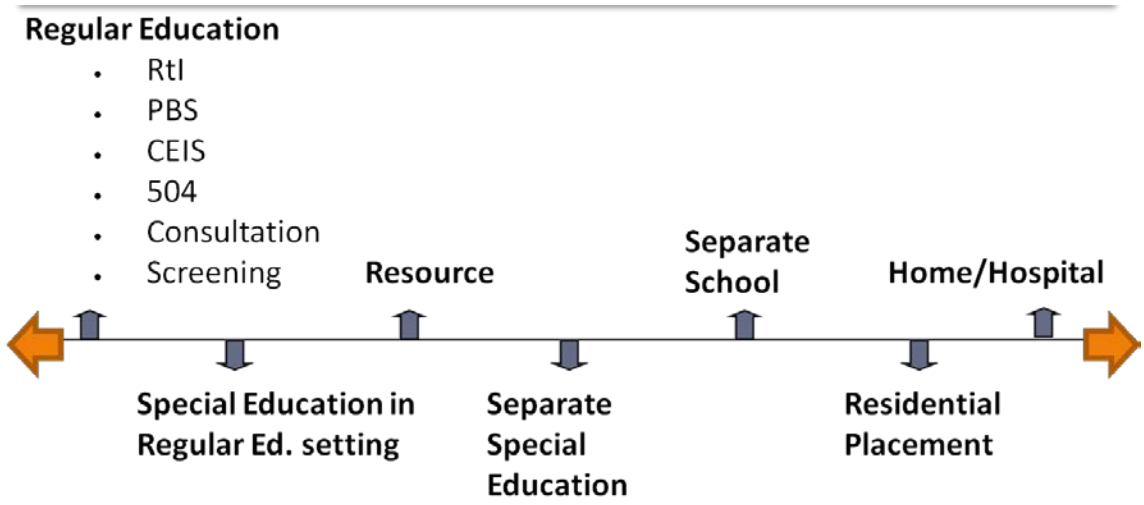
Policies Governing Services for Children with Disabilities, NCDPI, 2008, **NC 1500-2.28 (c)(6)f**

Least restrictive environment (LRE)

Least restrictive environment means that, to the maximum extent appropriate, children with disabilities shall be educated with children who are not disabled, and special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only when the nature of the disability is such that education in regular classes, even with the use of supplementary aids and services, cannot be achieved satisfactorily.

Policies Governing Services for Children with Disabilities, NCDPI, 2008, **NC 1500-2.21**

The diagram below illustrates the continuum of least restrictive environment options available for provision of occupational therapy services.



Medically Necessary

While the primary requisition for occupational therapy in schools is educational relevance, some educationally relevant services may also be medically necessary, and, as such, reimbursable according to North Carolina Division of Medical Assistance LEA Medicaid Policy. Medically necessary services under LEA Medicaid Policy are those clinical and rehabilitative health services (physical, mental and emotional) that:

- Are essential to prevent, diagnose or treat medical conditions OR
- Are essential to enable the individual to attain, maintain or regain functional capacity
- Are provided within professionally accepted standards of practice and national guidelines
- Are required to meet the physical and behavioral health needs of the individual
- Are not provided at the convenience of the individual, the provider or the payor
- Are reviewed by a physician who then provides orders for services outlined in the IEP

Questions to ask in determining medical necessity:

- Does this require the practitioner's licensed skills and knowledge?
- Would the student be able to participate and become educated without the licensed practitioner's skills and knowledge services?
- Would the student participate as do his/her peers without the practitioner's services?
- Would the practitioner provide the same service at a clinic or hospital?
- Did the practitioner's involvement improve or deepen another team members' understanding of the student?

AOTA Medically Necessary Statement:
"While there is no federal definition of medical necessity for Medicaid services in general, services required under EPSDT are subject to a federal provision that speaks to medical necessity." According to 42 USC S.1396d(a)(4)(B), Medicaid will pay for EPSDT services that are, "necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services, whether or not such services are covered under the state plan." This provision provides a basic definition of medical necessity for services provided under federal EPSDT requirements.

Here are a couple of examples from other states' school service handbooks:

Wisconsin: School based service is considered medically necessary and covered by Medicaid when the service:

- Identifies, treats, manages, or addresses a medical problem, or mental, emotional, physical disability.
- Is identified in the child's IEP
- Is necessary for a child to benefit from special education
- Is prescribed by a physician, when required. Refer to the service specific information in the handbook for prescription requirements.

School-Based Services Handbook PHC 1423, April 2005

Oklahoma: School based services are considered medically necessary when they meet the following standards:

- Services must be consistent with accepted health care practice standards and guidelines for the prevention, diagnosis, or treatment of symptoms of illness, disease or disability.
- Documentation submitted in order to request services or substantiate previously provided services must demonstrate, through adequate objective medical records, evidence sufficient to justify the client's need for service.
- Treatment of a client's condition, disease, or injury must be based on reasonable and predictable health outcomes.
- Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience of the client, family or medical provider.
- Services must be delivered in the most cost effective manner and most appropriate setting.
- Services must be appropriate for the client's age and health status and developed for the client to achieve, maintain or promote functional capacity.

Oklahoma Health Care Authority OAC 317:30-3-1(f)

Educationally Relevant

In the public school setting, the IEP Team determines the need for occupational therapy based on the student's goals and objectives, the skills of the team members, desired student outcomes, and

recommendations by the occupational therapy provider. To be included on a student's IEP, occupational therapy must be required to assist the student to benefit from special education. This implies:

- The student has a disability
- Therapy is educationally relevant and clear in purpose
- Therapy is necessary in order for the student to benefit from the IEP

If the team answers, "Yes" to the following questions, occupational therapy is probably educationally relevant:

- If the student does not receive occupational therapy, is there reason to believe that he or she will not have access to an appropriate education?
- If the student does not receive occupational therapy, is there reason to believe that he or she will not experience educational benefit?

Students can clearly benefit from some services that are not educationally necessary, but may be considered necessary or desirable by parents, other team members, or non-educational service providers. Because occupational therapy may not, in some cases, meet the educational relevance and necessity-to-benefit criteria (as required of related services under the IDEA) it does not mean the service is unimportant. Rather, it could mean the service is not the responsibility of the public school.

Very often, students with disabilities, as defined by IDEA and North Carolina policies, have medical, developmental, social, and/or functional limitations which affect participation at school *and* in settings outside of school. School occupational therapy practitioners may want to consider the following as they determine their role in addressing conditions that affect the child in all life settings:

- Identify which aspects of participation or performance are unique to school functioning
- Seek guidance from trained personnel (e.g., the child's pediatrician, social worker, community therapy providers) who have evaluated the child and designed the family/child's home or community intervention plan; school staff are generally not primarily responsible for evaluation, planning, and intervention of medical, developmental, social, and/or functional limitations which affect the child in all life settings
- Select those aspects of the pre-existing intervention plan that can be supported while the child is at school; if the school does support a community-initiated plan, all school staff must be trained and demonstrate competence in relevant aspects of intervention
- Help the school/IEP Team design reasonable accommodations to ensure student safety and health at school
- Help the school/IEP Team determine the educationally relevant aspects of intervention on a individualized basis, considering the skills and training of each team member when determining how intervention at school will occur

An example of a performance area that affects children in all life settings is eating. In a school cafeteria, the activity students find meaningful (occupational therapy's specialty) is often not about eating; meal time for typical students is often about:

- making choices in the lunch line
- talking and laughing with friends
- managing food containers and packages, lunch box, and/or tray
- using food as props for humor
- knowing you are not allowed to talk when the red cup is showing (or the lights are off, or...)

- sitting next to your (current) best friend
- being the table wiper/sweeper/trash collector during clean-up
- being line leader upon entry/exit from cafeteria

These are just a few of the aspects of eating unique to the school setting; more could be added. The point is, at school, mealtime is about socialization and celebrating being a child or adolescent. Occupational therapy practitioners are uniquely trained and can be leaders in designing and promoting opportunities for students with disabilities to enjoy mealtime and engage with all peers at school, rather than focusing only or primarily on discrete feeding skills.

While occupational therapy practitioners working in educational environments understand underlying components of function, the focus of evaluation and intervention is on the student's achievement of educational (**functional** and/or **academic**) tasks required to:

- attain his/her annual Individualized Education Program (IEP) goals
- be involved and progress in the general curriculum
- be educated and participate with other children, both disabled and nondisabled, in educational and extracurricular activities

Occupational therapy under IDEA does not focus on achieving decontextualized or isolated skills, such as one might see on a developmental milestone chart. Occupational therapy under IDEA does focus on engagement in activities necessary for participation in educational settings.

Occupational therapy practitioners must be able to articulate how the student's performance deficits inhibit benefit from the educational program; this is the principle of determining educational relevance. The appropriateness and extent of occupational therapy at school must be related to the academic and functional needs. If a student has an identifiable issue that does not affect the student's ability to learn, function, and profit from the educational experience, intervention is likely not the responsibility of the school system (Kentucky, 2006). The quality of a student's performance alone is not the focus of intervention unless it interferes with the student's ability to participate in school-related activities.

Distinctions

Required and Beneficial

According to North Carolina policy, occupational therapy as a related service must be "required to assist a child with a disability to benefit from special education." The question the IEP Team must answer is: does the child require the specific knowledge and expertise of an occupational therapy practitioner at school in order to make progress on and benefit from his/her educational program?" Often, the question is misconstrued as: will occupational therapy benefit this student? Theoretically, all students could *benefit* from occupational therapy; IEP teams are held to the strict standard of *requirement* when determining the need for related services.

If the team answers, "Yes" to any the following questions, occupational therapy is probably **not required**:

- Could the need be addressed appropriately by the special educator or classroom teacher?

- Could the need be addressed appropriately through core school faculty or staff (e.g., school nurse, guidance counselor, librarian, teachers, administrator, bus drivers, cafeteria staff, or custodians)?
- Could the student continue to benefit from his or her educational program without occupational therapy?
- Could the need be appropriately addressed during non-school hours?
- Does including occupational therapy in the student's program present any undesirable or unnecessary gaps, overlaps, or contradictions with other proposed services?
  (Giangreco, 2001a)

Educational and Clinical Services

Occupational therapy services are delivered in a variety of settings—hospital, clinic, home and school—each with its own set of standards and practices. Regardless of setting, therapy is therapy, right?

Actually, **no**. Occupational therapy practitioners are licensed no matter where they work in North Carolina, but the missions of the agency, school, or clinic where practitioners work are often very different. Therefore, the type and goals of intervention may be very different from one setting to another. It's important to understand the different delivery and outcomes of different models of therapy.

There are two primary models of occupational therapy for children: clinical and educational. The basic purpose behind each of these models is different, although they can overlap.

Fundamental similarities exist between the clinical and educational models. The student must have a recognized disability or disorder which adversely affects performance. The therapy must address a condition/situation for which it is an accepted, essential, evidence-based method of intervention. Evaluation data is collected and interpreted to determine need for service and develop an intervention plan. An objective and measurable intervention plan must document the student's functional strengths and limitations and address a condition/situation(s) that is expected to improve with a reasonable and generally predictable period of time, or establishes a safe and effective maintenance program. In the school setting, when activities are considered a standard part of another discipline's intervention/care, these activities are not routinely provided by therapy staff (e.g., handwriting instruction for kindergarteners; transfers for severely disabled high school students.)

Children and youth can receive services through one or both models. An IEP is a fluid document which can and should change to respond to student's needs and ensure the least restrictive environment for the student. For some children the frequency or intensity of therapy they receive at school through the educational model will not meet all therapy needs. A child may have therapy needs outside the school setting that would require home- or community-based services from the clinical model. The table below (Table 1) highlights the key differences between the educational and clinical models of occupational therapy.

TABLE 1

	EDUCATIONAL MODEL	CLINICAL MODEL
HOW DOES THE PROCESS START?	Teacher, parent or other involved person can ask the IEP Team to consider the need for evaluation	Referral generally initiated by physician based on observed delay or diagnosis

	EDUCATIONAL MODEL	CLINICAL MODEL
WHO DECIDES NEED FOR SERVICE?	• IEP Team consensus with recommendation from licensed OT/PT based on testing and classroom/campus observation •Assessment takes into consideration only needs associated with educational setting	• Testing and clinical observation by licensed OT • Assessment takes all settings into consideration • Frequently driven by physician's orders
HOW ARE GOALS AND THE INTENSITY OF SERVICES DETERMINED?	• IEP Team—including parents, student (if appropriate), educators, administrators and school based therapists—determine the focus, frequency and duration of therapy • A physician's order <u>does not</u> drive decisions about school therapy services	• In most cases, the OT determines location, focus, frequency and duration of therapy, in collaboration with family • Insurance coverage, physician's orders and transportation may be influencing factors
HOW CAN SERVICES BE CHANGED?	Changes to related services require an IEP meeting with parents, educators, administrators and the school based therapist present to discuss data and come to consensus	Physicians can alter orders or therapist can change therapy plan based on data; these changes are generally discussed with physician and parents
WHAT IS THE FOCUS OF THERAPY?	• Pre-referral consultation for classroom interventions • Access to education and school environment • Independence and participation • Intervention generally focused more on chronic problems that interfere with educational process	Works to get full potential realized
WHERE DOES THERAPY OCCUR?	• On school grounds, bus, halls, playground, classroom, lunchroom; total school environment • Work sites • Some daycare settings	In the clinic, hospital, childcare setting, home, or other community setting
HOW IS THERAPY DELIVERED?	Integrated/inclusive therapy, staff training, program development, collaboration with staff, group intervention, direct one-on-one treatments, consultation	Typically, direct one-on-one treatment; may use groups, and/or consultation to accomplish set goals
WHO PAYS?	No cost to student or family = free appropriate public education (FAPE); LEAs may recover cost for some therapy services under Medicaid	Fee-for-service payment by family, insurance, or governmental assistance
HOW ARE SERVICES DOCUMENTED?	Related to IEP with accessible, readable language guided by state and local policies reflecting best practice	Dictated by insurance requirements and guidelines of the setting; emphasis on medical terminology and billing codes

Roles

Evaluator

Occupational therapists participate in individual student assessment in both regular and special education, always with informed parental consent. Prior to referral for a special education evaluation, occupational therapists may conduct observations, review work samples, and listen to team members, including teachers, parent, and student, in order to suggest strategies for regular education implementation.

Occupational therapists may participate in the initial comprehensive evaluation of the student after the initial referral for a special education evaluation or after the student has been identified as a student with a disability that adversely impacts educational performance. The therapist collaborates with IEP Team members to determine what school-related activities challenge the student's participation in the educational setting, based on specific referral concerns. Data for an evaluation may be collected through:

- File review
- Skilled observations within the student's engagement in typical school environments and activities
- Review of student work samples
- Interviews with the student, teacher(s), parent(s), community providers
- Completion of standardized assessments of relevant skills or non-standardized functional performance assessments

The data provided and interpreted by an occupational therapist helps the IEP Team better understand:

- Whether or not the student has a disability
- Whether or not the disability adversely impacts the student's education
- Whether or not the student requires specially designed instruction
- What the student needs to access, participate, and make progress in the general education curriculum
- What supports the student's performance
- What limits the student's performance
- What the child needs to access the classroom and campus
- How to prioritize the student's strengths and needs
- What goals may be appropriate in the year ahead

The data provided and interpreted by an occupational therapist is *NOT* intended primarily to answer the question, "Does the student need OT?" Instead, the data is used, along with the information gathered by other IEP Team members, to identify the student's educational strengths and needs and to determine whether or not a student has a disability that adversely impacts educational performance and requires special education. **Only after IEP goals are developed, based on information gathered in the evaluation, is it decided which, if any, related services will support those goals.** The occupational therapy evaluation may also be considered one source of information for the adaptive behavior evaluation or the motor evaluation.

Interventionist

As in the role of evaluator, occupational therapy practitioners act as interventionists throughout the educational process—and at a variety of levels. Therapy staff may provide specialized interventionists, adapt materials or environmental, offer instruction, support and educate parent/school staff, train paraprofessionals, and assist in district planning.

At the system/LEA level, occupational therapy practitioners may consult with central office teams on equipment acquisition (e.g., for elementary school playgrounds or all self-contained classrooms for children with autism), protocol development (e.g., management of students with sensory differences during fire drills),

curriculum design and selection (e.g., analyzing developmental appropriateness of handwriting or driver education curricula), parenting issues (e.g., how to support students using organizational strategies for homework), and instructional methods (e.g., providing training on how to engage students in the work of the classroom).

At the school level, occupational therapy practitioners may provide student and staff training (e.g., organize an assembly on disability awareness or offering school-wide ergonomics checks), contribute to school-wide tiered processes (like Responsiveness to Instruction or Positive Behavioral Support), consult during building construction and renovation, or participate in school health and safety committees. At the grade level, occupational therapy staff may offer in-services at grade-level meetings (e.g., on how to use physical activity to teach and reinforce grade-level math concepts). At the classroom level, occupational therapy personnel may intervene as co-teachers or collaborators in the design of classroom environments, schedules, and routines. At the group level, occupational therapy practitioners may act as center in center- or station-based learning in a classroom. They may organize before or after school groups to address social skills, study skills, or fitness and personal care habits.

At the individual student level, OT practitioners develop, implement, and evaluate intervention services outlined in the IEP or, in rare cases, the 504 Plan. Based on the child's strengths, needs, interests, goals, and provisions, the occupational therapist develops an intervention plan which includes:

- Duration of plan
- Student goals for engagement for activities in the educational setting
- Frequency, duration, and location of service
- Intervention approaches:
    - Create/promote (e.g., performance enhancement/ health promotion)
    - Establish/restore (e.g., skill acquisition or remediation)
    - Modify/adapt (e.g., environmental modification)
    - Prevent (e.g., early intervening support; avoid secondary complications)
- Intervention Types:
    - One-on-One Interaction
    - Group
    - Whole class
    - Consultation with team members (e.g., problem solving)
    - Education of team members (e.g., training)
    - Environmental adaptation (e.g., assistive technology)
    - Program/routine development
- Outcome Measures:
    - Child meeting IEP goals
    - Increased team satisfaction with student performance
    - Increased competence or autonomy in student role
    - Prevention of further difficulties
    - Improved quality of life at school
    - Increased team/team member competence
- Suggestions for parents and teachers
- Team discussion about when the student will no longer require OT to benefit from the IEP
- Referral (e.g. community programs/resources, other disciplines)

OT practitioners intervene with students in the least restrictive environment, which usually means embedding therapy in the student's classroom schedule or daily routine. OT practitioners may help make modifications to a student's environment, activities, or assignments in order to increase participation. At any level of intervention, an OT practitioner collects data with which to evaluate the efficacy of the intervention and to modify strategies as needed.

Collaborative Consultant

OT practitioners often consult with teachers or other relevant school staff to make recommendations that may facilitate student performance at school. Through identification of mutual interests, cooperation, communication, timely sharing of perspectives and expertise, service coordination, interagency coordination, and service integration (Jackson, 2007), occupational therapy personnel can maximize contribution to student outcomes. Case consultation focuses on a specific student's needs and is intended to support the child in achieving identified goals. Consultation may occur with teachers on ways to incorporate pre-referral classroom interventions in their classroom. Building capacity with teachers in how to integrate functional skills—like classroom tool use, time management, or personal care—into their daily routines and instructional approach may decrease the need for direct services from specialists, like occupational therapy practitioners, for many children.

All team members are considered equal contributors in collaborating to determine how to best to support students. OT practitioners work collaboratively with other staff members to plan and implement intervention strategies within the context of the students' typical school routines. By collaborating with teachers and other school staff, OT practitioners can help tailor instruction and school environments to fit all students well.

Supervisor

Occupational therapists may take on the role of supervisor to occupational therapy assistants (OTAs). The supervising occupational therapist is legally responsible for the services an OTA provides under his or her supervision; however, supervision occurs along a continuum. The type and frequency of supervision must be discussed and agreed upon by both practitioners. According to AOTA, general supervision must occur once a month, though ongoing indirect supervision is encouraged (AOTA, 2009). According to Sec.0900 of North Carolina Board of Occupational Therapy (NCBOT) Rules for Supervision, supervision involves a review of all aspects of the OTA's practice. Finally, documenting supervision is the responsibility of both the occupational therapist and occupational therapy assistant.

According to Sec.0900 of the NCBOT Rules for Supervision, an occupational therapist may supervise, through planning and coordination of the clinical education experience, a Level I or a Level II fieldwork occupational therapy or occupational therapy assistant student. An OTA may also supervise a Level I or a Level II fieldwork occupational therapy or occupational therapy assistant student under the direction and guidance of a supervising occupational therapist. Occupational therapy practitioners may also supervise vetted volunteers.

Lead Occupational Therapist

LEAs employing five or more occupational therapy staff recognize the benefit of having an occupational therapist assume the role of team leader. These Leads assume responsibility for coordinating and managing functions of the occupational therapy program (see Job Specifications section in Chapter 5 for detailed list of Lead OT functions.) Establishing a Lead OT position provides therapists with an opportunity for career

advancement and decreases the administrative and supervisory responsibilities for Exceptional Children managers.

Role Model

Unlike other practice settings, public schools require occupational therapy practitioners to acknowledge and grow in their role as role model. Schools are environments where character develops and commitment to the student is the highest priority; as adults in the school environment, occupational therapy staff are identified as role models and therefore responsible for demonstrating desired conduct and attitude. Itinerant staff also share the responsibilities of instructional staff as outlined in § NC 115C-307, *Duties of teachers*. Further, occupational therapists are expert in the assessment, design, and modification of habits, and the habits students acquire in school not only constitute their current character but also form it for the future. Part of character education is encouraging the acquisition of these habits by offering students effective role models.

Qualifications

Occupational Therapist

- Graduation from an accredited occupational therapy educational program and completion of all fieldwork requirements
- Initial certification by the National Board for Certification of Occupational Therapy
- Currently licensed by the North Carolina Board of Occupational Therapy

Occupational Therapist Assistant

- Graduation from an accredited associate's degree occupational therapy assistant program and completion of all fieldwork requirements
- Initial certification by the National Board for Certification of Occupational Therapy
- Currently licensed by the North Carolina Board of Occupational Therapy
- Supervision by a qualified licensed occupational therapist

Recommended Experience and Training:

- One clinical fieldwork in a school system or other pediatric area
- Two years experience as an OTR/L or COTA/L in a pediatric practice setting
- Participation in continuing education courses related to pediatric and/or school-based practice

Chapter 2

OCCUPATIONAL THERAPY AS A RELATED SERVICE

The special education process, as defined by the 2007 North Carolina *Policies Governing Services for Children with Disabilities,* dictates the provision of related services. The following is not a comprehensive discussion of the special education process in North Carolina, but, rather, an overview describing how occupational therapy practitioners contribute to the special education process from referral to exit.

Referral

An occupational therapy evaluation can be requested at the time of initial referral for evaluation or after a child has begun receiving special education services, if the IEP Team needs information regarding the student's performance in the following areas:

- Personal Care (feeding, toileting, dressing, hygiene, managing personal belongings, personal organization, task-related mobility, safety awareness and protocols)
- Engagement in student role/Interaction Skills (following classroom, specials, school, bus, cafeteria protocols & routines, respecting the space/time/materials of others, staying seated, requesting help, making needs/wishes known, social awareness, building/maintaining relationships with teachers and peers)
- Learning academics/Skills Related to Learning Activities (following demonstrations, copying models, carrying out verbal directions, attending to instruction, using classroom tools, managing materials, completing assignments)
- Play/Unstructured Social Time (turn-taking, imaginative play, sharing materials, exploring new play ideas/opportunities, engaging socially with peers)
- Community Integration/Work (fieldtrips, school-related vocational training)
- Graphic communication (writing process, keyboarding, drawing, coloring, art)

Additionally, the occupational therapy evaluation can be used as one of two required sources for adaptive behavior information. In North Carolina, occupational therapists do not need a referral from a physician to evaluate or provide services that are outlined on a student's IEP. The IEP Team, not a physician, determines what information is needed to determine if the student has a disability that adversely affects academic or functional performance at school and is in need of specially designed instruction.

Sample Referral for Occupational Therapy Evaluation

Evaluation

The purpose of a school-based occupational therapy evaluation is to contribute to the IEP Team's body of knowledge about the student in the areas described in the *Referral* section. The data helps the team understand and prioritize the student's educational strengths and needs and, if needed, build a relevant, manageable IEP. The occupational therapy evaluation data helps the IEP Team answer such questions as:

- What supports this student's performance?
- What limits this student's performance?
- What does this child need to access the classroom and campus?
- Does this student have a disability?
- Does the disability adversely affect academic and/or functional performance? If so, how?
- Does the student require specially designed instruction?
- What does the child need to access, participate and make progress in the general education curriculum?

The school-based occupational therapy evaluation is not intended to answer the question: "Does this student need occupational therapy as a related service?" If the need for occupational therapy is based solely on a therapist's evaluation (whether school- or community-based), important information from other sources may be missed or misinterpreted. Evaluations can include, but are not limited to, observations, interviews, behavior checklists, structured interactions, play assessments, adaptive and developmental scales, criterion- and norm-referenced instruments, clinical judgment, and other techniques and procedures as deemed appropriate by the evaluator.

Parents must understand what the occupational therapist will be assessing with their student and provide written consent prior to evaluation. If the parent provides current occupational therapy evaluation data from a community-based setting, the IEP Team should consider the educationally relevant aspects as part of the data used for eligibility determination and IEP development. Upon completion of the evaluation, the school-based occupational therapist provides a written report to the IEP Team according to policy timelines. IEP Teams are strongly encouraged to include occupational therapists as early as possible in the evaluation process in order to ensure access to quality, comprehensive data. Likewise, the IEP Team should include the occupational therapist in all meetings where occupational therapy data are discussed. **The occupational therapy evaluation should not include goals, recommended services, or frequency of services; these are decided by the IEP Team during the development of the IEP.**

Sample/Template for Occupational Therapy Evaluation

See Appendix E for a list of commonly used standardized assessments in school-based occupational therapy.

Eligibility for Services

In North Carolina, if a student is found eligible for special education in one of the fourteen areas of eligibility, then the student "qualifies" for any and all related services needed to implement the IEP. It belongs to the IEP Team to determine which related services are needed--*after* the development of goals and identification of supplemental aids, services, accommodations, and modifications.

If the need for OT as a related service is determined prior to the development of a student's IEP, services may be duplicated or missed, or student outcomes may not be addressed appropriately (Giangreco, 2001b; Muhlenhaupt, 2000; Rainforth, 1996). When team members prematurely focus on which services are desired, or how services will be provided, they may not fully understand the meaning of related services within the context of IDEA. In each case, ineffective collaboration results in a fragmented program in which occupational therapy is not provided to support the student's ability to participate in the educational program, but rather to improve a student's isolated skills (AOTA, 2007). In best/evidence-based practice, the occupational therapy provider contributes collaboratively in the assessment process and the development of the student's plan, based on evaluation data.

IEP Development

Occupational therapists contribute to the development of the entire IEP, not just goals and service delivery considerations. Occupational therapy data informs descriptions of the student's overall strengths and needs, special factors, and present level of academic and functional performance. Based on these data, the occupational therapist collaborates with the IEP Team to develop integrated, student-centered, curriculum-based, team-based goals and supports for achieving progress in the least restrictive environment. While the occupational therapist may take the lead in developing some goals and supports—particularly if the team has prioritized needs in student performance areas evaluated and/or intervened in by an occupational therapist—the IEP should not contain "occupational therapy" goal pages.

Service Delivery Decisions

The decision regarding the frequency and amount of occupational therapy service is made by the IEP Team. The team should consider how the therapy will affect the student's participation in the general education curriculum and participation with non-disabled peers. If the team determines the need for occupational therapy as a related service, the IEP must specify frequency, duration, and location of services. The selection of frequency, duration, and location is based on student need and expertise of the IEP Team. Staff availability, adult schedules, personal preferences and Medicaid eligibility should not influence service delivery decisions. Theoretical frames of reference, intervention approaches, and methodology are not described in the IEP. Teams are encouraged to select a location and frequency of services that provide flexibility, given the multiple opportunities for contextual intervention in schools. For example, outlining services for 2 hours per month in the "total school environment" (i.e., any location where the student has access to nondisabled peers) might be more effective than 30 minutes per week in the classroom alone.

If the IEP mandates the need for the occupational therapy, the occupational therapist subsequently develops an intervention plan. There should be a clear distinction between IEP goals and intervention plans. The intervention plan is not part of the IEP, but can serve as clear and proactive communication tool between the practitioner and other team members. The intervention plan "documents the goals, intervention approaches, and types of interventions to be used to achieve the [student's] identified targeted outcomes" (AOTA, 2008) in the IEP. IEP goals are determined by the team as a whole; intervention plans are the methods or strategies that will be used by the OT to support goal attainment. This means that decision-making about type/extent of service should not be made until *after* the team develops IEP goals and determines OT services are needed. The occupational therapy provider and team should not discuss intervention possibilities until the concerns (e.g., lack of skill, decreased performance, problematic behavior) and expected performance or outcomes (goals) have been clearly defined (*AOTA, 2007).*

The following questions may help guide decision-making on the extent, type, and duration of occupational therapy:

- What is the least restrictive means of providing support in the student's education program?
- What evidence exists to support the focus and frequency of the occupational therapy intervention program?
- What impact will the intervention have on social participation with peers?
- Does the student's health and safety depend on the occupational therapy provider's presence in the educational environment?
- How much/often will the occupational therapy provider contribute to environmental changes that improve the student's ability to function in the present educational setting?
- Considering the student's strengths and weaknesses, what is the potential for this student to improve functional skills and ultimately decrease or eliminate the need for special services of any kind, especially those of the occupational therapy provider?
- How well has the student responded to previous or other types of intervention?
- How much do this student's deficits interfere with his or her ability to profit from the educational process in the present setting?
- To what extent is the expertise of the occupational therapy provider needed to communicate adequately (verbally and in writing) with professionals outside the educational environment?

Sample Intervention Plan Template

Intervention

Once the IEP Team determines a student requires occupational therapy to benefit from the educational program, the occupational therapist develops interventions based on IEP goals, supported by current best practice models, research, and input from other members of the IEP Team. Therapists must utilize the principles of educational relevance and the least restrictive environment when making decisions in regard to therapeutic interventions. The following points adapted from the *Handbook for OT and PT Services in the Public Schools of Virginia (*Virginia Department of Education, April, 2004) provide an excellent framework for implementing services:

- **Services are provided to enable the student to benefit from his or her special education program and facilitate access to the general curriculum**
  - Strategies should be integrated into the classroom and school environment to support learning of curriculum content and functional skills
  - Interventions should support skills that are needed for graduation with a diploma and/or successful implementation of a transition plan
- **Services are embedded in the student's daily educational routine**
  - Students' skills are facilitated across all relevant educational settings
  - Intervention occur throughout the school day and often are implemented by instructional staff in collaboration with the occupational therapy practitioner
  - Natural environments are the first consideration for service delivery

- **Services are provided through a team approach**
    - Team members share information and strategies to assure continuity of services
    - Educational strategies and interventions are developed and implemented jointly by the IEP Team members, including the student when appropriate
    - Regular team meetings (using a variety of media/meeting types) enable communication to guide the plan of activities and instruction in the classroom, home and community
- **Services are provided through the use of a variety of delivery models**
    - Service delivery models include monitoring, consulting and working directly with the student
    - Effective therapy services generally include a combination of models to meet the unique needs of each student
    - Effective therapy services include the following:
        - Working directly with students to build participation routines and implement adaptive strategies
        - Training parents and school staff in activities and accommodations to be implemented throughout the student's day
        - Observing and critically analyzing student performance and responses that prevent the student from benefiting from his or her educational program
        - Identifying, selecting, and adapting special materials and equipment
        - Collaborating and coordinating with teacher and families for needed changes in instruction and in the learning environment
        - Consulting with students, parents and school staff
- **A student's need for occupational therapy may vary over time**
    - Student therapy needs differ in intensity and in focus during the students' school years
    - These fluctuations are reflected in the IEP and should be fluid and flexible, based on the immediate educational needs at any time during the student's course of study

Documentation & Progress Reporting

Both professional guidelines for occupational therapy practitioners and IDEA mandate ongoing data collection and progress monitoring as part of the intervention process. The *AOTA Guidelines for Documentation* requires that occupational therapy practitioners document the following:

1. All contacts between the client and the occupational therapy practitioner. Includes telephone contacts, interventions, and meetings with others.
2. Types of interventions used and client's response.
3. Client information—name/agency, date of birth, gender, diagnosis, precautions, and contraindications.
4. Therapy log—date, type of contact, names/positions of persons involved, summary or significant information communicated during contacts, client attendance and participation in intervention, reason service is missed, types of interventions used, client's response, environmental or task modification, assistive or adaptive devices used or fabricated, statement of any training education or consultation provided, persons present, and the occupational therapy practitioner's signature

In addition, North Carolina Medicaid LEA policy requires each contact be documented with the following:

Most school-based occupational therapy practitioners maintain computer or hard copy files of intervention notes for each student. The intervention note data informs the effectiveness of intervention, development of

progress notes, annual IEP reviews, and re-evaluations. These student files are the property of the LEA and processes should be in place to:

- monitor currency, completion, and quality of all required documentation
- readily access student therapy files in the event of audit or student transition to a new school
- archive files once students have exited services, graduated, or moved out of the LEA
- ensure adherence to all FERPA and HIPAA confidentiality rules

State policy requires parent be informed of their student's progress toward annual IEP goals as often as regular education students receive report cards. Typically, this mandate is met with a quarterly progress report from the IEP school team members to the parents.

Sample Occupational Therapy Intervention Note Template

Sample Documentation Audit Process

Sample Progress Note Template

Re-evaluation

As in the initial evaluation, occupational therapy's contribution to the re-evaluation process is to provide the team with knowledge about the student's current level of performance in the areas of personal care, student role/interaction skills, learning academics/processing skills, play, community and work integration, and graphic communication. Every three years, but not more often than yearly, the IEP Team reviews all relevant existing data about the child's performance to determine what information it has, and what information it needs, in order to determine if the student continues to be a student with a disability in need of specially designed instruction. The re-evaluation process may provide new information about a particular performance area, inform transition planning, and/or serve to evaluate the effectiveness of the IEP and related interventions. Occupational therapists may bring the team data from intervention notes, progress notes, teacher and parent report, student work samples, and other sources specific to the case during the re-evaluation process. If the team decides it needs additional information on the student's performance in the areas addressed by occupational therapy, the OT may be asked to do additional assessment.

Re-evaluation is a process which addresses the whole child. It is not a process specific to a particular service; i.e., there is no re-evaluation process for determining the ongoing need for occupational therapy alone. If an occupational therapist reaches a point with a student where the role of the OT practitioner becomes unclear (e.g., goals have been met; no evidence for efficacy of ongoing intervention in a particular performance area; other team members have reached competency delivering OT-designed programming; etc.), the occupational therapist has an obligation to inform the team and/or request a review of the child's program.

Transitions

Preschool Transition

Transition from early intervention services (IDEA, Part C) to preschool programs is significant for many families. Changing from a system in which children may receive services in the context of the family and community to a school-based model in which occupational therapy may be provided in the classroom setting is often difficult for parents to conceptualize (Arizona, 2008). Further, the scope of practice for occupational therapy under IDEA Part B (child-centered) is different from Part C (family-centered), secondary to the parameter of educational relevance. Transition requirements ensure that a child's team (teachers, early

intervention providers, school district representatives, related service providers) works collaboratively with families to plan and provide for a smooth transition to the public school setting. Advance planning for a transition should begin as soon as appropriate (starting when the child is between 2.6–2.9 months of age). School-based occupational therapists may participate in a child/family's transition to preschool special education programming by serving on trans-disciplinary preschool assessment teams, conducting community-based observations of the child, and collaborating in the IEP processes described above.

Secondary Transition

In North Carolina, secondary transition services are planned for special education students beginning at age 14, or earlier if so determined by the IEP Team. Transition planning is a results-oriented process where the student and the IEP Team identify activities to facilitate the student's movement from school to post-school activities. Post-school activities including post-secondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living, and/or community participation. The secondary transition plan is based on the student's strengths, preferences, and interests; and may include:

- instruction
- related services
- community experience
- development of employment and other post-school adult living objectives
- acquisition of daily living skills and functional vocational evaluation.

Occupational therapy practitioners may play a vital role in transition planning for these students. Supporting the student's community experience, assisting in the acquisition of daily living skills, performing functional vocational evaluations, and assisting in adaptations, staff training, and access to employment and other post-school living opportunities are just some of the ways in which occupational therapy practitioners may contribute to the student's transition plan and post-school outcomes.

Exit

The process for removing occupational therapy as a related service on a student's IEP is the same as adding it. The team, including the OT who has been serving the student, develops the IEP in proper sequence: special factors → goals → LRE → special education → related services. If the present level of academic and functional performance of the student, the skills IEP Team, and the supports in the environment are supportive and sufficient for progress without occupational therapy, then OT as related service is not included on the new plan.

Currently in North Carolina, policy requires the completion/documentation of the re-evaluation process when the team develops a new IEP without a related service that appeared on the student's previous IEP.

Chapter 3

REGULAR EDUCATION CONTRIBUTIONS

As discussed in Chapter 1, school-based occupational therapy practitioners work at a variety of levels within the LEA. In many cases, the practitioner's contribution may target a student or group of students with disabilities, but benefit the broader regular education population. In a growing number of LEAs, regular education staff and administrators are accessing the expertise of occupational therapy practitioners for programming and initiatives for all students. While this requires careful attention to informed parental consent procedures and funding streams for practitioner salaries, the natural problem-solving skills of occupational therapy staff make them key players in pre-referral and early intervening efforts in regular education.

Responsiveness to Instruction (RtI)

Responsiveness to Instruction (RtI) is North Carolina's name for the national initiative called Response to Intervention. No Child Left Behind makes provision for the use of "pupil services personnel"—which include related services as that term is defined in section 602 of the Individuals with Disabilities Education Act—for non-disabled students in need of support. RtI is one model for assisting students in need and, as defined in North Carolina, is the practice of:

- providing high quality instruction matched to student need
- monitoring progress frequently to make decisions about changes in instruction or goals
- applying child response data to important educational decisions

RtI is a multi-step problem solving process based on high-quality, research-based instruction and interventions matched to student need at varying levels of intensity (in North Carolina there are four tiers of intervention.) RtI's focus on high-quality instruction, rather than specific student weakness, shifts the occupational therapy practitioner's focus as well. The instructional team, rather than the student, is the "client" for the OT under RtI. Occupational therapy practitioners are a natural fit for participation in RtI processes because of their:

- history of evidence-based practice
- history of collaborative practice
- value of early intervention and prevention
- training in dynamic assessment
- sophisticated skills and knowledge regarding:
    - contextual observation
    - data collection
    - progress monitoring
    - customer service

The following table provides a summary of ways occupational therapy practitioners can contribute to RtI processes in each tier:

Tier I **Consultation between Teacher and Parent**	Tier II **Consultation with Other Resources**	Tier III **Consultation with Problem Solving Action Team**	Tier IV **IEP Consideration**

• collaboration – preventive
  o curriculum design (e.g. universal design for learning)
  o curriculum-based assessments
  o prevention programming
  o parent partnership initiatives
• screenings
• professional development
  o school-wide
  o written resources
  o in-services
	• collaboration – diagnostic
	  o grade-level meetings
	  o environmental modifications
	  o progress monitoring
	  o data analysis
	• observations & evaluations
		• collaboration – intervening
		• shared teaching
		• skills-focused small group instruction
		• classroom coaching
		• after-school programming
		• parent training
			• special education referral
			• goals for specially designed instruction
			• direct intervention
			• least restrictive environment
			• supplemental aids and services

Positive Behavior Support (PBS)

Where RtI focuses on academic achievement, PBS processes address behavioral health and social participation. Occupational therapy practitioners are educated and experienced in the environmental, psychosocial, developmental, and sensory processing aspects of student participation. These staff are experts in the assessment and design of environments and schedules, as well as establishing habits and routines. All of these enable practitioners to contribute richly to PBS initiatives, again, with the instructional team as the "client." In North Carolina, PBS is defined as a broad range of systemic and individualized strategies for achieving important social and learning outcomes while preventing problem behavior. As in RtI participation, OT practitioners bring different skills and knowledge to bear at different tiers/intensities of intervention.

At the primary prevention level, occupational therapy practitioners can contribute to the creation of system and school-wide behavioral expectations based on their knowledge of the development of social skills and participation challenges related to behavior. They may provide in-service training to instructional staff in these areas, as well. Additionally, OT staff must be aware of and participate in applying consistent strategies, acknowledging appropriate behavior, and correcting misbehavior in the PBS-implementing schools they serve. This level of participation may require the practitioner to pursue/advocate for being included in site-based PBS training.

At the secondary prevention level, occupational therapy practitioners may contribute to:

- assessment of classroom environments
- collaboration in developing classroom routines
- consultation on appropriate, effective sensory strategies (e.g. changing auditory, visual, or vestibular experiences in the classroom)
- ongoing training and support of instructional staff
- facilitating small group learning of targeted social, self-management, and coping skills

At the tertiary prevention level, OT staff can participate in behavioral support teams for individual students and, often times, lead functional behavior assessment and behavior intervention planning. Occupational therapy's focus on the interconnected aspects of person, environment, and activity, along with the practitioner's ability to synthesize data from each domain to identify performance supports and inhibitors, makes OT staff valuable contributors at the tertiary level.

Coordinated Early Intervening Services (CEIS)

LEAs may (and in LEAs with significant disproportionality, must) use up to 15% of IDEA Part B funds to provide services to students in kindergarten through grade 12 (with a particular emphasis on students in kindergarten through grade three) who are not currently identified as needing special education or related services, but who need additional academic and behavioral supports to succeed in a general education environment (US DOE, 2008c). According to the Federal Register (71 Fed. Reg. at 46627-8), "Nothing in the Act [IDEA] or regulations prevents States and LEAs from including *related services personnel* in the development and delivery of educational and behavioral evaluations, services, and supports for teachers and other school staff to enable them to deliver coordinated, early intervening services." CEIS activities may include professional development for instructional staff and evaluation, services, and supports to non-disabled students in need. CEIS funds can be used to support other initiatives, like RtI and PBS, or to develop innovative programming, like a before-school study skills club, based on student need.

Occupational therapy practitioners may participate in CEIS activities if deemed appropriate at the local level. The LEA determines which students are in need of CEIS and what type of programming or intervention each student needs. The LEA should also have procedures in place to ensure the parent's informed written consent. As CEIS participants, occupational therapy practitioners might provide professional development for instructional staff (e.g., how to use movement in the course of the classroom routine to reinforce instructional concepts and enhance classroom management) or direct intervention to students.

Section 504Plans

All students found eligible for special education under IDEA are protected by Section 504, which insures students will not be discriminated against because of a disability. In this way, it is helpful to view IDEA and Section 504 as complimentary, rather than parallel and distinct, programs affording different provision to, by

and large, the same population of students. IDEA provides the policies, procedural safeguards, and funds for educating students with disabilities, and Section 504 provides the protection of those students' rights.

LEAs are strongly encouraged to apply the same comprehensive, interdisciplinary process of referral, evaluation, and identification of the all students suspected of having a disability, whether the outcome is an IEP, a 504 plan, or the continuation of regular education. The probability of errors increases when different or truncated evaluation procedures are used in pursuit of a 504 plan. Indeed, "the Section 504 regulatory provision at 34 C.F.R. 104.35(c) requires that school districts draw from a variety of sources in the evaluation process so that the possibility of error is minimized" (U. S. Department of Education, 2008b).

It is not uncommon for a family or school staff member to suggest a regular education student "needs OT" due to difficulty in one area of performance (e.g. completing independent work) and seek a 504 plan to access services. If the LEA conducts only an occupational therapy evaluation in response, it has not met the requirement for a multi-disciplinary evaluation drawing data from a variety of sources. An occupational therapy evaluation alone is not sufficient to determine if a student is a student with a disability, which is the first requirement for a 504 plan.

In some rare instances, a student may be found to have a disability, but not qualify for special education under IDEA. Such a student would have the civil rights protection afforded under Section 504, which includes access to an individualized, free appropriate education, but remain a regular education student. If such a student's disability or impairment "substantially limits" a major life activity at school (e.g., caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working, and the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions") the LEA may need to make reasonable accommodations to the general curriculum, instruction, and/or environment for the student to access all the activities and opportunities available to children without disabilities. These accommodations, which may include related services, would be documented in a 504 plan.

OT is included in the plan only if the 504 committee deems occupational therapy services are required in order to ensure the student:

- is not being discriminated against based on his/her disability
- has access to the same activities and educational opportunities as non-disabled students
- has access to required, reasonable accommodations

LEAs may not use IDEA funds for services outlined in a 504 plan for a student who is not eligible for services under IDEA, including occupational therapy practitioner salaries.

Chapter 4

EVIDENCE-BASED PRACTICE

The No Child Left Behind Act of 2001 and IDEA 2004 emphasize the importance of evidence-based practice (EBP) in providing best practice in the school setting. In IDEA the phrase used is "peer-reviewed research to the extent practicable" (CFR 300.320(a)(4). This means, whenever possible, practitioners should select practices and interventions that draw on a strong research base. That said, "the mere presence of peer reviews does not require adoption of a certain approach, nor does the absence of such reviews necessarily mean that an approach is not appropriate. (Seigel, 2009, p. 125). Moreover, the use of evidence to guide practice is a critical component of AOTA's Centennial Vision for the profession. By providing evidence-based services in North Carolina schools, occupational therapy practitioners "integrate professional wisdom with the best available empirical evidence in making decisions about how to deliver instruction" to improve academic and functional outcomes for all students (NCLB, 2001).

According to Collins (2006), best practice in evidence-based decision-making involves integrating three components:

- relevant research evidence
- OT practitioner's clinical experience
- client's values and preferences

School-based OT practitioners must provide interventions that support a student's learning and participation in school. Though other interventions may have research evidence to support their effectiveness, they may not facilitate the student's ability to do what he or she needs or wants to do in school (Collins, 2007). When developing an intervention plan or when asked by others to do a specific type of intervention, OT practitioners must evaluate:

- Whether the intervention has a research base
- Whether the intervention is considered to be "standard care" by a majority of experienced, reasonable school-based OT practitioners
- Whether they are trained/competent to provide the intervention
- Whether the intervention will facilitate the student's achievement of an IEP goal, while still maintaining a LRE (Minnesota Handbook, 2002).

Research

Best practice in occupational therapy involves using intervention strategies with evidence of effectiveness. Providing services based in research evidence requires that OT practitioners actively seek out and review current research in their area of practice and use this research evidence in their clinical reasoning. This involves reading scholarly journals, taking continuing education courses, and familiarizing oneself with the

position of professional OT associations (Minnesota Handbook, 2002). There remains a need for scientifically-based research examining the impact OT services have on targeted student outcomes (Swinth, Spencer, & Jackson, 2007). Given that the evidence base for school-based OT remains limited, exploration of research generated by other disciplines may help OT practitioners answer clinical questions. Some suggestions of cost-effective options for accessing current research include:

- joining the Friends of the Library at your local university
- exploring databases available through your local library (you may even be able to create an account and access these databases from home or work)
- searching free databases, including OTSeeker, PubMed, PsychInfo, OTDBase
- becoming a member of AOTA - AOTA members have access to online evidence
- briefs, Critical Appraisal of Topics (CATs), and an Evidence-Based Practice Resource
- Directory, including a special interest section on Children and Youth
- developing article review groups or journal-share groups which discuss practice
- issues and review recent research

Continuing education courses are another means for therapists to keep current on EBP. To assure that course content is evidence-based and not just the presenter's opinion, attendees can request that the instructor provide supporting evidence and bibliographies for course content.

Clinical Experience

OT practitioners enter the field with similar basic knowledge and education. Through clinical experience, continuing education courses, and engagement in post-professional learning, practitioners tailor their knowledge base to professional interests; their practice setting; and the populations they serve. Practitioners should regularly evaluate their knowledge, skills, strengths, and weaknesses, as well as the efficacy of their evaluation and intervention strategies (Minnesota Handbook, 2002). AOTA members can use the Professional Development Tool to assess professional strengths and area of needs; develop a professional development plan; and create a professional development portfolio.

OT practitioners must evaluate the effectiveness of their intervention methods in order to develop practice-based evidence with which to guide future clinical decisions. According to Swinth et al. (2007), when evaluating the efficacy of one's treatment practices, one should begin by asking themselves:

- What impact did the OT intervention have on the student's *performance* of educational activities?
- To what extent did OT intervention influence the student's *participation* within the education context?

Data collection is an effective way of tracking the efficacy of interventions and determining factors which impact change. When tracking data on a specific intervention or program, practitioners:

- Identify outcomes to track
- Determine frequency and duration of data collection
- Identify mechanisms and personnel required for data collection

Identifying outcomes of interest allows the OT practitioner to document student progress toward a goal. Results demonstrating a lack of progress help identify when intervention needs to be modified, while results suggesting progress towards a goal help support the efficacy of the intervention. When including other members of the student's team in data collection, OT staff must ensure the methods used are feasible for others to use. While data collection only demonstrates the effectiveness of interventions for a specific student or group of students, practice-based evidence may guide clinical reasoning when designing interventions for other students working towards similar goals.

Goal Attainment Scaling (GAS) is an example of a student-centered data collection method which can be used to measure outcomes and build a clinical research base. The OT practitioner works with the IEP Team to prioritize goals, then develops a metric with which to quantify progress toward each goal. Descriptions of a continuum of possible outcomes are assigned a rating between +2 and -2, with the best possible outcome being +2; performance of goal being 0; and the least optimal outcome being -2. The client's performance in each trial for which data is collected is then recorded to measure the client's progress. An example for school-based practice follows (Mailloux, May-Benson, Summers, Miller, Brett-Green, Burke, Cohn, Koomar, Parham, Roley, Schaaf, & Schoen, 1997).

GOAL ATTAINMENT SCALING EXAMPLE:

CONCERN: A 2nd grade student is having difficulty achieving/maintaining adequate time on task for work completion during independent work times for all academic content areas**.**

GOAL: To be able to initiate, stay on task, and complete assigned work during independent work times

INTERVENTION PERIOD: 36 sessions for duration of the IEP

–2 Much Less Than Expected Level	**–1** Less Than Expected Level	**0** Expected Level of Performance	+1 Better Than Expected Level	**+2** Much Better Than Expected Level
Does not complete independent work with satisfactory quality in the allotted time; does not access external supports	Completes a portion of independent work with fair quality in the allotted time; occasional use of external supports	Complete independent work with satisfactory quality in the allotted time, provided non-verbal external supports	Complete independent work with good quality in the allotted time, requiring minimal external supports	Complete independent work with superior quality in less than the allotted time with no external supports

IEP Team Decisions and Preferences

In the school setting, the "client" is the student *and* the IEP Team. EBP involves identifying the client's goals and involving the student/IEP Team in the entire intervention process. Therapeutic relationships should begin with a dialogue with the student and IEP Team members regarding the vision for the student's future and expected outcomes of intervention. Focusing on the IEP Team's priorities and respecting the team's culture, beliefs, and value system creates a team-centered approach to practice. Writing goals that are meaningful to the student and IEP Team is a key component of EBP in the school setting. This involves talking with the student, his or her family/caregivers, and relevant school staff to:

- identify the student's ability and willingness to perform identified school tasks
- define team satisfaction with the student's present level of performance (Minnesota Handbook, 2002)

Student and team preferences should be integrated with research evidence and results of the comprehensive special education evaluation in order to set realistic goals. Only after goals are set do evidence-based IEP Teams decide which services and interventions would best promote progress. Thus, evidence-based practice does not mean that decision-making should be guided solely by research evidence; rather this evidence should be integrated with the clinical expertise of OT practitioners and with the IEP Team values and priorities. (Minnesota Handbook, 2002).

Evidence-Based Practice Bibliography

Below is a bibliography of research relevant to school-based OT practice. This list is not exhaustive and is not intended to endorse specific intervention models or researchers. The purpose of this bibliography is to provide a list of relevant research which OT practitioners in pursuit of providing EBP are encouraged to review and evaluate.

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Chapter 5

ADMINISTRATIVE ISSUES

Managing Occupational Therapy Personnel

Occupational therapy practitioners are natural, clever, resourceful problem-solvers and systems analyzers. They tend to be people-oriented, social, flexible, and creative (Lysack, 2001). These versatile staff are highly attuned and responsive to needs of the moment. OT practitioners working in public schools celebrate children and youth, and value the relationships built around serving students, families, and school staff. They see learning, playing, and making friends not simply as the work of students in school, but as primary human occupations that matter long after graduation.

School-based OT practitioners believe in public education and see themselves as advocates and leaders in creating opportunities for students with disabilities to participate as fully as possible in life "between the bells." This commitment is demonstrated every day in North Carolina—around tables in IEP meetings, in classrooms, in cafeterias, on buses, on playgrounds, under stairwells, and in closets serving as "work space"—and in the progress made by students served by these personnel. The commitment is also seen in dollars: the average hourly wage for an OT in North Carolina is $30.51/hour, the average salary for the same OT working in North Carolina public school is $26.31/hour (per NC DPI salary grade 78) —a $672/month salary discrepancy (North Carolina Employment Security Commission, 2008.)

The strengths of school-based occupational therapy practitioners can also present unique conditions for management. As health care professionals in an educational setting, school OT personnel sometimes perceive their work is not well understood. This is often compounded by the itinerant nature of their work, which, together, can create feelings of isolation and frustration. Given their background in systems and activity analysis, OT practitioners often want to know why things work the way they do, including policies, procedures, and processes. Administrators are encouraged to not interpret this inquisitive reasoning as insubordinate, at the same time, practitioners are encouraged to respectfully share their questions with administrators. OT practitioners, by personality, work best when given the freedom to problem-solve, plan, and practice independently (Lysack, 2001). While this is a good match for the autonomy of school-based practice, it can cause friction when practitioners meet with layers of policy constraints, documentation requirements, and team-decision making. Given their strength in spontaneous, expedient response to present demands, OT practitioners may be challenged by long-term planning and benefit from external support for time management.

Given this general profile, managers of school-based occupational therapy personnel are encouraged to:

- Include OT practitioners in decision-making that affects their work
- Create opportunities for OT practitioners to experience a sense of belonging
- Let OT practitioners know their work is valued
- Set clear expectations for work and routinely assess progress toward meeting expectations

Job Specifications

Please note: These specifications have been designed to represent the general nature and level of work found in positions in this class. As such, it is not intended to contain all of the duties and qualifications required of an employee in a single position (job). Consequently, it is not to be perceived as a position (job) description or as identification of essential functions as required by ADA. Always contact the school system in which you are interested for a finalized job description.

Occupational Therapist

SALARY GRADE: 78

NATURE OF WORK:

Occupational therapists lead the process in development, implementation, and coordination of the occupational therapy program. Screening, evaluation, educational program and transition planning, therapeutic intervention, and exit planning is provided for students identified with or suspected of having disabilities that interfere with their ability to perform daily life activities or participate in necessary or desired occupations. Professional judgment and clinical knowledge are used to develop individualized programming based on occupational performance deficits in the areas of personal care, student role, interaction skills, process skills, play, community integration/work, and graphic communication. Occupational therapist regularly collaborates with other disciplines and services at departmental and system levels. Occupational therapist is expected to independently review outcomes and modify intervention programs. Clinical reasoning and professional judgment are essential to ensuring the safety of students and protecting liability of the school system and the therapist. Errors may result in serious harm to students. Direct supervision may be exercised over support personnel, such as occupational therapy assistants and clerical staff.

ILLUSTRATIVE EXAMPLES OF WORK:

Identification, Evaluation, and Planning

- Collaborates with other disciplines to ensure team understanding of student occupational performance strengths and needs, through evaluation, educational program planning, and service delivery
- Evaluates the student's ability and formulates the student's occupational profile through a variety of functional, behavioral, and standardized assessments, skilled observation, checklists, histories, and interviews.
- Synthesizes evaluation results into a comprehensive written report which reflects strengths and barriers to student participation in the educational environment; directs program development; and guides evidence-based intervention.
- Develops occupationally based intervention plans based on student needs and evaluation results.
- Participates in interdisciplinary meetings to review evaluation results, integrate findings with other disciplines, offer recommendations, and develop individual education plans and intervention plans to achieve IEP goals.

Service Delivery

- Provides targeted, evidence-based therapeutic intervention to facilitate student participation and occupational performance within the school environment.
- Consults with the school-based team to achieve student outcomes.
- Adapts and modifies the environment including assistive technology and training instructional staff to meet individual needs and to help students function as independently as possible.

- Educates student, educational personnel, and family to facilitate skills in areas of occupation as well as health maintenance and safety.
- Monitors and reassess the effects of occupational therapy intervention and the need to continue, modify, or discontinue intervention.
- Documents occupational therapy services to ensure accountability of service provision and to meet standards for reimbursement of services as appropriate.

Program Administration and Management

- Prioritizes and schedules work tasks independently.
- Manages inventory of therapeutic equipment and assessments, and project needs for budget planning.
- Maintains clinical and administrative records in accordance with professional standards, state guidelines, and school system policy.
- Provides legal and ethical supervision of occupational therapy assistant assuming responsibility for the students served by assistant.
- Supervises non occupational therapy support personnel.
- Adheres to federal and state legislation, regulation, and policies that affect occupational therapy practice.
- Reviews occupational therapy services for quality improvement and makes changes as needed to ensure quality of services.

Education

- Teaches, monitors, and collaborates with educational personnel, community agencies, parents, and students to increase understanding of the student's occupational performance.
- Provides continuing education and in-services for educational personnel, parents, and community based service providers.
- Provides fieldwork education and supervision for occupational therapy and occupational therapy assistant students.

Professional Growth and Ethics

- Participates in continuing education for professional development to ensure practice consistent with best practice and to meet N.C. Licensure requirements.
- Uses professional literature, evidence based research, and continuing education content to make practice decisions.
- Uses professional Code of Ethics and standards of practice to guide ethical decision making in practice.

KNOWLEDGE, SKILLS, AND ABILITIES:

- Knowledge of human development throughout the life span, integrated with student's unique developmental status.
- Knowledge and appreciation of the influence of disabilities, socio-cultural and socioeconomic factors on student's ability to participate in occupations.
- Knowledge and use of occupational therapy theories, models of practice, principles, and evidence based practice to guide intervention decisions.
- Knowledge of the federal, state, local legislation, regulations, policies and procedures that mandate and guide occupational therapy practice in schools.
- Ability to gather and assess outcomes program evaluation data and use to modify services at the programmatic level.
- Ability to maintain current reporting, documentation, scheduling, and billing in accordance with professional standards, state and local guidelines, and reimbursement requirements.

- Ability to determine the need for an occupational therapy evaluation and to select and administer appropriate assessment tools to evaluate the student.
- Ability to interpret the evaluation data and write a comprehensive report that reflects strengths and barriers to student's participation and occupational performance.
- Ability to participate collaboratively with multi-disciplinary educational teams to develop Individualized Education Programs to meet student needs.
- Ability to develop occupationally based intervention plans based on evaluation information.
- Ability to provide evidence based occupational therapy intervention to improve student's performance skills and participation.
- Ability to adapt and modify environments, equipment, and materials including assistive technology.
- Ability to plan, coordinate, and conduct continuing education for educational personnel, parents, and students.
- Ability to use professional literature, evidence based research, and continuing education content to make practice decisions.
- Ability to provide legal and ethical supervision of occupational therapy assistants.
- Skill in effective oral and written communication.

EDUCATION AND EXPERIENCE:

- Have successfully completed and graduated from an accredited occupational therapy professional program recognized by NBCOT and have completed all fieldwork requirements.
- Two years of experience as an occupational therapist, preferably in school system or other pediatric practice setting.

SPECIAL REQUIREMENTS:

- Initial certification by National Board for Certification of Occupational Therapy.
- Current license by the North Carolina Board of Occupational Therapy.

Occupational Therapy Assistant

SALARY GRADE: 67

NATURE OF WORK:

An employee in this class assists in the process of screening and evaluation, and the development and implementation of intervention services under the supervision of a licensed occupational therapist. The occupational therapy assistant works with students identified with or suspected of having disabilities that interfere with their ability to perform daily life activities and participate in necessary and desired occupations.

The assistant is expected to implement individually designed interventions based on occupational performance deficits in the areas of personal care, student role/interaction skills, process skills, play, community integration/work, and graphic communication. The interventions are planned with the supervising occupational therapist. The occupational therapy assistant is expected to review outcomes and modify intervention programs in coordination with the supervising occupational therapist.

Errors in service could result in serious harm to students and potential liability for the school system, the supervising occupational therapist, and the assistant. The supervising occupational therapist defines the level of supervision required in the work environment based on recommendations by The North Carolina Board of Occupational Therapy.

ILLUSTRATIVE EXAMPLES OF WORK:

- May contribute to the occupational therapist's evaluation of student's abilities through a variety of functional, behavioral, and standardized assessments, data collection, checklists, and interviews with

family, student and educational personnel, and observations once competency has been demonstrated.
- May contribute to the occupational therapist's development of individualized intervention plans.
- Based on the intervention plan, selects and implements therapeutic interventions to enhance student performance in areas of occupation, safety, and social participation within the school environment.
- Based on the intervention plan modifies environment including equipment, materials, devices, and adapts processes including the application of ergonomic principles.
- Explains intervention techniques to student, parents, and educational personnel.
- Continuously monitors through observation and consultation student progress and the effect of intervention and need for continuation, modification, or termination. Communicates this information to the occupational therapist.
- Documents occupational therapy intervention services and maintains administrative records in accordance with state guidelines, school policy, and reimbursement standards.
- Participates in multi-disciplinary team meetings to communicate student progress.
- Maintains inventory of therapeutic equipment and projects needs for budget planning.
- Maintains, organizes, and prioritizes workload and treatment environments including inventories.
- Uses professional literature to make informed practice decisions.
- Uses good time management skills.

KNOWLEDGE, SKILLS AND ABILITIES:

- Knowledge of basic features of main occupational therapy theories, models of practice, principles, and evidence-based practice.
- General knowledge of human development throughout the life span.
- Ability to articulate the role of the occupational therapy assistant and the occupational therapist in the evaluation, intervention planning, intervention process.
- Ability to articulate difference between occupation and activity.
- Ability to analyze tasks relative to areas of occupation, performance skills, activity demands, context (s), and student factors to implement the intervention plan.
- Ability to recognize occupational performance deficits in the areas of personal care, student role/interactive skills, process skills, play, community integration/work, and graphic communication.
- Ability to articulate the influence of socio-cultural, socioeconomic, and diversity factors on student occupational performance.
- General knowledge of the federal, state, local legislation, regulations, policies and procedures that mandate and affect school-based occupational therapy services.
- Skill in gathering screening and evaluation data, completing checklists, histories, and interviews.
- Ability to select, adapt, and sequence relevant occupations and purposeful activities that support intervention goals.
- Ability to provide occupationally based interventions to achieve student participation in school environment.
- Skill in effective oral and written communication.
- Ability to maintain safe environments, equipment, and materials.
- Ability to prepare and maintain accurate records and progress notes.

SUGGESTED TRAINING AND EXPERIENCE:

- Successful completion and graduation from an accredited associate's degree Occupational Therapy Assistant program recognized by NBCOT and completion of all fieldwork requirements.
- Two years of experience as an occupational therapy assistant, preferably in pediatrics.

SPECIAL REQUIREMENTS:

- Initial certification as an occupational therapist assistant by the National Board for Certification of Occupational Therapy (NBCOT).
- Current license as an occupational therapist assistant by the North Carolina Board of Occupational Therapy

Lead Occupational Therapist

SALARY GRADE: 78
NATURE OF WORK:
In addition to the work and qualifications of staff occupational therapists, the Lead OT Specialist also performs the following functions:

- Coordinates hiring and orientation of new occupational therapy team members
- Coordinates contract services
- Performs mid-year and annual staff evaluations, including site visits
- Coordinates disciplinary process of occupational therapy team members
- Assigns caseloads for the occupational therapy team members
- Provides clinical support, mentorship, and advocacy for occupational therapy team members
- Maintains and reports on caseload/student data/CECAS data
- Orders treatment supplies and test protocols
- Coordinates occupational therapy intern program
- Coordinates OT staff meetings
- Provides link between EC Administration and occupational therapy team/program
- Processes monthly and yearly program statistics
- Supervises and assists in occupational therapy team member projects
- Coordinates Extended School Year OT staffing
- Maintains current occupational therapy team employee manual
- Maintains inventory of supplies

EDUCATION AND EXPERIENCE:

- Have successfully completed and graduated from an accredited occupational therapy professional program recognized by NBCOT and have completed all fieldwork requirements.
- Five years of experience as a public school occupational therapist

SPECIAL REQUIREMENTS:

- Initial certification by National Board for Certification of Occupational Therapy.
- Current license by the North Carolina Board of Occupational Therapy.

Performance Appraisal

The quality of occupational therapy services in North Carolina public schools impacts student achievement. An essential element in promoting good service delivery is the evaluation of staff. An evaluation system should serve to assess competence of the employee in order to assure quality. Evaluation processes also function as tools to improve practitioner skills and knowledge by identifying strengths and weaknesses. In this role, the evaluation guides the professional development and growth of the employee. Finally, evaluations provide specific information for employment decisions. For the public schools, employee evaluation provides a means to improve student performance by helping therapists and other staff to assess and improve their skills.

The work of occupational therapy personnel must be routinely evaluated. School systems have the option of adopting evaluation instruments provided in Appendix A of this manual or may choose to use instruments developed by the school system. Locally developed evaluations must be properly validated and include standards and criteria that are similar to those of the provided samples. School systems are encouraged to select evaluation instruments and processes that best meet their needs and desired results. (NCDPI, 2009) In addition to formal annual performance appraisals, managers and administrators may want to include the following in assessing therapy staff:

- At least one on-site formal observation per year, with pre- and post-observation conferences
- At least two informal observations per year
- Feedback from parents and staff who work with staff member
- Documentation reviews (e.g. intervention notes, progress notes, evaluation reports, Medicaid logs, weekly schedules, mileage submissions, etc.)
- Employee input/reflection on own work
- Performance Plan

Employment Options

LEAs have a variety of options when acquiring practitioners to provide occupational therapy services. The LEA may choose to hire the practitioner directly, either on a full-time or part-time basis, or they may choose to establish a contractual agreement through private practitioners, therapy clinics, home health agencies, health departments, or hospitals. A combination of these options may also be used. Advantages of directly hiring OT staff may be increased contact with school staff, increased availability of the practitioner, and flexibility of scheduling. Contracting is an advantage to the public agency when there are low numbers of students who need services. Sufficient time should be allowed for all the responsibilities of the therapist with either method of hiring. (Alabama Handbook, 2008)

Employment

School employment is attractive to many occupational therapy practitioners because of the state benefits, shortened work year, breaks during the school year, and shorter work days. In cases of direct employment, the occupational therapy practitioner is generally a full-time employee with benefits or a part-time employee with no or limited benefits. LEAs have the option of sharing a therapist with neighboring education agencies. The school system is responsible for recruitment, verification of credentials, retention, and liability of OT personnel. The LEA reimburses travel expenses if the practitioner travels to different schools and provides access to tools, materials, and tests for the therapist to perform his/her work. The practitioner receives training specific to local policy, generally with other special education teachers and related service providers (Alabama Handbook, 2008).

Contracting

This section is intended as guidance for Exceptional Children administrators, finance officers, and school Medicaid program administrators. It was developed based on request by school administrators and companies providing contracted therapists to school systems. The first section includes suggestions for all related service contracts and the second outlines considerations when Medicaid cost recovery affects contracted agencies or personnel. This is not legal counsel; it merely offers suggestions about what to consider when developing contracts for related services under IDEA.

LEAs using contracted occupational therapy staff, may want to consider the following:

- The contract and job performance of contracted staff should be reviewed at least annually
- Contracts should clearly state that all documentation/work product (e.g. daily treatment notes) completed by contracted personnel is the property of the LEA and shall remain in the LEA
- LEAs should establish the process and time-line for collecting and archiving documentation/work products completed by contracted personnel
- Private therapy services (non-school related) should not be provided at school due to liability issues, even when parents are agreeable
- Appropriate supervision of contracted therapy assistants must be ensured according to licensure board standards for related service providers. LEAs should make every effort to contract therapy assistants and supervising therapists from the same agency.
- Caseload limitations, as outlined in DPI EC policy NC 1508-4, apply to contracted therapists as well as directly hired therapists
- Documentation of current licensure for contracted personnel must be provided to the LEA annually and copies kept by the LEA
- The roles/duties of contracted personnel (attending IEP meetings, staff training, duties outside of school hours/work sites)should be clearly stated
- LEAs should consider requiring continuing education hours focused on school-based practice
- LEAs should verify that contracted personnel contact the DPI OT Consultant annually to ensure compliance with state policy and best practice standards
- Competitive salary information is available on the North Carolina Occupational Employment and Wages website http://eslmi23.esc.state.nc.us/oeswage/
- Remember, the LEA is paying for these services and should negotiate for what is fair and needed

Medicaid Cost Recovery Considerations:

Best practice suggests that service providers, whether contracted or directly hired:

- be blinded to a student's Medicaid eligibility
- have workload assignment based on logistics or provider strengths
- understand clearly whether the LEA or the contracting agency will be submitting claims to Medicaid for services rendered by contracted personnel
- If the contracting agency is submitting claims to Medicaid for school services, then there should be little, if any, additional rate paid by the LEA for those services
- If an LEA is experiencing a personnel shortage, make sure coverage is not provided only to Medicaid-eligible students

Factors to consider in the administration of Medicaid cost recovery programs:

- Medicaid eligibility should NEVER influence decisions about eligibility for special education, evaluation, service delivery or discharging a service. Be aware that there may be financial incentives for decision makers/IEP Team members and have appropriate safe guards in place
- Decisions about service delivery, type or model of service and location are dictated individually by the IEP Team, NOT Medicaid policy

New Therapist Orientation

School administrators should be aware that OT pre-service training may not necessarily address all of the competencies needed to be practitioners in an educational setting (Missouri Handbook, 2009). As such, whether new to the field of occupational therapy or new to school-based practice, occupational therapy

practitioners working in public schools for the first time require close supervision and support for at least 90 days, and structured supervision for at least six months following hire. In addition to orientation to and mastery of local policy and procedure, school-based practitioners need to learn state and federal regulations governing practice. The learning curve for documentation in school-based practice is very steep and should be closely monitored by compliance officers, case managers, and/or more experienced related service providers. Many of the learning objectives described in the following section on Fieldwork Programs will apply to new therapist orientation and can be modified for that purpose. In addition, North Carolina DPI offers a *New Therapist Boot Camp* each August to prepare new practitioners for school-based practice and introduce them to available resources. It is recommended that new practitioners review these *Guidelines* as part of orientation.

It is also recommended each school district develop an occupational therapy procedure manual that may include the following information:

- Job description
- Organizational chart and direct line of supervision
- Performance evaluation process
- Policies related to the provision of occupational therapy services
- Policies related to the supervision of COTA and FW students
- Description of service delivery approaches
- Referral process for occupational therapy services
- Evaluation and assessment procedures
- Documentation guidelines
- Samples of forms and description of how to complete the forms
- Procedures to requisition materials and equipment
- Procedures to inventory and maintain equipment
- Procedures to request travel reimbursement
- Procedures to request leave (i.e., professional, sick, and personal)
- Confidentiality requirements
- Policies related to conflict of interest
- A list of available community services relevant to students with disabilities

(Kentucky Handbook, 2006)

Recruitment and Retention

Recruitment

At the end of the 2008-2009 school year, there was a shortage of 100-125 occupational therapy practitioners in North Carolina public schools. NC DPI is engaged in the following efforts to address the shortage:

- Contracts with UNC Chapel Hill for an OT consultant to serve the state
- Offers tuition reimbursement grants to 8 new OT graduates per year. Eligible OTs must have graduated in the past year and commit to two years of service in an North Carolina LEA
- Provision of continuing education opportunities for school-based OTs:
    - Annual OT Institutes at NC DPI Conference on Exceptional Children
    - Summer Institutes
    - Related Service Summits

    - Regional meetings
    - LEA site visits
    - Topical trainings (Medicaid, Ethics, New Therapist)
- Provision of technical support on an individual or small group basis
- School OT website and listserv
- Annual offer for OT Consultant lectures at North Carolina university and community college OT training programs
- Collaboration with North Carolina university and community college OT training programs to create school-based internships (Fieldwork)

LEAs may want to consider advertising for occupational therapy vacancies in some of the following:

- North Carolina School-based OT website job postings (no fee) - http://www.med.unc.edu/ahs/ocsci/nc-school-based-ot-site/jobs
- TeachersTeachers.com (no fee to North Carolina LEAs) - http://www.teachers-teachers.com/
- North Carolina Occupational Therapy Assoc. (fee) - http://ncota.org/resources/classifieds
- Advance for Occupational Therapy Practitioners (fee) - http://www.advanceweb.com/web/advertising_PDFS/2009/recruitment/OT_RecRates_2009.pdf
- National Coalition on Personnel Shortages in Special Education & Related Services - www.specialedpros.com

In addition to advertising vacancies, LEAs can support local development of occupational therapy practitioners by including OT in high school career fairs and having an OT speak in health professions courses.

Retention

Turnover of occupational therapy staff has significant cost in terms of educational outcomes and resources to fill vacated positions. LEAs can expect to spend an additional one-quarter of a practitioner's annual income to recruit and orient an occupational therapy practitioner. The impact on student performance and the investment of resources suggest LEAs make every effort to retain occupational therapy staff. Many strategies are practical, rather than financial, and with good planning and intentional communication, LEAs are finding these practitioners enjoying long, effective careers in school-based practice. Some suggestions follow:

- Communicate who will supervise these related service providers
    - Who will conduct their performance appraisal?
    - Who will provide their ongoing supervision?
    - To whom will they direct workplace concerns, e.g., logistical, administrative, material support?
- Conduct performance appraisal at least annually
- Include these practitioners in staff development/training
- Include these practitioners in EC/LEA communications
- Implement local salary step schedules to acknowledge years of experience
- Allocate ABC bonuses and local supplements to school-based OTs
- Consider benefits that would offset below-market salaries:
    - Reimbursement for state licensure
    - Reimbursement for membership in professional association (North Carolina Occupational Therapy Association and/or American Occupational Therapy Association)
    - Reimbursement for continuing education (specifically NC DPI Conference on Exceptional Children and Occupational Therapy Institute)
    - Reimbursement for individual malpractice insurance

- Provision of requested professional journals and include relevant resources in LEA professional library
- Provision of administrative supports for itinerant providers (e.g., laptops, pagers, PDAs)
- Allocation of funds for treatment supplies

In addition, the National Clearinghouse for Professions in Special Education (2002) makes the following suggestions:

- Encourage participation by OT staff is stakeholder groups at the state (e.g. Related Service Summits, Summer Institutes, annual OT Institute) and district levels (e.g. staff meetings)
- Use electronic media to communicate at the national, state, and district levels (e.g. participation in AOTA School System Special Interest Section, membership in North Carolina School OT listserv, accessing North Carolina School-based OT website at http://www.med.unc.edu/ahs/ocsci/nc-school-based-ot-site
- Complete "environmental scanning," including exit interviews, whereby factors that affect attrition are identified
- Increase communication flow from administration offices to practitioners
- Provide opportunities for shared decision-making
- Implement activities that facilitate the sharing of information between general, special educators, and related service providers

Liability

Liability is a complicated issue for occupational therapy practitioners working in North Carolina public schools. As stated above, the work of these personnel is often not well understood. Due process, malpractice and/or misconduct allegations, and practitioner status as "at will" employees doing work which incurs high liability risk with children contributes to the complexity. As such, occupational therapy practitioners are strongly encouraged to obtain their own professional liability insurance to supplement coverage provided by the LEA. Reimbursing this important professional liability insurance for therapy staff is one effective means of employee retention for LEAs.

Therapist Allocation and Workload Determination

Assessing Personnel Needs

Based on the 2008 North Carolina Public Schools Statistical Profile, LEAs including charter schools reported student enrollment of 1,481,981 students, and of those, 186,753 were identified as students with disabilities (ages 3-21) being served in exceptional children programs. In the last five years, about 11% of students with disabilities have received occupational therapy as a related service. Using this figure, we can estimate about 20,500 students in North Carolina have OT as part their IEP. This assumes a statewide need of 585 occupational therapy practitioners serving in public schools (using an average caseload number of 35 students; see following section). Data from the UNC Sheps Center Allied regarding employment setting for allied health practitioners indicate 462 occupational therapy practitioners (331 occupational therapists and 131 occupational therapy assistants) report working at least some portion of their work week in an educational setting. At minimum, an additional 123 OT practitioners are needed to work in North Carolina public schools.

Given these data, LEAs can use a ratio of 1 occupational therapy practitioner for every 2055 enrolled students as a starting point in determining full-time equivalent (FTE) needs. LEAs with fewer than 2055 students should employ at least a half-time occupational therapist. This ratio is a rough starting point and not intended to be formulaic in determining OT allotment. The variability of local demographics and supports, as well as the individualized nature of the IEP, require each LEA to assess its own staffing needs.

The number of occupational therapy staff required in an individual LEA depends on several factors. Mainly, full-time equivalent (FTE) allocation is driven by the collective service delivery time on all IEPs where OT is included. Some cases may, from time to time, require more time and attention than the IEP service delivery indicates. (If service to a particular student routinely exceeds the IEP service delivery time, the IEP Team may need to consider changing the documented IEP service delivery to accurately reflect therapist time.)

Assigning Work

The Exceptional Children Division *Policies Governing Services for Children with Disabilities(2007)* Section 1508-4 states the total caseload for individual related service providers is not to exceed fifty (50) students. This section is intended to provide additional guidance on how to determine workload and staff allocation for occupational therapy practitioners. The number of related service staff required in an individual LEA depends on several factors. Mainly, full-time equivalent (FTE) allocation is driven by the collective service delivery time on all IEPs where the related service is indicated. Some cases may, from time to time, require more time and attention than the IEP service delivery indicates; that said, if service to a particular student/team routinely exceeds the documented IEP service delivery time, the IEP team may need to consider changing the documented IEP service delivery to accurately reflect provider time. In addition to these IEP contact hours, the provider workload includes time for:

- IEP meetings
- Pre-referral meetings and screenings
- Evaluations and observations
- Documentation, including Medicaid logging
- Case management (for SLPs only)
- Provider assistant supervision, when applicable
- Program consultation
- Communication & consultation with staff/parents/outside agencies
- Travel between sites (varies based on number of sites served and distance between sites)
- Regular education initiatives, e.g., 504 plan interventions, Responsiveness to Instruction (RtI) interventions, Coordinated Early Intervening Services (CEIS) interventions, Positive Behavioral Support (PBS) initiatives
- Equipment acquisition, maintenance, and training
- Intervention planning and scheduling
- Professional development
- Staff meetings, site-based committee meetings, and site-based duties, as assigned
- Lunch

The formula to compute the required FTE of a related service type at a given site, or an entire LEA, is based on the number of IEP contact hours. This requires accurate caseload data management; LEAs are encouraged to obtain updated caseload rosters, by school or site, from each provider on a frequent (e.g. monthly, quarterly) basis. Minimal requirements for a school's therapy roster include:

- STUDENT NAME/DOB
- SCHOOL
- FREQUENCY OF SERVICE (e.g., 1x30 minutes/week)
- IEP CONTACT HOURS PER WEEK, for example (provided as example only; actual service frequency should be determined based on each student's need and may not appear below):
    - 1x30 minutes/week = .5
    - 1x60 minutes/week = 1.0
    - 2x30 minutes/week = 1.0
    - 1x30 minutes/month = .125
    - 2x45 minutes/month = .375
    - 7x30 minutes/9-week reporting period = .38

NCDPI Consultants can help LEAs determine the number of FTE needed and the relative productivity of existing staff, if required student data is available, using the following method:

1. The weekly IEP contact hours for the site or provider are totaled.
2. Total IEP contact hours are then multiplied by a factor ranging from 1.7 - 2.7 to derive the number of service hours needed to effectively serve the site.*****
3. The service hours are then divided by 37.5 (1 FTE). The resulting number indicates the number of FTE needed for the site or the percentage FTE the provider is using.
4. Based on this factor, one FTE can be expected to deliver somewhere between 20-22 IEP contact hours per week, depending on the severity of students served, evaluation load, and distance between/number of sites served.

Further staff time may be allocated for tasks not related to Exceptional Children service delivery, depending upon LEA needs, values, human resource philosophy, student/family needs, and provider availability. Many related service providers make valuable contributions to student assistance teams, RtI and PBS initiatives, site-based staff meetings and professional development, and other site-based or student-support duties, including transition and work place support. If assigning tasks not related to service delivery to related service providers, administrators are encouraged to prioritize school improvement and student success initiatives. Time for these duties must be factored into providers' workloads when determining caseload assignment, to ensure quality service delivery.

***** The 1.7 multiplier is derived (based on breakdown of 1 FTE full-time equivalent at 37.5 hours/week) as follows:

- 72% - intervention, documentation, and planning (allowing 1 hour of documentation for every 4 hours spent intervening)
    - for 37.5 hours/week, this means 27 hours for intervention, documentation, and planning
    - of those 27 hours, 20%, or 5.4 hours will be spent documenting
    - this leaves 21.6 hours available for student contact, e.g., 21.6 IEP hours can be assigned per FTE
- 13.3% - assessment (5 hours/week)
- 8% - IEP meetings and staffings (3 hours/week)
- 6.7% - lunch (2.5 hours/week)

The formula suggests:

- 21.6 contact hours (58% of a provider's time) is used for intervention
- remaining 15.9 hours (42% of time) is used for extra-intervention duties

- ratio of 21.6 : 15.9 = 1 : .74

This means, for each 1 hour of service indicated on an IEP, the provider needs an additional .74 hours, or 1.74 hours total (about 1 hour, 45 minutes) to do the job. Looking at it another way, 21.6 (max. contact hours) x 1.74 (contact hours + the rest) = 37.5 (1 FTE). In practice, (e.g., in determining workload distribution and school assignment) by summing the IEP hours at a given school and multiplying by a factor ranging from 1.7 - 2.2, the FTE needed to serve the site would be determined. This generally works effectively for providers serving 1-2 sites and not supervising therapy assistants.

For providers who serve more than 3 or more sites, supervise entire/multiple assistant workloads (which is the case for many North Carolina LEAs), or have heavy case management responsibilities, 1.74 does not suffice. In this case, allotting up to an additional 5 hours/week (6.7% or .067) for travel between sites (or 30 minutes a day) and increasing IEP meetings/staffing/case management (to include supervision time) to 10 hours/week (26.6% or .266).

***** The 2.7 multiplier is derived (based on breakdown of 1 FTE full-time equivalent at 37.5 hours/week) as follows:

- 46.7% - intervention, documentation, and planning (allowing 1 hour of documentation for every 4 hours spent intervening)
  - for 37.5 hours/week, this means 17.5 hours for intervention, documentation, and planning
  - of those 17.5 hours, 20%, or 3.5 hours will be spent documenting
  - this leaves 14 hours available for student contact, e.g., 14 IEP hours can be assigned per FTE when serving multiple sites and/or supervising therapy personnel
- 13.3% - assessment (5 hours/week)
- 26.6% - IEP meetings, staffings, and case management (10 hours/week)
- 6.7% - travel between sites
- 6.7% - lunch (2.5 hours/week)

The travel-/supervision-/case management-intensive formula suggests:

- 14 hours (37.3% of a provider's time) are used for intervention
- remaining 23.5 hours (62.7% of time) are used for extra-intervention duties
- ratio of 14 : 23.5 = 1 : 1.68

This means for each 1 hour of service indicated on an IEP, the provider needs an additional 1.68 hours, or 2.68 hours total (2 hour, 41 minutes) to do the job. Looking at it another way, 14 (max contact hours) x 2.68 (contact hours + the rest) = about 37.5 (1 FTE).

The following table may be helpful in selecting the factor to use when calculating workload for a given OT provider:

FACTOR	**EXTRA-INTERVENTION DUTIES**
1.7 – 1.8	*Very minimal*; use for therapy assistants & providers who: • Serve 1-2 sites • Serve students with low-intensity needs • Do not supervise therapy assistants • Have limited or no participation in regular education

	initiatives • Majority of workload are students with minimal need/severity
1.9 – 2.0	*Minimal*; use for therapy assistants & providers who: • Serve 2-3 sites • Serve students with varied intensity of need • Do not supervise therapy assistants • Have some participation in regular education initiatives • Majority of workload are students with low need/severity
2.1 – 2.2	*Moderate*; use for providers who: • Serve 3-4 sites • Serve students with varied intensity of need • Supervise 1 therapy assistant • Have routine participation in regular education initiatives • Majority of workload are students with mild need/severity
2.3 – 2.4	*Somewhat extensive*; use for providers who: • Serve 3-4 sites • Serve students with varied intensity of need • Supervise 1-2 therapy assistants • Have routine participation in regular education initiatives • Majority of workload are students with moderate need/severity
2.4 – 2.5	*Extensive*; use for providers who: • Serve 4-5 sites • Serve students with high intensity of need • Supervise 2-3 therapy assistants • Have routine participation in regular education initiatives • Majority of workload are students with significant need/severity
2.6 – 2.7	Very extensive; use for providers who: • Serve 5 or more sites • Serve students with high intensity of need • Supervise 2-3 therapy assistants • Have significant participation in regular education initiatives • Majority of workload are students with maximal need/severity

Co-practice and Service Teams

Many LEAs employ a team approach to occupational therapy service delivery. Faced with the challenges of effective consultation in self-contained classrooms, changes in evaluation approach and focus, and more complex scheduling/planning needs mandated by inclusion, working as a solo OT provider has become increasingly demanding. Some LEAs have experienced some staff attrition in light of these changes, and with the job market looking favorable for occupational therapists in non-school settings, retention is a priority.

Staff need support; the availability of another therapist to offer accountability, think creatively about clinical issues, and share the load addresses that need.

In addition to these challenges, several myths exist regarding COTA supervision: namely, that it increases work load; it decreases productivity; and COTAs need not only supervision, but clinical "coaching." These may be true in part or at times, but most COTAs working in North Carolina public schools are gifted, experienced clinicians who are at least as strong in many areas (e.g., organization, documentation, program development) as their occupational therapist peers. Done well, the COTA/OT partnership can be extremely effective and far more efficient than the therapist working alone.

Finally, service to different student populations is differently suited to and energizing among practitioners. Some practitioners may find some settings perplexing and/or intimidating, especially in middle and high school where:

- students can be hard to find and schedule
- self-contained classrooms tend to be fairly entrenched cultures
- therapists are not on-site as often and may not participate in the school community
- service efficacy is harder to envision

Team caseloads, or co-practice, can bring equity to both the COTA supervision and setting-preference aspects of caseload distribution, and opens doors for creative, positive service to all students. Co-practice offers an opportunity to, if nothing else, share the challenges—and joys—of school-based practice. Some of the benefits of team caseload assignment include:

- fewer missed intervention sessions
- increased effectiveness and "clout" of classroom interventions and teacher collaboration
- more consistent OT representation at IEP meetings
- capacity building for practitioners
- more sustainable programming

So, what does this look like in practice? Does the team of therapists and assistants intervene together with the same students? Do they just divvy up the caseload list and plan to meet up at the end of the year? How does this increase quality and productivity? No doubt, each team will choose to access the opportunities inherent in co-practice differently. Some examples of potential scenarios follow:

A) There is a self-contained class with 6 students receiving weekly OT for 30 minutes. Seen separately by one therapist in the classroom, these students require 3 hours of service delivery, plus planning & documentation time. Two therapists running a weekly 30-minute group—based on the IEP goals and needs of each student—in the classroom for these 6 students requires 1 hour of labor, plus planning and documentation time. This represents a savings of 2 hours of labor, allows more opportunity for modeling and consultation with classroom staff, and increases the clout/impact of recommendations and follow-up. This model remains time-efficient with groups as small as 2 students. Use of group service delivery occurs when intervention in a group is what each participant needs in order to make progress on IEP goals.

B) A therapist is anticipating a change in service frequency with the student at the annual review meeting three-months pending. To check clinical impressions, the two practice partners alternate intervention sessions with the student for several weeks and then discuss the case. The plan is presented to the team at the annual review meeting with the professional opinion of two therapists. If needed, both may attend the meeting, particularly in difficult cases.

C) An LEA has 247 students receiving occupational therapy as a related service. Two full-time occupational therapists, two half-time occupational therapists and three full-time COTAs serve the LEA. The administrator divides the entire LEA OT caseload, based on IEP contact hours, and assigns work as follows:

TEAM 1 - 2/3 OF OT CASELOAD	TEAM 2 - 1/3 OF OT CASELOAD
Full-time Occupational Therapist	Half-time Occupational Therapist
Full-time Occupational Therapist	Half-time Occupational Therapist
Full-time COTA	Full-time COTA
Full-time COTA	

Each team is responsible for assigning students to team members and reporting back to administrator with caseload rosters for each practitioner.

D) At a certain elementary school there are four 3rd graders with written communication goals. One of the third grade teachers, Mr. Wise, has two of the four students, and has agreed to have the OT co-practice partners work weekly in his class during cursive handwriting instruction. The other two students are each in different classrooms, but come visit Mr. Wise's class during the weekly cursive session with the OTs. Again, four students are seen inclusively by two therapists requiring one hour of labor, compared to the two hours of labor required if seen in a one-on-one pullout model by one therapist.

Co-practice is a new way of thinking and working. LEAs are encouraged to consider building in an assessment/tracking element as they implement the approach.

Teams can be formed based on several factors:

- number of service hours each team represents
- geography
- practitioner preference
- practitioner experience and skill sets
- prior school assignments

Effort should be made to keep the ratio of service hours available to actual hours required for assigned sites similar across teams. Additional time may need to be allocated for teams with preschool assignments, given the rapid growth in these caseloads through the school year. It is not recommended teams start the year with a ratio above .90, given annual/historic 7-8% growth in LEA OT caseload number through the school year.

Materials, Equipment, and Space

While needs for space vary from therapist to therapist and school to school, occupational therapists must have access to space to conduct assessments and store costly therapy supplies/equipment. As caseloads

increase, therapists will be spending more time in one location. At minimum, occupational therapy personnel need:

- Intercom or phone access in work area
- Internet access in work area
- Keyed access to testing area with noise level/environmental hazards commensurate with regular classroom and adjustable table with 4 chairs
- Locking storage and/or file cabinet for confidential student records, for which therapist is a key holder
- Voice mail
- Mail box in office with other staff mail boxes
- Access to copier and teacher resource room
- Access to PTA funds when they are made available to other EC staff (e.g. speech language pathologists, physical therapists)

Materials and equipment to support the provision of therapy services are necessary and their purchase and storage need to be addressed by administrators and practitioners. Practitioners fabricate some materials that require additional workspace and special purchasing considerations. Materials and equipment should support the goals and accommodations and/or modifications as stated in the student's IEP.

Examples of frequently used materials and equipment include the following:

- Positioning equipment (e.g., adapted chairs, potty chairs)
- Self-help devices (e.g., spoons, scoop plates, zipper pulls)
- Supplies for adapting materials and equipment (e.g., velcro, splinting material, strapping)
- Technology devices (e.g., switches, computers, light boards)
- Adaptive classroom tools (e.g., picture schedules, slant boards, adapted scissors)
- Standardized assessments (e.g., test kits and manuals)

(Alabama Handbook, 2008)

Continuous Quality Improvement

Peer Review

For school OT personnel who often work in isolation, routine sharing of work with colleagues in the field increases the probability that practice will be improved. Peer review is the process of the putting the employee's work under the scrutiny of impartial other occupational therapy practitioners in order to:

- Identify strengths and needs in skills (e.g., intervention methods, communication, or organization) and work product (e.g. evaluation reports, IEP goals, progress reports)
- Recruit a system of support for work (e.g., when a recommendation is likely to be contested)
- Create a catalog of exemplary work samples
- Create a culture of best practice, accepted standards
- Provide a consistent product or service to children, schools, families, and IEP Teams

In practice, school-based occupational therapy peer review teams meet regularly (at least monthly) and, using a preset rubric, comment on submitted evaluation reports, goal and intervention plans, progress reports, and intervention notes. In smaller LEAs where there are only one or two occupational therapists, peer review can be organized with OT practitioners in neighboring LEAs. The DPI OT Consultant is available to facilitate development of peer review teams and processes.

Continuing Competency

In North Carolina, occupational therapists and occupational therapy assistants must acquire at least 15 contact hours in approved continuing competence activities between July 1 and June 30 in order to stay licensed. These activities may include continuing education, academic coursework, small group study, formal mentorship agreements, fieldwork supervision, professional writing, presentation or instruction, attending professional meetings, board or specialty certification, and research and grants. Every other (odd- numbered) year, OT practitioners must have at least 1 contact hour of an ethics course related to the practice of occupational therapy, which DPI offers free of charge to school-based practitioners. DPI also routinely offers continuing education for related service providers in Related Service Summits, summer training opportunities, and the OT Institute as part of the annual DPI Conference on Exceptional Children. LEA administrators should encourage therapy personnel to participate in continuing competence related to working in schools and provide support for participation through funding and educational leave.

Staff Meetings

In LEAs employing three or more occupational therapy practitioners, conducting regular staff meetings is encouraged. Staff meetings allow for caseload management, case consultation, continuing education, literature review, communication of policy and procedure changes, program planning, and team-building. Regular staff meetings maintain uniform standards and values of practice among team members. In LEAs where one or two OT practitioners are employed, staff meetings can include other related service providers. Even in larger LEAs, occasional staff meetings of all related service providers can enhance collaboration for improving student performance.

Chapter 6

ETHICAL ISSUES

Ethical Standards in School-based Practice

Ethics—the consideration and valuing of "rightness" and "wrongness"—guide decision-making, clinical reasoning, behavior, and outcomes in school-based practice. In North Carolina, licensed occupational therapy practitioners working in public schools are held to two ethical standards:

- AOTA Code of Ethics
- Policy regarding the Code of Ethics for North Carolina Educators

Together, these prescriptive codes provide a framework for orienting new practitioners, guiding conduct for all practitioners, communicating expectations to employers, and ensuring public safety. All school-based OT practitioners and supervisors of these personnel should be familiar with the content of each code. Additionally, occupational therapy practitioners in North Carolina must participate in at least one hour of ethics training every other year in order to maintain licensure. DPI is committed to providing this training free of charge in required years to all school-based practitioners.

Ethical Decision-making

In most cases, school-based occupational therapy personnel operate with a high degree of autonomy in a setting beset with multiple overlapping layers and levels of policy, documentation processes, supervision, trans-disciplinary practice, and potential conflicts of interest. School OT staff members have limited natural opportunities for reflection and often do not have access to the power of a unified, professional voice at the state and national level, compared to other settings or professions. This combination of autonomy and complexity requires a reliable method for recognizing and confronting moral issues on the job. In resolving ethical issues, school-based practitioners are encouraged to consult with knowledgeable others if unsure of how to proceed or to clarify the nature of conflict; contact information for resources are found in the Appendices and include the following:

- North Carolina Board of Occupational Therapy
- North Carolina Occupational Therapy Association
- American Occupational Therapy Association
- NCDPI Occupational Therapy Consultant
- Four North Carolina University OT programs, and four North Carolina COTA programs
- NCDPI Policy, Monitoring, and Audit Section
- LEA Board Attorneys

All ethical issues should be resolved in adherence to the two codes cited above. Practitioners are encouraged to start resolution of perceived violations internally and proceed to the next agency/institution with jurisdiction over OT practice only if unsuccessful internally.

To resolve ethical dilemmas, the *Guidelines to the OT Code of Ethics* (AOTA, 2006) suggest the following decision-making process:

1. Clearly define the issue with relevant facts. If you can't do this step, identify and gather additional needed facts.
2. Identify the stakeholders, e.g. who will be affected by the outcome? Who's rights will be violated or who will benefit? Who gets to decide? How will the final decision be made (e.g. consensus, seniority, outside/objective agent?)
3. Identify ethical principles that apply.
4. Identify the options/possible courses of action; NOTHING is always an option.
5. Evaluate the consequences/conflicts/benefits of each option.
6. Get objective/informed help.
7. Have a team discussion – ethical decision-making is not a solo pursuit.
8. Make a decision – which option will result in the most good? Is the choice defensible?
9. Act…and be prepared to make revisions to your plan: "the difficult part of ethics is following through on the decision one has reached—knowing what is right and doing what is right are two different things"(Morris, 2003).
10. Evaluate the decision. How can the situation be avoided in the future? Why did the conflict arise in the first place? What were your roles in the dilemma and what role expectations are influencing your thinking? How does the decision align with relevant *Codes*? How does the decision align with general ethical principles/societal norms?
11. Follow-up with stakeholders; ensure support and respect for everyone.

Ethical Tensions in School-based Practice

In school-based practice, the occupational therapy practitioner is primarily committed to the student and the IEP Team. For the practitioner, this dual accountability drives:

- service delivery decisions
- selection of intervention types and methods
- advocacy for students, programs, and services
- diplomacy and collaboration
- evidence-based practice
- confidentiality
- pursuit of continuing competence
- personal skill building
- supervision of delegated tasks and programming
- awareness of policies affecting school-based practice
- time management as an itinerant employee
- documentation and Medicaid cost recovery

While ethical tension can develop in any of these areas, service delivery decisions are often raised as a primary area of ethical concern for school practitioners. Occupational therapy practitioners are, first and foremost,

client-centered; in school practice this means "student-centered" and "IEP Team-centered." That said, therapy staff may be perceived as holding the balance of power in matters regarding service delivery because the therapist has specialized knowledge and skills on which the team is dependent. In school practice, the occupational therapy practitioner's role on the IEP Team is to provide expert advice to inform decision-making; professional opinion does not trump IEP Team decision. The practitioner would only very rarely be unable to lend support to the IEP Team's decision in regard to occupational therapy, in which case one or more of the following conditions must be met:

- no data support the planned service or intervention
- a large body of similarly informed and responsible peer opinion does not support the planned service or intervention
- the OT practitioner is not competent to provide the planned service or intervention
- the decision violates practitioner conscience or mission of public education

(Weijer, Singer, Dickens, & Workman, 1998)

The other area of frequent ethical inquiry for school-based practitioners regards Medicaid cost recovery. Two questions clarify the tension:

1) Does recovering costs from Medicaid for school services violate FAPE?

Answer: IDEA 2004 Title I B 612a12A(i)(i) Agency financial responsibility.--An identification of, or a method for defining, the financial responsibility of each agency for providing services described in subparagraph (B)(i) to **ensure a free appropriate public education to children with disabilities, provided that the financial responsibility of each public agency described in subparagraph (B), including the State Medicaid agency and other public insurers of children with disabilities, shall precede the financial responsibility of the local educational agency (or the State agency responsible for developing the child's IEP).**

- Centers for Medicare & Medicaid Services 2003 Administrative Claiming guide: IDEA-related health services. The Individuals with Disabilities Education Act (IDEA) was passed to "assure that all children with disabilities have available to them… a free appropriate public education which emphasizes special education and related services designed to meet their individual needs." The IDEA authorizes federal funding to states for medical services provided to children through a child's Individualized Education Program (IEP), including children that are covered under Medicaid. In 1988, section 1903(c) of the Act was amended to **permit Medicaid payment for medical services provided to Medicaid eligible children under IDEA and included in the child's IEP.**

2) Are there inherent conflicts with school-based therapists participating in recovering costs from Medicaid?

Answer- **NO**

- IDEA makes provision for schools to recover their costs from public and/or private insurance
- In most cases in North Carolina, the LEA is the Medicaid provider, not the individual practitioner (may not be true in some contract arrangements)
- LEAs cannot 'make' money on Medicaid reimbursement. LEAs recover cost of extremely expensive, but mandated, services and personnel. Medicaid now requires each LEA to submit a cost report which specifies how much the LEA spent on services for students and how much they received from Medicaid. If they received more than they spent, they must return the difference; Medicaid eventually returns the difference if the LEA spent more that they received.
- Services are determined proscriptively through the IEP process and costs are recovered after the fact.

Answer – **THERE CAN BE**

- If service decisions are ever, in any way influenced by cost recovery, such as...
    - Performing evaluations only when service seems likely
    - Increasing service frequency or duration when the student has Medicaid
    - Students with Medicaid getting priority in receiving services (e.g., during staffing shortage)
- If the position of the service provider is funded from federal sources, billing Medicaid for the services would be considered 'double-dipping'
- If serving a student at school, North Carolina policy 16 NCAC 6C .0601 and 16 NCAC 6C .0602 stipulates that educators and service providers may not also solicit to serve that student in other settings, and need superintendent approval to do so:

    "Proper remunerative conduct. The educator shall not solicit current students or parents of students to purchase equipment, supplies, or services from the educator in a private remunerative capacity. An educator shall not tutor for remuneration students currently assigned to the educator's classes, unless approved by the local superintendent."
- If a contract stipulates the individual provider, not the LEA, will bill Medicaid (including Extended School Year services), it is recommended safeguards include:
    - LEA employees oversee eligibility determination, least restrictive environment/service location, and service delivery decisions
    - All providers, including contracted providers, serve a representative caseload of students, not Medicaid-eligible students only
    - All providers, including contracted providers, are familiar with IDEA and North Carolina Policies for Exceptional Children, and participate in continuing education relevant to school-based practice
    - All providers, including contracted providers, use the resources of the DPI Consultant in their practice area (e.g. school-based therapy web sites, listservs, and direct contact with the consultant)
- If the service provider is the only pediatric therapist in the area and must serve students in multiple settings, safeguards should be taken to ensure all decisions are based on data, well-supported and documented, and that other settings/procedures/relationships/income sources do not influence decisions for school services

Chapter 7

CLINICAL EDUCATION

Experiences for Occupational Therapy Students

Clinical education, or "fieldwork" as it is called in the occupational therapy profession, is far and away the most effective occupational therapy practitioner recruitment tool for LEAs. When OT students experience school-based practice and see the direct links between performance and participation in context, they are often compelled to select school practice as their first job.

When developing or revising a Fieldwork II OT/OTA Program, LEAs may want to visit the Fieldwork Education page on the American Occupational Therapy Association (AOTA) website, from which much of the information in this chapter was compiled.

While FW I students typically come with objectives and assignments from their academic program, FW II objectives, assignments, and expected outcomes are typically designed by the fieldwork site. According to AOTA, Level II Fieldwork is intended to "develop competent, entry-level, generalist occupational therapists or occupational therapy assistants" (AOTA, 2000a) by giving students experience delivering services. Fieldwork experiences help students develop clinical skills, as well as interpersonal skills needed to collaborate effectively in a given practice setting. OT students are encouraged to pursue FW opportunities in settings in which they would like to work eventually. For students interested in school-based practice, a Fieldwork Level II in the school setting will help increase their understanding of national and state legislation which govern OT practice, as well as increase their knowledge of how a school system operates. A school-based fieldwork also allows students to identify the OT practitioner's role in relation to families, teachers, and other school staff (Griswold & Strassler, 1995).

In their study of fieldwork experiences in school settings, Griswold and Strassler (1995) found that school-based OT practitioners who have supervised students were motivated to have FW students in the future because serving as a clinical instructor created opportunities for professional growth and because they believed the FW student positively influenced school administrators' view of OT. When determining how to structure supervision in an LEA, the articles included in the literature review at the end of this chapter can serve as a resource.

This chapter provides guidance for developing fieldwork objectives, assignments, and a 12-week program schedule for a well-rounded, fulfilling fieldwork experience that augments the learning and training of OT students, while contributing to services provided in North Carolina schools.

Organizational Procedures for Fieldwork Students

Each school system has different requirements for student interns and volunteers, such as TB tests, criminal background checks, and signing a confidentiality agreement. Initial contact with fieldwork students should include:

- a list of procedures to complete prior to or during their first week of fieldwork.
- typical hours his or her supervisor work
- dress code
- general information about parking and lunch (e.g. whether they will have access to a refrigerator or microwave)
- general information about caseload, including ages, common diagnoses, and service delivery methods

Introduction of Fieldwork Student

Prior to the beginning of each student's affiliation with the school system, LEAs may want to send out a letter to relevant school administrators, teachers, and parents of children on the supervisor's caseload. For example, below is a sample letter:

[Your LEA/Program Name Here] Occupational Therapy Department is fortunate to be affiliated with universities and colleges as a fieldwork site. This is an excellent opportunity to teach Occupational Therapy student interns about educationally relevant therapy and to have direct, hands-on experience with children with special needs within the school setting.

Our current intern_____ is from_____ College/University and will be working with [Your LEA/Program Name Here] from_____ to _____. He/She will be serving your child under the direct supervision of the site Occupational Therapist.
If you have any questions or concerns, please contact your site Occupational Therapist at _____.

Thank you.

Student Fieldwork Manual

Developing a Student Fieldwork Manual helps orient the student and may help clinical instructors organize and plan their time and activities. AOTA (2000b) recommends that a Student Manual include:

1. Orientation Outline –(see sample Fieldwork Student Orientation Checklist)
2. Assignments
3. Safety Procedures/Codes
4. Behavioral Objectives
5. Week-by-Week Schedule of Responsibilities
6. Confidentiality Information (Patient Rights)
7. Guidelines for Documentation:
    - Completed samples of all forms
    - Acceptable medical abbreviations
    - Discharge plan
    - Billing
    - Dictation Directions, if applicable
8. The Occupational Therapy Practice Framework: Domain and Process, 2nd Edition

You may also want to include:

- HIPAA Guidelines for Fieldwork
- The Occupational Therapy Code of Ethics
- Department Information (e.g. Policy and Procedures, Mission Statement, Dress Code)
- Organizational Chart for your facility
- List of Regularly Scheduled Meetings
    - Date/time
    - Location and directions
    - Purpose of meeting
- Description of Responsibilities of FW Supervisor and FW Student
- Guidelines for Determining Need for School-based Occupational Therapy
- Guidance on writing IEP goals, including sample long-term goals and IEP benchmarks (see sample Goal Bank)
- Information of differences between Medical and Educational Models of Therapy Provision
- Statement on OT as an educational relevant related service (see page 5-6 in Guidelines)
- Job Description for school-based OTR/OTA and/or a self-assessment of one's ability to fulfill Major Functions of School-based Practitioner
- Information on legislation and policies which govern OT practice in school settings (see chapter 1 of Guidelines)
- Sample Evaluation, Re-evaluation, IEP, and Transition Plans (using pseudonyms for all client-specific information)
- Relevant research articles supporting school-based OT (see EBP bibliography at end of Chapter 4)
- Any relevant material from your LEA's employee handbook or Human Resources Department

Assignments

Student assignments will likely be site-specific and may include unique learning opportunities (such as local site visits) or in-service presentations (on an area of interest to the FW student or on a topic currently of interest to LEA staff).

Some examples for assignments for FW students follow:

- **Written Treatment Plan:** At the beginning of the second week, the student will develop a written treatment plan for 1 session with a student with whom he/she is working. This plan will include the goal to be addressed and the plan for the treatment session, including the setting and materials needed. This assignment is intended to help the student problem solve and articulate an intervention plan. It will enable the FW supervisor to understand the vision for the session and provide feedback. The student may be asked to continue to submit written plans until she/he gains more autonomy with the caseload.
- **In-service Presentations or Special Project**: During the tenth week of fieldwork the FW student will either present an in-service or complete a special project based on the needs of the OT department/school; the needs of the students with whom the FW student has worked; and/or the FW student's professional interests. This project should be something of benefit to the OT practitioners in the LEA, but should also advance the FW student's professional growth. In the first few weeks of FW, the FW student should try to identify needs of the setting and/or identify topics of interest related to school-based practice. Special projects might include: developing a piece of assistive technology for a specific student or classroom; leading an OT-related training for teachers; or reorganizing resources

throughout the OT department. *FW students should decide on a topic for the in-service or special project by Week 6.*

- **Case Study**: FW students will prepare a 10-minute presentation about a student with whom they have worked closely, to be shared during an OT or related service provider team meeting. The case study student should be one that presents some challenges and for whom the FW student would like input from others regarding suggested approaches to intervention.
- **Individual Case Load**: FW students will be assigned their first client on the second week of FW, with additional students being added each week until reaching a minimum caseload of 20 students. FW students will be expected to maintain this caseload and fulfill the following responsibilities for all students on caseload:
    - Treatment Planning and Implementation - based on existing IEP
    - Development of Treatment Materials - to be used in treatment session
    - Collaboration with IEP Team - sharing relevant information with treatment team as needed
    - Daily Documentation - daily notes, progress notes, and Medicaid data submission
    - Evaluations - initial or re-evaluation
    - IEP Development in collaboration with IEP Team

  It is recommended the FW student maintain a separate notebook that includes:
    - Copies of IEP goals for all students treated (using only the student's first name and last initial)
    - Written treatment plans for every student on the caseload
    - Copies of daily notes and progress notes
    - Copies of work samples (revised from assignments developed by Julie Pace and Leslie Loe)
- **Contextual Observation:** FW students will be responsible for observing students and collecting data using the Sample/Template for Occupational Therapy Evaluation.
- **Assessment Administration**: FW students will be responsible for reviewing manuals and test materials for pediatric assessments used in the LEA. FW students will be responsible for evaluating the occupational-relevance of the assessment to school-based practice. Throughout the fieldwork, OT students will eventually take on full responsibility for conducting evaluations. Before completing the 12-week internship, the FW student would be expected to administer, in its entirety or a section of, each of the following assessments, when applicable:
    - Beery-Buktenica Developmental Test of Visual Motor Integration – 5th Edition (Beery VMI)
    - Bruininks-Oseretsky Test of Motor Proficiency - 2nd Edition (BOT-2)
    - Children's Handwriting Evaluation Scale (CHES)
    - Developmental Test of Visual Perception—2nd Edition (DTVP-2)
    - Evaluation Tool Of Children's Handwriting (ETCH)
    - Motor-Free Visual Perception Test – 3rrd edition (MVPT-3)
    - School Function Assessment (SFA)
    - Peabody Developmental Motor Scales- 2nd Edition (PDMS-2)
    - Pediatric Evaluation of Disability Inventory (PEDI)
    - Sensorimotor Performance Analysis
    - Sensory Processing Measure (SPM)
    - Sensory Profile
    - Sensory Profile School Companion
    - Adolescent/Adult Sensory Profile
    - Visual Skills Appraisal (VSA)
    - Clinical observations
    - Motor screening

- **Weekly Review:** During the first week, FW students and supervisors should establish a time to meet each week. This weekly performance review should be an opportunity for the student to ask questions and ask for feedback on specific concerns. The FW student and supervisor should also use this time to (either verbally or in writing) discuss:
    - the student's strengths
    - the student's areas for growth
    - the student's goals for the next week
- **Recommended Activities:** Observe and participate in:
    - Wheelchair Assessment Evaluation
    - Adaptive PE class
    - Assistive Technology Evaluation
    - In-service presentations and staff meetings

Behavioral Objectives

Fieldwork objectives inform FW students about the entry-level competencies expected by the end of the FW experience and may be used by supervisors to evaluate the student's progress throughout the affiliation. The LEA may want to use the AOTA fieldwork evaluation form to guide development of objectives or may choose to develop short-term or weekly objectives (AOTA, 1998). Finally, FW supervisors should talk with FW students about their expectations and goals in order to incorporate these into the objectives for the affiliation.

Sample Objectives:

- Adheres to guidelines for confidentiality.
- Articulates the value and role of occupational therapy in school-based practice.
- Articulates best practice in occupational therapy.
- Identifies client factors that are strengths and concerns.
- Based on evaluation results, develops appropriate long and short term goals to facilitate student in accessing and benefiting from his or her education.

For a full list of suggested Behavioral Objectives in the School Setting:
http://www.aota.org/Educate/EdRes/Fieldwork/SiteObj.aspx

Week-by-Week Schedule of Responsibilities

Providing FW students with a 12-week schedule will help students structure their time and monitor their progress towards meeting the behavioral objectives for their affiliation. This schedule might include: a plan for how and when the FW student will take on new responsibilities; a timeline for completion of assignments; and additional learning opportunities to take advantage of. Having a FW student requires an OT practitioner to deviate from his or her typical routine, thus a weekly schedule may help the clinical instructor structure the process of giving their student increasingly more responsibility.

Below is a sample schedule of assignments and activities students may be expected to engage in as they progress to taking on a full caseload. This is a selection of activities and expectations that might be appropriate as the student progresses through his or her FW; however, completion of many activities (such as attending IEP meetings, conducting evaluations, and leading group interventions) will be dependent on the supervising practitioner's schedule and caseload.

SAMPLE LEVEL II OT STUDENT PROGRAM PLAN

(revised from schedule developed by Julie Pace and Leslie Loe)

Week 1:

- Read student manual.
- Review assignments with supervisor.
- Student will be oriented to Fieldwork experience and expectations; the Exceptional Children's program; the OT team; and team members at the schools at which they will be working.
- Supervisor will review and discuss information on IDEA, Section 504, NCLB, and ADA and how they apply to related services.
- Supervisor will review with student any medical precautions relevant to students on caseload (including transfer training, pressure points, how to use wheelchairs and other assistive devices)
- Introduction to daily note and progress note formats and Medicaid billing.
- Introduction to goal writing and the development of short-term benchmarks.
- Review evaluation format and assessments.
    - Select at least one assessment to review in depth (perhaps one to be performed in upcoming weeks).
- Observe full schedule/assist as needed.
- Review student files and IEPs.
- Review procedures for assessment administration with supervisor.
- Observe partial evaluation.
- Observe consultation with teacher/staff.
- Student will maintain log of children seen (throughout fieldwork)

Week 2:

- **Assignment Due:** *Written Treatment Session*
- Continue to observe full schedule/assist as needed.
- Continue review of student files and IEPs.
- Continue review of assessment tools.
- Independently observe at least 1 client that will be added to your caseload in the upcoming weeks.
- Plan and lead ½ individual session for 2 students.
- Plan and lead ½ of two group sessions (*if group interventions are a part of clinical instructor's caseload)*.
- Begin writing daily notes for those students you treat.
- Collect observational data for evaluation in more than one school setting.
- Plan and provide consultation on 1 student.

Caseload: 1 student

Week 3:

- Continue to observe full schedule/assist as needed.
- Plan and lead individual sessions for 4 students.
- Plan and lead two group sessions.
- Complete daily notes for all students seen.
- Collect observational data for evaluation in more than one school setting.
- Assist in presenting information at IEP meetings.
- Plan and provide consultation on 2 students.

Caseload: 3 students

Week 4:

- Continue to observe full schedule/assist as needed.
- Plan and lead 2 intervention sessions **a day**.
- Plan and lead three group sessions.
- Complete daily notes for all students seen.
- Assist with at least 1 assessment.
- Collaborate with supervisor and IEP Team members to generate an IEP for 1 student.
- Assist in presenting information at IEP meetings
- Plan and provide consultation on students as needed.

Caseload: 7 students

Week 5:

- Continue to observe full schedule/assist as needed.
- Plan and lead individual session for 2-3 sessions a day.
- Plan and lead 3-4 group sessions.
- Complete daily notes for all students seen.
- Assist with at least 1 assessment.
- Continue collaborating with supervisor and IEP Team members to generate IEP for students on your supervisor's caseload.
- Assist in presenting information at IEP meetings.
- Plan and provide consultation on students as needed.

Caseload: 8 students

Week 6:

- Meet with supervisor to complete Mid-term Evaluation
- Continue to observe full schedule/assist as needed.
- Plan and lead individual session for 4-5 sessions a day.
- Plan and lead all group sessions.
- Complete daily notes for all students seen.
- Student will take primary responsibility for conducting evaluation for 1 student (if there are evaluations to complete)
- Continue collaborating with supervisor and IEP Team members to generate IEP for students on your supervisor's caseload.
- Assist in presenting information at IEP meetings.
- Plan and provide consultation on students as needed.
- **Assignment Due:** *Select In-service Topic or Special Project*

Caseload: 10 students

Week 7:

- Plan and lead individual session for 5-6 sessions a day.
- Plan and lead all group sessions.
- Complete daily notes for all students seen.
- Student will take primary responsibility for conducting evaluations on 1-2 students.
- Student will continue to present information at IEP meetings on students on his or her caseload
- Plan and provide consultation on students as needed.
- **Assignment Due:** *Case Study Presentation at OT team meeting*

Caseload: 15 students

Week 8:

- Plan and lead individual session for 6-7 sessions a day.
- Plan and lead all group sessions.
- Complete daily notes for all students seen.
- Student will continue to take primary responsibility for conducting evaluations on all assigned students.
- Student will continue to present information at IEP meetings on students on his or her caseload.
- Plan and provide consultation on students as needed.

Caseload: 20 students

Week 9:

- Student will have primary intervention responsibility for full caseload of students.
- Student will have primary responsibility for conducting evaluations for all assigned students
- Student will continue to present information at IEP meetings on students on his or her caseload
- Complete daily notes for all students seen.
- Plan and provide consultation on students as needed.

Caseload: 20 students

Week 10:

- Student will have primary intervention responsibility for full caseload of students.
- Student will take primary responsibility for conducting evaluations for all assigned students
- Student will continue to present information at IEP meetings on students on his or her caseload
- Complete daily notes for all students seen.
- Plan and provide consultation on students as needed.
- **Assignment Due:** *In-service or Special Project*

Caseload: 20 students

Week 11:

- Student will have primary intervention responsibility for full caseload of students.
- Student will take primary responsibility for conducting evaluations for all assigned students
- Student will continue to present information at IEP meetings on students on his or her caseload
- Complete daily notes for all students seen.
- Plan and provide consultation on students as needed.
- Begin discussing with students that next week will be your last week on fieldwork, in order to prepare students for your departure.
- Meet with supervisor to plan for transition of caseload.

Caseload: 20 students

Week 12:

- Meet with supervisor to complete Final Evaluation
- Student will have primary intervention responsibility for full caseload of students.
- Student will take primary responsibility for conducting evaluations for all assigned students
- Student will continue to present information at IEP meetings on students on his or her caseload
- Complete daily notes for all students seen.
- Plan and provide consultation on students as needed.

- Say goodbye to students and staff. Be sure to reinforce that this will be your last week, to prepare students to transition to working with your supervisor.
- Meet with supervisor throughout the week to begin transitioning caseload.

Caseload: 20 students

OCCUPATIONAL THERAPY FIELDWORK BIBLIOGRAPHY

GUIDANCE FOR FIELDWORK SUPERVISORS

Costa, D. M. (2006). The importance of feedback. [Electronic Version]. *OT Practice, 11*(16), 7-8.

Costa, D. M. (2006). Why take fieldwork students? [Electronic Version]. *OT Practice, 11*(12), 6.

Costa, D. M. (2007). Fieldwork issues: Fieldwork educator readiness [Electronic version]. *OT Practice, 12*(20), 20, 22.

Costa, D. M., & Burkhardt, A. (200). The purpose and value of occupational therapy fieldwork education (2003 Statement). *American Journal of Occupational Therapy, 57*, (6), 644.

Dour, M., Grey, C., & Michaelsen, S. (2007). Collaborative learning: The student perspective. [Electronic Version]. *OT Practice, 12*(4), 9–10.

Glassman, S. (2006). First-time level II fieldwork supervisors: Resources, training, and advice. [Electronic Version]. *OT Practice, 11*(20), 9–10.

Griswold, L. A. S. (1996). Six steps to developing a Level II fieldwork program in your school setting. *School System Special Interest Section Newsletter, 3*(4), 1-2.

SUPERVISION MODELS

Cohn, E., Dooley, N., & Simmons, L. (2002). Collaborative learning applied to fieldwork education. *Occupational Therapy in Health Care, 15*, 69-83.
For more than 10 years now AOTA has encouraged clinical reasoning and reflective practice during fieldwork experiences. One way to accomplish this is through collaborative learning, according to which knowledge is actively constructed within a cooperative environment. The five basic conditions of a collaborative learning situation, namely positive interdependence, face-to-face interaction, individual accountability, cooperative skills, and group processing, are illustrated by examples from three different clinical settings (psychiatric hospital, rehabilitation center, and adult day program).

Costa, D. (2007). Fieldwork issues: Fieldwork educator readiness [Electronic version]. *OT Practice, 12,* 20,22.
AOTA provides two resources for preparing therapists to be fieldwork educators. *Role Competencies for a Fieldwork Educator* identifies necessary skills in five domains; the domains are knowledge, critical reasoning, interpersonal skills, performance skills, and ethical reasoning. The second resource identified is the *Self-Assessment Tool for Fieldwork Educator Competency*, which includes competencies in the areas of professional practice, education, supervision, evaluation, and administration. It is suggested that a professional development plan be crafted following completion of the self-assessment tool.

Costa, D. (2007). The collaborative fieldwork model. [Electronic Version]. *OT Practice, 12*, 25–26.
The collaborative learning approach in fieldwork II, in which two or more students share a single supervisor, promotes autonomy and increased self-confidence in students and fosters a commitment to lifelong learning. With the supervisor not on-site full-time, most student learning occurs among the students rather than between supervisor and student. Principles include positive interdependence,

face-to-face interaction, individual accountability, cooperative skills, and group processing. This approach more closely mirrors social collaboration in the work place than does the traditional fieldwork model.

Costa, D. & Burkhardt, A. (2003). The purpose and value of occupational therapy fieldwork education. *American Journal of Occupational Therapy, 57,* 644.
AOTA's current statement on fieldwork education emphasizes that fieldwork integrates academic knowledge with practical knowledge, toward the end of developing competent entry-level general practitioners.

Dour, M., Grey, C., & Michaelsen, S. (2007). Collaborative learning: The student perspective. [Electronic Version]. *OT Practice, 12*(4), 9–10.
The article describes the student perspective of a collaborative learning fieldwork II experience with moderate supervision in a psychosocial rehab setting. The supervisor was on-site two or three days a week, and more often as needed. Supervision strategies included observation, reflective journals, individual meetings, and peer learning. A significant portion of this model involves student interdependence in learning from and teaching each other. Tips for a successful psychosocial fieldwork placement are provided.

Glassman, S. (2006). First-time level II fieldwork supervisors: Resources, training, and advice. [Electronic Version]. *OT Practice, 11,* 9-10.
As the title suggests, this article mentions resources, primarily through AOTA, that would be useful for preparing new fieldwork supervisors for their role. Among the advice included is the reminder that the fieldwork supervisor's role is to model appropriate behavior and clinical skills while allowing the student to develop his/her own personal style and therapeutic use of self.

Griswold, L. & Strassler, B. (1995). Fieldwork in schools: A model for alternative settings. *American Journal of Occupational Therapy, 49,* 127-132.
In the process of expanding the number of Level II fieldwork placements in the public schools, faculty from the University of New Hampshire developed a model to prepare both students and school-based occupational therapists for the experience. The model consists of recruitment of occupational therapists willing to serve as fieldwork educators, preparing occupational therapists to be fieldwork supervisors, preparing occupational therapy students for school settings, and supporting both supervisors and students during the fieldwork placement. The article also describes an exploratory study in which the authors obtained an overview of school-based practice in their geographic region, and the needs of occupational therapists working in the schools in relation to being fieldwork supervisors. Positive outcomes were noted from the initial implementation of the model by occupational therapy students, their fieldwork supervisors, and public school administrators.

Precin, P. (2007). An aggregate fieldwork model: Interdisciplinary training/intervention component. *Occupational Therapy in Health Care, 21,* 123-131.
An aggregate Level II occupational therapy fieldwork model combining research or clinical publication, cooperative learning, and interdisciplinary training and intervention was developed for use in a psychosocial setting. This article describes the implementation of the interdisciplinary training and intervention component over the course of two and one-half years with 50 OT interns. Necessary ingredients of the interdisciplinary training program are an interdisciplinary staff, on-going

communication, and a method for measuring program effectiveness. The author states that this method of training and intervention can be used in other settings as well. While not explicitly identifying school systems as potential clinical areas using this model, it does lead one to consider aspects of this component which may be appropriate and beneficial in school settings. Most salient, perhaps, is the training that interns from various fields provide to each other. Having a better understanding of the roles and functions of other team members is helpful in designing and implementing interdisciplinary interventions.

Richard, L. (2008). Exploring connections between theory and practice: Stories from fieldwork supervisors. *Occupational Therapy in Mental Health, 24,* 154-175.

This exploratory study of three occupational therapy fieldwork supervisors focuses on the supervisors' perceptions of how they think and feel about this role. The overarching theme was identified as providing supportive clinical education. The supervisors' views were believed to be shaped by current and prior experiences, and the author connects their views to the literature related to adult learning styles. The author concludes by encouraging further research into the fieldwork supervision process as a means to improve "quality professional preparation based on best practices in education."

APPENDIX A – **Sample Forms & Guidance Documents**

PRE-REFERRAL CLASSROOM INTERVENTIONS
Organization and Personal Care
Play & Peer Interactions
Following Routines
Handwriting
Work Behaviors
Posture & Positioning

WORKLOAD, CASELOAD, & DATA MANAGEMENT
Caseload Roster template
Determining Required OT FTE
COTA Supervision Rules
Contracting Related Service Providers

PERSONNEL FORMS
Occupational Therapist Job Description
Occupational Therapy Assistant Job Description a
Occupational Therapist Performance Appraisal Instrument
Occupational Therapy Assistant Performance Appraisal Instrument
Employee Goal Plan
Observation/Snapshot Report
Mid-Year Review
Peer Input
Regular Educator Input
Special Educator Input
Fieldwork Student Input
Employee Input

Employee Documentation of:
- Mentorship
- Committee/Taskforce work
- Presentations

EVALUATION SUPPORTS
Guidance on Motor Screens
Sample Referral for Occupational Therapy Evaluation
Sample/Template for Occupational Therapy Evaluation
Sample/Template for Occupational Therapy Preschool Evaluation
Parent Notification of Evaluation
Caregiver Questionnaire
Caregiver Questoinnaire - Spanish version
Student Questionnaire

Organization Survey - Teacher
Contextual Observation Considerations
Determining Need for School-based Occupational Therapy

IEP & INTERVENTION SUPPORTS

Standard Course of Study Alignment for Goals and Intervention

- K-2 Math
- 3-5 Math
- 6-8 Math
- 9-12 Math
- K-1 Language Arts
- 2-3 Language Arts
- 4-5 Language Arts
- K-2 Science
- 3-5 Science
- 6-8 Science
- 9-12 Science

Preschool Foundations Intervention Matrix
Goal Bank
Exit from Service
Protective Device Documentation
Therapeutic Device Documentation
Guidance for Use of Group Intervention
Intervention Plan Template

PROGRAM SUPPORTS

OT in Schools Brochure
Sample Annual Report
Medical and Educational Models of Therapy Provision
NC Restraint Law
Press Release - April OT Month

PARENT & FAMILY COMMUNICATION

Determining Need for School-based Occupational Therapy: A Guide for Families
Parent Notification of Service and Contact Information Request
Summer Activity Calendar
Medicaid Cost Recovery: A Fact Sheet for Families
Activities for Preschool Hands

APPENDIX B – **North Carolina College & University Occupational Therapy Programs**

Occupational Therapy Assistant Accredited Programs:

Cabarrus College of Health Sciences
Occupational Therapy Assistant Program
401 Medical Park Drive
Concord, NC 28025-2405
(704) 783-1555 or 1556
E-mail contact: admissions@cabarruscollege.edu or ngreen@cabarruscollege.edu
Website: www.cabarruscollege.edu

Cape Fear Community College
Occupational Therapy Assistant Program
411 North Front Street
Wilmington, NC 28401-3993
(910) 362-7000
E-mail contact: damini@cfcc.edu
Website: http://cfcc.edu/ota

Durham Technical Community College
Occupational Therapy Assistant Program
1637 Lawson Street
Durham, NC 27703-5023
(919) 536-7233 x8120
E-mail contact: chengs@durhamtech.edu
Website: www.durhamtech.edu

Pitt Community College
Occupational Therapy Assistant Program
P.O. Drawer 7007
Greenville, NC 27835-7007
(252) 493-7370
E-mail Contact: wperrini@email.pittcc.edu
Website: http://styx.pittcc.edu/division/department/occtherapy/index.html

Occupational Therapist Master's-Level Accredited Programs:

East Carolina University
Occupational Therapy Department
School of Allied Health Sciences
3305 Health Sciences
Greenville, NC 27858-4353
(252) 744-6199
E-mail contact: veldeb@ecu.edu or jonesanne@ecu.edu

Website: www.ecu.edu/ot

Lenoir-Rhyne University
Occupational Therapy Program
Box 7547
Hickory, NC 28603-7547
(828) 328-7300
E-mail contact: admission@lrc.edu
Website: http://ot.lr.edu/

University of North Carolina at Chapel Hill
Division of Occupational Science
Department of Allied Health Sciences, School of Medicine
Bondurant Hall, Suite 2050, CB#7122
Chapel Hill, NC 27599-7122
(919) 966-2451
E-mail contact: osinfo@med.unc.edu
Website: www.med.unc.edu/mahp/ocsci/

Winston-Salem State University
Occupational Therapy Program
430 F.L. Atkins
601 Martin Luther King, Jr. Drive
Winston-Salem, NC 27110-0003
(336) 750-3177
E-mail contact: speasa@wssu.edu
Website:
www.wssuhttp://www.wssu.edu/WSSU/GraduateStudies/Graduate+Programs/Occupational+Therapy/.edu

Post-Professional Occupational Science Doctoral-Level Programs:

University of North Carolina at Chapel Hill
Division of Occupational Science
Department of Allied Health Sciences, School of Medicine
Bondurant Hall, Suite 2050, CB#7122
Chapel Hill, NC 27599-7122
(919) 966-2451
E-mail contact: rhumphry@med.unc.edu
Website: www.med.unc.edu/mahp/ocsci/OS_PhDprogram.htm

APPENDIX C – **Professional Associations & Boards**

Professional Associations:

American Occupational Therapy Association (AOTA)

www.aota.org
The American Occupational Therapy Association, Inc.
4720 Montgomery Lane
PO Box 31220
Bethesda, MD 20824-1220
Phone: 301-652-2682
TDD: 1-800-377-8555
Fax: 301-652-7711

North Carolina Occupational Therapy Association (NCOTA)

www.ncota.org
304 Forbush Mountain Drive
Chapel Hill, NC 27514
Phone: 919-785-9700
Fax: 919-771-0115

Credentialing Agencies:

NATIONAL BOARD FOR CERTIFICATION IN OCCUPATIONAL THERAPY (NBCOT)

NBCOT is the credentialing agency that provides certification for the occupational therapy profession. OTR candidates must have an entry-level, post-baccalaureate degree in occupational therapy to apply for the OTR Certification Examination. COTA candidates must have graduated from an accredited occupational therapy education program at the associate or technical degree level to apply for the OTA Certification Examination.

The examination application is available online at http://www.nbcot.org/. Currently, the application fee is approximately $565.00. The NBCOT examination is offered in a computer delivered format on an on-demand basis. Once deemed eligible to sit for the national certification examination, one has 90 days to take the exam. Upon passing the exam, one becomes an Occupational therapist Registered (OTR),

Contact NBCOT at:
National Board for Certification of Occupational Therapy
800 S. Frederick Avenue, Suite 200
Gaithersburg, MD 20877-4150
(301) 990-7979
www.nbcot.org

NORTH CAROLINA BOARD OF OCCUPATIONAL THERAPY

In order to practice in North Carolina, occupational therapists and occupational therapy assistants practicing must be licensed by the North Carolina Board of Occupational Therapy (NCBOT). NCBOT will *not* issue a temporary license for those completing the licensure process. A license must be issued before one can begin practice in North Carolina. The current license application fee is $10.

Requirements for Licensure:

- License fee: $100
- Good moral character
- Completion of an accredited occupational therapy or occupational therapy assistant program
- Completion of the NBCOT exam

North Carolina licenses expire on June 30th every year. In order to **renew**, one must complete the following requirements:

- Completed Application for Annual License Renewal
- $50 renewal fee
- Completed and signed Continuing Competence Activity record Card

Contact NCBOT at:
North Carolina Board of Occupational Therapy
PO Box 2280
Raleigh, NC 27602
(919) 832-1380
www.ncbot.org

APPENDIX D – **Web Resources**

Websites below are listed as a resource and are not related to, endorsed or supported by NC DPI. Readers are encouraged to contribute resources here via email to lauren_holahan@med.unc.edu

Practitioner Information

NC School-based Occupational Therapy Website:
http://www.med.unc.edu/ahs/ocsci/nc-school-based-ot-site/

Employment Links

http://www.ncpublicschools.org/employment/classified_jobs/occ_therapist.html
http://www.ncpublicschools.org/employment/classified_jobs/occ_therapistasst.html

Association Links

American Occupational Therapy Association - www.aota.org
American Occupational Therapy Foundation - www.aotf.org
North Carolina Occupational Therapy Association - www.ncota.org
National Board for Certification in Occupational Therapy - www.nbcot.org
North Carolina Board of Occupational Therapy - www.ncbot.org

Evidence-based Practice Links

OT Seeker—Occupational Therapy Systematic Evaluation of Evidence: www.otseeker.com
Child and Family Studies Research Programs, Occupational Therapy Department, Thomas Jefferson University: www.tju.edu/cfsrp/home/html
Cochrane Library: www.cochrane.org
ERIC Digests: www.ericfacility.net/ericdigests/index/
PEDro: www.pedro.org.au
Research and Training Center on Early Childhood Development:
www.researchtopractice.info/products.php
What Works Clearinghouse: www.w-w-c.org
American Occupational Therapy Association, Evidence-Based Practice Series (AOTA members only):
www.aota.org (click on Practice and Ethics)
American Occupational Therapy Foundation, Evidence-Based Practice Resources:
www.aotf.org/html/evidence.html
American Academy for Cerebral Palsy and Developmental Medicine: http://www.aacpdm.org/
CanChild Centre for Childhood Disability Research: www.fhs.mcmaster.ca/canchild
Center for Evidence-Based Practices: www.evidencebasedpractices.org
Centre for Evidence-Based Medicine: www.cebm.net
IDEA Partnerships: http://www.ideapartnership.org/
Communities of Practice Portal for IDEA Partnerships: www.sharedwork.org

Family Support/Advocacy

Handbook on Parent's Rights - http://www.ncpublicschools.org/ec/policy/resources/
EC Forms used statewide - www.ncpublicschools.org/ec/policy/forms
Exceptional Children's Assistance Center - www.ecac-parentcenter.org
Family Support Network of North Carolina - www.fsnnc.org
Association for Persons with Severe Handicaps - www.tash.org
United Cerebral Palsy - http://www.ucp.org/
Families and Advocates Partnership for Education - www.fape.org
Interdisciplinary Council on Developmental and Learning Disorders - www.icdl.com
Rehabilitation Research & Training Center on Aging with Developmental Disabilities - www.uic.edu/orgs/rrtcamr
United States Access Board - www.access-board.gov
Nation Ctr. on Accessibility - www.ncaonline.org
National Network of ADA Centers - www.adata.org
Pathways Awareness Foundation - www.pathwaysawareness.org
Partnerships for Inclusion (products) - http://www.fpg.unc.edu/~pfi/pages/products.cfm

Activities for Individuals with Disabilities:

National Center on Physical Activity and Disability - www.ncpad.org
WHEELCHAIR SPORTS, USA - www.wsusa.org
Blaze Sports - www.blazesports.com
Children, Youth and Family Consortium - www.cyfc.umn.edu
Circle of Inclusion - www.circleofinclusion.org
SeeBility - www.seeability.org
National Organization on Disability - www.nod.org
North American Riding for the Handicapped Association - www.narha.org
North Carolina Office on Disability and Health - www.fpg.unc.edu/~ncodh

Legislation/Policy

IDEA 2004 - http://idea.ed.gov/
No Child Left Behind Act - www.ed.gov/nclb/landing.jhtml
Special Education Law Bulletin - http://west.thomson.com/store/product.aspx?product_id=40560054
Special Ed News - www.specialednews.com
Mountain Plains Regional Resource Center - http://www.rrfcnetwork.org/mprrc

Special Interest Organizations

Disability Resources on the Internet - www.disabilityresources.org
Health Choice Handbook and Health Info. For Children with Special Needs Booklet - www.dhhs.state.nc.us/dma/cpcont.htm
Health info in Spanish - www.healthfinder.gov/espanol

NC AHEC Latino Health Resource Center - http://hhcc.arealahec.org/
North Carolina Council on Developmental Disabilities - www.nc-ddc.org
North Carolina Vocational Rehabilitation - http://dvr.dhhs.state.nc.us/
Council for Exceptional Children - www.cec.sped.org
The ARC of North Carolina - www.arcnc.org
Interdisciplinary Council on Developmental and Learning Disorders - www.icdl.com

Specific Diagnoses

National Institutes of Health - www.health.nih.gov
National Organization for Rare Disorders - www.rarediseases.org
Spina Bifida Association of North Carolina - www.ncspinabifida.org/
Torticollis Kids - www.torticolliskids.org
Pediatric Orthopedics & Sport Medicine - www.orthoseek.com
Brachial Plexus Center - brachialplexus.wustl.edu
Genetics Search Engine - http://biology.about.com/od/genetics/Genetics.htmwww.beginningssvcs.com

Equipment

North Carolina Assistive Technology Program - http://www.ncatp.org/
Generations Tadpole AT Lending Library - http://www.tadpole.org/
Wheelchair Foundation - http://www.wheelchairfoundation.org/
Wheelchair Net - www.wheelchairnet.org

Medicaid

NC DPI Medicaid Resource - http://www.ncpublicschools.org/ec/medicaid/
National Alliance for Medicaid in Education - https://www.medicaidforeducation.org/
Division of Medical Assistance Policy for LEAs - http://www.dhhs.state.nc.us/dma/medicaid/

APPENDIX E – **Commonly Used Assessments in School-based Practice**

Beery-Buktenica Developmental Test of Visual Motor Integration – 5th Edition (Beery VMI) –

- Keith E. Beery and Natasha A. Beery
- Assesses: visual-motor integration
- Target Population: ages 2-100
- To order: Pearson Assessments, Minneapolis, MN
  - http://www.pearsonassessments.com/beery.aspx

Bruininks-Oseretsky Test of Motor Proficiency - 2nd Edition (BOT-2)

- Robert H. Bruininks and Brett D. Bruininks
- Assesses:
- Target Population: ages 4-21
- To order: AGS Publishing, 5910 Rice Creek Parkway, Shoreview, MN 55126
  - www.agsnet.com
  - Product # 58001

Children's Handwriting Evaluation Scale (CHES)

- Joanne Phelps, Lynn Stempel, and Gail Speck
- Assesses: rate and quality of penmanship
- Target Population: grades 3 - 8
- To order: Texas Scottish Rite Hospital for Crippled Children, Dallas, Texas

Developmental Test of Visual Perception—2nd Edition (DTVP-2)

- Donald D. Hammill and Nils A. Person
- Assesses: visual-motor and visual-perception
- Target Population: ages 4-0 through 10-11
- To order: PRO-ED, Inc., 8700 Shoal Creek Boulevard, Austin, Texas 78757-6897
  - http://www.proedinc.com
  - Order number: 6090

Evaluation Tool Of Children's Handwriting (ETCH)

- Susan J. Amundson
- Assesses: manuscript and cursive handwriting
- Target Population: children who are experiencing difficulty with written communication in grades 1-6
- To order: O.T. Kids, P.O. Box 1118, Home, Alaska 99603

Motor-Free Visual Perception Test – 3rrd edition (MVPT-3)

- Ronald P. Calarusso and Donald D. Hammill
- Assesses: overall visual perceptual ability

- Target Population: ages 4-95 (ages 4-10 administer items #1-40 only; age 11 and older administer #14-65)
- To order: Academic Therapy Publications, Academic Therapy Publications, 20 Commercial Boulevard, Novato, CA 94949
    - http://www.academictherapy.com
    - Order # 8288-2

Peabody Developmental Motor Scales- 2nd Edition (PDMS-2)

- M. Rhonda Folio and Rebecca R. Fewell
- Assesses: motor skills
- Target Population: birth – 5 years
- To order: PRO-ED, Inc., 8700 Shoal Creek Boulevard, Austin, Texas 78757-6897
    - http://www.proedinc.com

Pediatric Evaluation of Disability Inventory (PEDI)

- Stephen M. Haley, Wendy J. Coster, Larry H. Ludlow, Jane T. Haltiwanger, and Peter J. Andrellos
- Assesses: functional capabilities (self-care, mobility, social function)
- Target Population: children 0.5 - 7.5 years with a variety of disabilities
- To order: The Psychological Corporation/Therapy Skill Builders, San Antonia, TX

School Function Assessment (SFA)

- Wendy Coster, Theresa Deeney, Jane Haltiwanger, and Stephen Haley
- Assesses: Participation, Task Supports, and Activity Performance.
- Target Population: grades K- 6
- To order: The Psychological Corporation/Therapy Skill Builders, San Antonia, TX

Sensorimotor Performance Analysis

- Eileen Richter and Partricia Montgomery
- Assesses: gross and fine motor
- Target Population: 5 years - adult
- To order: PDP Products, Hugo Minnesota
    - ISBM # 0-9623709-1-2

Sensory Processing Measure (SPM)

- L. Diane, Paham, Cheryl Eckner, Heather Miller Kuhaneck, Diana A. Henry, and Tara J. Glennon
- Assesses: sensory processing issues, praxis, and social participation in elementary school-aged children
- Target Population: ages 5- 12 years
- To order: Western Psychological Services, 12031 Wilshire Blvd. Los Angeles, CA 90025-1251
    - www.wpspublish.com

Sensory Profile

- Winnie Dunn
- Assesses: sensory processing abilities
- Target Population: 5 – 10 years
- To order: The Psychological Corporation

- www.tpceb.com

Sensory Profile School Companion

- Winnie Dunn
- Assesses: sensory processing abilities and effect on the student's functional performance in classroom and school environment
- Target Population: 3 – 11 years
- To order: PsychCorp
  - www.psychcorp.com

Adolescent/Adult Sensory Profile

- Catana Brown and Winnie Dunn
- Assesses: identifies sensory processing patterns and effects on functional performance in adolescents and adults
- Target Population: 11 years and older

Visual Skills Appraisal (VSA)

- Regina G. Richards
- Assesses: visual performance and coordinated classroom activities
- Target Population: Kindergarten - 4th grade
- To order: Academic Therapy Publications

APPENDIX F – **Options for Occupational Therapy Professional Liability Insurance**

AMERICAN PROFESSIONAL AGENCY, http://www.americanprofessional.com/allied/index.htm

HPSO, http://www.hpso.com/professional-liability-insurance/professions-covered.jsp

LOCKTON, http://ahc.lockton-ins.com/pl/sitemap.html

MARSH/PROLIABILITY, https://www.proliability.com/ (this is the one linked from AOTA website)

APPENDIX G – **References**

Alabama Department of Education Division of Instructional Services Special Education Services. (2008). Guidelines for occupational therapy and physical therapy for students receiving special education services in Alabama.

AOTA. (1998). Steps to Starting a Fieldwork Program. Retrieved June 3, 2009, from the American Occupational Therapy Association website: http://www.aota.org/Educate/EdRes/Fieldwork/NewPrograms/38245.aspx

AOTA. (2000a). Most Frequently Asked Fieldwork Questions. Retrieved June 3, 2009, from the American Occupational Therapy Association website: http://www.aota.org/Educate/EdRes/Fieldwork/NewPrograms/38242.aspx

AOTA. (2000b). Recommended Content for a Student Fieldwork Manual. Retrieved June 3, 2009, from the American Occupational Therapy Association website: http://www.aota.org/Educate/EdRes/Fieldwork/NewPrograms/38250.aspx

AOTA. (2006) Guidelines to the OT Code of Ethics. *American Journal of Occupational Therapy, 60, 652-658.*

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