*SPECIAL EDUCATION IN NORTH DAKOTA*
North Dakota Department of Public Instruction
Kristen Baesler, State Superintendent
Office of Special Education
600 E. Boulevard Ave., Dept. 201
Bismarck ND 58505-0440
701-328-2277 (voice)
701-328-4920 (TDD)
701-328-4149 (Fax)

NDDPI *Guidelines for Occupational and Physical Therapy in Educational Settings*

Building the Legacy: IDEA 2004
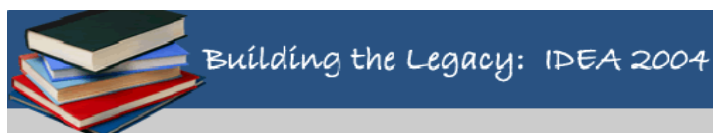
United States Department of Education, Office of Special Education Programs (OSEP)

The Department of Public Instruction appreciates the time and effort spent by the task force members in contributing to the development of this guidance document.

TASK FORCE MEMBERS
Facilitators: Michelle Woodcock and Shauna Crane

Kelly Anderson	Bobbi Carrlson
Leah Faul	Lesley Fettig
Brandi Freeman	Matia Gjellstad
Mary Hellman	Julie McCann
Jennifer Neznik	Erika Hanson
Jason Hogan	Lisa LaFleur
Marcia Wehe	Karla Magnuson
Kim Meyers	Carrie Odden
Carol Olson	Mary McCarvel-O'Connor

Table of Contents

Introduction

These guidelines for occupational therapists and physical therapists define and explain the collaborative process of therapy services within the school environments of North Dakota. As best educational practices have evolved to support the integration of children with disabilities in all aspects of school and community life, the practices of occupational therapy and physical therapy in school have also changed. The emphasis of school-based therapy relates directly to the child's educational program. Guiding the decisions made for educational programs are federal regulations and state rules, including the Individuals with Disabilities Education Act (IDEA 2004), and Section 504 of the Rehabilitation Act of 1973. When receiving support from either of these programs, the occupational therapists and physical therapists work collaboratively with general educators, special educators, and parents to problem-solve by sharing information, coordinating activities, and teaching strategies to other team members. It is anticipated these guidelines will encourage a cooperative effort between those involved in the delivery of occupational therapy and physical therapy as related services and the educational providers across the state. The intention of these guidelines is to encourage a cooperative effort to provide services to students (ages 3-21) throughout the North Dakota school system.

Occupational Therapists

Occupational therapists (OTs) and occupational therapist assistants (OTAs) work in school-based programs with children, parents, caregivers, educators, and other team members to facilitate the child's ability to engage in meaningful occupations. The OTs focus on performance in the following areas of occupation: activities of daily living (ADL), instrumental activities of daily living (IADL), education, leisure, play, social participation, and work. The OT service delivery process includes evaluation, intervention, and outcomes.

Physical Therapists

School-based physical therapy focuses on enabling the student to participate fully in his or her educational environment and achieve needed functional skills for current and further education, employment, and independent living. The school physical therapist (PT) and physical therapy assistant (PTA) address movement skills, particularly functional mobility, physical fitness to ameliorate secondary impairment and disability, and improve endurance for participation, activities of daily living, and other motor needs that may be necessary for the student to benefit from special education.

Determining Student Need for School-based OT/PT Services

General Education Support

Occupational and physical therapists may be utilized within the general education setting to collaborate with educators to best support student performance in schools.

Multi-Tier System of Supports

Multi-Tier System of Supports (MTSS) is considered to be current best practice in schools to assist students prior to needing IDEA services; however, is not required and may be implemented differently between school districts. North Dakota's Multi-Tier System of Supports (NDMTSS) is a framework to provide all students with the best opportunities to succeed academically, socially, emotionally, and behaviorally in school. NDMTSS focuses on providing high-quality instruction and interventions matched to student need, monitoring progress frequently to make decisions about changes in instruction or goals. Data is used to allocate resources to improve student learning and support staff implementation of effective practices.

> **Tier 1**: Focused on all students – Universal screening

> **Tier 2**: Focus is on students identified as at risk of performing below or significantly above expected outcomes

> **Tier 3**: Focus is on students who present with exceptionally high academic or very low academic or behavioral achievement, or who have not responded to Tier 1 and Tier 2 instruction, or students with disabilities who do not meet their IEP goals: additional layer to Tier 1 and Tier 2

Within an MTSS framework, occupational therapy practitioners can work with educational teams to provide a continuum of services to students in general education to support promotion, prevention, early identification, and intervention associated with occupational performance needs. Occupational therapy practitioners can work with educational teams to participate at every level of MTSS. (Frolek Clark, Rioux, & Chandler, 2019, p 213)

Occupational performance areas addressed in all tiers may include, but are not limited to: school mental health, including self-regulation and social participation; fine motor and writing for all; activities of daily living; use of sensory and movement; providing educational in-services.

Physical therapists may also be included within all tiers of MTSS and may include:

> Adapting environments to facilitate student access and participation in the educational program; Educating school personnel and families to promote inclusion of students within the educational setting by developing, demonstrating, training, and monitoring the effectiveness of strategies and intervention activities, and subsequently using gathered data to make program modification decisions. This includes the use of assistive technology for access and participation in the general education curriculum; supporting the safe transportation of students. (APTA Physical Therapy in School Settings)

Multi-Tiered Model Example

Multi-Tiered Model Example	
Tier 1 - **Scientifically based core** **classroom instruction**	• Teacher contacts OT/PT about what has been attempted and receives suggestions. • Classroom teacher and/or parent implements one intervention at a time. It should address the primary concerns (e.g. motor, attention, sensory). • Provides framework for in-class and home intervention to be implemented by teacher and parents. • Monitors student progress periodically.
Tier 2 - **Targeted intervention and** **small group instruction**	• Teacher requests OT/PT attendance at an MTSS meeting. OT/PT can provide suggestions for the teacher and school staff. • Provide intervention in small groups. • Collaborate with parents, teachers and other professionals to monitor OT/PT interventions and provide additional targeted intervention if needed.
Tier 3 - **Intensive individual** **intervention**	• Collaborate with others to determine the need for intensive intervention. • Provide intensive intervention with continuous data analysis to determine next steps.

Intervention Process

General Education Intervention Strategies (MTSS)

Not Successful / Successful

OT/PT provide additional intervention suggestions or determine if evaluation is recommended.

Continue interventions. Monitor Success.

Successful / Not Successful

Not Successful

Multi Disciplinary Team meeting: is a special education evaluation needed?
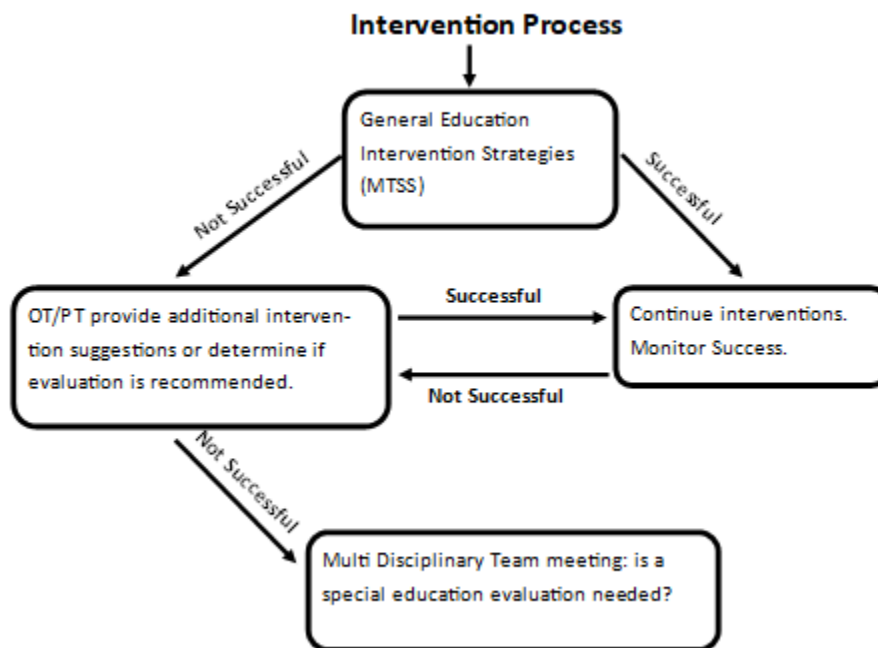
Screening

As part of child find responsibilities, school districts can conduct screening activities. Screening activities assist in identifying students who are at risk of not progressing according to expectations, or who are suspected of needing additional supplemental services. As part of the district's screening process, qualified personnel may identify risk factors that impact the student's ability to learn in areas such as:

- vision
- hearing
- speech and language
- social-emotional or mental health
- preschool developmental areas, and
- secondary-level for students who are at higher risk of dropping out or who have dropped out of school (to verify that the reasons for dropping out are not related to a previously unidentified disability)

The result of the screening process is a systematic collection of information for every student screened. The professional(s) that review the results of the screening need to determine whether the student should be: 1) screened again at a later time; 2) referred for follow-up services by the school or another agency; or 3) referred to special education for a comprehensive evaluation.

Section 504

The purpose of Section 504 of the *Rehabilitation Act of 1973* is to ensure that no student with a disability will be excluded from participation, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity that receives or benefits from federal financial assistance. A person with a disability is defined in the Section 504 regulations as, "…any person who has a physical or mental impairment which substantially limits a major life activity, has record of such an impairment, or is regarded as having such an impairment."

Unlike IDEA 2004, Section 504 does not provide a specific list of categories for disabilities with strict eligibility requirements. Section 504 includes short-term and long-term disabilities that may be interfering with the child's ability to access the general curriculum.

There may be students who are not eligible for services under IDEA 2004 who may qualify under Section 504. As in IDEA 2004, Section 504 regulations provide that students with disabilities be placed with non-disabled peers to the "maximum extent appropriate" to meet their individual needs. Section 504 further requires that students with disabilities be placed in the "regular environment" unless it is established that a satisfactory education cannot be achieved with supplementary aids and services.

Section 504 does not require an individualized education program (IEP), but it does require its functional equivalent, which is termed a 504 plan or an educational plan. Local education agencies must have procedures for implementing Section 504 services.

Occupational and Physical Therapists can provide services under Section 504 if the school team determines they are needed for the student in order to access the general curriculum. IDEA funds may not be used to pay a therapist when providing 504 services.

504 Process

```
┌─────────────────────────────────┐          ┌──────────────────────┐
│ Multi Disciplinary Team meeting: │  Yes     │ Begin IEP            │
│ is a special education           │ ───────> │ Evaluation Process   │
│ evaluation needed?               │          │                      │
└─────────────────────────────────┘          └──────────────────────┘
              │ No
              ▼
┌─────────────────────────────────┐
│ Evaluate for Section 504         │
│ eligibility                      │
└─────────────────────────────────┘
              │
              ▼
┌─────────────────────────────────┐
│ Eligible under 504?              │
└─────────────────────────────────┘
    Yes │              │ No
        ▼              ▼
┌──────────────┐  ┌──────────────┐
│ Develop a 504│  │ School team  │
│ plan based on│  │ considers    │
│ evaluation   │  │ other        │
│ needs        │  │ supports     │
└──────────────┘  └──────────────┘
        │
        ▼
┌──────────────┐
│ Ensure plan  │
│ includes     │
│accommodations│
└──────────────┘
        │
        ▼
┌──────────────┐
│Implement Plan│
│ & Monitor    │
│ Progress     │
└──────────────┘
        │
        ▼
┌──────────────┐
│ Review Plan  │
│ Yearly and   │
│ Amend as     │
│ Needed       │
└──────────────┘
```

Special Education / IDEA

The provision of occupational therapy (OT) and physical therapy (PT), as related services in special education, is required by the *Individuals with Disabilities Education Act* (IDEA 2004). IDEA 2004 is intended to help children with disabilities achieve high standards by promoting accountability for results enhancing parental involvement, using proven practices and materials, providing more flexibility and reducing paperwork burdens for teachers, local school districts, and states.

The IDEA states:

> 300.34 Related services

(a) General. Related services means transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. Related services also include school health services and school nurse services, social work services in schools, and parent counseling and training.
(b) Exception; services that apply to children with surgically implanted devices, including cochlear implants.

300.324 Development, review, and revision of IEP

(6) Occupational therapy—
    (i) Means services provided by a qualified occupational therapist; and
    (ii) Includes—
        (A) Improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation;
        (B) Improving ability to perform tasks for independent functioning if functions are impaired or lost; and
        (C) Preventing, through early intervention, initial or further impairment or loss of function.
(9) Physical therapy means services provided by a qualified physical therapist.

IEP Process

The Referral Process

For students who have not made satisfactory progress after classroom interventions have been tried, the school district will need to move to the written referral process to pursue a comprehensive evaluation for eligibility. The referral contains information that will assist the multidisciplinary team (MDT) in developing an evaluation plan that will ensure a comprehensive and appropriate evaluation is conducted, addressing the needs observed throughout the intervention process.

Note: Complete information on the referral and evaluation process is available in the NDDPI Guidelines: *Evaluation Process,* available on the Department of Public Instructions website.

Parent(s) are essential members of the MDT. During the course of the intervention process, parents should be informed of the concerns observed and the interventions proposed to address those concerns. Schools are encouraged to have parents be active participants in their school's building level team throughout the intervention process. Parents can contribute valuable information to the intervention effort on such things as behaviors observed in the home and community as well as the student's strengths and interests. Often, parents may become part of intervention efforts, receiving support from the school to provide consistency in implementation across environments.

Multidisciplinary Team

The Multidisciplinary Team must consist of the required team members and other qualified professionals. Ultimately, the MDT is responsible for gathering the necessary observations and other

data from a variety of settings, which will allow the team to make an appropriate determination of eligibility and identify all needs that require support from individualized programming.

The MDT has the responsibility to:
- develop a Student Profile: Evaluation;
- develop an Assessment Plan with modifications, as needed;
- carry out the Assessment Plan;
- analyze the findings throughout the process; and
- prepare an Integrated Written Assessment Report to summarize pertinent observational data and other relevant assessment results that will determine if the student has a disability that adversely affects education.

Educational Evaluation

The MDT will determine the nature and extent of the educational evaluation based on the student's suspected disability and how this disability impacts the student's functional school performance, movement and mobility skills, self-regulation, and life skills.

An OT or PT assessment in the school setting may be one component of a special education team evaluation. If the students' suspected delay or discrepancy in performance lies within one of the domains, an OT and/or PT will be part of that MDT team.

An OT/PT could complete an assessment for a student independently from an initial or re-evaluation. This requires signed parental consent and a prior written notice of special education action (PWN) that includes information regarding the assessment plan.

More information on education evaluation can be found in the NDDPI Guidelines: *Evaluation Process, and Related Services Guidance.*

Selecting Tools - Overview

The main purpose of an evaluation tool is to answer three fundamental questions: "What is the educational impact?", "To what extent?", and "How would I know if the student is improving?". Answers to these questions are based on the appropriate selection of evaluation tools. School-based therapists must determine what category and sub-category (construct/domain/concept) need evaluation based on the information coming from the IEP team and the therapists' expertise. Based on the findings of an appropriate evaluation tool, all three questions can be answered.

As part of a therapists' expertise in the selection of an evaluation tool, an understanding of the different types of tools is needed.

Type of evaluation tools:

- Norm-Referenced Tests: Determines what a child knows and can do compared to a group. Change is noted in comparison to peers in terms of percentile ranks that have been established by the test.
- Criterion-Referenced Tests: Determines what a child knows and can do (not in relation to a group). Change is noted in comparison to the child only within criteria noted in the test.

- Judgment Based Tests: Determines what a child knows and can do without relation to a group or a noted criterion. Change is noted in comparison to the child only without reference to specific established criteria.

Burton, K. (2015). Continuing my journey on designing and refining criterion-referenced assessment rubrics, *Journal of Learning Design*, v8 n3 p1-13, 2015.

Selection of an appropriate evaluation tool must include the category of what is being measured. Following category selection, determining what sub-category is being assessed is needed. The use of the International Classification of Functioning (ICF) Framework (see page 29) helps guide the therapist in this process. Please note that these categories often influence each other and may have multiple categories measured with a single evaluation tool.

Category:

Category	Sub-Category (limited examples):
Body Function/Structure:	Balance, endurance, sensory function, pain, walking, stair negotiation
Activity:	Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL)
Participation:	Student roles, vocational roles, quality of life
Class Systems:	Classification based on motor function or hand function
Program Evaluation:	Outcomes of children who receive related services
Student Specific:	Student specific scales are unique in that they can be made for each individual student to measure level or change based on IEP team goals

Often inventories, checklists, observations, caregiver and/or teacher interviews and non-standardized tests are appropriate assessment methods to assist in obtaining an accurate picture of the student's sensory-motor status and functional performance level in school. These evaluations assist the team in understanding the functional deficits that impact learning and access to education.

The educational evaluation should be documented in a written report including identifying procedures and instruments used to gain the data, results obtained, and implications for the students' education program. The report may also include a statement of the reason for referral, relevant background information and behavioral observations. The report should be completed in a timely manner.

This written report will be included in the Integrated Written Assessment Report (IWAR) if completed as part of an initial or 3-year reevaluation process. If a related services evaluation was completed as a stand-alone event (not associated with either the initial or the reevaluation) the information would be documented in an Individual Diagnostic Report (IDR).

See the Appendix, page 38 for evaluation tools.

Therapists Role in Disability Identification

Before the IEP team discusses whether or not a student is eligible for occupational therapy or physical therapy, the IEP team determines if the student is a child with a disability under IDEA. The definition of a child with a disability includes both the existence of an impairment and a need for special education. First, the IEP team determines if the child meets the criteria for one of the impairment areas. Second,
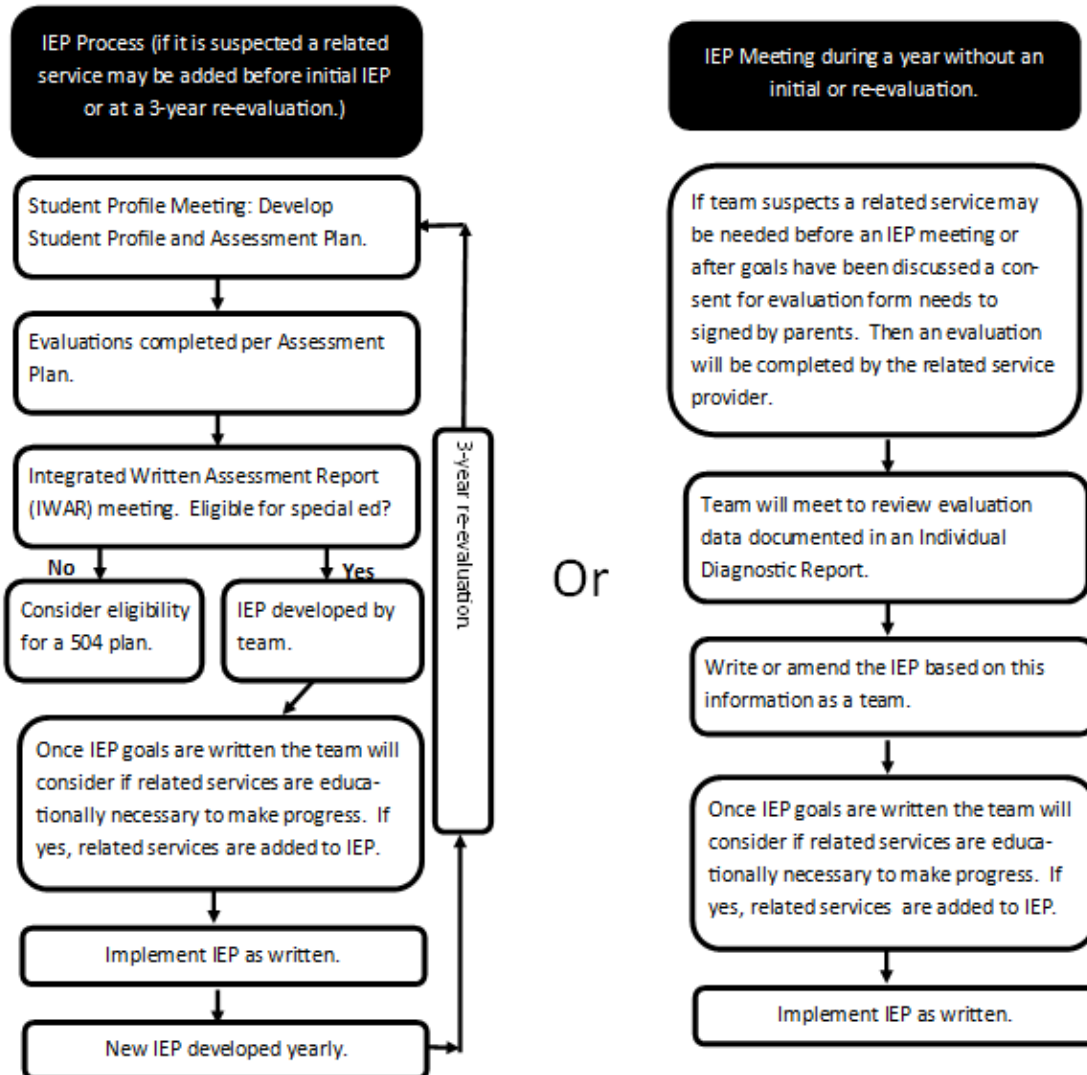
the team decides if the identified impairment is adversely affecting the child's education causing a need for special education. The IEP team considers evaluation data gathered by all members when making both decisions. The OT and PT share their professional judgments based on data gathered from the evaluation to help the team determine if the student is a child with a disability. If the IEP team includes an OT or PT and that team decides that the child has an impairment and needs special education, they can write an IEP at the meeting or schedule another IEP team meeting. The OT and PT help inform the team about the student's present level of academic achievement and functional performance as stated in the IEP, determine the child's educational needs, and develop goals that address those needs. The team then determines the type of specially designed instruction the child needs to meet the goals.

One should not assume the therapist must address what he or she directly evaluated. Instead, occupational therapy and physical therapy evaluations contribute to the IEP team's understanding of the child's educational and functional needs. As team members, therapists participate in developing goals for the child and discussing strategies to help the child achieve the goals. The team determines if occupational or physical therapy will be added to the IEP by applying IDEA's definition of related services: those that "are required to assist a child with a disability to benefit from special education."

Preschool Student Evaluation

As a school-based OT/PT you may be asked to participate in the transition of students from IDEA Part C, Early Intervention, to IDEA Part B, Early Childhood Special Education. Transition may look different for every child. Part C, Early Intervention will refer children for Part B services by 2 years, 6 months to the LEA where the child lives to determine if the child would be eligible for Early Childhood Special Education services. The first joint meeting with Early Intervention and LEA occurs when the child is 2 years 7 months of age. At this time the child's current Individualized Family Service Plan (IFSP), assessments, outside evaluations, and other relevant records will be reviewed. An evaluation process will be planned with any needed additional assessments scheduled to determine eligibility for the Early Childhood Special Education and related services. It is at this time that an OT/PT would decide if further testing is needed to determine the need for a related service. It is then the OT/PT's responsibility to complete further testing. The educational team would then complete any additional assessments and meet when the child is 2 years 9 months of age with the child's parent(s) and the Early Intervention team to complete an Integrated Written Assessment Report and determine eligibility for Early Childhood Special Education services. More information can be found in the NDDPI's document: *Understanding Early Childhood Transition: A Guide for Families and Professionals.*

Paths to Adding A Related Service

IEP Process (if it is suspected a related service may be added before initial IEP or at a 3-year re-evaluation.)

Student Profile Meeting: Develop Student Profile and Assessment Plan.

Evaluations completed per Assessment Plan.

Integrated Written Assessment Report (IWAR) meeting. Eligible for special ed?

No → Consider eligibility for a 504 plan.

Yes → IEP developed by team.

Once IEP goals are written the team will consider if related services are educationally necessary to make progress. If yes, related services are added to IEP.

Implement IEP as written.

New IEP developed yearly.

3-year re-evaluation

Or

IEP Meeting during a year without an initial or re-evaluation.

If team suspects a related service may be needed before an IEP meeting or after goals have been discussed a consent for evaluation form needs to signed by parents. Then an evaluation will be completed by the related service provider.

Team will meet to review evaluation data documented in an Individual Diagnostic Report.

Write or amend the IEP based on this information as a team.

Once IEP goals are written the team will consider if related services are educationally necessary to make progress. If yes, related services are added to IEP.

Implement IEP as written.

Individualized Education Program (IEP)

IEP Development

Following the MDT's determination that a student has met the eligibility criteria for a disability area in North Dakota, the IEP team will meet to outline a plan to address the student's needs identified through the assessment process. The IEP must be developed and implemented within 30 days of the eligibility determination. Decisions regarding the delivery of services must ensure that a student with a disability receives a Free and Appropriate Public Education (FAPE) in the least restrictive environment (LRE).

The IEP team will ensure that all needs, both special education and related services, identified during the assessment/eligibility process are documented during the development of the student's IEP. Careful consideration must be given to the student's strengths and abilities, as well as the challenges they face,

in order to ensure the goals, services, and supports included in the IEP address the unique needs of the individual as determined through the evaluation process.

The IEP tells a student's "story." The IEP team should carefully consider the details included in that story when developing sections of the document, such as present levels of performance, special considerations, supplementary aids and services, and goals. In the event of a student with a disability transferring to another district, a more complete story will increase the student's ability to successfully transition to a new school by providing critical information on services and supports that lead to positive outcomes.

IEP Team

The IEP team is identified in **34 CFR §300.321**, and is discussed in detail in the NDDPI document, *Guidelines: Individual Education Program Planning Process.*

The regulations suggest—at the discretion of the parents and the school district—that individuals who have "*special expertise regarding the child, including related service personnel as appropriate,*" be included on the team. Parents are welcome to invite other individuals with specific expertise or who may have pertinent information about their child.

Parent/Guardian Participation

Parents are critical partners in the IEP process for any student with a disability. Observations outside the school setting are relevant to the discussion of needs and support efforts for the student. The IEP team must make every effort to ensure that one or both parents of the student have the opportunity to participate in the IEP process. Meaningful parent participation is an essential element in developing a foundation of trust and collaboration that will support positive outcomes for the student with a disability. The IEP process is a communication vehicle between parents and school staff working with their child.

Present Levels of Academic Achievement and Functional Performance (PLAAFP)

An essential ingredient in providing FAPE to an eligible student with a disability is the documentation of needs from the evaluation/eligibility process in the IEP. PLAAFP documentation includes such things as the student's strengths, needs, preferences, and interests, as well as how the student's disability impacts their ability to make progress in the general education curriculum. This implies the need to discuss the standards or expectations of the general education curriculum and the student's performance as measured against those standards. When present levels are significantly different from grade/age level expectations, the team must identify those skills most critical to closing the gap between current performance and desired performance.

The PLAAFP should contain documentation of parent input on the process, including student strengths and concerns. Recognition of this input is the first step in ensuring that parents participate as equal partners in the IEP development process.

PLAAFP content should be provided in a narrative format, not simply a listing of test scores. It seeks to answer the question, "What do we know about this student?" It also analyzes how the student's disability impacts his or her involvement and progress in the general education curriculum. The PLAAFP should include a description of fine motor, gross motor, and sensory interventions that have been implemented previously and the outcome of the interventions. The PLAAFP is the foundation on which the rest of the IEP is developed.

IEP Goals

After establishing the PLAAFP, the IEP team develops the student's measurable annual academic and functional goals. Annual goals are linked to a child's present level of academic achievement and functional performance and describe a reasonable expectation of the child's achievement within one year in priority areas. As such, the IEP team should write goals specific enough so that anyone working with the child could determine if the child has achieved that goal. Annual goals are designed so the child can be involved and make progress within the general education curriculum. OTs and PTs should be part of the IEP team and contribute to the IEP goals.

1) Annual goals should be **functional**. Functional refers to activities that another person must do for a student if the student cannot do them independently (e.g., getting to class on time, eating lunch independently, playing safely on the playground, writing one's name on classwork, deciding which book to read during free reading time). Functional also means that the student will be active: that is the student will **do** something (i.e., the student will get his own lunch, the student will do math problems). It is important to differentiate things that people will do for the student, such as acquiring a wheelchair, from the things the **student will do**. Things that other people do are not written into the IEP as goals. These are written as services to be provided. It also is important to avoid making goals of passive activities the student will do, such as "tolerate" standing or "participate" in a toileting program. Instead, either state the active behavior the student will accomplish or write the passive activity in the characteristics section of the goal.

2) Annual goals should be multidisciplinary (**discipline-free**). Multidisciplinary goals are goals that the team decides are most important for the student to accomplish, without regard to the discipline usually associated with them. In the IEP meeting, all team members decide on the annual goals together. Each team member contributes to the development of the IEP by providing information from their own points of view and disciplinary perspectives to identify the most important and achievable goals for the student.

3) Annual goals should be **developmentally appropriate**; however, the outcome measures should be appropriate to their **chronological age**. Students should be engaged in activities in which peers of the same age would participate. For example, it would be inappropriate for a 12-year-old child with severe cognitive and motor delays to be playing with a baby doll or a busy box on a mat on the floor. If the goals for the student addressed independent play, cause and effect, or both, perhaps a soft baseball or a superhero toy could replace the baby doll, and a radio or computer with switch access could replace the busy box. Additionally, most students should be upright, rather than lying on the floor when engaging in school activities. Occupational therapists, physical therapists, and other service providers must be creative to develop age-appropriate activities for students, particularly for students with severe disabilities.

4) Annual goals should be **meaningful**. Meaningful goals are goals that the student, family, and other IEP team members think are particularly important for the student to learn. If goals are meaningful then the student will be self-gratified with goal accomplishment. Self-gratification is a motivator in obtaining specific tasks or goals. A nonmeaningful goal is one that the student

and family have no interest in. As an example, the student will stack four square blocks in one minute. A more meaningful goal is the student will put the cups away after snack. In this example, the student puts the cups away by stacking them on the shelf. The student may need to work on the motor skill of stacking, but the skill is embedded in a more functional goal. Putting the cups away at school may be more meaningful for a student if the student has the same responsibilities/chores at home. If the child receives an allowance for putting away cups and dishes at home, then putting away the cups at school may be more meaningful to the student than stacking blocks.

5) Annual goals should include activities that will be **frequently used across a variety of environments**. Frequency provides many opportunities to learn. Students are in school for only a small part of their lives, therefore, educational goals need to address tasks/activities that students will do often on a daily basis, in the future, and within a variety of environments. If a physical therapist works with a student to squat, pick up a beanbag, and then stand to throw the beanbag in a bucket, but the student has no opportunities to practice similar activities outside the therapy session, the benefit of the activity is questionable. Some examples of frequently used activities that students use across a variety of environments include: drinking from a straw, unbuckling a seat belt, transferring to a toilet, using a computer, writing one's name (either with a pencil or a keyboard), and communicating effectively.

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

Remember, OT/PT are related services that should contribute to collaborative team goals for student-centered progress across educational environments. Services are determined by the IEP team after student-centered goals are written.

Writing Collaborative Goals

The North Dakota Department of Public Instruction (NDDPI) *Individualized Education Program Planning* Guidelines states that there are four primary ***components*** of a goal:

A. The behavior or skill being addressed,

B. The desired ending level of achievement,

C. The intent or purpose for accomplishment, and

D. Characteristics of services

Specifics for goals

Intent /purpose: (Component C of NDDPI's intent or purpose for accomplishment.) What is the participation limitation that this goal is going to address? Some areas to consider would be playground/recess, transportation, bathroom/toileting, transitions, mealtime/snack time, and general education environment/setting. This is similar to a clinical, long term goal. Where is the participation restriction?   When the team was discussing the student profile or the PLAAFP, what was a participation or functional limitation discussed that a skilled therapist could help address?

> *Example A*: In order for the classroom teacher to assess Jeremy's knowledge of content through written work

> *Example B:* In order to improve Sally's participation in visual-motor skills such as writing, cutting, and drawing in the classroom setting,

> *Example C:* In order for George to decrease his dependence on adults and make functionally-based decisions with improved independence,

Behavior: (Component A of NDDPI's behavior or skill.) The student will complete some type of educational function.

> *Example A*: Jeremy will improve the legibility of his writing.

> *Example B*: Sally will be able to complete the following tasks:

> a. trace the uppercase letters of her first name with correct letter formation
> b. draw a square with four distinct sides and corners
> c. write her first name in uppercase form, using adequate formation, so that the letters are legible to the reader
> d. cut on a 1/4" thick line to cut out a 3" square, for at least ¾" length of the shape

> *Example C:* George will decrease the amount of assistance required for multiple functionally-based school tasks.

Ending Level: (Component B of NDDPI's measurable data and goal.)   Include current status. This should include something that can be measured or could be graphed.

> *Example A*: Jeremy currently has proper spacing in 10% of his written work handed into the teacher in 1 week. Ending level goal of proper spacing in 90% of written work in 1 week.

> *Example B*: Sally will complete this goal with 75% accuracy (3 of 4 tasks) over three charted opportunities. If this goal is met as written prior to her IEP, Student will work toward meeting this goal with 100% accuracy. She currently is unable to complete any of these tasks. (0%)

Example C:

1. George will load and carry his own lunch tray independently with 4-6 verbal cues. He currently requires 1 physical and 2 verbal cues.
2. George will deliver a small pencil box (5"x8") loaded with supplies up/down a flight of stairs with supervision from a distance only (no cuing) and a foot over foot pattern with use of the handrail. He currently requires 3 verbal and 1 physical cue.
3. George will put supplies into his locker with 2-3 verbal cues. He currently requires 3-4 physical cues and 1-2 verbal cues.
4. George will climb onto 20-30% of playground equipment with a peer with supervision only; no cuing required from an adult. He currently climbs on 75% of the equipment with 1-2 physical cues and 3-4 verbal cues from an adult.

Characteristics of Services: (Component D of NDDPI's goal.) What and where will therapy be like? Each goal must also include a description of where, how, and by whom the services will be delivered, unless the goal includes short-term objectives that will include this information.

Example A: Occupational therapist will address this goal through direct intervention in a resource room. (direct minutes) OT will also practice skills in the regular education classroom in order to generalize skills across all educational settings (direct minutes). Indirect occupational therapy minutes will be used to create sensory breaks/treatments, visual schedules, and/or pre-writing tasks to be completed by support staff in class during writing times.

Example B: This skill will be addressed collaboratively by the special education teacher, general education teacher, and the occupational therapist across general and special education setting(s). Skills may be addressed in 1-on-1, small group, or classroom settings.

Example C: Direct physical therapy treatment will occur across all academic settings to instruct George on skills and gross motor components required for skills, model for and instruct staff, and make adaptations to the environment as necessary. Direct occupational therapy in a resource room/outside general education will support this goal by addressing foundational skills such as upper extremity coordination, fine motor coordination, strength and motor planning in a resource room in order to facilitate George's progress in the areas noted above.

How and when periodic progress reports will be provided

Example A: Progress will be monitored and reported on by the occupational therapist, with input and written work collected from the classroom teacher.

Example B: This goal will be implemented by the educational team and monitored and reported on by the classroom teacher and the occupational therapist. Progress will be reported 3 times a year through a written progress report and parent-teacher conferences.

Example C: Progress will be monitored and reported at the trimesters by the physical therapist.

The GOAL at the top of a progress report combines intent, behavior and ending level into one paragraph. All therapists are required to document the student's starting level and the anticipated ending level in the goal (their goal from component B), as well as report progress at the trimester or

quarter. At each progress reporting period, therapists will track the student's current level and report progress according to IEP documentation requirements.

Related Services: Determining Need

After the student's IEP goals are written, the team asks the qualifying question regarding school occupational therapy and school physical therapy: Are occupational therapy or physical therapy services required to assist the child to benefit from special education? Being able to determine the need for these related services flows from knowing the nature of the specially designed instruction the child will receive. The timing of this decision helps the team focus on the child's goals and the expertise needed to help meet them, rather than on identified deficits. Also, this timing moves the process away from using erroneous criteria to qualify or disqualify a child for occupational therapy or physical therapy. See the Related Services checklist in the appendix on page 40 as an example of questions that may assist the team in deciding whether or not the related service of OT/PT may be educationally relevant. This checklist is not required, nor a comprehensive list of questions.

Standardized test scores are not required but can be helpful in making a determination for related services. The standardized scores will help the team in determining if the student may have a Non-Categorical Delay (NCD). More information about how to determine if a student is eligible for NCD as a primary disability please read the NDDPI *NCD Guidelines*.

IDEA school-based physical and occupational therapy services are provided to support IEP goals. Therefore, a therapist cannot provide stand-alone services with no other special education service needs identified. A student who does not qualify for services through IDEA could receive OT or PT as a related service if they qualify under Section 504 of the 1973 Rehabilitation Act. The IDEA funds may not be used to provide such services to a qualified Section 504 student. It is at the discretion of the school administrators to determine how students on a 504 plan will be served.

Special Education and Related Services

The IEP team determines the amount, frequency, duration and location of the services the student will receive in order to attain the annual goal. The OT and PT participate in this determination. If a therapist and/or team is having difficulty determining the amount or type of services required to achieve the collaborative goal, the team may refer to dosage guides such at the American Physical Therapy Association's (APTA) Dosage considerations and the Determination of Relevant Therapy Tools (OT), see page 38 in the appendix. Some suggestions for documenting amount, frequency, location and duration of services are listed below.

- The amount of therapy must be stated in the IEP so that the level of the agency's commitment of resources is clear to parents and all who are involved in the IEP development and implementation.
- The amount of time per episode/session/day/week/month must be appropriate to the service.
- The amount of therapy should be based upon the student's needs, not the availability of staff.
- The duration of service is considered the length of the IEP unless otherwise stated. When the duration is different than the rest of the IEP, the IEP should show the starting date and duration.

*For more information on types of service refer to the service delivery section, page 22

Progress Reports

Related services are added to a student's IEP to support specific goals. Therefore, it is the responsibility of the related service provider to report progress towards these goals as frequently as progress is reported for their peers (typically each quarter or trimester). (Sec. 300.320(a)(3)).

Extended School Year Services (ESY)

All children with disabilities who have a current IEP must be considered for ESY services at least annually. The determination of need rests with the IEP team. The primary criteria in determining a child's need for ESY services are the likelihood of significant regression of previously learned skills during a break in service, limited or delayed recoupment of these skills after services resume, or the student being at a critical point of instruction for an emerging skills.

ESY is established by the Individuals with Disabilities Education Act (IDEA), CFR 300.309. ESY services are also authorized under state law in North Dakota, ND Century Code 15.1-32-17. More information on ESY can be found on the NDDPI website.

Transition Services

All students will transition through different stages/levels as they experience school life. Some occur at natural progressions as the student ages through grade levels and advance from elementary to middle and eventually high school. Some of these transitions have more formal guidelines such as when a child transitions from early intervention to the school system and when they transition out of school into the adult world. Because occupational therapists and physical therapists have knowledge across the lifespan, they can provide unique expertise to help the team plan for the future needs of the student. In best practice, therapists can use their expertise in task analysis and environmental adaptations to provide opportunities for children and families to participate in meaningful activities in their home, school, work or community. In all types of transition, communication and collaboration are key aspects for all team members.

Early Childhood Transition

Children receiving early intervention services will have a transition plan as part of their Individualized Family Service Plan (IFSP). The IFSP assists in preparing the child and family for the transfer of services to the public school after the child turns three years of age. Early intervention (ages 0-2, IDEA Part C) and the public school (ages 3-21, IDEA Part B) are separate systems, which follow different regulations and eligibility requirements. The IFSP is based on family needs, and the IEP is based on the student's educational needs. The role of OT/PT in early childhood transition must include addressing the needs of both the child and the family. It is crucial that therapists help to identify skills and strategies needed for success in the new environmental setting. Therapists may also be involved in the evaluation process, developing intervention plans, and collaborating with the family and other team members to determine appropriate goals.

Postsecondary Transition Services

Secondary transition is a process in which students and families work with school personnel to establish a written plan for life after high school. Services to achieve this plan are documented in a student's Transition IEP and include developing measurable postsecondary goals in education or training,

employment, and independent living if appropriate. Transition planning should focus on a student's specific preferences, needs, strengths, and interests in the areas of post-secondary education, employment and independent living skills. It is essential that students are actively engaged in the development and implementation of their transition plans.

OTs and PTs are experts in task analysis and environmental adaptations and can apply them to daily living, education, work, leisure, and community participation. OTs and PTs can help to gather information regarding the current level of occupational performance, student and family goals for life after high school, and the intended postsecondary environment. Therapists may help to determine the necessary supports for employment or daily living.

Discontinuation of Occupational Therapy or Physical Therapy Services

The IEP team should begin a discussion of discontinuing services when initial eligibility is determined. Discontinuation criteria are tailored to student need. Discontinuation criteria assist IEP team members in making decisions regarding the termination of occupational therapy or physical therapy services. One or more of the following criteria should be met before the discussion to discontinue the student from related services.

1. The student has accomplished the IEP goals for which the therapy was necessary, and therapy will no longer have an impact on the child's functioning in special education, i.e., services are no longer necessary to meet the remaining IEP goals.

2. The student performs at a standard expected of his or her typical peers.

3. The intervention no longer results in measurable benefits, regardless of multiple documented interventions.

4. The student continues to make gains but there is no evidence that the related services interventions are related to the gains.

5. The identified priority skills are no longer a concern within the student's educational context.

6. The student is no longer eligible for special education and therefore no longer eligible for a related service under IDEA 2004.

When determining the appropriateness of terminating services, the student needs, the context for performance, and the future needs of the student should be considered. The IEP team can discontinue the related service without conducting a reevaluation. The child would not have to be re-evaluated in the area of the related service at the next reevaluation unless the IEP team suspects the child may require a related service to benefit from special education. If the IEP team's decision is to dismiss the student from a related service, the related service providers must document in the IEP the date of dismissal, justification for dismissal, supported by data, and any plans for recommendations.

Parents may be fearful that a discontinued service will never be offered to their child again. It is helpful to reassure the parent that the IEP team will reconsider occupational therapy and physical therapy based upon new needs or challenges that the child may have, such as transition from elementary school to middle school or preparing for transition from high school to adult life.

Service Delivery

Who Should Provide Services?

Occupational Therapist: a person who practices occupational therapy in the school setting and provides a related service for the assessment, consultation, and treatment of children whose disability, dysfunction, or developmental delay interferes with their ability to learn in the areas of fine motor function, sensory processing, or activities of daily living.

Occupational Therapist Assistant (OTA): a person licensed to assist in the practice of occupational therapy, who works under the supervision of an occupational therapist. The OTA may not independently complete evaluations or design treatment plans and is supervised by a licensed occupational therapist.

Physical Therapist (PT): a person who practices physical therapy. A physical therapist in the school setting provides a related service for the assessment, consultation and treatment of children whose physical disability, motor deficit or developmental delay interferes with the student's learning.

Physical Therapist Assistant (PTA): a person licensed to assist in the practice of physical therapy, but may not complete evaluations or design treatment plans, and is supervised by a licensed physical therapist.

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

Types of Service Delivery

Direct: The IEP team may determine that the student's goals and objectives will be met most effectively through direct services. In a direct service model, the therapist is the primary service provider. Direct service may be provided individually or in groups. The objective of this service model is to help the child make changes primarily through direct interaction. Direct services may be offered in a variety of settings (the classroom, the cafeteria, the playground or other school settings). The type, location, and amount of services are adjusted to meet the needs of the student. Whenever possible, the intervention should be provided in the least restrictive setting and result in the least amount of disruption to the student's academic day.

Indirect: Indirect services, or consultative services, are provided when a student's IEP specifies support for school personnel as a part of the accommodations, modifications, or supplemental support services provided to a teacher on behalf of the student. These services include providing information and demonstrating effective instructional and facilitation procedures. The therapist may provide support for staff or analyze, adapt, modify, and create instructional materials and assistive technology for targeted

students. While providing indirect services on behalf of a child, the therapist will monitor the student's progress.

This model is appropriate for students who are nearing dismissal from OT or PT services or students whose teachers require additional support to create materials, implement specific motor or sensory strategies, use assistive technology, or modify equipment. The classroom teachers may request assistance as they plan, monitor student progress, or make decisions regarding the presentation or selection of materials.

Consultative services (indirect) may be provided to family members. Such consultation can include information on development and facilitation, home programs, recommended environmental changes, or parent- support groups. This level of service may be provided to a family member of a child who is receiving services.

Information, home programs, and demonstration that can positively impact motor or sensory development or maintenance skills may be offered. This type of support is especially valuable for families and teachers when there is concern about the child's development.

Both direct and indirect minutes should be documented on the Education Environment/Related Services page of the IEP. If a related service is providing both direct and indirect minutes they would need to enter the minutes separately.

Examples

Examples of amount, frequency and location that are student-specific, versus scheduling based on therapist availability. These are simply ideas that might help therapists think differently about service delivery, specific to the collaborative goal, and avoid assigning minutes based on how it has typically been done in the past.

- *Typical:* Direct occupational therapy two times per week for 30-minute sessions in the resource room, outside the general education classroom.
- *Short-term intensive:* Direct physical therapy five times per week at 45 minutes each session for the first semester outside the regular classroom.
- *Infrequent:* Occupational therapy four times during the second semester, for 25 minutes each session.
- *Group*: Physical therapy for one hour, two times per week, in a group of 3-5 children in the regular classroom.
- *Predicted Schedule*:
  - *Sept 1 – Nov 1*   Physical therapy done 3x per week, 40 minutes per session outside the regular classroom.
  - *Nov 2 – Jan 15*   Physical therapy 2x per week, 30 minutes per session in the regular classroom.
  - *Jan 16 – Jun 3*   Physical therapy 30 minutes once per week in the regular classroom.

Location designates whether the student receives services in the general education classroom with access to non-disabled peers or away from non-disabled peers in a special education room. "General education class" means with nondisabled peers, whether it is in lunch, the classroom, the hallways, recess, physical education, music, art, etc. "Special education room" means the child does not have access to nondisabled peers. Services provided outside the general education class are considered

removal from general education. The IEP team documents the location for OT and PT services and describes them in terms of the extent to which the child will be removed from general education and nondisabled peers.

Educational Environment

Delivery of OT and PT within the least restrictive environment (LRE) is consistent with the collaborative model of service delivery. Generalization of skills is most likely to occur if the skills are practiced in the environment in which the skills are supposed to occur (Reid et al., 2006). When pushing into the classroom for therapy versus an isolated setting, transfer of skill is not necessary because it is being taught in the natural environment (Karnish, et al, 1995). There is also increased carry-over of skills during non-therapy times by teaching staff how to work on the skills in the classroom (i.e. teachers, paraprofessionals). Direct service skillfully embedded in the classroom setting is best for the student's function, which is not just treatment (intervention) taking place in the classroom; i.e. not pulling a child to the back of the room (Nolan et al, 2004).

Benefits of push-in therapy include:
- Less stigma, less being singled out
- Less disruption/lost instruction time
- Increased collaboration and consultation with teachers
- Benefits to other students
- More opportunities to practice skills in a natural setting (generalization)
- More effective problem-solving
- Peer modeling. Peers are invaluable assets - demo, modeling, motivation
- Goals and interventions are directly tied to classroom functioning

Regardless of the approach employed to determine the type and level of related services, IDEA 2004 requires that special education services be provided in an environment that is the least restrictive environment appropriate for the child in order to achieve the collaborative goal.

Some children require individual interventions to achieve an IEP goal that the therapist cannot provide in a classroom. The nature of the intervention, the space or equipment required for the intervention, or the potential distraction to the other children are acceptable reasons for the therapist to implement the child's therapy interventions in a location other than a classroom with other children. However, teachers and therapists also recognize that they cannot always ensure educational relevance through isolated, pull-out services. To promote educational relevance, OTs and PTs should attempt to observe and work with children in the context of educational programs, whether services are direct or indirect. For many school teams, the "push-in" model requires a considerable change in roles and practices.   All occupational and physical therapists working in the school setting in North Dakota should ensure they are using the three components of evidence-based best practices for service delivery/treatment.

Evidence-Based Practice Expectations

There are 3 components of Evidence-Based Practice

1- **Best Available Evidence**
   Although evidence-based practice encompasses more than just applying the best available evidence, many of the concerns and barriers to using Evidence-Based Practice revolve around finding and applying research. PTs and OTs need to find and understand the latest research that is relevant to each patient/student/IEP team. Some research studies are better than others. When available, meta-analysis and systematic reviews are best since they synthesize different studies into one report. See appendix, page 42 for resources for gathering research evidence.

2- **Clinician's Knowledge and Skills**
   Physical and Occupational therapist's knowledge and skills are a key part of the evidence-based process. School-based PTs and OTs need to use their competence, scope of practice, clinical reasoning and decision-making to provide the best possible care and reach the outcomes the student and IEP team prefers.

3- **Student's Wants and Needs**
   The student's wants and needs are a key part of the evidence-based process. Ask and understand what the IEP team (student/parents/teachers/etc) values and prefers. The student's interest and motivation is key to their success. Even proven interventions can fail, if the student and their caregivers are not interested in the outcomes or the intervention itself. Writing integrated, team-based goals as outlined in these guidelines will help to ensure this 3rd prong of evidence-based practice is utilized. Incorporating a student's cultural considerations, needs, and values is a necessary skill to provide best practice services.

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

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

See appendix, page 42 for a comprehensive list of federal education laws, regulations, and documents as well as AOTA and APTA professional documents that endorse evidence-based practice.

Teletherapy/Telehealth

American Occupational Therapy Association (AOTA) defines Telehealth as the application of evaluative, consultative, preventative, and therapeutic services delivered through telecommunication and information technologies.

Telemedicine means the practice of medicine by a practitioner, other than a pharmacist, who is at a location remote from the patient and is communicating with the patient, or health care professional who is treating the patient, using a telecommunications system. Telehealth is a service delivery model that allows an occupational therapy practitioner to deliver evaluation, treatment, and consultation through telecommunication and information technologies overcoming distance, transportation expenses, and patient access barriers.

The provider of services is responsible for understanding the licensure requirements for Telehealth within North Dakota.

Occupational Therapy in Telehealth

Chapter 55.5-03-01-03 Scope of Services

Telehealth is not a separate service. It is a medium to deliver care. Occupational Therapy practitioners must adhere to the same standards as expected for on-site service delivery. Interventions with physical assessment feedback may not be easily determined through a telehealth encounter. Each practitioner must assess and determine if the service delivery method of telehealth meets the standard for each patient encounter situation using their clinical reasoning and ethical judgment.

All legal, regulatory, and ethical rules apply consistent with an on-site service. Confidentiality and HIPAA compliance with network connection security in place for video and non-video connections is an important factor.

Chapter 55.5-02-03-01.1 Supervision: Definitions

An occupational therapy practitioner may provide occupational therapy personnel supervision requiring direct supervision and indirect supervision through electronic medical record technology and video teleconferencing. The practitioner will be responsible for the appropriate use of teleconferencing mediums in the supervision of services and maintain the privacy standards in all patient-related interactions.

Physical Therapy in Telehealth

Chapter 61.5-01-02

"Consultation by means of telecommunications" means that a physical therapist renders professional or expert opinion or advice to another physical therapist or health care provider via telecommunications or computer technology from a distant location. It includes the transfer of data or exchange of educational or related information by means of audio, video, or data communications. The physical therapist may use telehealth technology as a vehicle for providing only services that are legally or professionally authorized. The patient's written or verbal consent will be obtained and documented prior to such as consultation. All records used or resulting from a consultation by means of telecommunications are part of a patient's record and are subject to applicable confidentiality requirements.

"Direct supervision" means the physical therapist is physically present on the premises and immediately available for direction and supervision. The physical therapist will have direct contact with the patient during each visit. Telecommunications does not meet the requirement for direct supervision.

Educational vs Medical Services

When occupational therapy, physical therapy, and other therapies are related educational services, decisions regarding what therapy is provided, how it is provided, and who is to provide the therapy are directly tied to the student's overall educational program. The IEP team members and school staff are responsible for IEP implementation to support and foster the attainment of these educational goals. Therapy and other related services thus become a means or method to attain educational goals rather than the focus of separate goals. School-based therapy is then integrated into the student's educational program as a means to enhance functioning and attain educational goals. As with all other related services, school-based OT and PT are provided only if a student requires it to benefit from special education. Other services may be provided under MTSS or a 504 plan.

Clinic/hospital-based therapy is based on a medical model of intervention. Intervention is aimed primarily at improving functioning in skills that may or may not relate to the school setting. Historically, medical rehabilitation services have not been directed toward educational goals or the natural environment in which the individual must function. Using this "isolated therapy" model for students with more severe and multiple disabilities often does not emphasize the carryover and/or generalization needed by the student for daily functioning or attainment of educational goals.

Communication between educational and non-educational therapists is important for optimal coordination of services to children. Sharing information between educational, community, and hospital environments promotes a collaborative model of services important for consistent and effective outcomes. Coordination is especially critical for children who are receiving services in multiple environments. Written parent consent is required prior to any exchange of information with medical providers.

Therapy Services in IDEA Environments

| EDUCATIONAL SETTING	NON-EDUCATIONAL SETTING
Who is served by PT/OT?	
Children who qualify for special education services and who require OT/PT: 　　　**ECSE** – 3 to 5 years 　　　**School Age** – 5 to 21 years 　　　**Transitional** – 18-21 years 　　　Students qualifying under Section 504.	All ages without distinction, diagnoses within scope of practice.
Who is not served by PT/OT?	
Children with or without disabilities who do not require individual, specially designed instruction, related services or Section 504 accommodations. A medical diagnosis alone is **not** a criteria for service.	Resource limited per insurance, private pay, or Medicaid/Medicare.
What is the focus of service?	
EI / ECSE – enhance the development of toddlers with disabilities and maximize independent living	Physical and occupational therapy services are provided to maximize quality of life by promoting health and

EDUCATIONAL SETTING	NON-EDUCATIONAL SETTING
School Age – designed to meet special needs of students. **Transition** – preparation for living, working and learning in post-high school environments.	wellness and decrease participation restrictions of people of all ages and diagnoses in a medical model. May include a focus on home, community, and other environments.
Where are services provided?	
ECSE – Natural environment, preschool, daycare, Head Start, etc. School-Age – School setting Transition – School or community setting	Hospital, out-patient clinic, home, work, nursing facilities, community
What is the process for entering the system?	
Referral from one of multiple sources and evaluation to determine the need for services	Physician referral/self-referral-direct access
What is the evaluation process?	
Written parent consent to evaluate is required and information about the process explained to parent. Parents are given their procedural safeguards. Evaluation is completed within 60 school days, results are shared with the team. Eligibility for a related service is determined as part of an IEP meeting.	Every patient is evaluated using a variety of assessment tools and instruments
What is the plan of care?	
ECSE/School-age - IEP Transition – IEP with transition goals and services	OT/PT Plan of care
What is the plan of care development process?	
Collaboration within the IEP team, which determines priority of interdisciplinary goals and objectives.	Developed by the therapist in collaboration with the patient, family, and health care team and based on examination findings.
How is the plan of care/service evaluated?	
ECSE/School-age/Transition - IEP student progress reports	Periodic reassessments as required by state practice acts
How are modifications to the plan of care made?	
IEP team convenes to make changes to IEP	In collaboration with the patient, family, and health team
How is service documented?	
Progress notes and updated information in the students PLAAFP at an IEP meeting	Progress notes in the patient record
What types of services are delivered?	
Related Services, supplemental aids and services, and services on behalf of the child, including modifications, accommodations, and supports for personnel. • Direct • Indirect • Consultative	Wide range of services may be provided

EDUCATIONAL SETTING	NON-EDUCATIONAL SETTING
Who may provide follow up on the implementation of the plan of care?	
Identified per the IEP	PT, PTA OT, OTA
What Federal and State Statutes and Rules regulate PT/OT practice?	
OT: ND Century Code 43-40; PT: ND Century Code 43-26 IDEA 2004: 34 CFR Part 300 and 301 Section 504: 34 CFR Part 104	OT: ND Century Code 43-40 PT: ND Century Code 43-26
When regulations are in conflict, which set of regulations take precedence?	
Most restrictive regulation (IDEA and state regulations)	State practice acts and HIPAA apply

ICF Model and Explanation

The International Classification of Functioning, Disability, and Health (ICF) framework is used by AOTA and APTA to organize therapists' examination, evaluation, and the intervention process.

The ICF Framework
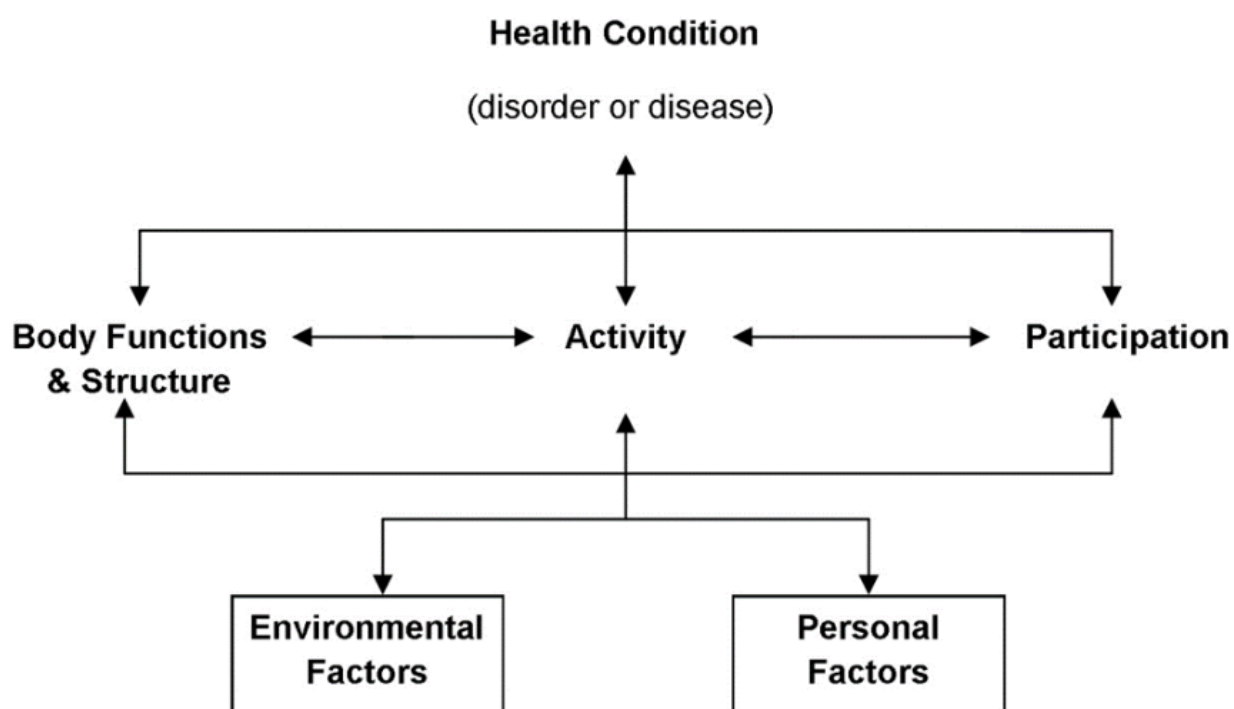
Elements and definitions of the ICF framework include:

- **Participation**: Role fulfillment such as functioning as a student in an educational environment.

- **Activity**: Functional tasks, e.g., writing responses to an exam, attending school plays, playing on the playground, giving a book report, or eating lunch.
- **Health Condition**: Specific pathology, diagnosis, and prognosis of condition courses such as spina bifida, autism, cerebral palsy, or limb deficiency.
- **Body Structure**: The anatomical parts of the body such as organs, limbs, and their components.
- **Body Function**: The physiological function of body systems (including psychological functions).
- **Personal and Environmental Contributing Factors**: External physical factors may include materials, environment, climate, geography, or rural/urban settings. Social factors may include language, relationships, or cultural expectations.

Prior to 2002, the model for service delivery recommended by the World Health Organization (WHO) and the National Center for Medical Rehabilitation Research (NCMRR) identified five dimensions of disability, known as the "Disablement Model."

This model was primarily a hierarchical model which implied that a change in one level would impact the next level in a somewhat linear relationship. There were several limitations to the model and the result was that in many cases too much emphasis was placed on impairment with the expectation that this would have a positive impact on function. Research in the area of motor learning and motor control did not bear this out.

Since 2002 the American Physical Therapy Association (APTA) and the American Occupational Therapy Association (AOTA) use the WHO's International Classification of Functioning, Disability, and Health (ICF). This framework is used to organize the therapists' examination, evaluation, and intervention process throughout all practice venues and across the lifespan of therapy recipients. An explanation of this classification framework succinctly melds with the intent of the IDEA 2004. The ICF framework reflects an emphasis on an individual's participation in activities germane to his/her current and future roles in a variety of environmental contexts.

Assistive Technology

The availability of technology in general education and the school's responsibility to provide assistive technology (AT) in the educational setting has had a significant impact on children with disabilities. The availability of AT services and devices for students with disabilities ensures their participation in both academic and social communities. The use of AT can facilitate:

- An increase in student access to and participation in the general education curriculum
- An increase in productivity
- Expansion of a student's educational/vocational options
- Enhancement of communication opportunities
- Reduction of the amount of support services needed
- An increase in a student's independence

The IEP team has the responsibility under IDEA to determine if the student requires AT for the provision of FAPE. Arriving at this decision may require an AT assessment or consultation from a team of professionals who are knowledgeable on the specific AT. This team may include speech-language pathologists, occupational therapists, physical therapists, special education teachers, technology specialists, and vision and/or hearing specialists, among others. Some districts have identified an AT

team that has been trained to provide AT assessments at the local level and has developed a process for this task. Parent and student input and participation is critical to the assessment process.

Assistive technology solutions can include a wide range of no-tech, low-tech, mid-tech, and high-tech devices, hardware, software, and other instructional technology tools that the student's IEP team may identify as educationally necessary. The team's considerations should not be limited to the devices and services currently available within the district.

Adaptive technologies are a type of AT that includes customized systems that help individuals communicate, move, and control their environments. Adaptive technologies are specifically designed for individuals with disabilities and are a sub-set of AT devices.

For more information on assistive technology please see the NDDPI *Guidelines for the Provision of Assistive Technology to Student with Disabilities under IDEA Part B.*

Evacuation Plans

Employees need to be trained in techniques for assisting the student with mobility impairments in the event of an emergency. Physical/occupational therapists may need to assist in the training when a student with mobility impairments requires a modified evacuation plan. An evacuation plan is considered modified whenever it differs from that of the student's main classroom of peers. Staff should know their own physical limitations. Therapists/teams should ascertain the person with mobility impairments condition and preferences by asking them. People with disabilities live with their impairments every day and often have ideas for the best methods for assistance; ask for their input. If possible and safe, students should have the opportunity to move themselves with as much assistance as required versus being carried with total assistance. For example, if a student can and prefers to walk down the stairs with moderate assistance of 2, and it is safe and efficient for both the student and staff members, that method should be used versus an evacuation chair or sling with total assistance. Adequate and proper emergency equipment should be staged at strategic locations throughout the facility to enable not only employees to assist the student with disabilities but also for use by emergency professionals that may respond to the scene.

Pre-planning and preparation will increase the margin of safety, save lives and property when an emergency arises. Evacuation of a person with a disability can be carried out if proper policies and techniques are implemented to:

- Train employees in methods of assisting the student
- Train employees how to effectively communicate during an emergency
- Assign specific tasks during an emergency
- Identify the specific needs of the student
- Provide a facility-specific response plan

The use of a modified evacuation plan should be documented in the adaptation section of the IEP.

Administration

Caseload/Workloads

Workload vs Caseload Approach

Caseload and workload are different approaches to both student assignment and staff allocation for service. The *caseload method* designates staff based on a specific number of students assigned in IEPs and 504 plans without regard to the time required to meet each student's needs or the therapist's other responsibilities within the broader school setting. Caseloads can also be quantified in terms of the number of intervention sessions available during a given time period. A caseload approach is reflective of a medical model and does not capture the variety or range of service demands placed on OTs and PTs in school settings.

Workload refers to all activities required to be performed by therapy practitioners and address the range of demands placed upon OTs and PTs. Increasingly, students in special needs programs may exhibit complex medical and behavioral challenges while they are being directed to meet more rigorous academic standards. With the reauthorization of IDEA 2004 and its focus on inclusion and accountability, the workloads of therapy practitioners have broadened from traditional "direct and indirect" services to include student participation in educational initiatives, such as Universal Design for Learning (UDL), Positive Behavioral Intervention Supports (PBIS), and Multi-Tier System of Supports (MTSS). There is a growing need to support all students in the least restrictive environment (LRE) and facilitate participation in the general education curriculum; a workload approach helps to meet this demand.

The workload is reflective of educational setting requirements and includes assessment and interventions as well as ongoing collaboration with regular and special education staff, communication with parents, and participation in school and district-level committees. To serve all students appropriately, a variety of measures may be used, including but not limited to assistive technology, accommodations, modifications, and therapeutic strategies. Workload includes time spent performing other activities necessary to support students' education programs (e.g., traveling between schools, documenting, attending meetings), implement evidence-based practice, and ensure compliance with IDEA and other mandates.

In essence, the workload approach looks at how the therapist's time is spent versus the number of students with IEPs/504 Plans the therapist serves. A caseload approach looks solely at the number of students needing services or the number of intervention sessions required. Given the increasing roles, responsibilities, and demands on OTs and PTs in school-based practice settings, a workload approach seems most likely to ensure compliance with IDEA 2004 requirements and state and local mandates.

Workload Factors

A therapist's caseload is determined as a result of the workload.

The number of students requiring special education or 504 services that the occupational therapist or physical therapist can adequately serve is influenced by the following workload factors:

- Program planning and development

- Pre-referral interventions

- Screenings

- Evaluations and re-evaluations

- Intervention strategies

- Writing classroom and home programs

- Providing therapy as indicated in the IEP or 504 plan

- Collaboration and training with school personnel, student, and parents

- In-service training

- IEP team meetings

- Travel between schools

- Equipment and supply ordering, maintenance, and inventory

- Documentation and communication of student evaluations, progress and consultations with parents and school staff

- Fabrication of equipment, splints, and other assistive technology

- Obtaining medical records and referrals

- Consultation/planning with the education agency on issues such as evacuation procedures, bus transport of wheelchairs, etc.

- Consultation with equipment providers and with parent permission, consultation with medical doctors, and other agencies

- Supervision of therapist assistants

- Third-party billing requirements

School closings due to weather or holidays, student field trips or absences, and seasonal fluctuations in workload are all variables in the process of providing services. "Typical time" should be considered when making schedules (i.e., the amount of time that is available to any student, whether or not the student has a disability). *Letter to Balkman*, 23 IDELR 646 (OSEP 1995) and *Letter to Copenhaver*, 108 LRP 33574 (OSEP 03/11/08) state the only reason related service minutes for a student would not be provided is if a student is absent or school is closed (i.e., due to weather). If a student needs these services in order to receive FAPE, they need to be offered or made up if missed. Per these letters field trips, school-related activities, or service providers in meetings/trainings are not acceptable reasons to miss minutes.

Licensure & Certification requirements

Refer to the North Dakota State Board of Occupational Therapy Practice for licensure requirements and practice law.

Refer to the North Dakota Board of Physical Therapy for licensure requirements and practice law.

Continuing Education Requirements

Occupational Therapy

The North Dakota State Board of Occupational Therapy Practice requires documentation of continuing education **upon application for license renewal**. All licensed Occupational Therapists and Occupational Therapy Assistants must acquire a minimum of **twenty contact hours** (2.0 CEU's) **within the twenty-four months prior to the date the completed application for renewal of licensure is received by the NDSBOTP office**. Continued competency hours may only be used for one renewal of licensure period.

- 20 contact hours are required if initially licensed after June thirtieth of the even-numbered year and before July first of the odd-numbered year.

- 10 contact hours are required if initially licensed after June thirtieth and on or before December thirty-first of the odd-numbered year.

- 0 contact hours are required if licensed on or after January first of an even-numbered year. Licenses will not renew their license until the following licensing period when the licensee is required to complete twenty contact hours and renew the license for that and each subsequent licensing period.

Calculation of hours
A contact hour for continuing education is based on a 50-minute hour. The minimum program length has been established as one contact hour.

The equations listed below should assist you in understanding and calculating your hours:

> 1 contact hour = 50 minutes
>
> 0.1 CEU = 1 contact hour
>
> 0.2 CEU = 2 contact hours
>
> 1.0 CEU = 10 contact hours
>
> 2.0 CEU = 20 contact hours

Continuing Education Content
Continued Competency must

- be directly related to or supportive of occupational therapy practice

- enhance the occupational therapist's or occupational therapy assistant's professional development and competence

- be specific to the applicant's or licensee's current area of practice or an intended area of practice within the next year.

Verification**:** A copy of the certificate, containing licensee's name, program title, date(s), and contact hours, must be submitted with the application for renewal. If a certificate of completion was not

granted for a specific program, the licensee must submit a completed Individual License holder's Continued Competency Attendance form signed by their supervisor. This form can be printed from the board's website on the Continued Competency page.

Failure to comply with the continued competency requirements and renewal procedures as outlined in the Board's rules can result in late fees and delay or denial of the renewal and may result in disciplinary action. The Board may waive or allow exceptions due to medical hardship or other extraordinary circumstances.

Please refer to the State Board for updated continuing education requirements.

Physical Therapy

Continuing Competence Requirements
Continuing Competence 61.5-03

All competence activities related to physical therapy sponsored by the APTA, State PT Associations, Medical/Educational institutions or certified by the Federation of State Boards of Physical Therapy (FSBPT) are automatically approved as "certified activities".

Any continuing competence activities sponsored by national or state organizations are automatically approved as certified activities as long as they meet the course standards found in the North Dakota Administrative Code, section 61.5-03-02-02. The same is true of postsecondary coursework taken at an accredited educational institution.
Examples of certified activities include:

- Clinical Certifications = 15 units

- PRT (Practice review tool) = 15 units

- Successful completion of an accredited PT residency program = 25 units

- Option assessment = 3 units

- Online courses certified by FSBPT/ProCert or sponsored by the APTA, state PT associations, Medical/educational Institutions.

Changes "non-clinical" to "**Approved activities**". The **maximum** number of "**approved**" units which may be applied for the two year recording period will equal **10 units**.

"Approved activities" must be related to the therapist's job and do not go through a formal certification process. They also must meet the credit standards found in section 61.5-03-02-02.
Examples of approved activities include:

- Online courses that are not sponsored by the APTA, State PT associations, Medical/educational institutions, national or state organizations or are not certified by FSBPT/ProCert

- Clinical Instructor. One unit for every 165 hours of clinical instruction. A maximum of 5 units per two year recording period.

- Teaching an approved continuing competence activity (see 61.5-03-02-02 #6)

- Teaching at an accredited PT/PTA program as long as teaching is **not** your primary occupation. One unit per direct contact hour in teaching. Maximum of 5 units per two year recording period.

- CPR = up to 3 units per recording period

Changes in terminology took effect on January 1, 2016. All licensees due to report CC activity will be required to fill out the CC reporting form. Those that are audited will be required to send copies of course completion certificates to the board. Aptitude will be accepted in lieu of filling out the reporting form and will be accepted for audit purposes as well. Please refer to the State Boards for updated continuing education requirements.

Changes "clinically related" to "certified activities" The total number of continuing competence units remains the same at 25 units per renewal cycle (i.e. every 2 years). The minimum number of "certified" units which may be applied for the two year recording period will equal 15 units.

Medicaid

The education agency is responsible for providing FAPE and may utilize available resources to do so. For those education agencies participating in the Medicaid/Third Party Billing program, Medicaid and third-party resources may be utilized to pay for services provided. If the related service is identified on the IEP, the education agency must be responsible for the provision of service.

An amendment to IDEA, included in the Medicare Catastrophic Coverage Act of 1988, clarified that Medicaid funds could be used to pay for health-related services provided under IDEA. For health-related services provided under IDEA to be reimbursed by Medicaid, they must be:

> 1) provided by a participating Medicaid provider,

> 2) medically necessary,

> 3) included in the state's Medicaid plan,

> 4) provided to an individual eligible for Medicaid and

> 5) screened for any other third-party payment that may be available for reimbursement.

To receive ND Medicaid payment, the services must be part of a special education program and otherwise covered by ND Medicaid. ND Medicaid will not directly pay private schools but can make payments to the public school district for IEP-related services for children in that district who are attending private educational facilities.

Medicaid will reimburse for school-based services provided by licensed occupational and physical therapy practitioners. OTs and PTs must sign off on reimbursements submitted by OTAs and PTAs.

Documentation requirements for Medicaid/Third Party Billing
If therapists are completing proper documentation in the IEP, further documentation (such as daily notes) is not required for billing. If therapists are concerned about this, the best practice is to use the note section on Compuclaim Service Portal. This is not a requirement.

More information on ND Medicaid can be found on the Department of Human Services website or in a document titled "*General Information for Providers North Dakota Medicaid and Other Medical Assistance Programs*."

Free Care and Third-Party Billing Services provided to Medicaid-eligible children that are part of an IEP are not subject to the same Medicaid Free Care and Third Party Liability requirements. The Medicaid statute contains an exception in section 1903(c) of the Act, which requires that Medicaid serve as the primary payer to services provided by schools to Medicaid eligible children in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) under the IDEA. Public agencies (schools) with general responsibilities to ensure health and welfare are not considered liable third parties.

"*General Information for Providers: North Dakota Medicaid and Other Medical Assistance Programs*" document states the following with regards to occupational and physical therapists: "The following must be documented in the member's plan of care:

• The member's medical diagnosis and any contraindications to treatment;

• A description of the member's functional status;

• The objectives of the rehabilitative and therapeutic service;

• A description of the member's progress toward the objectives."

If IEP documentation is completed correctly and thoroughly, the IEP should meet these documentation requirements.

Daily Notes

Therapists' daily documentation requirements differ between school districts. At a minimum, therapists should track attendance, minutes, and reasons for missed visits. Most therapists also collect data for weekly/daily progress towards goals and objectives.

Physical therapists are not required to complete a daily note for each interaction with a patient: per North Dakota's physical therapy practice act: "43-26.1-11. Patient care management.

1. A physical therapist is responsible for managing all aspects of each patient's physical therapy. A physical therapist shall provide:
   a. Each patient's initial evaluation and documentation.
   b. Periodic re-evaluation and documentation of each patient.
   c. The documented discharge of the patient, including the response to therapeutic intervention at the time of discharge."

The OT licensure law does not require any specific documentation, so there is no requirement to complete daily notes. Documentation required is site-specific, so would be different in school-based practice, vs. SNF, vs. outpatient, etc. The ND licensure law for OT's states, "Occupational therapy practice includes evaluation by skilled observation, administration, and interpretation of standardized and non-standardized tests and measurements."

The above information from the state PT/OT licensure requirements again explains that if therapists are correctly documenting and measuring progress according to IEP requirements, their documentation requirements should be met.

Appendix

Dosage Considerations

The purpose of this list is to provide samples of forms used to guide service delivery. This is not a required or comprehensive list of available tools.

Dosage Consideration Documents (titles are searchable online):

Section on Pediatrics, APTA. Dosage considerations: Recommending School-based physical therapy intervention under IDEA Resource Manual.

NSSEO School-based therapy guidelines (Northwest Suburban Special Education Organization)

Considerations for Educationally Relevant Therapy (Florida Department of Education-CERT)

Occupational and Physical Therapy Service Needs Checklist (Office of Special Education Programs of the Oregon Department of Education)

OT/PT Evaluation Tools

The purpose of this list is to provide samples of evaluation tools that may be administered by the OT or PT. This is not a required or comprehensive list of available tools.

CATEGORY	NAME	SUB-CATEGORY
Body Function and Structure	30-Second Walk Test	Walking distance
	6 Minute Walk Test	Endurance
	Faces Pain Scale	Pain
	Functional Reach Test	Balance
	Timed Up and Go (Modified)	Standing balance and walking
	Pediatric Berg Balance Scale	Balance
	Standardized Walking Obstacle Course	Functional Ambulation
	10 Meter Walk Test	Gait Speed
	Sensory Integration and Praxis Test	Sensory defensiveness
Activity	Bruininks-Osteretsky Test of Motor Proficiency, 2nd ed. (BOT-2)	Overall motor function (can have sub-categories that measure at Body Function and Structure Level)
	Functional Independence Measure	Functional performance
	Gross Motor Function Measure (GMFM-88 or GMFM-66)	Gross-Motor ability

CATEGORY	NAME	SUB-CATEGORY
	Movement Assessment Battery for Children (MABC-2)	Motor ability
	Peabody Developmental Motor Scales (PDMS-2) 2nd edition	Gross and Fine Motor ability
Activity/ Participation	Pediatric Evaluation of Disability Inventory (PEDI)	Activity: Functional activities, mobility Participation: Social function
	School Function Assessment	Activity: Fine/Gross motor performance Participation: School-related activities, level of assistance needed
	Canadian Occupational Performance Measure	Measures self-perception of functional performance over time
	Enderle-Severson Transition Rating Scale	Measures needs, preferences, and interests for secondary transition
Participation	Assessment of Life Habits (LIFE-H)	Social participation
	Children's Assessment of Participation and Enjoyment (CAPE) and Preference for Activity of Children (PAC)	Participation in leisure activities
	Pediatric Quality of Life Inventory	Physical, emotional, social, and school function
Classification Systems	Gross Motor Function Classification System (GMFCS)	Classifies students based on motor ability
	Manual Ability Classification System	Classifies students based on hand usage
Program Evaluation	School Outcomes Measure (SOM)	Measures at all three levels of ICF and collects outcomes within a school-based context
Student Specific	Goal Attainment Scaling	Therapist flexibility to measure at all three levels of ICF
	Patient-Specific Functional Scale	Therapist flexibility to measure at Body function/structure and activity level

Related service Checklist

What is the proposed related service? (List here):		
Is the proposed related service educationally relevant? (Circle Yes or No) • If NO, the service should not be considered as a related service • If YES, continue…	YES	NO
What purpose does it serve for the student? Check all that apply. ___ select or maintain equipment, specify: ___ make adaptations or design support programs, specify: ___ transfer information or skills to other school staff, specify: ___ be a resource or support to the family, specify: ___ provide services or therapies to the student, specify: ___ other, specify: ___ other, specify:		
Is the service educationally necessary? Circle YES or NO for each question. *If the team answers, "yes" to the following question, it is an indication that the service under consideration probably IS educationally necessary:*		
• Will the absence of the service interfere with the student's access to, or participation in, his or her educational program this year?	YES	NO
If the team answers "yes" to any of the following questions, the service under consideration probably IS NOT educationally necessary:		
• Could the proposed service be addressed appropriately by the special educator or classroom teacher?	YES	NO
• Could the proposed service be addressed appropriately through core school faculty or staff (e.g., school nurse, guidance counselor, librarian, teachers, administrator, bus drivers, cafeteria staff, or custodians?)	YES	NO
• Has the student been benefiting from his or her educational program without the service?	YES	NO
• Could the student continue to benefit from his or her educational program without the service?	YES	NO
• Could the service be appropriately provided during non-school hours?	YES	NO
• Does the proposed service present any undesirable or unnecessary gaps, overlaps, or contradictions with other proposed services?	YES	NO

Major points from team discussion:

Decision by the team about the need for the proposed related service:

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

Endorsing Body	Focus of Evidence-Based Practice Endorsement
Federal & State education laws, regulations, and documents	**Individuals with Disabilities Education Act (IDEA 2004)** • The child's individualized education program (IEP) will provide "a statement of the special education and related services and supplementary aids and services, based on peer-reviewed research to the extent practicable" (20 USC §1414(d)(1)(A)(i)(IV)). • The education of children with disabilities can be made more effective by ''supporting high-quality, intensive preservice preparation and professional development for all personnel who work with children with disabilities in order to ensure that such personnel have the skills and knowledge necessary to improve the academic achievement and functional performance of children with disabilities, including the use of scientifically based instructional practices, to the maximum extent possible" (20 USC § 1414(c)(5)(E)). **Every Student Succeeds Act (ESSA)** • State and local agencies are encouraged to use evidence-based interventions. This increases the likely hood that interventions will be successful, since prior data demonstrated their effectiveness. • Under ESSA there are four tiers or levels of evidence: strong evidence, moderate evidence, promising evidence, and demonstrates a rationale. **Response to Intervention (RtI)** • Ensures "the access of all children to effective, scientifically based instructional strategies" (20 USC § 1413(f)(2)(A). • "Data-based documentation reflecting continuous monitoring of child performance and progress during interventions" (NJCLD, 2005). • "Evidence-based practices" includes educational practices and instructional strategies that are supported by relevant scientific research studies (ND Administrative Rule 67-23-06-01). **Core Content Access: Curriculum Guide for Children with Moderate to Severe Disabilities** • Monitoring of progress includes "establish[ing] method(s) of collecting data" (CCESA/SEACO 2005, A-3).
AOTA	**Occupational Therapy Code of Ethics (2005)** • Occupational therapists must "critically examine available evidence so they may perform their duties on the basis of current information" (p. 640). • It is an occupational therapist's duty to further expand professional knowledge by "maintaining and documenting competence in practice, education, and research by participating in professional development and educational activities" (p. 640).

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

Resources for Gathering Research Evidence

Type of Resource	Name of Resource	Main Focus	Accessibility
Databases and search engines	Ovid	Database of medical, scientific and academic research	Free www.ovid.com
	ERIC	Education bibliographic references and full-text articles	Free www.eric.ed.gov
	TRIP database	Systematic reviews, Meline articles, full-text articles and medical guidelines	Free www.tripdatabase.com
	Free medical journals	Full-text articles in medical journals	Free www.freemedicaljournals.com
	Biomed Central	Full-text articles in medical journals (including pediatric journals)	Free www.biomedcentral.com
	ACP Journal Club	Critical appraisals of systematic reviews and research articles	Must purchase subscription
	OT Seeker	Systematic reviews and randomized controlled trials relevant to OT	Free www.otseeker.com
	PEDro	Physiotherapy bibliographic references and abstracts of randomized controlled trials, systematic reviews and guidelines for physiotherapy	Free www.pedro.org.au

Type of Resource	Name of Resource	Main Focus	Accessibility
Journals	Occupational Therapy International	International OT research articles	Must purchase a subscription
	Journal of the American Physical Therapy Association	PT research articles	Must be an APTA member

References

Burton, K. (2015). Continuing my journey on designing and refining criterion-referenced assessment rubrics, *Journal of Learning Design*, v8 n3 p1-13, 2015

Clark, G. F., Fioux, J. E., & Chandler, B. E. (2019). *Best practices for occupational therapy in schools*. Bethesda, MD: AOTA Press/The American Occupational Therapy Association

Karnish, Kristen, Bruder, Mary Beth, Rainforth, Beverly (1995) A Comparison of Physical Therapy in Two School Based Treatment Contexts, *Physical & Occupational Therapy In Pediatrics,* 15:4, 1-26

Nolan, Karen W. PT, MS, PCS; Mannato, Lori MS, PT; Wilding, Gregory E. PhD *Pediatric Physical Therapy*: July 2004, 16(2) 121-128

Physical Therapy in School Settings. (2016). Retrieved from American Physical Therapy Association

Reid, D., Chiu, T., Sinclair, G., Wehrmann, S., & Naseer, Z. (2006) Satisfaction and outcomes of occupational therapy school-based consultation services. *Canadian Journal of Occupational Therapy, 73. 215-244*

Sackett D, Strauss S, Richardson W, Rosenberg W, Haynes R. Evidence-Based Medicine: How to Practice and Teach EBM. 2nd ed. Churchill Livingstone; Edinburgh

Whitehurst, Grover J. (2002) Evidence-Based Education (EBE), Educational Research and Improvement presentation

Workload Approach: A Paradigm Shift for Positive Impact on Student Outcomes, Joint Statement, AOTA, APTA, ASHA, 2014

The following state guidelines were used as references in writing the North Dakota guidelines:

Guidelines for Occupational Therapy and Physical Therapy for Students Receiving Special Education Services in Alabama, 2008

Guidelines for the Provision of Occupational Therapy and Physical Therapy Services Under the Individuals with Disabilities Education Act (IDEA), Montana Office of Public Instruction, 2018

Handbook for Occupational and Physical Therapy in Virginia Public Schools, 2010

Occupational Therapy and Physical Therapy – A Resource and Planning Guide, Wisconsin Department of Public Instruction, 2011

Occupational Therapy and Physical Therapy in Oklahoma Schools, Technical Assistance Document, undated

Physical and Occupational Therapy Under IDEA in Oregon: Early Intervention, Early Childhood and School Age Special Education, 2016