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Purpose of Guidelines

The purpose of these guidelines is to provide a concise, comprehensive reference manual for occupational therapy practitioners, administrators, and families that defines the role of school occupational therapy and best practices in its implementation in the school setting. The sections that follow detail important considerations in the provision of school occupational therapy services, including:

- ◆ Laws and regulations
- ◆ Collaboration
- ◆ Evaluation
- ◆ Interventions
- ◆ Documentation
- ◆ Administration
- ◆ Professional responsibility

Helpful resources are embedded in each section as well as catalogued in the **Resources** section. It is the intent of the Connecticut State Department of Education (CSDE) that practitioners, administrators, and families use these guidelines as a resource to better understand:

- ◆ The meaningful contributions school occupational therapy practitioners make to Pre-Kindergarten – Grade 12 (PK-12) education;
- ◆ How school occupational therapy practitioners support successful student outcomes; and
- ◆ Key factors in implementing best practices in school occupational therapy that result in meaningful contributions to PK-12 education and successful student outcomes.

Throughout this document a deliberate decision was made to drop the suffix ‘based’, as in school-based practitioner. Given that the term based refers to a location or where something or someone is situated, the term does not seem well suited for the 21st century. School occupational therapy practitioners have an impact at many levels within the educational system and consider the many environments in which students learn and participate. In addition, dropping the suffix ‘based’ aligns with our professional counterparts (e.g., school teachers, school social workers, school nurses, and so on).

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OCCUPATIONAL THERAPY IN SCHOOLS

Section 1

Learning Objectives

Readers will gain a better understanding of:

- ◆ The scope of practice for occupational therapy in school settings;
- ◆ The role of the occupational therapist in the school setting;
- ◆ The role of the occupational therapy assistants in the school setting; and
- ◆ With whom school system occupational therapy practitioners work.

Overview of Occupational Therapy

Occupational therapy practitioners¹, are professionals with "knowledge and skills in the biological, physical, social, and behavioral sciences" to work with people across the lifespan (American Occupational Therapy Association (AOTA), 2011, p. 1). Practitioners work with people across the lifespan to ensure they can participate in activities they need and want to do through the therapeutic use of everyday activities (AOTA, 2015, para. 2). Everyday activities include: activities of daily living (ADLs) (e.g., dressing, grooming); instrumental activities of daily living (IADLs) (e.g., shopping, meal preparation); work; leisure; and wellness (e.g., rest and sleep). Occupational therapy practitioners work in an array of settings, including schools.

Occupational therapy practitioners, including school practitioners, are both registered and licensed professionals. Practitioners are registered with the National Board for Certification in Occupational Therapy, which requires practitioners to complete continuing education regularly and renew their certification every three years. In Connecticut, practitioners must also apply for a license to practice. Practitioners apply for and are granted a license to practice through the Connecticut Department of Public Health (DPH). The Connecticut DPH requires practitioners to complete continuing education regularly and renew their license every two years. Please see the *Professional Conduct* section for further information on licensing and continuing education requirements for Connecticut state licensure.

In Connecticut, as in many other states, there is a state statute that describes what occupational therapy practitioners can and cannot do in their capacity as a licensed practitioner (i.e., "Connecticut's OT Practice Act"). Connecticut General Statutes (Conn. Gen. Stat.) Chapter 376a § 20-74a(1) defines occupational therapy as the evaluation, planning, and implementation of a program of purposeful activities to develop or maintain adaptive skills necessary to achieve the maximal physical and mental functioning of the individual in his daily pursuits. The practice of "occupational therapy" includes, but is not limited to, evaluation and treatment of individuals whose abilities to cope with the tasks of

¹ In these guidelines, the term "occupational therapy practitioners" refers to both occupational therapists and occupational therapy assistants.

living are threatened or impaired by developmental deficits, the aging process, learning disabilities, poverty and cultural differences, physical injury or disease, psychological and social disabilities, or anticipated dysfunction, using:

- a) such treatment techniques as task-oriented activities to prevent or correct physical or emotional deficits or to minimize the disabling effect of these deficits in the life of the individual;
- b) such evaluation techniques as assessment of sensory motor abilities, assessment of the development of self-care activities and capacity for independence, assessment of the physical capacity for prevocational and work tasks, assessment of play and leisure performance, and appraisal of living areas for the handicapped; and
- c) specific occupational therapy techniques such as activities of daily living skills, the fabrication and application of splinting devices, sensory motor activities, the use of specifically designed manual and creative activities, guidance in the selection and use of adaptive equipment, specific exercises to enhance functional performance, and treatment techniques for physical capabilities for work activities. Such techniques are applied in the treatment of individual patients or clients, in groups, or through social systems.

Conn. Gen. Stat. Chapter 376a § 20-74a(2),(3) goes on to define occupational therapist as “a person licensed to practice occupational therapy as defined in this chapter and whose license is in good standing” and occupational therapy assistant as “a person licensed to assist in the practice of occupational therapy, under the supervision of or with the consultation of a licensed occupational therapist, and whose license is in good standing.” More specifically, occupational therapists are responsible for all aspects of service delivery (i.e., collaboration, evaluation, interventions, progress monitoring, documentation) and are accountable for its effectiveness (AOTA, 2011, p. 1). Occupational therapy assistants provide services “under the supervision of and in partnership with an occupational therapist” (AOTA, 2011, p. 1).

To learn more about occupational therapy’s scope of practice, please see AOTA’s webpage, [About Occupational Therapy](#).

Overview of School Occupational Therapy

The *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2014) describes central concepts that guide occupational therapy practice. Education is one area of occupation included in the occupational therapy domain of practice. Education is defined as “activities needed for learning and participating in the educational environment” (AOTA, 2014). “The fundamental background of occupational therapy practitioners is rooted in concepts related to promoting meaningful participation, optimum development, and engagement within natural contexts or least restrictive environments” (AOTA, 2012). The occupation of education includes academic (e.g. math, reading, writing), non-academic (e.g. recess, lunch, self-help skills), extracurricular (e.g. sports, band, cheerleading, clubs), and prevocational and vocational activities (Knippenberg, C., Hanft, B, *School System SIS Quarterly*, AOTA, 2004).

School occupational therapy services are, therefore, different from occupational therapy services in a more traditional medical setting (i.e., clinic, hospital). In general, laws and regulations relevant to school occupational therapy services assure students' ability to participate in their educational program; they do not include provisions to reduce underlying medical impairments, unless it is feasible and clearly improves access and participation in education. Rather, school practitioners help students, aged 3-21, "prepare for and perform important learning and school-related activities" (AOTA, 2010, p. 1). That is, practitioners focus on removing barriers from students' ability to learn and participate, and on helping students develop skills, which increase their independence in all aspects of the school environment (e.g., classroom, cafeteria, playground, afterschool activities) and academic performance. Practitioners provide interventions primarily to promote academic success and social participation.

Practitioners may work directly with general education students, students at-risk, and students with disabilities to enhance student outcomes (AOTA, 2009, p. 1). Additionally, they may collaborate with educators and families to enhance student outcomes (AOTA, 2009, p. 1). Academic student outcomes include success in meeting literacy and math grade-level expectations (AOTA, 2010, p. 1). Non-academic student outcomes include success with behavior management; social skills; self-help skills; and participation in recess and extracurricular activities, such as sports and after school clubs (AOTA, 2010, p. 1). Practitioners are members of a school's educational team. They work with administrators, educators, students, families, and community members to help *all* students engage in their educational activities.

Conn. Gen. Stat. Chapter 376a § 20-74a does not specifically define nor limit the role of school occupational therapy practitioners. The specific role of Connecticut school occupational therapy practitioners is better defined through review of federal education legislation and regulations; state statutes and regulations; and AOTA reference documents. Below is an overview of how these laws, regulations, and policies shape the role of school occupational therapy. Please see the *Laws and Regulations* section for further information on the laws, regulations, and policies that govern school occupational therapy.

Scientifically Research-Based Interventions²

The Elementary and Secondary Education Act (ESEA) and the Individuals with Disabilities Education Improvement Act of 2004 (IDEA 2004) address Response to Intervention (RTI). "RTI is the practice of providing scientific, research-based instruction and intervention matched to students' needs, with important educational decisions based on students' levels of performance and learning rates over time" (CSDE, 2008, p. 3). In Connecticut, RTI is called Scientific Research-Based Interventions (SRBI). SRBI emphasizes the importance of high-quality core general education practices (e.g., curriculum, instructional strategies, positive/safe school climate) as well as targeted interventions for students experiencing learning, social-emotional, or behavioral difficulties. Interventions used are scientific and research-based wherever possible.

² Language in this section was taken from the CSDE publication, *Connecticut's Framework for RTI* (2008), to ensure consistency among CSDE publications.

Two key elements of SRBI include data-driven educational decision making and a tiered continuum of support. Educational decision making is driven by data that illustrates students' growth and performance relative to their peers. Data are carefully and collaboratively analyzed by teams of educators (e.g., data teams); the results are used to inform instruction for individual students, core general education practices, and the efficacy of interventions. The tiered continuum of support is part of the general education system, with interventions increasing in intensity and/or individualization across multiple tiers. Interventions are implemented in the general education classroom at the onset of concern about student performance.

Given occupational therapy practitioners' "knowledge and skills in the biological, physical, social, and behavioral sciences", they are in an excellent position to support general educators implementing core general education practices and targeted interventions (AOTA, 2011, p. 1). Additionally, they are in an excellent position to provide targeted interventions, where appropriate. Administrators may call upon school practitioners to support general educators and/or support students at-risk.

Services under Section 504 of the Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the basis of disability by programs that receive federal funds. One of its many protections calls for accommodations and services for PK-12 students with disabilities (as defined under the law) to ensure their equal opportunity to participate in all academic and extracurricular school programs. Students with a disability who do not qualify for services under the IDEA may be eligible for accommodations and services under Section 504, including school occupational therapy services. The Section 504 Team conducts an initial evaluation with a student suspected of having a disability. If the team determines the student is a student with a disability and requires accommodations and services to ensure his/her equal opportunity to participate, the team identifies those accommodations and services and how they will be implemented. Occupational therapy is one of many related services recognized under Section 504 and can be provided as a sole service, where necessary. In addition to services for the student, school occupational therapy services under Section 504 can include consultation with other educational professionals; training for families; and adaptations to different environments within the school (e.g., classroom; cafeteria; playground; restrooms).

The Individuals with Disabilities Education Act 2004

Related Services under an IEP

Part B of the IDEA 2004 affords students with disabilities (as defined under the law) ages 3-21 special education and related services to ensure their access, participation, and progress in the general education classroom/curriculum and legal protections for students and their parents³. Under the IDEA 2004, the individualized education program (IEP) team (in Connecticut, the planning and placement team (PPT)) determines the student's need for special education and related services. The PPT designs a comprehensive evaluation for a student suspected of having a disability. If a student is deemed eligible for special education and related services under the IDEA 2004, the PPT develops an IEP for him/her. The IEP details the instructional supports, special education, and related services the

³ The term "parent(s)" in this document includes parents and guardians.

student requires to access, participate, and progress in the general education classroom/curriculum. The PPT must develop annual goals and related objectives to regularly measure the student's progress and identify his/her annual outcomes.

Occupational therapy is one of many related services available under the IDEA 2004 to assist a student in benefitting from his/her special education services. In addition to services for the student, services can also include: consultation with other educational professionals; training for families; and environmental adaptations within the school (e.g., classroom, cafeteria, playground, restrooms). In 2013, more than 25% of all occupational therapy practitioners worked in or with programs funded under the IDEA 2004. (Frolek Clark & Chandler, 2013, p. 4).

Services under a Services Plan

Students with a disability who are enrolled by their parents in private schools (i.e., “parentally-placed private school students”) do not have an individual right to special education and related services they would receive if enrolled in a public school (34 CFR § 300.137(a)). The IDEA 2004, however, requires school districts to spend a proportionate share of its IDEA federal funding to provide equitable services for a certain number of parentally-placed private school students. Equitable services are services that allow for a parentally-placed private school student to participate in services funded under the IDEA 2004, which the school district makes available.

In consultation with administrators of the private schools located within the school district, the school district designates which students with disabilities will receive services and determines which services will be provided. Services can include indirect services (e.g., consultation, equipment, training) as well as direct services (e.g., special education, related services – including occupational therapy).

Together, school district personnel, the parent, and a representative of the private school meet to develop a services plan for any student designated to receive equitable services. The services plan describes the equitable services the student will receive. The school district shall determine which IEP components are appropriate to include in the services plan and review the services plan at least annually.

Given occupational therapy is a related service under the IDEA 2004, administrators may call upon school practitioners to help implement equitable services, when deemed appropriate. As stated above, occupational therapy services under a services plan can include indirect and direct services.

Early Intervening Services

Additionally, the IDEA 2004 allows school districts to set aside a certain portion of its IDEA federal funding to:

develop and implement coordinated, early intervening services...for students in kindergarten through grade 12 (with a particular emphasis on students in kindergarten through grade three) who are not currently identified as needing special education or related services, but who need additional academic and behavioral support to succeed in a general education environment (34 CFR § 300.226(a)).

Early intervening services may include professional development for school personnel as well as services for students. Professional development activities should focus on enhancing school personnel's ability "to deliver scientifically based academic and behavioral interventions" (34 CFR § 300.226(b)(1)). Services for students should focus on "providing educational and behavioral evaluations, services, and supports" (34 CFR § 300.226(b)(2)).

Given occupational therapy practitioners' "knowledge and skills in the biological, physical, social, and behavioral sciences", they are in an excellent position to offer both professional development for school personnel and services for students at-risk (AOTA], 2011, p. 1). Administrators may call upon school practitioners to help implement these services.

The American Occupational Therapy Association

AOTA promotes a comprehensive role for the school practitioner in which the practitioner "provides a continuum of services and supports to students and personnel..." (AOTA, 2013, p. 2). This continuum of support includes:

- ◆ Services for struggling learners in general education under SRBI, including:
 - Assistance with SRBI screenings, data collection and analysis, teacher training, and whole classroom and small group activities;
- ◆ Services for students with a Section 504 Accommodation Plan or an IEP as well as support for the student's teacher(s) and family;
- ◆ Participation on collaborative teams, such as PPTs, data teams, and curriculum committees;
- ◆ Training for school personnel and families on topics, including:
 - Child development;
 - Mental health;
 - School participation;
 - Bullying prevention; and
- ◆ Partnering with districts to enhance district targets for student outcomes, by:
 - Assisting in the implementation of district or school-wide initiatives, such as positive behavior interventions and supports (PBIS) and universal design for learning (UDL);
 - Helping students achieve their academic and behavior outcomes; and
 - Preparing students future education, employment, and independent living (AOTA, 2013, p. 2).

School occupational therapy services focus on the whole student and all of his/her educational environments. Practitioners, educators, administrators, families, and the

student work together to determine appropriate interventions, through general education or special education initiatives, that promote the student’s success in his/her PK-12 education as well as in college and career. Occupational therapy’s scope of practice in ensuring people can participate in activities they need and want to do (e.g., work, self-care, community participation), therefore, aligns perfectly with the goal of public education – to prepare students learning, working, and independent living. Please see the **Collaboration** and **Interventions** sections for further information on implementing school occupational therapy services for students, school personnel, and families. Please see the **Administration** section for further information on considerations for practitioners’ use of a “workload”, rather than a caseload.

Frequently Asked Questions

1. How can I learn more about occupational therapy?

For more information on the profession of occupational therapy, please visit the AOTA website at <http://www.aota.org/> and the Connecticut Occupational Therapy Association (ConnOTA) website at <http://www.connota.org>.

2. How can I learn more about Connecticut’s OT Practice Act and related licensure requirements?

Please visit the Connecticut DPH web site for more information. Occupational therapists may visit the Connecticut DPH web site, [Occupational Therapist Licensure](#). Occupational therapy assistants may visit the Connecticut DPH web site, [Occupational Therapist Assistant Licensure](#).

3. How can I learn more about the role of school occupational therapy?

The AOTA has created several resources for people who want to learn more about the role of school occupational therapy, such as:

- [Occupational Therapy In School Settings](#);
- [Frequently Asked Questions: What Should the Occupational Therapy Practitioner Know About the Common Core State Standards \(CCSS\)?](#);
- [Frequently Asked Questions for Educators Help ALL Students Achieve Greater Success in Academic Performance and Social Participation](#);
- [Occupational Therapy and Universal Design for Learning](#);
- [Occupational Therapy and School Mental Health](#);

- [What Parents Need to Know About School-based Occupational Therapy;](#)
- [Brochure for Parents: What is the Role of the School-based OT Practitioner?;](#) and
- [Brochure for School Administrators: What is the Role of the School-based OT Practitioner?](#)

4. How can I learn more about the role of school occupational therapy and SRBI?

The [AOTA](#) has created several resources for people who want to learn more about the role of school occupational therapy practitioners in SRBI, such as:

- [AOTA Practice Advisory on Occupational Therapy in Response to Intervention;](#)
- [Response to Intervention Consumer Brochure;](#)
- [Frequently Asked Questions: What Should the Occupational Therapy Practitioner Know About the Common Core State Standards \(CCSS\)?;](#)
- [Frequently Asked Questions for Educators Help ALL Students Achieve Greater Success in Academic Performance and Social Participation;](#)
- [Occupational Therapy and Universal Design for Learning;](#)
- [Occupational Therapy and School Mental Health;](#) and
- [Workload Approach: A Paradigm Shift for Positive Impact on Student Outcomes.](#)

For more information on SRBI in Connecticut, please visit the [CSDE Web site Scientific Research-Based Interventions](#). In addition, you may wish to read the CSDE publication, [Connecticut's Framework for RTI](#).

5. How can I learn more about the role of school occupational therapy and provision of equitable services to parentally-placed private school students?

The U.S. Department of Education has created several resources to address the provision of equitable services to parentally-placed private school students, such as:

- [Questions and Answers on Serving Children with Disabilities Placed by Their Parents in Private Schools;](#) and
- [Provisions Related to Children With Disabilities Enrolled by Their Parents in Private Schools.](#)

References

- American Occupational Therapy Association. (2015). [About Occupational Therapy](#). Retrieved July 2, 2015.
- American Occupational Therapy Association. (2013). [What is the Role of the School-based Occupational Therapy Practitioner? Questions and Answers for School Administrators](#). Bethesda, MD: AOTA.
- [American Occupational Therapy Association. \(2011\). Occupational therapy services in early childhood and school-based settings](#). *American Journal of Occupational Therapy*. Retrieved July 19, 2015.
- [American Occupational Therapy Association. \(2010\). Occupational therapy in school settings](#). Bethesda, MD: AOTA.
- [American Occupational Therapy Association. \(2009\). Help all students achieve greater success in academic performance and social participation](#). Bethesda, MD: AOTA.
- Connecticut General Statutes, [Chapter 376a § 20-74a et seq](#). Retrieved July 11, 2015.
- Connecticut State Department of Education. (2008). [Connecticut's Framework for RTI](#). Hartford, CT: CSDE.
- Frolek Clark, G. & Chandler, B. (2013). [Best practices for occupational therapy in schools](#). Bethesda, MD: AOTA Press.
- The Individuals with Disabilities Education Improvement Act of 2004, 34 CFR § 300 *et seq*. (2008).

LAWS AND POLICIES

Section 2

Learning Objectives

Readers will gain a better understanding of:

- ◆ The definitions of laws and regulations, guidance, policy, and professional resources;
- ◆ Key general education laws and regulations relevant to school system occupational therapy services;
- ◆ Key special education laws and regulations relevant to school system occupational therapy services; and
- ◆ Key laws and regulations relevant to educational records, Medicaid reimbursement, and safety.

Definitions: Laws & Regulations, Guidance, Policies, & Professional Resources

Public education is governed by numerous federal education legislation and regulations; state statutes and regulations; guidance; and policies. Before we explore key laws and regulations relevant to school occupational therapy, let us briefly review how laws and regulations, guidance, and policies work together to inform best practices in education.

Laws and Regulations

Laws (i.e., federal legislation, state statutes) are rules created by the federal and state legislature that guide actions taken by society. Oftentimes, laws will grant administrative agencies (e.g., U.S. Department of Education, CSDE) the authority to develop regulations, which detail requirements under the law. Administrative agencies develop proposed regulations, which are put out for public notice and comment. Following the public comment period, agencies release the final regulations for their implementation.

Federal laws and regulations, generally speaking, supersede state law and regulations. That is, federal laws and regulations prevail over any state laws and regulations. When permitted under federal law, states can set a different, higher standard than the one stated in the federal law. For example, the IDEA 2004 states a timeline for completing initial evaluations; states, however, may establish their own timeline. Furthermore, state laws and regulations can grant rights or dictate requirements *in addition* to any set by federal laws and regulation.

Guidance

Administrative agencies often create guidance documents to provide detailed information and implementation considerations regarding regulatory responsibilities. These non-regulatory guidance documents do not impose any requirements beyond those required under applicable federal or state law and regulations. The CSDE has created a number of guidance documents, addressing an array of topics. For guidance documents specific to special education, please see the [CSDE](#) web site.

Policies

Administrative agencies also adopt policies, often designed to explain an agency's view on specific issues or influence actions taken by its constituents. Like guidance documents, policies do not have any legal authority or impose any requirements beyond those required under applicable federal or state law. The Connecticut State Board of Education has adopted a number of policies (i.e., "position statements") that address an array of topics. Please see the [CSDE](#) web site for more information.

In addition, school districts adopt policies and procedures, which often include processes by which the district will implement federal and state legal requirements. Practitioners should familiarize themselves with the policies and procedures of the district(s) in which they work. Furthermore, practitioners may wish to reach out to district administration to see in what way they may contribute their expertise to the development of district policies and procedures as well as school-wide and district-wide initiatives. Please see the **Collaboration** section for further information on how practitioners can support this work.

Professional Resources

National professional associations, such as the AOTA, produce resources for professionals to promote best practices in the implementation of client services. Other resources are designed for colleagues and families to enhance their knowledge of the profession and how the profession can assist. To learn more about AOTA's school practice resources, please see the AOTA webpage, [School Practice](#).

Laws & Regulations Relevant to School Practice: General Education

Below is a description of key general education laws and regulations that shape the provision of school occupational therapy services. The list of laws and regulations, however, is not exhaustive. Additionally, the descriptions provided serve as a brief summary; the full text of these laws and regulations should be referred to for fuller understanding and to support any decision-making.

The Elementary and Secondary Education Act⁴

The federal Elementary and Secondary Education Act (ESEA) of 1965 was passed to ensure all children have a fair and equal opportunity to obtain a high-quality education and are proficient in the state's academic standards (ESEA, 2001). In its 2001 reauthorization, known as the No Child Left Behind (NCLB) Act, the ESEA focused on improving outcomes for ALL students, with an emphasis on highly-qualified personnel, scientifically based interventions; student assessment; and state and school district accountability.

In 2011, the U.S. DOE offered states an ESEA flexibility process (i.e., "the ESEA flexibility waiver") to request flexibility regarding specific requirements of the NCLB Act in exchange for a rigorous and comprehensive State-developed accountability system to assess school performance. In May 2012, the U.S. DOE approved Connecticut's ESEA flexibility waiver for three years, which improves the State's ability to provide more accurate and appropriate interventions, support and recognition to local schools. The new system:

- Recognizes and values improvement in student achievement at all performance levels unlike the old system, which only recognized movement of students from 'not proficient' to 'proficient';
- Raises expectations by setting the target that all students perform at the 'goal' level on the majority of tests they take rather than just perform at the 'proficient' level, as in the old system;
- Integrates all tested subjects, encouraging schools to improve instruction not only in Mathematics and Reading (as under No Child Left Behind), but also in Science and Writing;
- Includes graduation rates as important indicators of high school success;
- Identifies schools with struggling student subgroups, which in the past, may have been less visible to parents and educators; and
- Enables schools to be classified into new categories, including Turnaround, Review and Focus, Transitioning, Progressing and Excelling Schools, that will enable districts and the State to provide tailored support to individual schools.

To learn more about the ESEA, please see the [U.S. DOE's ESEA](#) web site.

To learn more about the CSDE's state accountability system, please see the [CSDE's accountability](#) web site.

⁴ Language in this section was taken from the CSDE publications, *Connecticut Assistive Technology Guidelines*, Appendix 4 (2013) and *Guidelines for Identifying Children with Learning Disabilities*, pp. 5, 8-10 (2010), to ensure consistency among CSDE publications.

Scientifically Research-Based Interventions⁵

As stated above, the purpose of the ESEA is to ensure all children have a fair and equal opportunity to obtain a high-quality education and are proficient in the state's academic standards (ESEA, 2001). A central way for schools to build their capacity to meet a range of student needs is to implement RTI. The NCLB Act and IDEA 2004 address RTI. "RTI is the practice of providing scientific, research-based instruction and intervention matched to students' needs, with important educational decisions based on students' levels of performance and learning rates over time" (CSDE, 2008, p. 3). In Connecticut, RTI is called Scientific Research-Based Interventions (SRBI). SRBI emphasizes the importance of high-quality core general education practices (e.g., curriculum, instructional strategies, positive/safe school climate) as well as targeted interventions for students experiencing learning, social-emotional, or behavioral difficulties. Interventions used are scientific and research-based wherever possible. Two key elements of SRBI include data-driven educational decision making and a continuum of support.

Universal screening and routine progress monitoring of student progress are the best ways to detect and address difficulties at an early stage. Educational decision making is driven by data that illustrates students' growth and performance relative to their peers. Data are carefully and collaboratively analyzed by teams of educators (e.g., data teams); the results are used to inform instruction for individual students, core general education practices, and the efficacy of interventions.

SRBI consists of a three-tiered model (see below). Tier I involves general education core curriculums, instruction, and a system of social-emotional learning and behavioral supports for all students. Tier II involves short-term interventions for students with academic or behavioral/social-emotional difficulties who have not responded adequately to Tier I. Tier III involves more intensive or individualized short-term interventions for students failing to respond sufficiently to Tier II interventions. This continuum of support is part of the general education system, with interventions increasing in intensity and/or individualization across multiple tiers. Interventions are implemented in the general education classroom at the onset of concern about student performance.

Given occupational therapy practitioners' "knowledge and skills in the biological, physical, social, and behavioral sciences", they are in an excellent position to support general educators implementing core general education practices and targeted interventions (AOTA, 2011, p. 1). Additionally, they are in an excellent position to provide targeted interventions, where appropriate. Administrators may call upon school practitioners to support general educators and/or support students at-risk.

For more information on SRBI in Connecticut, please visit the [CSDE](#) web site.

Also, please see the CSDE publications, [Connecticut's Framework for RTI](#) and [A Family Guide: Connecticut's Framework for RTI](#).

⁵ Language in this section was taken from the CSDE publications, *Guidelines for Identifying Children with Learning Disabilities*, pp. 5, 8-10 (2010) and *Connecticut's Framework for RTI*, pp. 3, 13-14 (2008), to ensure consistency among CSDE publications.

Section 504 of the Rehabilitation Act of 1973⁶

Section 504 of the Rehabilitation Act of 1973 (Section 504) is a broad federal civil rights law that prohibits discrimination on the basis of disability by programs that receive federal funds. Section 504, therefore, applies to preschool, elementary, and secondary schools that receive federal funds. One of the law's many protections calls for accommodations and services for PK-12 students with disabilities to ensure their equal opportunity to participate in all academic and extracurricular school programs.

The Office for Civil Rights (OCR) at the U.S. DOE enforces Section 504 with programs that receive funding from the U.S. DOE. School districts are required to have a Section 504 Coordinator, who oversees the district's Section 504 policies, procedures, practices, and service delivery.

Student with a Disability

The Americans with Disabilities Act of 1990 (ADA) was amended in 2008 as the ADA Amendments Act (ADAAA). The ADAAA "includes a conforming amendment to the Rehabilitation Act of 1973 that affects the meaning of disability in Section 504" (OCR, no date, p. 2).

Under Section 504 and the ADA, a student with a disability is a person who has a physical or mental impairment which substantially limits one or more major life activities; who has a history or record of such an impairment, or who is regarded by others as having such an impairment 29 USC § 705(9)(B); 42 USC § 12102(1). In relation to school occupational therapy, we will focus on the first prong of the definition of disability – a person who has a physical or mental impairment that substantially limits one or more major life activities.

A person's physical or mental impairment does not need to "prevent or severely or significantly restrict a major life activity to be considered substantially limiting" (OCR, no date, p. 4). School districts define the term "substantially limits". In their analysis of whether an impairment substantially limits, however, school districts cannot take mitigating measures such as medications, prosthetic devices, or assistive devices, into account. (Exceptions to this rule are ordinary eyeglasses or contact lenses). Similarly, a student with an impairment that is episodic or in remission, but when active would substantially limit a major life activity, is considered a student with a disability. (OCR, no date, p. 4). In contrast, a student with an impairment that is "transitory (meaning that it has an actual or expected duration of six months or less) and minor" is not considered a student with a disability (OCR, no date, p. 4).

Major life activities include walking, seeing, hearing, speaking, learning, reading, writing, performing math calculations, working, caring for oneself and performing manual tasks (29 USC § 706(8)(B)). Learning is only one of a number of major life activities the Section 504 Team should consider when determining if a student is a student with a disability under Section 504 and the ADA (OCR, no date, p. 6). The team must consider how an impairment substantially limits *any* major life activity of the student and, if necessary,

⁶ Language in this section was taken from the CSDE publications, *Connecticut Assistive Technology Guidelines*, Laws and Policies Section and Appendix 4 (2013) and *Guidelines for Identifying and Educating Students with Emotional Disturbance*, Section 2 (2012), to ensure consistency among CSDE publications.

assess what accommodations and/or services the student requires to afford him/her an equal opportunity to participate in academic and extracurricular school programs (OCR, no date, p. 6).

For more information on eligibility under Section 504, please see the OCR publication, [*Questions and Answers on the ADA Amendments Act of 2008 for Students with Disabilities Attending Public Elementary and Secondary Schools*](#).

Free Appropriate Public Education

Section 504 entitles a student with a disability to a free appropriate public education (FAPE). Under Section 504, FAPE is defined as "the provision of regular or special education and related aids and services that are designed to meet individual educational needs of persons with disabilities as adequately as the needs of persons without disabilities are met" at no cost (34 CFR § 104.33(b)(1)). Special education and related services under Section 504 are defined using the definitions under the IDEA 2004. (Please see below.)

Occupational therapy is one of many related services recognized under Section 504 and can be provided as a sole service, where necessary. In addition to services for the student, school occupational therapy services under Section 504 can include consultation with other educational professionals; training for families; and adaptations to different environments within the school (e.g., classroom; cafeteria; playground; restrooms).

Accommodations and services provided must be equal to those afforded to typical students and must be as effective in affording students with disabilities an equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as their typical peers. This includes an equal opportunity to participate in all academic and extracurricular school programs.

The FAPE definition also requires school districts to adhere to the Section 504 regulatory procedural requirements (e.g., evaluation, placement, procedural safeguards). The provision of FAPE, therefore, requires both appropriate services and compliance with procedural requirements.

For more information on the provision of FAPE under Section 504, please see the OCR publication, [*Free Appropriate Public Education for Students With Disabilities: Requirements Under Section 504 of The Rehabilitation Act of 1973*](#).

The Section 504 Team and Accommodation Plan

The Section 504 Team determines the student's need for accommodations and services. The team conducts an initial evaluation for a student suspected of having a disability. The team also ensures periodic reevaluations for the student; it is recommended reevaluations occur at least once every three years. If the team determines the student is a student with a disability who requires accommodations and/or services, those specific accommodations and services are often documented in a Section 504 Accommodation Plan. It is recommended that the Section 504 Team meet at least annually to review the student's Section 504 Accommodation Plan and revise its provisions to meet the student's needs for the following year, as appropriate.

The Section 504 Team is defined as a group of persons who are knowledgeable about the student; understand the evaluation data; and are familiar with placement options (34 CFR § 104.35(c)). It is recommended the team include:

- The student's parent(s)⁷;
- The student's teacher(s);
- Support services personnel (e.g., special educator, psychologist, social worker, school nurse, occupational therapist); and
- An administrator(s).

The make-up of the team should be tailored to include persons who are knowledgeable about the student's specific disability and who will provide the recommended accommodations and services.

To learn more about Section 504, please see the OCR Frequently Asked Questions (FAQ) publication, [Protecting Students With Disabilities](#).

The American with Disabilities Act of 1990⁸

The federal ADA, amended in 2008 as the ADAAA, went into effect on January 1, 2009. In March of 2011, the Equal Employment Opportunity Commission released the ADAAA Regulations for Titles II and III, which went into effect on May 24, 2011.

The ADAAA and the subsequent regulations prohibit discrimination on the basis of disability. To be protected by the ADA, one must have a disability (i.e., a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is regarded by others as having such an impairment) or have a relationship or association with an individual with a disability. The ADA also has a civil rights statute to protect the rights of persons with disabilities in almost every facet of their lives, including school, work, and recreation.

ADA Title II: State and Local Government Activities

Title II of the ADA, which reinforces many of the requirements of Section 504, covers state and local government services *regardless of whether these entities receive federal financial assistance*. It prohibits discrimination on the basis of disability in services, programs, and activities provided by state and local government entities. Local government entities include school districts and publicly operated preschool programs.

The regulations of Title II of the ADA state that: "No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs or activities of a public entity, or be subjected to discrimination by the public entity" (28 CFR § 35.130(a)). State and local governments are required to follow specific architectural standards and transportation provisions. Where necessary, they are required to make reasonable modifications to policies, procedures, and practices to avoid

⁷ The term "parent(s)" in this document includes parents and guardians.

⁸ Language in this section was taken from the CSDE publication, *Connecticut Assistive Technology Guidelines*, Appendix 4 (2013), to ensure consistency among CSDE publications.

discrimination, unless they can demonstrate that doing so would fundamentally alter the nature of the service, program, or activity being provided.

In order to comply with the Title II discrimination prohibitions, school districts may be required to make reasonable modifications in policies, procedures, and practices to provide “auxiliary aids and services” to the student with a disability (28 CFR § 35.130(b)(7)). Auxiliary aids and services” include assistive technology devices such as tape recorders, computers, and listening devices. In addition, the terminology includes assistive technology services, such as the acquisition or modification of equipment (28 CFR § 35.104).

ADA Title III: Public Accommodations

Title III covers businesses and nonprofit service providers that are public accommodations; privately operated entities offering certain types of courses and examinations; privately operated transportation; and commercial facilities. Public accommodations are private entities that own, lease, lease to, or operate facilities including: day care centers, private nursery schools, and private elementary and secondary schools. Transportation services provided by private entities are also covered by Title III.

Title III of the ADA prohibits places of public accommodation from discriminating against persons with disabilities. Public accommodations must comply with basic nondiscrimination requirements that prohibit exclusion, segregation, and unequal treatment. Individuals with disabilities may not be denied these goods and services because of disability. They may not be required to accept goods and services that are unequal or separate from those provided to non-disabled individuals.

To learn more about the ADA, please see the [U.S. Department of Justice, Civil Rights Division’s](#) web site.

Laws and Regulations Relevant to School Practice: Special Education

Below is a description of key special education laws and regulations that shape the provision of school occupational therapy services. The list of laws and regulations, however, is not exhaustive. Additionally, the descriptions provided serve as a brief summary; the full text of these laws and regulations should be referred to for fuller understanding and to support any decision-making.

The Individuals with Disabilities Education Improvement Act of 2004⁹

The federal Individuals with Disabilities Education Improvement Act of 2004, Part B (IDEA 2004) affords students with disabilities (as defined under the law) ages 3-21 special education and related services to ensure their access, participation, and progress in the general education classroom/curriculum and legal protections for students and their parents. The 1975 Education for All Handicapped Children Act was reauthorized as the

⁹ Language in this section was taken from the CSDE publications, *Connecticut Assistive Technology Guidelines*, Laws and Policies Section and Appendix 4 (2013) and *Guidelines for Identifying and Educating Students with Emotional Disturbance*, Section 2 (2012), to ensure consistency among CSDE publications.

Individuals with Disabilities Education Act (IDEA) in 1991. Since then the IDEA has been reauthorized two additional times, in 1997 and 2004. Its implementing regulations can be found at 34 CFR Part 300. The Office of Special Education Programs (OSEP) at the U.S. DOE enforces the IDEA 2004.

Student with a Disability¹⁰

Part B of the IDEA 2004 defines a student with a disability (i.e., school-age child) as one who has been identified as having any of the 13 disabilities described in the law that has an adverse impact on his/her educational performance and, therefore, needs special education and related services as a result. These disabilities are autism, deaf-blindness, deafness, emotional disturbance, hearing impairment, mental retardation (intellectual disability in Connecticut), multiple disabilities, orthopedic impairment, other health impairment, specific learning disability, speech or language impairment, traumatic brain injury, and visual impairment. Young children (ages 3 to 5 in Connecticut) are eligible if determined to have a developmental delay as described in the law or any of the other disabilities mentioned above.

The hallmark of disability eligibility in Part B of the IDEA 2004 is that the identified problems must be shown, through evaluation, to adversely affect the child's educational performance. Included in Part B are several mandates to include that each eligible child be provided with a free appropriate public education (FAPE) in the least restrictive environment (LRE) with his or her nondisabled peers to the maximum extent appropriate.

Free Appropriate Public Education¹¹

Free appropriate public education means special education and related services are:

- provided at public expense, under public supervision and direction and without charge;
- meet the standards of the state education agency (i.e., the CSDE);
- include an appropriate preschool, elementary school, or secondary school education; and
- are provided in conformity with an IEP that meets legal requirements (IDEA, 2004).

Special education means specially designed instruction, at no cost to parents, to address the unique needs of a child with a disability and to ensure access of the child to the general curriculum, so that the child can meet the educational standards, including instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings; and instruction in physical education. (IDEA, 2004)

Related services mean developmental, corrective or supportive services that are required to help a child with a disability benefit from special education. These include: transportation; speech-language pathology and audiology services; interpreting services; psychological services; physical and occupational therapy; recreation, including therapeutic recreation; social work services; school nurse and health services; counseling services, including

¹⁰ See footnote above.

¹¹ Language in this section was taken from the CSDE publications, *Connecticut Assistive Technology Guidelines*, Laws and Policies Section and Appendix 4 (2013) and *Guidelines for Identifying and Educating Students with Emotional Disturbance*, Section 2 (2012), to ensure consistency among CSDE publications.

rehabilitation counseling; orientation and mobility services; medical services for diagnostic or evaluation purposes; early identification and assessment of disabling conditions; and parent counseling and training (34 CFR § 300.34(a)).

Occupational therapy is one of many related services available under the IDEA 2004 to assist a student in benefitting from his/her special education services. Occupational therapy is defined as services provided by a qualified occupational therapist and includes:

- Improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation;
- Improving ability to perform tasks for independent functioning if functions are impaired or lost; and
- Preventing, through early intervention, initial or further impairment or loss of function (34 CFR § 300.34 (c)(6)).

In addition to services for the student, services can also include: consultation with other educational professionals; training for families; and environmental adaptations within the school (e.g., classroom, cafeteria, playground, restrooms). In 2013, more than 25% of all occupational therapy practitioners worked in or with programs funded under the IDEA 2004. (Frolek Clark & Chandler, 2013, p. 4).

The “free” in free appropriate public education means that all aspects of the special education and related services provided to children with disabilities between the ages of 3 and 21 must be at “no cost to the parents.” This rule prohibits schools from refusing to include equipment or services in an IEP because it is too expensive. The only time “cost” can be a consideration is when two *equal* alternatives exist that would each enable the child to receive an appropriate education—in this case, the school may choose the less expensive option. In addition, schools cannot require parents to pay for devices and services that appear as part of their child’s IEP.

The term “appropriate” in FAPE does not mean “best.” Schools are required to provide a student with a disability with an “appropriate” education. IDEA 2004 does not define the term “appropriate.” However, the U.S. Supreme Court looked at the issue of “appropriate” vs. “best” in the *Board of Education of the Hendrick Central School District v. Rowley* (1982) case. The court ruled that the special education and related services offered to a child with disabilities must meet two criteria to be “appropriate” for the purposes of the IDEA:

- The IEP must be developed in accordance with the procedures set forth in IDEA, including those governing resolution of disputes between parents and schools; and
- The IEP must be “reasonably calculated to enable the child to receive educational benefits” (Boundy and Ordovery, 1991).

The Rowley decision, as the ruling has come to be known, established a “basic floor” for special education quality by holding that the IDEA does not require the school to provide an educational program that is designed to maximize a student’s potential. The educational program must, however, “confer a benefit to the student that is more than trivial.” The IEP must be one “under which educational progress is likely” (Boundy and Ordovery, 1991).

Least Restrictive Environment¹²

The least restrictive environment (LRE) requirement in the IDEA states that to the maximum extent appropriate, children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are not disabled; and, special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability of a child is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily (34 CFR § 300.114(a)(2)). Additionally, to the maximum extent appropriate, students should have access to extracurricular activities or any other program that nondisabled peers would be able to access. The IDEA 2004 requires school districts to ensure there is a continuum of alternative placements available to meet special education and related services needs of ALL students with disabilities. Alternative placements include: instruction in regular education classes, special classes, special schools, home instruction, and instruction in hospitals and institutions (34 CFR § 300.115).

Planning and Placement Team

Under the IDEA 2004, the IEP team (in Connecticut, the PPT) determines the student's need for special education and related services. The PPT designs a comprehensive initial evaluation for a student suspected of having a disability. Initial evaluations must be conducted by a multidisciplinary team, including at least one teacher or specialist with knowledge about the suspected disability. Students should be assessed in all areas related to the suspected disabilities. The PPT also ensures timely reevaluations for the student at least once every three years (i.e., triennial evaluation), if conditions warrant, or if parents or the students' teachers request it. The purpose of the re-evaluation is to determine the student's continuing eligibility for special education and related services. If a student is deemed eligible for special education and related services under the IDEA 2004, the PPT develops an IEP for him/her. The PPT meets at least annually to review each student's IEP and revise its provisions to meet the student's needs for the following year, as appropriate.

The PPT is composed of:

- The student, when appropriate;
- At least one special education teacher or where appropriate, at least one special education provider;
- At least one regular education teacher;
- A school district representative who is qualified to provide or supervise the provision of specially designed instruction; is knowledgeable about the general curriculum and about the availability of resources of the school district;
- The parents of the student;
- An individual who can interpret the instructional implications of the evaluation results, who may otherwise be a member of the PPT; and

¹² Language in this section was taken from the CSDE publications, *Connecticut Assistive Technology Guidelines*, Laws and Policies Section and Appendix 4 (2013) and *Guidelines for Identifying and Educating Students with Emotional Disturbance*, Section 2 (2012), to ensure consistency among CSDE publications.

- At the discretion of parents or school district, other individuals who have knowledge or special expertise regarding the student, including related services personnel (34 CFR § 300.321(a)).

If the purpose of the PPT meeting is consideration of transition services for a student, the LEA shall invite the student and consider whether a representative of an outside agency should be invited.

Individualized Education Program¹³

The IEP includes information on the student's present level of educational performance, including how the student's disability affects involvement and progress in the general curriculum. The PPT uses this information to design the student's supports and services for the following year. The IEP details the instructional supports, special education, and related services the student requires to access, participate, and progress in the general education classroom/curriculum. The PPT must develop goals and objectives, determine appropriate supports and services, and agree on the service providers *prior* to determining placement in the LRE least restrictive educational setting. (IEP objectives are a required component of the IEP under Connecticut state special education regulations).

The definition of special education found in 34 CFR § 300.39, clarifies that special education and specialized instruction encompass more than only academic instruction. PPTs must consider all aspects of the child's functioning at school, including social/emotional, cognitive, communication, vocational and independent living skills and not limit the development of goals and objectives to academic areas.

The IEP includes information on how the student's progress toward the annual goals and related objectives will be measured, including objective criteria and evaluation procedures. It also requires the IEP to include a statement of how the student's parent(s) will be regularly informed of the student's progress toward the annual goals and related objectives. School districts must report the student's at least as frequently as the school reports progress of typical students (i.e., regular report card periods).

For more information on the provision of special education and related services, please see the OSEP publication, [*Questions and Answers On Individualized Education Programs, Evaluations and Reevaluations*](#).

Transition Services

Transition services are a coordinated set of activities, designed within an outcome-oriented process, that promote a student's movement from school to post-school activities including post-secondary education, vocational training, integrated employment, continuing and adult education, adult services, independent living, or community participation (34 CFR § 300.43(a)(1)). Services must be based on the students' needs, taking into account the student's interests and preferences (34 CFR § 300.43(a)(2)). Services include instruction, related services, and community experiences (34 CFR § 300.43(a)(2)).

¹³ Language in this section was taken from the CSDE publication, *Guidelines for Identifying and Educating Students with Emotional Disturbance*, Section 2 (2012), to ensure consistency among CSDE publications.

The PPT must begin transition planning “at the annual review following a student’s 15th birthday, or earlier if determined appropriate by the PPT, and annually thereafter” (CSDE, 2015, p. 10). Transition assessments should occur on an ongoing basis, with the results used to develop transition services and related goals (CSDE, 2015, p. 10). The PTT must develop postsecondary goals that address postsecondary education or training; employment; and, if appropriate, independent living/community participation (CSDE, 2015, p. 10). In Connecticut, these goals are called Post-School Outcome Goals Statements (PSOGS) (CSDE, 2015, p. 10). PSOGS are future-oriented, goals the student will complete after graduation or upon exiting high school (CSDE, 2015, p. 11). Each PSOGS requires a corresponding annual goal and related objectives.

For more information on secondary transition, please see the [OSEP publication, *Questions and Answers on Secondary Transition*](#).

Also, please visit the CSDE web site, [Secondary Transition Resources](#).

Services for Parentally-Placed Private School Students

Students with a disability who are enrolled by their parents in private schools (i.e., “parentally-placed private school students”) do not have an individual right to special education and related services they would receive if enrolled in a public school (34 CFR § 300.137(a)). The IDEA 2004, however, requires school districts to spend a proportionate share of its IDEA federal funding to provide equitable services for a certain number of parentally-placed private school students. Equitable services are services that allow for a parentally-placed private school student to participate in services funded under the IDEA 2004, which the school district makes available.

In consultation with administrators of the private schools located within the school district, the school district designates which students with disabilities will receive services and determines which services will be provided. Services can include indirect services (e.g., consultation, equipment, training) as well as direct services (e.g., special education, related services – including occupational therapy).

Together, school district personnel, the parent, and a representative of the private school meet to develop a services plan for any student designated to receive equitable services. The services plan describes the equitable services the student will receive. The school district shall determine which IEP components are appropriate to include in the services plan and review the services plan at least annually.

For more information on the provision of equitable services, please see the [OSEP publication, *Questions and Answers On Serving Children With Disabilities Placed by Their Parents at Private Schools*](#).

Early Intervening Services

Additionally, the IDEA 2004 allows school districts to set aside a certain portion of its IDEA federal funding to:

develop and implement coordinated, early intervening services...for students in kindergarten through grade 12 (with a particular emphasis on students in kindergarten

through grade three) who are not currently identified as needing special education or related services, but who need additional academic and behavioral support to succeed in a general education environment (34 CFR § 300.226(a)).

Early intervening services may include professional development for school personnel as well as services for students. Professional development activities should focus on enhancing school personnel's ability "to deliver scientifically based academic and behavioral interventions" (34 CFR § 300.226(b)(1)). Services for students should focus on "providing educational and behavioral evaluations, services, and supports" (34 CFR § 300.226(b)(2)).

For more information on early intervening services, please see the [OSEP publication, *Questions and Answers On Response to Intervention \(RTI\) and Early Intervening Services \(EIS\)*](#).

Procedural Safeguards

Parents have the right to be involved in all decisions relating to special education, including their child's identification, evaluation, and placement. The IDEA 2004 also grants parents due process rights to resolve any disputes between school districts and parents regarding their child's identification, evaluation, services, and placement. In addition, Connecticut state special education statutes and regulations have some provisions that coincide with the federal requirements (CSDE, 2011, p. 1). Please see the CSDE's publication, [Procedural Safeguards Notice Required Under IDEA Part B](#), which details both the federal and state requirements. (Please note: This publication does not reflect the 2013 revisions to the Connecticut state special education regulations (e.g., changes to parent consent, prior written notice)).

For more information on procedural safeguards, please see the OSEP publication, [Questions and Answers On Procedural Safeguards and Due Process Procedures For Parents and Children With Disabilities](#).

Also, please see the CSDE publication, [A Parent's Guide to Special Education in Connecticut](#). (Please note: The guide does not reflect the 2013 revisions to the Connecticut state special education regulations (e.g., changes to parent consent, prior written notice)).

Connecticut General Statutes Section 10-76a to 10-76h, inclusive

The special education system in Connecticut is based on the IDEA 2004 and its implementing regulations, in combination with the state's special education law, CGS §§ 10-76a to 10-76h, inclusive and its implementing regulations (CSDE, 2007, p. v). The Connecticut special education regulations can be found at Regulations of Connecticut State Agencies (RCSA) §§ 10-76a to 10-76h, inclusive.

Connecticut state statutes and regulations do not include occupational therapy in its definition of special education; that is, it cannot be provided as a sole service on an IEP as in other states. The Connecticut special education regulations contain some state imposed special education requirements (i.e., not required by the IDEA 2004 or its implementing regulations) (CSDE, 2015, p. Section IV-1). Below is a brief summary of state imposed

special education requirements (as of July 1, 2014) that are relevant to school occupational therapy:

**Regulations of CT
State Agencies**

Topic

State Imposed Requirement

§ 10-76a-1

Child with a Disability

The disability category “developmental delay” is applicable only with students who are 3-5 years old and experiencing a developmental delay

§ 10-76d-7

Referral to PPT

- Referrals can come from a physician, clinic or social worker permitted provided the parent allows it
- CSDE to provide standard referral form for school district's use
- General education interventions shall be explored before a referral is made
- Students who are suspended repeatedly or whose behavior, attendance or progress in school, including children who are truant, is considered unsatisfactory or at a marginal level of acceptance must be referred promptly

§ 10-76d-9

Determining Existence of a Learning Disability

Specific requirements for initial evaluation and eligibility determination

§ 10-76d-14

Trial Placement for Diagnostic Purposes

- The PPT may use a trial placement for diagnostic purposes: a structured program of no more than 40 school days, with written goals and objectives and the PPT shall meet at least once every ten school days unless waived to review the placement
- Five days before the end of the diagnostic placement, the PPT reconvenes to write the child's IEP based on the findings made during the placement
- Trial placement is an evaluation and is not considered the child's current placement for purposes of due process unless the parents and school district otherwise agree

Regulations of CT
State Agencies

Topic

State Imposed Requirement

§ 10-76d-11

IEP Components

Additional requirements include:

- Short term instructional objectives
- List of individuals implementing the IEP
- Indication if residential placement is being recommended for other than educational reasons
- Specifics of student's transportation needs

§ 10-76d-13

Timelines:

IEP shall be provided to parents within five school days after PPT meeting

Parent Receipt of IEP

§ 10-76d-13

Timelines:

If an initial referral is made during the academic year, the IEP must be implemented within 45 school days of referral, exclusive of the time necessary for parental consent

IEP Implementation

If the PPT recommends an out-of-district or private placement, the IEP shall be implemented within 60 school days of the date of referral, exclusive of the time necessary for parental consent

§ 10-76d-19

Related Services:
Transportation

- Travel time not to exceed one hour each way
- In-service training of operators of vehicles required
- All vehicles shall meet DMV requirements
- Transportation aides as are appropriate
- If LEA requests parent transports a student, parent shall be reimbursed (rate of reimbursement to be two round trips to drop off and pick up student)

Regulations of CT
State Agencies

Topic

State Imposed Requirement

§ 10-76d-15

Homebound and
Hospitalized Instruction
(HHI)

- Required to be provided when a student will be absent from school for medical reasons
- Conditions to be met include:
 - Provision of doctor's note indicating length of absence from school (length of absence may be consecutive days of absence or repeated short-term absences) and anticipated date of return
 - Instruction to begin no later than two weeks from the first date of absence
- Preschool children receive services as determined by the PPT
- Students in K-6 receive at least 5 hours of instruction a week
- Students in grades 7-12 receive at least 10 hours of instruction a week
- Resolution process when school district and parent disagree about the child's need for HHI
- Services required for children who are pregnant or who has given birth and cannot attend school for medical reasons

§ 10-76d-3

Extended School Year
Services (ESY)

PPTs shall consider ESY services early enough to allow parents to challenge decision unless clearly not feasible to do so

Laws and Regulations Relevant to School Practice: Operational

Below is a description of key laws and regulations that address some operational aspects of the provision of school occupational therapy services. The list of laws and regulations, however, is not exhaustive. Additionally, the descriptions provided serve as a brief summary; the full text of these laws and regulations should be referred to for fuller understanding and to support any decision-making.

Family Educational Rights and Privacy Act¹⁴

The purpose of the Family Educational Rights and Privacy Act (FERPA) and its corresponding regulations is to protect the privacy of parents and students. Generally, protection under FERPA transfers from parents to students at age 18 (34 CFR § 99.3(a)(5)). In the case of a divorce, separation or custody dispute, both parents retain their FERPA rights unless a court order or other legally binding document that revokes these rights is presented (34 CFR § 99.4).

FERPA and its corresponding regulations apply to educational agencies and institutions that receive federal funds. The FERPA regulations, at 34 CFR Part 99, address access to and the disclosure, release, and transfer of educational records. The Family Policy Compliance Office at the U.S. DOE enforces FERPA.

Personally Identifiable Information Protected

Except in certain circumstances, before a school can disclose personally identifiable information from a student's record, it must secure written consent from the parents or eligible student (34 CFR § 99.30). One exception permits disclosure to school officials, including teachers who have been determined by the district to have legitimate educational interests (34 CFR § 99.31). Another exception concerns the transfer of student records when a student enrolls in a new school district.

CGS §10-220h requires the student's new school district to provide written notification of the student's enrollment to the student's previous school district. Upon notification, the student's previous school district shall transfer the student's education records no later than ten days. Timely transfer of the education records of a student with a disability is critical to the student's educational progress.

"Because FERPA affords adequate privacy protections for student information", the U.S. DOE has determined "records protected by FERPA are not subject to the Health Insurance Portability and Accountability Act of 1996" (AOTA, no date, para 1).

Right to Inspect and Review Educational Records

FERPA gives parents and eligible students the right to inspect and review the student's education records or to receive a copy of the requested records if circumstances effectively prevent them from inspecting or reviewing the records (34 CFR § 99.10). Connecticut state

¹⁴ Language in this section was taken from the CSDE publications, *Connecticut Assistive Technology Guidelines*, Appendix 4 (2013), to ensure consistency among CSDE publications.

special education regulations entitle these individuals to one free copy of the requested record, which the school must send within 5 school days of a written request for the copy (RCSA § 10-76d-18(b)(2)).

Right to Request an Amendment to Educational Records

Parents and eligible students may request an amendment to the student's records if they believe that information in them is inaccurate, misleading or violates the student's right to privacy. If the district refuses, it must inform the parties seeking the amendment of their right to a hearing. If the hearing officer rules in favor of the parties requesting the amendment, the district must amend the records accordingly and inform the party of the amendment; otherwise, the parties may place a statement concerning the contested information in the record and this statement must be disclosed along with the records under the disclosure provisions of the law (34 CFR § 99.21).

For more information on FERPA, please visit the U.S. DOE web site, [Family Educational Rights and Privacy Act \(FERPA\)](#).

Please see the **Documentation** section for further information on FERPA as well as record keeping.

Medicaid Reimbursement: School Occupational Therapy Services

Medicaid is a joint state-federal program (Department of Social Services (DSS), no date, para 2). "Since 1988, Medicaid has been required to pay for certain IDEA services that are both educationally related and also medically necessary services under Medicaid" (AOTA, no date, para 1).

School occupational therapy services provided under the IDEA 2004 may be deemed medically necessary under criteria set by the state Medicaid agency and the state educational agency in an interagency agreement and would, therefore, be covered under Medicaid (AOTA, no date, para 2). The interagency agreement also details how school districts can seek reimbursement, including conditions and terms of reimbursement (AOTA, no date, para 9).

In Connecticut, the DSS is the state Medicaid agency. The DSS administers the Medicaid School Based Child Health Program, "the mechanism by which a school district may seek federal Medicaid reimbursement for many of the Medicaid covered services that are provided to an eligible student pursuant to the student's IEP" (DSS, no date, para 2). School occupational therapy services are covered services under Medicaid in Connecticut. Practitioners, therefore, may be involved in their school district's Medicaid billing. The focus of Medicaid on medically oriented therapy goals, rather than educational goals, however, could create some confusion. Seeking Medicaid reimbursement for school occupational therapy services does not require practitioners to use a medically-based model; practitioners should continue to provide school services and design IEP goals and objectives appropriate for school practice.

For more information on Medicaid reimbursement in Connecticut, please visit the DSS web site, [Medicaid School Based Child Health Program](#).

Please see the **Documentation** and **Administration** sections for further information on Medicaid reimbursement.

Seclusion and Restraint

CGS § 46a-150 through 46a-154 address restraint and seclusion in public schools. Its implementing regulations can be found at RCSA §§ 10-76b-5 through 10-76b-11. This area of state law has gone through several revisions in recent years, including this last legislative session. Public Act No. 15-141 (effective July 1, 2015) revises the previous statutes and includes changes such as:

- ◆ The statute and its requirements apply to all students, no longer just special education students, including students:
 - Enrolled in programs operated by Regional Educational Service Centers; and
 - Students receiving special education services in a state approved private program; and
- ◆ The statute and its requirements apply to all public schools as well as special education schools at facilities under contract with local education agencies.

Seclusion is defined as “the involuntary confinement of a student in a room, whether alone or with supervision, in a manner that prevents the student from leaving” (Public Act No. 15-141, Sec. 1(5)).

Physical restraint is defined as “any mechanical or personal restriction that immobilizes or reduces the free movement of a person's arms, legs or head” (Public Act No. 15-141, Sec. 1(3)) Physical restraint does not include:

- (A) Briefly holding a person in order to calm or comfort the person;
- (B) Restraint involving the minimum contact necessary to safely escort a person from one area to another;
- (C) Medical devices, including, but not limited to, supports prescribed by a health care provider to achieve proper body position or balance;
- (D) Helmets or other protective gear used to protect a person from injuries due to a fall; or
- (E) Helmets, mitts and similar devices used to prevent self-injury when the device is (i) part of a documented treatment plan or individualized education program...or (ii) prescribed or recommended by a medical professional...Public Act No. 15-141, Sec. 1(3)).

Seclusion and physical restraint shall only be used as an emergency intervention to prevent immediate or imminent injury to the student or to others, as long as the seclusion or restraint is not used for discipline and is not used as a substitute for a less restrictive alternative (Public Act No. 15-141). Only school personnel who have received training on the proper means for performing physical restraint or seclusion, as required by the statute, may seclude and physically restrain a student. The statute details the training requirements. School districts must notify a student’s parent of the student’s seclusion or

restraint no later than 24 hours after the student was placed in seclusion or physical restraint.

References

American Occupational Therapy Association. (no date). [Medicaid School-based Billing FAQs](#). Retrieved July 29, 2015.

American Occupational Therapy Association. (no date). [School System FAQs](#). Retrieved July 29, 2015.

American Occupational Therapy Association. (2011). [Occupational therapy services in early childhood and school-based settings](#). *American Journal of Occupational Therapy*. Retrieved July 19, 2015.

An Act Concerning Seclusion and Restraint In Schools. Public Act No. 15-141. (2015).

Boundy, K. and Orover, E. (1991). *Educational Rights of Children with Disabilities: A Primer for Advocates*. Washington, DC: Center for Law and Education.

Connecticut Department of Social Services. (no date). [Medicaid School Based Child Health Program](#). Retrieved July 29, 2015.

[Connecticut General Statutes. Chapter 170 § Sec.10-220h](#). Retrieved July 29, 2015.

Connecticut State Department of Education. (2015). [IDEA Part B Application for Federal Fiscal Year 2015](#). Hartford, CT: CSDE. Retrieved July 28, 2015.

Connecticut State Department of Education. (2015). *IEP Manual and Forms*. Hartford, CT: CSDE.

Connecticut State Department of Education. (2011). *Procedural Safeguards Notice Required Under IDEA Part B*. Hartford, CT: CSDE.

Connecticut State Department of Education. (2008). *Connecticut's Framework for RTI*. Hartford, CT: CSDE.

Connecticut State Department of Education. (2007). *A Parent's Guide to Special Education in Connecticut*. Hartford, CT: CSDE.

Frolek Clark, G. & Chandler, B. (2013). *Best practices for occupational therapy in schools*. Bethesda, MD: AOTA Press.

Regulations of Connecticut State Agencies. §§ 10-76a to 10-76h, inclusive. (2013).

Section 504 of the Rehabilitation Act of 1973. 29 USC § 701 et. seq. (1973).
The Americans with Disabilities Act of 1990. 42 USC 12101 et. seq. (1990).

The American with Disabilities Act of 1990. 28 CFR Part 35 et. seq. (2008).

The Elementary and Secondary Education Act of 1965. 20 USC § 6301 et. seq. (2001).

The Family Educational Rights and Privacy Act. 34 CFR Part 99 et. seq. (2011).

The Individuals with Disabilities Education Improvement Act of 2004. 20 USC § 1400 et. seq. (2004).

The Individuals with Disabilities Education Improvement Act of 2004. 34 CFR Part 300 et seq. (2008).

United States Department of Education. (no date). [Questions and Answers on the ADA Amendments Act of 2008 for Students with Disabilities Attending Public Elementary and Secondary Schools](#). Retrieved July 29, 2015.

EVALUATION IN SCHOOLS

Section 3

Learning Objectives

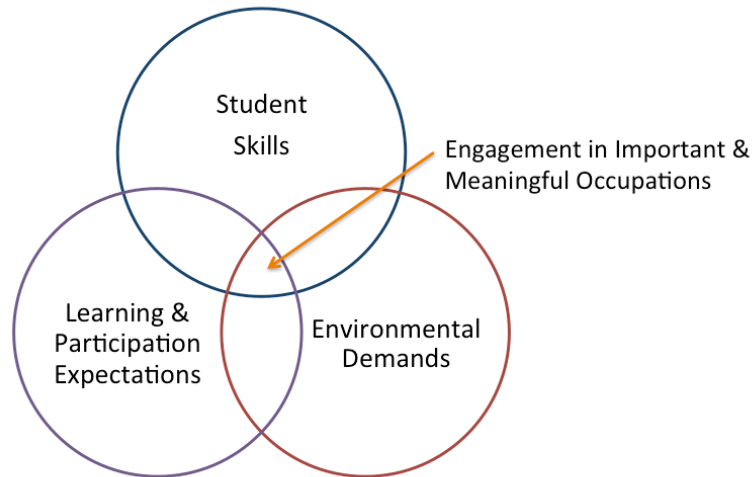
Readers will gain a better understanding of:

- ◆ The occupational therapist's unique lens when evaluating;
- ◆ The occupation centered evaluation process;
- ◆ Various approaches to assessment in school settings; and
- ◆ Evaluations at the program level.

Occupational Therapist's Distinct Lens

In school settings, occupational therapists may be part of an evaluation team to (a) determine whether a child is a child with an educational disability and requires special education and related services, (b) gain a comprehensive look at a student's present level of performance, and/or (c) gather information to revise a student's IEP. Occupational therapists bring a distinct lens to the team (parents and, at times, students are members of this team) in understanding a student's strengths and difficulties in relation to academic **as well as non-academic areas** (IDEA, 2004; Part 300 / A / 300.1). This focus aligns with the intent of IDEA, that is, to "ensure that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and ***prepare them for further education, employment, and independent living***"

The primary purpose of occupational therapy is "achieving health, well-being, and participation in life through engagement in occupation" (AOTA, 2014, p. S4). Applying this purpose to the school setting, occupational therapy practitioners focus on students (those with or at risk for an educational disability) optimizing their engagement in meaningful occupations (Frolek-Clark, Polichino, & Jackson, 2004; Swinth, Spencer, & Jackson, 2007). Occupations are those specific activities that occupy a student's school day (e.g., paying attention in class, playing with a friend, engaging in lunchtime routines, using school tools). With this in mind, students are often referred for an occupational therapy evaluation when their participation in learning and school activities are impeded (AOTA, 2014; Polichino, Frolek-Clark, Swinth, & Muhlenhaupt, 2007). School occupational therapists then proceed through an occupation-centered evaluation process to capture a contextual understanding of a student's skills, learning and participation expectations, and environmental demands that impact engagement (see Figure below). Dependent on the referral questions to be answered, student skill areas might include motor, process, interaction, and personal factors (e.g., habits, routines, and roles). Learning and participation expectations might consist of understanding curriculum, instruction, scheduling, and program requirements. Environmental demands might center on "the context and conditions for learning" (Frolek Clark, Chaill, & Ivey, 2015).



Person-environment-occupation model that school occupational therapists routinely use when gathering information and uncovering those factors that facilitate or hinder student engagement in important and meaningful occupations.

Definitions: Evaluation or Assessment

There can often be confusion with terminology about evaluation as there are multiple words used to describe the process of determining a student's strengths and difficulties (Polichino, Frolek-Clark, Swinth, & Muhlenhaupt, 2007). Some of these terms include evaluation, assessment, methods, measures, tests, tools, occupational profile, analysis of occupational performance, and others. AOTA defines evaluation as "process of obtaining and interpreting data necessary for intervention" (AOTA, 2008, p.670). Therefore, for the purposes of this chapter, the term evaluation means the entire process the occupational therapist goes through from start to finish to gather information about a student. Methods refer to the specific ways in which the therapist goes about that data gathering process. Methods include assessments, measures, observation, interview, and more. The term assessment can be used synonymously with tools, measures, or tests, and all will refer to the administration or completion of a specific method of gathering information that has very specific instructions to follow. Assessments, or tools, or measures, or tests may be published or unpublished, and may be of different types that will be further described below.

Requirements for Evaluation

When completing an evaluation in the schools, occupational therapists must follow federal and state laws, as well as adhere to AOTA guidelines (e.g., occupational therapy practice framework, the code of ethics, and the standards of practice [Coster & Frolek-Clark, 2013;

Polichino, et al., 2007]). In accordance with IDEA (2014) and occupational therapy practice standards, the following components must be followed:

- ◆ The person administering the assessment or completing the evaluation method is competent to do so.
- ◆ All methods chosen must be used in accordance with their stated purposes and must be valid and reliable.
- ◆ The methods chosen should be tailored to examine an area of specific need.
- ◆ All methods chosen must be completed in the child's language and must be non-discriminatory and not biased either racially or culturally.
- ◆ No single method should be used alone to determine needs.
- ◆ Since IDEA does not specify the process or the methods for a discipline specific evaluation, therapists should follow the *Occupational Therapy Practice Framework* (AOTA, 2014).

IDEA provides a timeline and a process for determining whether or not a student is eligible for special education. For more information on Connecticut's timelines and processes, please see the [CSDE](#) web site. For more information on national requirements, please see the [USDOE](#).

Evaluation Process

There are multiple purposes for occupational therapy evaluation in the schools (Bazyk & Cahill, 2015; Frolek-Clark & Kingsley, 2013; Polichino et al 2007). **First**, occupational therapists may be requested to assist the team in determining eligibility for special education. **Second**, they may receive a referral at a later date, that is, once an eligibility determination has already been made. In this case, the student may already have an IEP and the team is now considering whether occupational therapy is necessary as a related service. Evaluations completed at this point are meant to assist with program planning and to aid the team with the discussion about the need for related services—occupational therapy in particular. The focus of the occupational therapy evaluation, once a student already has an IEP, is to determine those factors that are supporting and/or limiting the student's learning and participation in school activities and how related services might help. **Third**, occupational therapists may be asked to complete a screening to capture a closer look at a student in comparison to classroom peers, to provide suggestions for instructional strategies to the school team, and/or to determine the need for a full evaluation (Frolek-Clark & Kingsley, 2013). **Lastly**, while an evaluation is required prior to determining a student is no longer a child with a disability (as defined under the IDEA 2004), an occupational therapy evaluation is not required to exit a student from occupational therapy services. Since these services are based on need rather than eligibility, the need for therapeutic supports drives the decision versus test results.

Under no conditions would results from an occupational therapy evaluation be used to *qualify* a student for occupational therapy services (Polichino et al, 2007). Occupational therapy as a related service is based on *need* not on eligibility. There are no standards for qualifying for occupational therapy in IDEA or in state law. Once a student is eligible for special education under IDEA, they are automatically eligible for related services that they require to benefit from that special education (Coster & Frolek-Clark, 2013).

No matter the stage of the process in which the occupational therapist receives the referral, an important component of the initial portions of the evaluation is establishing the specific questions that the evaluation is meant to answer (Coster & Frolek-Clark, 2013). These questions may come from a parent(s) or guardian(s), the teacher, or the student him or herself. Guiding questions for the evaluation may include topics such as:

- ◆ How is this student performing in his role as a student?
- ◆ Can he learn and document his learning to his teacher?
- ◆ How is this student managing transitions between school settings?
- ◆ How is this student performing in relationships with peers?
- ◆ What aspects of the environment are most supportive to this student's learning?
- ◆ How might environmental changes improve this student's attention?

In contrast, guiding questions for an occupational therapy evaluation should not include those such as: Does this student need occupational therapy for handwriting? There is also no scenario where the guiding question for the evaluation is: What are all of the things the student has trouble doing?

Selecting Evaluation Methods

Once parent permission to evaluate has been obtained and the therapist has established the purpose for the evaluation and the guiding questions to be answered, he or she next needs to determine the specific methods to be used. The therapist must use multiple methods and follow the requirements listed earlier in this chapter. AOTA recommends that when possible, the first step is to complete an occupational profile (AOTA, 2014).

Occupational Profile

Best practices suggest that the therapist develop an occupational profile before completing specific measures of occupational performance. The best methods for completing an occupational profile are record review and interview.

Record review. Record reviews are typically completed to gain an understanding of the child's history and prior levels of growth. Additionally, records (e.g., education and/or health records) can provide medical history and information that may help the occupational therapist understand any safety precautions that are necessary for the evaluation session. Finally, examining prior records allows the occupational therapist to see what evaluation methods were used before. This can allow comparison with prior measurement or ensure that specific assessment tools are not used again too soon, or by multiple disciplines. For example, if the student has a copy of a Visual Motor Integration assessment already completed by a school psychologist within the last 6 months, there is no need for the occupational therapist to do another. Information gathered from a recent assessment can be used to develop the student's occupational profile.

Interview. Interviews should be completed with the teacher, the parent(s)/guardian(s), and, when possible, the student. Interviewing the student allows the occupational therapist to understand the student's performance and behavior from his or her point of view, and may allow the therapist to tailor the evaluation to specific student needs. For example, a student named Roger was having troubles with attention and performance in math. The teacher

thought the problem had to do with visual perceptual skills. However, Roger was able to tell the therapist that one reason for his poor attentiveness in math was because the math class was being held in a room typically used to teach social studies. The items on the shelves and walls were a mismatch to the content to be learned and the student found this very distracting. This type of issue suggests a very different approach for the therapist than managing visual perceptual concerns. Interviewing students can be very illuminating when they have the communicative abilities to engage with the occupational therapist in this way.

Interviewing teachers should first provide information about the areas of student strengths. Key questions might include, “tell me what you like best about this student” and “What strategies are you currently using that are helping this student’s performance?” It can also be helpful to ask the teacher: Which school environments are the ones that the student is most successful in?

The interview of adults should also help the occupational therapist understand the expectations of the adults in the student’s life, and to identify the parameters of the adult concerns. Understanding the perspectives of adults can assist the therapist in knowing what areas to evaluate further, as well as what interventions have already been tried and their level of successfulness. If the adults identify a problem, it is the occupational therapists job to determine whom the problem ‘belongs’ to from their perspective. For example, for any one student behavior it may be bothersome for multiple people or no one. The problem may be bothersome to the student him or herself, or it may be bothersome only to the teacher, or to the teacher and the parents, or only the parents, or perhaps only to peers.

Additionally, interviews with adults can be important for another purpose. Sharing information with the family or the teacher as one is gathering it can help others on the team better understand the role of occupational therapy. Particularly during initial meetings as information is gathered, the family, and even the teacher, may have little understanding of occupational therapy. Important information may be left unsaid because particular questions were not asked and the parent(s) did not know occupational therapy could help so they did not mention the problem. As the occupational therapist asks questions of the family during an evaluation, it can be very helpful to also explain WHY questions are being asked. If the occupational therapist explains how the information is helpful, the family learns more about what an occupational therapist wants to know about, and the family will gain skill as informants and become better at providing information spontaneously.

At this stage the occupational therapist also builds rapport with the parent(s) and teachers and may begin the process of collaboration and information sharing. AOTA provides a variety of resources for occupational therapy practitioners to share with others. Please see the [AOTA resources for school based therapists](#), the [AOTA OT in Schools](#) document and [What Parents Need to Know About School-based Occupational Therapy](#).

Analysis of Occupational Performance

Following the completion of the occupational profile, the occupational therapist next completes an analysis of occupational performance (AOTA, 2014). This step is where the student’s strengths and difficulties are identified in relation to the classroom expectations and the curriculum. Occupational therapists should assess the student’s performance in all

appropriate school environments such as the classroom, hallway, cafeteria, playground, restroom, and even on the bus. Community and/or work environments may be included for older students beginning transition processes. During this portion of the evaluation, observation of actual performance in natural environments is typical and occupational therapists may additionally supplement these observations with the use of specific and targeted assessments. Standardized tools and measures should only be administered when they will provide relevant information for answering referral questions (McKinley-Vargas & Thomas, 2008). When analyzing a student's occupational performance there are multiple methods that may be included.

Observation and activity analysis

A key skill for an occupational therapist is observation and activity analysis through the occupational therapy lens (Miller-Kuhaneck, Spitzer, & Miller, 2010). Therapists are trained to view performance considering multiple interacting factors within the person, in the environment, and those that are part of the task the person is trying to accomplish. Applying the *person-environment-occupation* model (Law et al., 1996) and unique skill of activity analysis allows the occupational therapist to sort out what exactly is supporting and hindering the student's performance in any given task. No student evaluation in the schools is complete without direct observation of performance in the school settings of concern.

Observations may be guided by various frames of reference (Frolek-Clark & Kingsley, 2013; Miller-Kuhaneck, Spitzer, & Miller, 2010). The therapist should consider which frame of reference he or she is using as the student is being observed. For example, if the occupational therapist is observing a child in the cafeteria for performance with feeding and eating, then the following frames may be appropriate: developmental, biomechanical, motor control, neurodevelopment, behavioral, cognitive, and/or sensorimotor. Depending on the frames of reference applied and hypothesized underlying causes of identified problems, the suggested interventions can be very different. Making these hypotheses explicit will be critical in understanding those factors that contribute to or hinder a student's learning and participation in context.

These observations may provide quantitative or qualitative information about a student's performance in relation to other students that is crucial to the development of appropriate goals and interventions (Coster & Frolek-Clark, 2013). For example, observations may allow the therapist to compare a student's performance to the range of peer performance in the classroom (e.g., this student took 15 minutes to complete an activity that took others only 5-7 minutes, and this student needed 3 verbal redirections from the teacher in order to complete the activity). Observation provides the occupational therapist with information about the routines and classroom structures that may support or hinder the student such as seating arrangements, visual displays, and schedules. Observation may also allow an opportunity to assess environmental demands. For example, by observing a class time that was reported to be troublesome, the occupational therapist may discover that excessive cafeteria noise can be heard in the classroom from open windows, and that this noise appears to be distracting the student from classroom tasks. Observation may allow notation that during a lengthy writing assignment, the student worked very hard and attentively for 10 minutes, but then apparently began to fatigue. He began to shake out his hands, stop work on his task, and fidget with other items in his desk as he looked around the room.

Observation is crucial as this type of information is not often gathered through standardized assessment.

Standardized tools

This term means the assessment tool has very specific instructions that must be followed with each administration to ensure reliable and valid results. The test is administered and scored in the same way each time. Standardized tools can be norm referenced, criterion referenced, or both. For more information on standardized tools, please see <http://www.centerforpubliceducation.org/Main-Menu/Evaluating-performance/A-guide-to-standardized-testing-The-nature-of-assessment>

Assessment tools that are norm referenced have been developed for the purpose of comparing the child taking the test to a *normative* group of typical individuals who should in theory be similar to the child taking the test. These tools are meant to be diagnostic and they tell you that the child has a delay in some identified area that the test encompasses. The tests are developed to be highly reliable (consistent) and valid for very specific clearly defined purposes. While normative measures are helpful for identifying possible root causes of function or dysfunction, they need to be interpreted with caution, as they cannot be directly linked to school performance.

Tools that are criterion referenced are meant to explore a child's skills in comparison to specific criteria. Typically, they are structured in some sort of developmental sequence within each criterion category. These tools do not compare the child to other children, but just provide a snapshot or picture of what this child can and cannot do at this point in time.

There are a variety of standardized assessments frequently used by occupational therapists in school settings. There are many sources that list and describe these tools therefore this chapter will not provide that information. For information on possible pediatric tools please see Occupational Therapy **Evaluation** for Children: A Pocket Guide, Second Edition, **Asher's Occupational Therapy Assessment Tools**, 4th Edition, and online resources such as <http://www.therapro.com/Therapro-Handy-Evaluation-Chart-W5.aspx> and <https://www.med.unc.edu/ahs/physical/files/school-based-pt-docs/Ped%20Assessment%20Tools.pdf>

Other alternatives

There are other alternative methods of assessment often used in the schools (Frolek-Clark & Kingsley, 2013). Some teachers and therapists speak of authentic assessment where work samples are gathered and examined, or where a student portfolio is developed. Naturalistic assessment occurs through observation of actual daily tasks. Play based assessment occurs through observation of specific motor and cognitive skills used in play. Sometimes completed with peers or with parents these methods also allow for observation of interaction with others. Curriculum based assessment occurs when a criterion referenced tool is chosen and used that specifically aligns with the curriculum being taught and thereby allows direct examination of the student's performance within the curriculum. Dynamic assessment is chosen when the therapist wishes to see if the child can improve performance with specific instructional interventions. The student is tested, then taught, then immediately retested to see if performance improves. This information helps the therapist predict future performance after teaching.

Selecting evaluation methods based on purpose

The selection of evaluation methods should be individualized for each child, and family and based on the specific situation and the purpose of the occupational therapy evaluation (See Table 1). If the purpose is program planning, there are multiple methods that can provide rich information. As stated earlier, the most crucial skills of an occupational therapist are activity analysis and observation.

Norm referenced tests are not always necessary and often do not provide the occupational therapist or educational team with the best information. These tests are best saved for diagnostic purposes. If they are used, they should be used for very specific purposes, and the information they provide should be verified with other methods. Although schools may suggest that these tools are required or that they are the only credible source of information, they often are not valid for the purposes of an occupational therapy evaluation in schools. There is little information suggesting that just because a student scores well or poorly on text X, that their performance in the classroom will be Y. Multiple factors combine to create a student's performance in real situations and test scores do not always predict that performance well.

An additional note of caution must be provided here. Many children do not perform well in testing situations and some children may be untestable because of the strict need to adhere to complicated instructions required of norm referenced tests. Alternatively, therapists might try to use these tests but then alter the administration methods to allow a child to complete them. However, if norm referenced tests are not used properly, then scores should not be reported, as they would be unreliable and invalid.

Similarly, therapists should be cautioned about using standardized assessments and norm referenced assessment to document change over time. Norm referenced assessments often are not designed for this purpose. As the child ages, the comparison groups age as well. Therefore, the child may have improved greatly over time, but in comparison to age related peers, his or her performance may actually appear worse in comparison. This news can devastate families and in some ways negates all the progress actually made by the child in relation to his own prior performance. In this situation a criterion referenced tool would best document the changes over time. Additionally, some parent and teacher questionnaires are not meant to be used in a repeated fashion to document change. What can occur is that following the first administration, the parent or teacher becomes more aware of certain issues and more attuned to them. On second administration of the tool, scores may actually appear worse rather than better because the teacher or parent is now rating more accurately.

Purpose and Common Methods of Evaluation

The following examples are not intended to endorse one tool over others. They are merely examples.

Purpose	Methods and/or Assessment Type	Examples*
Diagnostic – delay in physical development	Norm referenced	Battelle Developmental Inventory Bayley Scales of Infant and Toddler Development
Program planning	Criterion referenced	The HELP The School Function Assessment
	Standardized parent questionnaires	The Sensory Profile The Sensory Processing Measure
	Standardized teacher questionnaires	The Sensory Profile The Sensory Processing Measure
	Authentic assessment	Classroom work samples
	Observation and activity analysis	Classroom and/or school observations Analysis of occupational expectations and/or environmental demands in relation to the student's skills
	Structured or semi-structured interviews	Teacher, parent, and/or student interview Canadian Occupational Performance Measure
	Formative assessment	DeCoste Writing Protocol
Monitoring progress	Criterion referenced	The Hawaii Early Learning Profile The School Function Assessment
	Authentic assessment	Classroom work samples
	Observation	Classroom and/or school observations focused on changes in student participation and performance since last observation
	Structured or semi-structured interviews	Teacher, parent, and/or student interview focused on changes in student participation and performance since last interview

Additional considerations: Approaches to evaluation

In the school setting, occupational therapists should approach the evaluation process with the intent of gathering the most meaningful information possible. Different approaches consist of top down, strength-based, client-perspective, and parent-inclusive.

Top down approach

A top down approach to evaluation means that the therapist begins with an examination of the student's performance in occupation and broadly identifies strengths, concerns, and difficulties in areas of occupation before completing specific assessments of client factors and skills (Bazyk & Cahill, 2015; Coster & Frolek-Clark, 2013). The administration of specific methods and measures is carefully planned and thought out, to help the therapist better understand the reasons for the student's occupational performance. Measures are selected specifically and carefully and are used sparingly to supplement authentic or naturalistic assessment methods. This is in contrast to the bottom-up approach which would mean that the therapist would provide a battery of assessment tools and document various skill deficits and difficulties with client factors first, assuming that these difficulties must have some impact on functioning in the schools (Bazyk & Cahill, 2015).

Strength-based approach

Beginning in at least the 1990s, school practice began to see a shift in thinking towards strength-based approaches (Dunst, 2000; Early, 2001; King, 2009; Tedeschi & Kilmer, 2005; Trivette, Dunst, Deal, Hamer, & Propst, 1990). An occupational therapist using a strength-based approach focuses first on determining what *is* working for a student. He or she will identify the student's strengths, as well as the supports and contextual features of the student's environment that encourage optimal functioning. The therapist will seek out knowledge about what is working and what strategies have been particularly helpful for this student. Additionally, the strengths focus will carry into intervention planning. The occupational therapist will integrate the identified strengths into helping the student manage or deal with difficulties.

Client-perspective approach

There are a variety of assessment tools* that may provide the occupational therapist with the student's perspective (Bazyk & Cahill, 2015; Coster & Frolek-Clark, 2013).

- ◆ The Perceived Efficacy and Goal Setting System
- ◆ The Child Occupational Self-Assessment
- ◆ The School Setting Interview
- ◆ The Short Child Occupational Profile
- ◆ Rosenberg Self Esteem Inventory

*The examples provided are not to endorse one tool over others. They are merely provided as examples.

Parent-inclusive approach

Parent inclusive practice consists of a set of beliefs and attitudes that value the uniqueness of parents and recognizes that they are the constant in a student's life. A therapist using this approach will consider the parent as the expert about the particular student, not the practitioner or teacher. Listening carefully and allowing parents to express their thoughts and feelings facilitates collaborative communication (Brady, 2004). Including parent's input at different stages of the evaluation process (e.g., referral question development, occupational profile contributions, information sharing, goal considerations) promotes parent-inclusive practices. This further allows the parent(s) to become an active member of the educational team and contribute to their child's IEP development.

Documenting results and sharing information

Occupational therapists need to carefully consider the format and contents of the evaluation report to ensure that accurate representation of a student's present level of performance in relation to the referral concerns is relayed. Reports can be structured in such a manner that the student's participation in the educational environment is described. The report may discuss the student's strengths in terms of the student's occupational performance before discussing the difficulties the student has. Discussion of skills and student factors should support and help explain the student's strengths and difficulties with occupational performance, rather than merely being included as a list of all of the specific skills that a student cannot do. Often, parents and teachers are well aware of the things the student cannot do and do not need this information outlined in great detail in a report.

Teachers and parents report that they prefer a strength-based approach, and the information they want in the report is the plan for how the educational team is going to help the student improve (Klein et al 2010). If each student is unique, then reports should not be one size fits all. The report should help the team make decisions about the creation of educational goals, accommodations, and supports for IEP development, and the need for different team members to implement the IEP. No one discipline makes these decisions alone. The occupational therapist **does not** decide independently of the team, whether or not a student needs or will receive therapy services (Polichino et al, 2007). Occupational therapy services are provided when it is required in order for the child to fully benefit from his or her special education services (Frolek- Clark & Kinglsey, 2013; Polichino et al 2007).

In addition to the written report, occupational therapists generally, although not always, explain the evaluation results to families prior to a formal IEP meeting. Therapists also have multiple opportunities to share information with other members of the educational team. There are methods of communication that encourage the involvement of others, and their ability to make their own informed decisions. By supplying information that makes sense or seems logical (i.e., answered the referral questions, aligned with educational relevance, and communicated without profession-specific jargon), the educational team (parents included) can consider and make informed decisions when developing the IEP and determining needed supports to implement the IEP.

Evaluation Process & Components

Evaluation Process	Components
Referral	<ul style="list-style-type: none"> • Ensure school district obtained written consent from parent(s) for the occupational therapy evaluation • Establish specific referral questions that the evaluation is meant to answer. <i>A referral sheet that covers general student information, academic status, perceived strengths/concerns, & referral questions will streamline this process.</i>
Occupational Profile	<ul style="list-style-type: none"> • Review education records to glean for history and nature of referral concerns • Review health records particularly when a medical history or safety precautions need to be understood • Interview multiple sources (e.g., parent, teacher, nurse, student) to understand those factors that facilitate or hinder the student's learning and/or participation in relation to referral questions • Determine the setting(s) and context(s) in which the student should be observed to better understand his or her occupational performance
Occupational Performance	<ul style="list-style-type: none"> • Observe the student in the setting(s) and context(s) that align with the referring concern(s). <i>A second observation in an environment that the student is most successful in may aid in understanding factors that contribute to successful learning and participation outcomes.</i> • Analyze those activities in context that align with the referral questions and are expected of the student • During observations and activity analysis identify supports and barriers to student learning and participation • Determine whether additional information (e.g., administration of standardized tools) is required and select tools or methods that will provide the most meaningful information
Document Results	<ul style="list-style-type: none"> • Structure the report to answer the referral questions • Explain the student's strengths and barriers to learning and participation in relation to the referral concerns • Write so others can draw meaning from the evaluation results • Complete the written summary to allow sufficient time in which parent(s) requesting a copy before the IEP meeting can receive one
Share Results	<p><i>At a parent meeting (may be combined with the IEP meeting)</i></p> <ul style="list-style-type: none"> • Review in detail the evaluation results, invite questions, provide information, and actively listen to parent(s) as they share their perspective <p><i>At an IEP meeting</i></p> <ul style="list-style-type: none"> • Provide a brief summary or snapshot of evaluation results and focus on those components that answer the referral questions and assist the educational team in developing the IEP

A Special Note on Section 504

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the basis of disability by programs that receive federal funds. One of its many protections calls for accommodations and services for PK-12 students with disabilities (as defined under the law) to ensure their equal opportunity to participate in all academic and extracurricular school programs. Students with a disability who do not qualify for services under the IDEA may be eligible for accommodations and services under Section 504, including school occupational therapy services.

The Section 504 Team conducts an initial evaluation with a student suspected of having a disability. If the team determines the student is a student with a disability and requires accommodations and services to ensure his/her equal opportunity to participate, the team identifies those accommodations and services and how they will be implemented. Occupational therapy is one of many related services recognized under Section 504 and can be provided as a sole service, where necessary. In addition to services for the student, school occupational therapy services under Section 504 can include consultation with other educational professionals; training for families; and adaptations to different environments within the school (e.g., classroom; cafeteria; playground; restrooms).

Occupational therapists, therefore, may be part of an evaluation team to (a) determine whether a child is a child with a disability (as defined under Section 504) and requires accommodations and/or services, (b) gain a comprehensive look at a student's current strengths and areas for growth, and/or (c) gather information to develop and/or revise a student's Section 504 Accommodation Plan. The best practices for the evaluation process as discussed above are also applicable to the occupational therapy evaluation process under Section 504.

Summary of Evaluations at the Student Level

Occupational therapists perform evaluations in the schools for a variety of reasons. The purpose of the evaluation should guide the methods chosen. However, in all cases, the outcome should be the provision of information to help the student, the family, and the school personnel function to their best abilities. When occupational therapists share information with others, they may empower all those who work with the student, in addition to the student him or herself to work towards improved occupational performance in multiple areas. In communications with members of the educational team, the occupational therapist performs an important function of explaining his or her role to others, and ensuring that others on the team understand the scope of practice of occupational therapy and the myriad ways in which the student and/or team can be supported.

Evaluations at the Program Level

Some occupational therapists may possess specialty knowledge and competencies in performing evaluations for program development (i.e., new or existing programs). Evaluation for program development might center on examining and prioritizing the needs of a group of students, a program, a school, or a district. When a concern exists in the following areas, then an occupational therapist would be valuable to have on the program development team:

- ◆ Developing a school emergency evaluation plan focused on students with disabilities
- ◆ Designing appropriate restroom facilities for training older students in independence with personal care
- ◆ Determining in-service and training needs for school district support staff in fostering independence in school self-care, implementing sensory diet strategies, and understanding fine motor development
- ◆ Helping a district choose an appropriate handwriting curriculum
- ◆ Auditing related services to determine alignment with educational benefit

Frequently Asked Questions

1. Can certified occupational therapy assistants perform evaluations?

While occupational therapists direct the evaluation process, occupational therapy assistants can contribute to the process and administer standardized assessment measures once he or she passed skill competency*. Occupational therapists have the primary responsibility for interpretation of assessment results and analysis of information gathered.

Refer to the standardized assessment manual to identify skill competency standards for a specific measure. The occupational therapy assistant would require training by the supervising occupational therapist. Documenting the training (e.g., dates, assessment measure, method) and pass of competency standards would be important. As changes in occupational therapy supervisors occur, skill competency may need to be re-assessed.

For more information on the standards of practice, please see the [AOTA](#) web site.

2. On average, how long does an occupational therapy evaluation take?

An evaluation may take up to 6-10 hours to complete dependent on the referral concerns being examined. A 6 hour evaluation can break down to .5 hour record review; .5 hour interview; .5 hour observation; 1 hour assessment; 2 hours scoring, interpretation, and write up; .5 hour review of other reports; 1 hour meeting to share results.

3. Does an evaluation have to include individual administration of standardized assessment tools?

IDEA (2004) supports the use of assessment tools that yield academic, developmental, and functional information pertaining to what the student knows and can do. Just the same, occupational therapy is not an eligibility service but rather a related service based on need; therefore, administration of standardized assessment tools is not a requirement. Although, adhering to a standard protocol for evaluations is highly recommended (as outlined in this chapter). In addition, occupational therapists might consider the use of standardized assessment measures to guide their observations and interviews.

For more information on assessment tools that are occupation-focused and include structured or semi-structured methods for observations and/or interviews, please see the [Model of Human Occupation](#) web site.

4. What if a medical provider or outside consultant prescribes occupational therapy services to be delivered in the school setting?

If the parent(s) obtains a prescription or recommendation for occupational therapy services, then the IEP team, in accordance with IDEA (2004), would consider the source of information. During consideration, the team would determine whether barriers exist and restrict the student's learning and participation in school activities. If identified barriers (or concerns) were in the domain of occupational therapy practice and not being addressed, then a referral for a school occupational therapy evaluation along with questions to be answered through the evaluation would be appropriate.

5. Can occupational therapy services be provided without an occupational therapy evaluation?

Following AOTA's Standards of Practice (2010), an evaluation precedes intervention (e.g., direct, indirect, consultation services).

For more information on standards of practice for occupational therapy, please see the [AOTA](#) web site.

6. When does a screening become an evaluation?

Quite often IEP teams will recommend that the occupational therapist provide a screening/evaluation focused on a particular area of concern. When the screening moves beyond determining appropriate strategies for instructional purposes, then the screening begins to align with an evaluation (IDEA, 2004). In particular, when screening outcomes are used for determining eligibility for special education and need for related services, then the screening would be considered an evaluation.

7. Can an IEP team direct which assessment tool be administered in an occupational therapy evaluation?

Directing the use of a specific assessment tool is not best practice. Instead, the team should identify areas of concern and generate questions to be answered through the occupational therapy evaluation. The occupational therapist in his or her professional expertise would then determine the best method for examining the area of need and selecting sources and tool(s) that will yield the most meaningful information for educational planning.

When completing the Notice and Consent to Conduct an Evaluation, test/evaluation procedures might consist of interview, observation, and/or individual administration; area of assessment would align with the area of concern (e.g., motor, visual perception, self-help); evaluator would be occupational therapist.

References

- American Occupational Therapy Association. (2014). Occupational therapy practice framework: Domain and process (3rd ed.). *American Journal of Occupational Therapy*.
- Bazyk, S. & Cahill, S. (2015). School system occupational therapy. In J. Case-Smith and J. O'Brien (Eds). Occupational therapy for Children and Adolescents (7th ed.). Elsevier.
- Brady, S. J., Peters, D. L., Gamel-McCormick, M., & Venuto, N. (2004). Types and patterns of professional-family talk in home-based early intervention. *Journal of Early Intervention, 26*, 146–159.
- Coster, W. & Frolek-Clark, G. (2013). Best practices in school occupational therapy evaluation to support participation. In G. Frolek-Clark & B.E. Chandler (Eds.). Best Practices for Occupational Therapy in the Schools (pp. 83-94). AOTA Press.
- Dunst, C. J. (2000). Revisiting" Rethinking Early Intervention". *Topics in Early Childhood Special Education, 20*(2), 95-104.
- Dunst, C. J., Hamby, D. W., & Brookfield, J. (2007). Modeling the effects of early childhood intervention variables on parent and family well-being. *Journal of Applied Quantitative Methods, 2*, 268–288.
- Dunst, C. J., Hamby, D., Trivette, C. M., Raab, M., & Bruder, M. B. (2000). Everyday family and community life and children's naturally occurring learning opportunities. *Journal of Early Intervention, 23*, 151–164.
- Early, T. (2001). Measures for practice with families from a strengths perspective. *Families in Society: The Journal of Contemporary Social Services, 82*(3), 225-232.
<http://www2.sunysuffolk.edu/bybeem/SS30/Measures%20for%20practice%20with%20ofamilies.pdf>

- Erchul, W. P., & Martens, B. K. (2001). ***School consultation: Conceptual and empirical bases of practice (2nd ed.)***. New York: Kluwer Academic.
- Erchul, W. P., & Raven, B. H. (1997). Social power in school consultation: A contemporary view of French and Raven's bases of power model. *Journal of School Psychology, 35*(2), 137-171.
- Fowler, C., Barnett, B., & McMahon, C. (2006). Working with families: A relationship-based approach. *Learning Links* (Information Sheet 45). Peakhurst, New South Wales, Australia: Learning Links. Retrieved November 15, 2010, from www.learninglinks.org.au/pdf/infosheets/LLIS%2045_Working%20w%20Families.pdf
- French, J. P. R., Jr., & Raven, B. (1960). The bases of social power. In D. Cartwright & A. Zander (Eds.), *Group dynamics* (pp. 607–623). New York: Harper & Row.
- Frolek-Clark, G. & Kinglsey, K. (2013). Occupational therapy practice guidelines for early childhood: Birth through 5 years. AOTA Press.
- Gallucci, C., Van Lare, M. D., Yoon, I. H., & Boatright, B. (2010). Instructional coaching building theory about the role and organizational support for professional learning. *American Educational Research Journal, 47*(4), 919-963.
- Hasbrouck, J., & Denton, C. A. (2007). Student-focused coaching: a model for reading coaches. *The Reading Teacher, 60*(7), 690-693.
- King, G. (2009). A relational goal-oriented model of optimal service delivery to children and families. *Physical & Occupational Therapy in Pediatrics, 29*(4), 384-408.
- King, S., Teplicky, R., King, G., & Rosenbaum, P. (2004). Family-centered service for children with cerebral palsy and their families: A review of the literature. *Seminars in Pediatric Neurology, 11*, 78–86.
- Klein, S., Wynn, K., Ray, L., Demeriez, L., LaBerge, P., Pei, J., et al. (2011). Information sharing during diagnostic assessments: What is relevant for parents? *Physical and Occupational Therapy in Pediatrics, 31*, 120–132. doi: 10.3109/01942638.2010.523450
- Law, M., Cooper, B., Strong, S., Stewart, D., Rigby, P., & Letts, L. (1996). Person–Environment–Occupation Model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy, 63*, 9–23. <http://dx.doi.org/10.1177/000841749606300103>
- Miller Kuhaneck, H., Spitzer, S. & Miller, E. (2010). *Activity analysis, creativity and playfulness in pediatric occupational therapy: Making Play Just Right*. Boston: Jones & Bartlett Publishers.

- Missiuna, C., Pollock, N., Law, M., Walter, S., & Cavey, N. (2006). Examination of the perceived efficacy and goal setting system (PEGS) with children with disabilities, their parents, and teachers. *American Journal of Occupational Therapy*, 60(2), 204-14.
- Polichino, J.E., Clark, G.F., Swinth, Y., & Muhlenhaupt, M. (2007). Evaluating occupational performance in schools and early childhood settings. In L. Jackson (Ed.). *Occupational therapy services for children and youth under IDEA* (3rd ed.). AOTA Press.
- Raven, B. H. (1965). Social influence and power. In I. D. Steiner & M. Fishbein (Eds.), *Current studies in social psychology* (pp. 371–381). New York: Holt, Rinehart & Winston.
- Sturm, R. E., & Antonakis, J. (2015). Interpersonal Power A Review, Critique, and Research Agenda. *Journal of Management*, 41(1), 136-163.
- Tedeschi, R. G., & Kilmer, R. P. (2005). Assessing strengths, resilience, and growth to guide clinical interventions. *Professional Psychology: Research and Practice*, 36(3), 230.
- Trivette, C. M., Dunst, C. J., Deal, A. G., Hamer, A. W., & Propst, S. (1990). Assessing family strengths and family functioning style. *Topics in Early Childhood Special Education*, 10(1), 16-35.
- Tschannen-Moran, M., & Hoy, A. W. (2007). The differential antecedents of self-efficacy beliefs of novice and experienced teachers. *Teaching and teacher Education*, 23(6), 944-956.

INTERVENTION IN SCHOOLS

Section 4

Learning Objectives

Readers will gain a better understanding of:

- ◆ Occupational therapy practitioner's unique expertise;
- ◆ Key considerations pertaining to intervention;
- ◆ The intervention process; and
- ◆ Intervention under IDEA, Section 504, and SRBI

Occupational Therapy Practitioner's Distinct Expertise

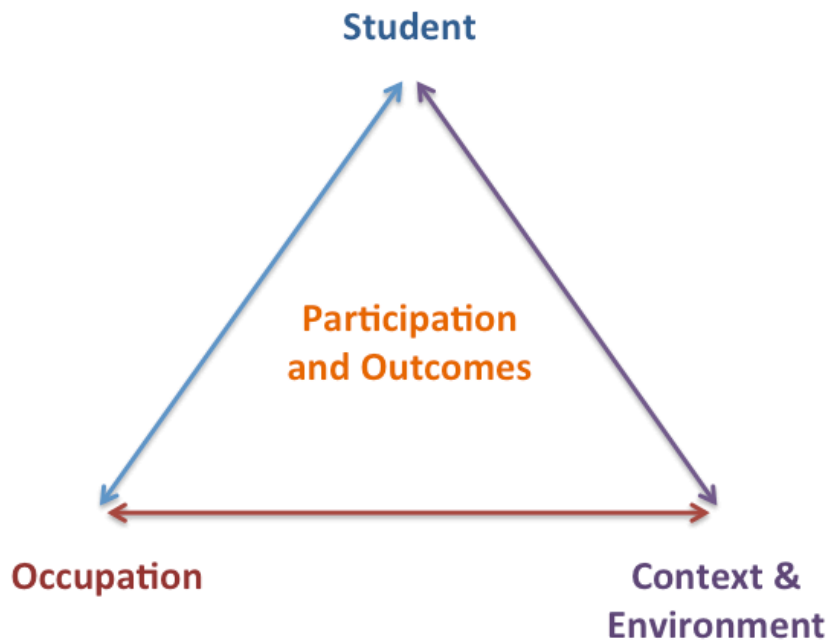
The profession of occupational therapy is concerned with a person's ability to participate in desired daily life activities or occupations. In schools, occupational therapy practitioners use their unique expertise to help children to prepare for and perform important learning and school-related activities and to fulfill their role as students. In this setting, occupational therapists (and occupational therapy assistants, under the supervision of the occupational therapist) support academic and non-academic outcomes, including social skills, math, reading and writing (e.g., literacy), behavior management, recess, participation in sports, self-help skills, prevocational/vocational participation, and more, for children and students with disabilities, 3 to 21 years of age.

(OTA: Occupational Therapy in School Settings, 2010)

Given the variety of everyday school occupations, the continuum across grades and ages (i.e., 3 to 21 years), and the inclusive definition of client (e.g., individuals, organizations, and populations), school occupational therapy practitioners provide a broad range of interventions. AOTA (2014) in the Occupational Therapy Practice Framework defines intervention as the "process and skilled actions taken by occupational therapy practitioners in collaboration with the client to facilitate engagement in occupation related to health and participation."

Occupational Therapy's View of Educational Performance

Occupational therapists and educators share a common context in public schools. The occupational therapist designs intervention and supports for students, schools, or districts after considering a variety of interrelated factors that influence student participation and educational outcomes (see Figure that follows). Occupational therapists focus on the interrelated aspects of specific student factors, the contextual and learning environment, and occupational demands expected of all students.



The interrelated factors that influence student participation and educational outcomes

Key Considerations in Intervention Planning

The Connecticut Context

The State of Connecticut is committed to the provision of a high quality education for all learners. In recent years, there have been major shifts in both general education and special education practices. The adoption of the Common Core State Standards (2010) is transforming education across Connecticut today. The educational environment presents educators and students with higher and clearer education standards, as well as significant shifts in instructional, assessment, and accountability practices. Transformative teaching and learning in Connecticut now includes research-based education curriculums; differentiated instruction; promotion of a physically, social-emotionally, and intellectually safe and respected climate; provision of a comprehensive system of social-emotional learning and behavioral supports; and data-driven decision-making. Occupational therapists bring a unique perspective to students' educational performance and participation, and have a valuable role to play in supporting students and teachers, in academic success and social participation.

For more information on occupational therapy and Common Core Standards, please see the AOTA web site at <http://www.aota.org/-/media/Corporate/Files/Secure/Practice/Children/FAQ-Common-Core-Standards.PDF>

In Connecticut, occupational therapy is identified as a Student and Educator Support Service. Service delivery of occupational therapy in public schools is aligned with the *CCT Rubric for Effective Service Delivery 2015*:

Domain 1: Learning Environment, Student Engagement and Commitment to Learning. Service providers promote student engagement, independence and interdependence in learning and facilitate a positive learning community

Domain 2: Planning for Active Learning. Service providers plan prevention/intervention to engage students in rigorous and relevant learning and to promote their curiosity about the world at large.

Domain 3: Service Delivery. Service providers implement prevention/intervention to engage students in rigorous and relevant learning and to promote their curiosity about the world at large.

Domain 4: Professional Responsibilities and Leadership. Service providers maximize support for student learning by developing and demonstrating professionalism, collaboration and leadership

Occupational Therapy Practice

The *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2014) describes central concepts that guide occupational therapy practice. Education is one area of occupation included in the occupational therapy domain of practice. Occupational Therapy's domain of practice, the purview of the profession's knowledge and expertise, includes:

1. Areas of occupation
2. Context and environments
3. Activity demands
4. Client factors
5. Performance skills
6. Performance patterns

Education is defined as "activities needed for learning and participating in the educational environment" (AOTA, 2014). "The fundamental background of occupational therapy practitioners is rooted in concepts related to promoting meaningful participation, optimum development, and engagement within natural contexts or least restrictive environments" (AOTA, 2012). The occupation of education includes academic (e.g., math, reading, writing), non-academic (e.g., recess, lunch, self-help skills), extracurricular (e.g., sports, band, cheerleading, clubs), and prevocational and vocational activities (Knippenberg, & Hanft, 2004). School therapists focus during intervention and service delivery is on removing barriers from students' ability to learn and participate, and helping students develop skills, which increase their independence in all aspects of the school environment and academic performance. Therapy intervention with the student is always educationally related, whether provided under the general education or special education process.

According to the *Framework* (AOTA, 2014) occupational therapy interventions include the use of "occupations and activities, preparatory methods and tasks, education and training, advocacy and group interventions to facilitate engagement in occupations to promote health and participation". In the school setting, occupational therapists utilize their skills in

identifying barriers to student's successful performance across contexts in school, and provide interventions primarily to promote academic success and social participation.

Intervention is defined as "process and skilled actions taken by occupational therapy practitioners in collaboration with the client to facilitate engagement in occupation relation to health and participation." Intervention approaches are specific strategies selected to direct the process of intervention. A specific intervention approach could promote, establish, maintain, prevent, or modify, in order to facilitate change in a student's performance.

Service delivery is defined as a "set of methods for providing service to or on behalf of clients" (AOTA, 2014). There are a range of service delivery and intervention options available for therapists to choose from. The choice of service delivery model/intervention approach will always be dependent upon child, the educational goals, and the educational context.

Evidence Based Practice

Occupational therapists recognize that evidence based practice is the integration of the best research evidence related to outcomes. A school therapy practitioner utilizes synthesized research evidence, scientific and clinical knowledge, and past experience throughout the intervention process. For more information on occupational therapy and evidenced based practice, please see the [AOTA](#) web site.

Theories, Models, and Frames of Reference

When team members focus on one diagnosis, theory, model, or frame of reference to determine when therapy is needed, they may overlook the student's strengths and what the student needs to be able to learn and do in school (Dunbar, 2007). For example, the team may focus on one component (e.g., a student's pencil grasp) and miss the wider perspective of classroom participation. When determining need and subsequently creating an intervention plan, occupational therapists integrate data from multiple sources with theories, models, and frames of reference to apply a client-centered and occupation-centered approach.

Theory. Provides a predictive line of thinking for explaining observed phenomenon (e.g., developmental theory).

Model. An abstract representation of a theoretical concept (e.g., person-environment-occupation model).

Frame of Reference. A systematic description and guide to support intervention planning (e.g., neurodevelopmental treatment frame of reference).

Intervention Process

All school therapists start with the basic question “What activities/participation issues – identified in the referral – does the child need to do in order to be successful at school?” Therapists then match information about the student with research, clinical judgment, and professional experience to choose frames of reference that guide intervention. This matching process is based on the needs and goals of each individual student. Occupational therapists do not utilize the same frame of reference for every child, and IEP teams should not expect a specific type of intervention when occupational therapy is included in the IEP. Frames of reference commonly used by therapists in schools include: motor control, developmental, behavioral, neurodevelopmental, biomechanical, cognitive, sensory processing, coping, and others (AOTA, 2007).

Educational Relevance and Educational Necessity

Under IDEA (2004) and Connecticut State Department of Education regulations, related school therapies are not parallel services to instruction in the classroom – the services must be both *educationally relevant and educationally necessary*. **Educational relevance** exists when the proposed service can be explicitly linked with a component of the student’s educational program. There must be a clear question or purpose when proposing a referral for school occupational therapy services. **Educational necessity** exists when we believe that the student will not have access to an appropriate education, or experience educational benefit, without the proposed related service.

Best Practice

Best practice in the delivery of occupational therapy in public schools is shaped by a variety of inter-related factors:

- Student-centered, occupation-based interventions, and a continuum of service delivery options, across both the general education and special education settings
- Integrated into the natural environment of the school such as classroom, playground, hallways or lunchroom
- A collaborative partnership with teachers and other education personnel; and inclusive of parents
- Focused on functional/educational outcomes
- Evidence based practice

In general, there have been major shifts in the provision of school occupational therapy services over the past few years (due to a number of different state education change initiatives). The intervention process actually begins in collaboration with other members of the educational team at the stages of screening, evaluating, intervening, and targeting outcomes. Occupation and enabling students to engage successfully in their everyday activities at school remains central to the occupational therapy process. Services are client-centered, involving collaboration with the student and the educational team at all times.

Determining Need for Occupational Therapy

During the occupational therapy evaluation process the therapist analyzes the student's ability to participate in school related activities, focuses on child-context interactions, defines needs and potential problems, and begins to contemplate possible interventions. Suggested questions for determining the need and relevance of occupational therapy might include:

- Will the absence of this service interfere with the student's access to, or participation in his or her educational program this year?
- Could the special educator or classroom teacher address the identified need appropriately and effectively?
 - Has the student been benefiting from his or her educational program without this service?
 - Could the student continue to benefit from his or her educational program without this service?
 - Do the proposed services present any undesirable or unnecessary gaps, overlaps, or contradictions with other proposed services?
 - Is this service necessary for improved student participation and academic success?

Answering these questions starts the process for determining need for occupational therapy services. Please see the table below for additional components.

Intervention Process & Components

Intervention Process	Components
Determine Need	<ul style="list-style-type: none"> • Occupational therapist provides professional input for the team to consider in IEP development or revision • Team creates IEP with educational goals and objectives • Team uses information gathered from occupational therapy evaluation and other sources of information to determine need for related service
Intervention Plan	<p><i>Occupational Therapist</i></p> <ul style="list-style-type: none"> • Integrates data from evaluation with theories, practice models, frames of reference, and evidence. • Creates intervention plan with therapy goals and approaches that will yield mastery of IEP educational goals and objectives. • Determines action for collaboration, training, supports, and resources needed to implement plan • Identifies potential discontinuation needs and plans
Intervention Implementation	<p><i>Occupational Therapist or Occupational Therapy Assistant (in collaboration)</i></p> <ul style="list-style-type: none"> • Determines and follows through with planned interventions • Monitors student's response to intervention and collects data (i.e., quantitative and/or qualitative)

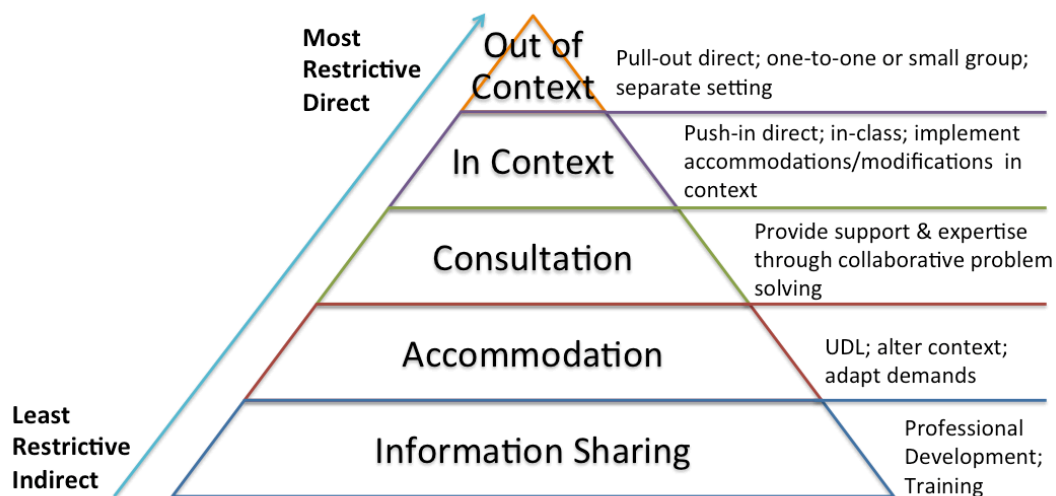
Intervention Review

Occupational Therapist or Occupational Therapy Assistant (in collaboration)

- Reports (or records) progress on IEP educational goals and objectives at scheduled timelines
- Re-evaluates the intervention plan and implementation based on data collected and whether sufficient progress is being made to achieve IEP educational goals and objectives upon target date
- Modifies the intervention plan as needed
- May request an IEP review meeting when student will not make expected progress on IEP educational goals and objectives
- At an IEP meeting, provides information to team to determine whether occupational therapy services are needed in order for student to benefit from his or her special education program (or requires other services)

Intervention Planning

Intervention requires planning. The therapist determines the most appropriate frame of reference, evidence and clinical reasoning to guide interventions, targeted towards a specific educational outcome. The outcomes of intervention are directed towards successful engagement and participation in school. Emphasis is placed on matching intervention implementation in the least restrictive environment possible (see Figure below).



Intervention continuum with desired least restrictive approach anchored at the bottom of the pyramid to most restrictive approach situated at the smallest point.

Direct Service. Refers to direct hands-on service delivered by the therapist with the student. Services may be provided one-on-one or in a small group, depending on student needs and the identified goals. The therapist uses remediation, prevention and compensatory strategies. Direct service can be delivered using an *integrated* or *pull-out*

model. Direct services can take place across a variety of school settings such as in the classroom, the separate therapy room, or the playground.

Integrated therapy service refers to a preferred method of service delivery, in which intervention is provided in the student's natural context, in a non-intrusive manner, addressing shared educational team goals. The therapist and the team determine an allocation of therapy time by week or a specific number of sessions per month or year. The therapist then determines on a daily/weekly/monthly basis how to best allocate direct and/or consultation times, to best facilitate achievement of goals. This delivery model supports both academic goals and nonacademic functional goals, and is delivered across many school contexts, embedded within the student's natural daily routine.

Indirect Service. This is a formal intervention service required to implement the IEP. Services are provided on behalf of the student and are often geared to exchange information, provide support, and or share expertise with general and/or special education teachers, paraprofessionals, and parents. The therapist uses his or her professional knowledge and skills to support the student's participation and learning. The student is not required to be present. An indirect service approach requires flexibility of scheduling.

Models of Intervention

Direct	Indirect
<p>Definition</p> <p>The occupational therapy provider (qualified practitioner) performs skilled services in which the student or group of students, and practitioner are simultaneously present.</p>	<p>The occupational therapy provider (qualified practitioner) exchanges information, provides supports, and shares expertise to implement next step plan for child in meeting his/her educational outcomes.</p>
<p>Criteria</p> <p>Practitioner and student/s are simultaneously present.</p>	<p>Student is not required to be present.</p>
<p>Service Model</p> <p><i>Pull Out:</i> Practitioner removes the student/s from the context of the classroom routine to provide skilled services. This may occur anywhere apart from the class routine (e.g., in therapy room or classroom).</p> <p><i>Integrated:</i> Practitioner sees the student/s within the context of his/her school routine to emphasize integration of skills into actual school activities.</p> <ul style="list-style-type: none"> • <i>Team Intervention:</i> Student/s is seen by more than one practitioner (e.g., OT and SLP or OT and PT) to target different focus areas. • <i>Co-teaching:</i> Teacher and practitioner jointly provide direct instruction to target student/s participation and learning. <ul style="list-style-type: none"> ▪ <i>Lead & Support:</i> One educator leads and another offers assistance and support to students. ▪ <i>Station Teaching:</i> Students divided into groups and work at classroom stations with each educator. Then switch. ▪ <i>Parallel Teaching:</i> Teacher and practitioner jointly plan instruction, and then deliver the same material to their group. ▪ <i>Alternative Teaching:</i> Practitioner works with a small group of students to pre-teach, re-teach, supplement, or enrich instruction and then teacher instructs the large group. ▪ <i>Team Teaching:</i> Teacher and practitioner share planning and instruction in a coordinated fashion. 	<p><i>Consultation:</i> Practitioner collaborates with the teacher or members of the educational team to develop and monitor intervention that will be carried out by persons in the school or home.</p> <p><i>Education Team or Parent Meetings:</i> The practitioner meets with members of the educational team and/or parents to develop, create, plan, or discuss student programming needs.</p> <p><i>Student-Specific Support Services:</i></p> <ul style="list-style-type: none"> • Making student-specific materials • Student-specific documentation • Technical assistance and training for staff to implement student-specific program (student may need to be present for experiential training instances) • Lesson planning that addresses student-specific needs • Service coordination <p><i>School Community Initiatives:</i></p> <ul style="list-style-type: none"> • Training and sharing professional knowledge (e.g., Positive Behavioral Interventions and Supports, bullying prevention, health and wellness).

Intervention Implementation

Implementing occupational therapy service firstly involves *therapeutic use of self*. This concept of therapeutic use of self refers to the occupational therapists use of their personal qualities and perceptions as part of the therapeutic process. Occupational therapists may utilize their personal qualities, as well as mindfulness, empathy, gentle humor and encouragement to fully engage with recipients of intervention. Secondly, therapeutic use of occupations and activities is an important aspect of intervention implementation. Activities are selected to address skill development and enable a student's successful and full participation in school. Thirdly, team collaboration is another aspect of implementation, which includes shared problem solving, shared goals and strategies. Finally, occupational therapists include the sharing of knowledge and expertise with others, as an important aspect of intervention.

Throughout intervention, the therapy practitioner monitors the student's response and collects meaningful data. Data can be quantitative, qualitative, or a combination of these. The intent of gathering data is to use evidence to design and guide effective interventions.

Interventions can be provided at the core instructional level within the classroom, through targeted group interventions, or through intensive individual interventions. Occupational therapy may also be provided as a system-wide support, as well as engaged as a district-wide support (see Table below).

Examples of Intervention Implementation

Everyday School Occupations

Acquiring Information

- Adjust the computer accessibility features (e.g., slow mouse speed and enlarged cursor, "Sticky Keys") so a student with motor challenges could access information electronically
- Work alongside the speech-language pathologist to provide science instruction for elementary school students with severe developmental and behavioral disabilities while promoting student participation, communication, and motor skill use

Expressing Learning

- Through the SRBI model provide intervention strategies for a general education student experiencing difficulty with handwriting
- Set up an ergonomically efficient work area so a student could conduct science experiments

Assuming Student Role through the Continuum

- Create a Playground Club to promote participation and to teach skills within the natural context with children who exhibit motor delays
- Locate resources for a high school student with cerebral palsy so she could participate in beginning driver education in a modified van

Performing School Self-Care

- Using the Alert Program, educate middle school students in self-regulation strategies

Examples of Intervention Implementation

School Clients

Individuals

- Play a vital role in a student's educational development beginning at preschool and continuing through the grades focused on early writing and organizational skills
- Through interdisciplinary teamwork, plan for safe seating, occupant restraint, and transport of students who use wheelchairs on school buses
- Work with students in their natural contexts to model intervention strategies, provide feedback, and measure outcomes

Organizations

- Advocate for the development of a school's emergency evacuation plans to align with the needs of students with disabilities
- Lobby for appropriate restroom facilities in order to train older students in independence with personal care
- Educate the school team about the role of occupational therapy in mental health and contributions for students with social emotional disturbance
- Hold in-services for school district's support staff on fostering independence in school self-care, implementing sensory diet strategies, and understanding fine motor development
- Increase the awareness of educators to the domain of school occupational therapy practice using an information gathering scavenger hunt
- Help a district choose an appropriate handwriting curriculum and provided professional development to educational staff

Populations

- Present at workshops and conferences on ergonomics, assistive technology, and role of school occupational therapy with specific populations (e.g., students with autism)
 - Educate students in backpack ergonomics during National School Backpack Awareness Day through community events and publications
-

Examples of Intervention Implementation

School Therapy Intervention

Educationally Relevant Intervention Plans

- Provide direct service to set up an ergonomically efficient work area for a student performing science experiments

Collaborative Consultation

- Collaborate with community-based occupational therapy practitioners as high school students prepared to transition from school

Outcomes

- Enhance learning and influenced students' awareness and application of anger management and self-regulation strategies through a collaborative team teaching program

Note. Examples for this section were collected from articles on school occupational therapy practice and published in a 2011 report submitted to AOTA's Commission on Continuing Competence and Professional Development titled: *Report on School Systems as an area for Specialty Certification.*

Intervention Review

This is the ongoing “process of reevaluating and reviewing the intervention plan, the effectiveness of its delivery, and progress toward outcomes” (AOTA, 2014). During this process the therapy practitioner collaborates with others (e.g., special education teacher, speech-language pathologist, parent) to gather information and determine whether changes are needed in the intervention plan.

Summary of Intervention under IDEA

Common to school practice, Connecticut occupational therapy practitioners provide a majority of intervention with and for students receiving special education under IDEA (2004). IDEA and the Connecticut General Statutes define special education and related services. Students, ages 3 through 21 years of age, who are determined to be a child with an educational disability are eligible for special education. Related services would then be based on need. Does the child *need* related services (e.g., occupational therapy) to benefit from his or her special education? If so, then the related service, in this case occupational therapy, would be linked to special education. The common focus of these services may center on the following intervention approaches to assist the student in their learning and participation in school activities:

- ◆ Establishing or restoring a student's skills and abilities
- ◆ Altering the context to support the student(s)
- ◆ Adapting the demands of a task or modifying environmental variables
- ◆ Designing strategies to prevent anticipated problems
- ◆ Creating opportunities through Universal Design
- ◆ Training and educating students, staff, or families to implement specific programs, use equipment, and/or incorporate specific instructional strategies

In order for students to receive school occupational therapy services under IDEA, federal law requires that the students be eligible for special education. Special education is

understood to mean *specially designed instruction* that meets the unique needs of the student. Related occupational therapy services must be determined *educationally necessary* to assist students with disabilities to benefit from their special education program.

Therapists should consider current evidenced based practices when designing and implementing therapeutic interventions in the educational environment. Data collection and documentation should be in collaboration with educational staff to effectively measure student outcomes.

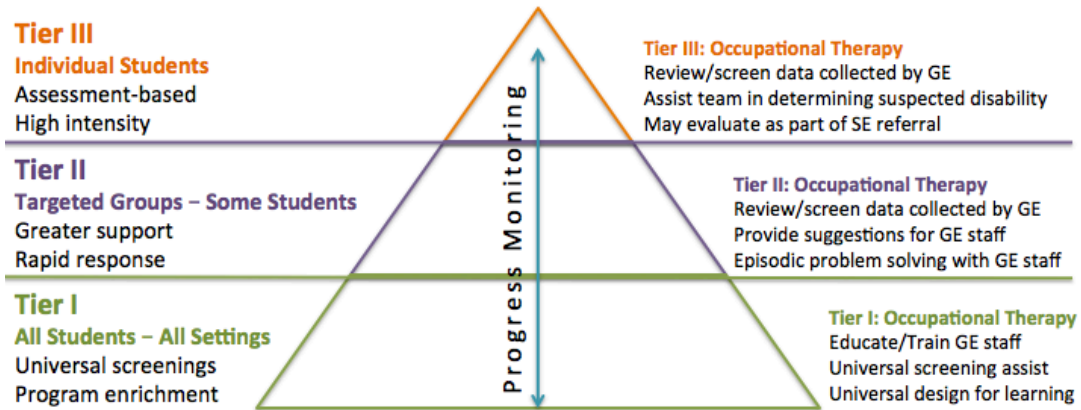
A Special Note on Section 504

Section 504 of the Rehabilitation Act is intended to level the playing field for students having, or suspect of having, a medical disability. The aim is to ensure equal access to academics and school activities. Given occupational therapists specialized knowledge in health sciences, they may be asked to serve on a student's 504 team. In this capacity, they can provide education to the school team around the student's medical disability and collaborate with the student's medical team when appropriate. From this information, the team can identify needed accommodations and when necessary modifications (i.e., "practices that change, lower, or reduce learning expectations" [CCSO, 2011, p. 10]). In addition, the team can determine whether support services are required to implement accommodations or modifications and ensure access to learning content and school activities. Occupational therapy practitioners may provide these intervention services.

For more information on accommodations for students under Section 504 of the Rehabilitation Act, please see the [Council of Chief State School Officers](#) web site.

A Special Note on SRBI

In Connecticut, occupational therapists as pupil personnel may be involved in universal screenings at the Tier 1 level (see following Figure). In addition, they may provide input to SRBI teams at the Tier 2 level. This input may center on specific accommodations, instructional strategies, and/or specialized materials to address targeted group needs. At the Tier 3 level, the SRBI team may add occupational therapy consult to provide student specific recommendations. To gather information for making these recommendations, the occupational therapist would, at a minimum, complete a screen.



Scientific Research Based Intervention [SRBI] model in which occupational therapists as pupil personnel may provide input.

For more information on SRBI, please see the [CSDE](http://www.csde.org) web site or the AOTA website at: <http://www.aota.org/-/media/Corporate/Files/Secure/Practice/Children/AOTA%20RtI%20Practice%20Adv%20final%20%20101612.pdf>

Frequently Asked Questions

1. What is the difference between interventions in the clinical setting versus the school setting?

There are certainly fundamental similarities in how interventions are provided in the two settings. There are also distinct differences around who determines the need for intervention, what will be the focus of therapeutic intervention, where will intervention occur, and how services will be delivered.

In the school setting, the PPT determines (with input from the occupational therapist) whether the student needs occupational therapy to benefit from his or her special education program. Under IDEA, Part B (2004), occupational therapy services are tied to special education. The focus of therapy services is centered on the child *accessing educational opportunities and benefiting from their special education instruction*. School practitioners routinely work with children in the context of their school day. They may provide (a) pull-out service to help the child acquire new skills to use in school activities; (b) integrated service to trial strategies, modify educational task demands, or adjust the learning environment; and/or (c) consultation service with the educational team to develop and monitor classroom strategies, train staff, and provide resources.

In the clinical setting, the focus of intervention centers on helping children reach their potential. Therapy practitioners place specific emphasis on minimizing the impact of the child's disability while maximizing the child's independence and skill

development. The intervention plan is typically aimed toward habilitation or rehabilitation. In the medical model, the physician, family, and therapist make the decision regarding amount, frequency, and duration of therapy recommended.

Understanding the framework in which therapists practice is important. Families, team members, and service providers can make more informed decisions, gain better access, and coordinate services in the best interest of the child. At times, the child might benefit from school therapy services, medically based therapy services, or a carefully communicated and coordinated combination of both. School services are provided to assist a child with an educational disability to benefit from special education. Medical services are provided to optimize the child's functional performance in relation to needs in home and community settings. Collaboration is critical to understand the child's performance and participation in different contexts. Collaboration may take the form of phone calls, written communication logs, or team meeting discussions.

2. Can therapeutic equipment be used without prior training by the student's assigned occupational therapist?

Prior to using therapeutic equipment with a student (e.g., therapy swing, weighted product, oral motor chewy, brushing), the occupational therapist needs to be consulted. In collaboration with the student's team, the occupational therapist would promote thoughtful decision-making in designing a plan, ensure awareness of individualized accommodations, emphasize health and wellness considerations, identify desired outcomes, and determine a data collection system for monitoring progress. In addition, staff training needs, parent inclusion strategies, logistical considerations, and other information can be addressed. Having protocols for the use of therapeutic equipment will help this process.

3. Can occupational therapy practitioners work with a student on feeding, eating, and swallowing skills?

The Connecticut State Department of Education published *Guidelines for Feeding and Swallowing Programs in Schools* in 2008. Since that time, a shift has begun to occur with terminology pertaining to school settings, that is, using the term *mealtime skills* versus the clinical terminology of feeding and swallowing. No matter the term used, in the school setting, mealtime skills for students experiencing feeding, eating, and swallowing challenges are addressed through a team approach. A school occupational therapy practitioner with specialized knowledge in this area may lead the educational team, in collaboration with the medical team, to design a student's mealtime support plan. The emphasis of the plan would be toward the student engaging in safe mealtimes, having access to adequate nutrition to sustain learning and productivity throughout the school day, and participating in the least restrictive environment. Having a mealtime support planning form will help this process.

For more information on Connecticut's guidelines for feeding and swallowing programs, please see the [CSDE](#) web site.

4. What if an outside clinical provider makes specific intervention recommendations? Is the school occupational therapy provider required to implement those interventions in the school setting?

If an outside provider makes specific intervention recommendations, then the assigned school occupational therapist, and at times the IEP team, would consider the source of information. During consideration, the therapist would contemplate whether the intervention was (a) supported by evidence, (b) necessary for the student to benefit from his or her special education program, (c) a fit for the student achieving his or her IEP goals and objectives, and/or (d) reasonable to provide in the context of school programming. If the intervention were educationally necessary and relevant, then the therapist would need to consider, among other things, his or her competence in delivering the intervention. At times, an intervention, or intervention strategy, works well in a clinical setting but does not translate well into the educational environment (and vice versa).

5. How is frequency of occupational therapy service best determined?

Once the IEP is developed and the need for occupational therapy services determined, the therapist drafts an intervention plan. The plan would serve as a guide to estimate the direct and indirect time required to implement the interventions that would impact student outcomes. Time estimates can range from a traditional frequency (e.g., .5 hour/week, 1 hour/month, 28 half hour sessions/year), a short-term intensive to front load services, intervals to check in on students at specific points during the school year (e.g., 1 hour/marking period), and under certain conditions (e.g., 1 hour when transitioning to a new work site). Time should be calculated based on student need not based on IEP management systems. Direct time would appear on the related service grid. Indirect time (i.e., service time delivered on behalf of the student) would appear on page 8 of the IEP. Service time that does not follow the traditional frequency should be described in the meeting minutes for the purposes of transparency and clarity should the student transition to a new school or therapist.

6. What is the occupational therapist's role in supporting students with mental health concerns?

Occupational therapists include mental health as part of their considerations for intervention, no matter what the barriers to performance might be for a student. Occupational therapists possess expertise and knowledge in mental health promotion, prevention, and intervention when working with children and youth—those with and without disabilities, mental illness, or both—in schools and community settings. In public schools, occupational therapy is an intervention resource available for students who experience mental health concerns.

References

- American Occupational Therapy Association. (2010). [*Occupational therapy in school settings*](#). Retrieved on August 11, 2015.
- American Occupational Therapy Association. (2014) *Occupational therapy practice framework: Domain and process*. 3rd Edition. AOTA Press.
- Connecticut State Department of Education. (2015). [*The Connecticut common core of teaching rubric for effective service delivery 2015*](#). Retrieved on December 8, 2015.
- Dunbar, S. B. (2007). *Occupational therapy models for intervention with children and families*. Thorofare, NJ: SLACK Inc.
- Knippenberg, C., & Hanft, B. (2004). The key to educational relevance: Occupational throughout the school day. *School System SIS Quarterly*, 11, 1-3.
- Swinth, Y., Spencer, K. C., & Jackson, L. L. (2007). *Occupational therapy: Effective school-based practices within a policy context*. (COPSSSE Document Number OP-3E). Gainesville, FL: University of Florida, Center on Personnel Studies in Special Education.

COLLABORATIVE TEAMING & SYSTEM SUPPORTS

Section 5

Learning Objectives

Readers will gain a better understanding of:

- ◆ Collaborative teaming in the school setting;
- ◆ Systems of collaboration;
- ◆ Workload considerations; and
- ◆ Documentation of collaboration services.

What is collaborative teaming in schools?

Collaboration is a mutual and interactive process with multiple individuals. As members of the school team, occupational therapy practitioners can offer input and support by collaborating with team members (e.g., teachers, paraeducators, parents, other related service providers, outside providers, other school staff) related to the needs of the student(s). Collaboration may include addressing educationally-related functional activities, assistive technology, adapting materials, instructing school staff on specific activities, training staff, or collaborating on instruction methods that will facilitate a student's performance at school. Effective team collaboration ensures that all students access educationally relevant occupations throughout their typical school routines and within naturally occurring environments (Hanft & Shepherd, 2008).

Elements to consider when collaborating

- Mutual respect, equal relationship, collective responsibility
- Focused in facilitating academic achievement for all students through effective teaming with school, staff, and families
- Team cohesion, shared purpose/goals
- Means of Collaboration (including but not limited to):
 - In person
 - Web and/or video conferencing (live or recorded)
 - Electronic Communications (cloud and internet-based file sharing, email, etc.)

For more information specific to documents supporting the role of occupational therapy in collaboration, please see the following: Scope of Practice (AOTA, 2010) at <https://www.aota.org/-/media/Corporate/Files/AboutAOTA/OfficialDocs/Position/Scope-of-Practice-edited-2014.PDF> and [Occupational Therapy Code of Ethics and Ethics Standards](#) (AOTA, 2015).

Systems of Occupational Therapy Collaboration

Occupational therapy practitioners possess skills in inter-professional collaboration to support all students, families, and school district personnel. They foster communication among stakeholders and contribute to the development of programs at various levels. Below are examples of collaborative systems that school therapy practitioners are involved in:

System 1: Individual Student Supports

Occupational therapy practitioners provide collaborative supports for individual students receiving services along the educational continuum. This may include, but is not limited to:

- Evaluation, planning, development, and implementation of individual student programs
- Co-teaching and/or inclusion services (i.e.: occupational therapy provides services in the classroom)
- Co-treatment and development of transdisciplinary goals (e.g.: occupational therapy provides services with another service provider focused on overlapping, related, or complementary practice areas)
- Team meetings (informal and formal)
- Direct consultation and collaboration with individual school staff for:
 - Collection and management of student data
 - Carryover of strategies and student programs
 - Ongoing school staff support
 - Training and professional instruction
- Staff observation of occupational therapy sessions (e.g.: para educator attends occupational therapy session for instruction and modeling of occupational therapy strategies)
- Identification and review of individual accommodations/modifications
- Collaboration with outside medical and/or private providers
- Family supports and development of home programs
- Transition planning

System 2: Classroom Supports

Classroom-level supports provided by an occupational therapy practitioner can take on various forms of service delivery within the general education and special education settings. This includes, but is not limited to, the multi-tiered approach for scientifically research-based interventions (SRBI), early intervening services (EIS), and positive behavioral intervention supports (PBIS). The role of the occupational therapy practitioner in participating in classroom-focused collaboration is to offer strategies and interventions for the classroom staff and all students. The following table depicts examples of a multi-tiered approach to collaboration and the role of occupational therapy within this system.

Multi-tiered Approach to Collaboration & Role of Practitioner

Tiered Interventions (SDE, 2008b) Role of Practitioner (AOTA, 2012)

Tier I: Core Instructional Interventions

At this level all students in the general education setting are addressed with one interventionist (classroom teacher). This may involve differentiated instruction, flexible groups, or whole group reteach. The focus is preventative and proactive.

- Provide educational training to teachers
- Assist with universal screenings for instructional purposes
- Use population approach for general education students.

Examples:

- Conduct handwriting screenings for all kindergarten students
- Present a workshop on sensory processing or age appropriate fine motor skills.

Tier II: Targeted Group Interventions

At this level the focus is on students that are at-risk. This may involve supplemental small group instruction, typically comprised of 4-6 students and one interventionist (classroom teacher, specialist, instructional aide, tutor, or paraeducator). Students are grouped by same skill or strategy.

- Review data collected by the general education teacher
- Provide suggestions for general education staff
- Provide occasional problem-solving for the purpose of assisting general education staff

Examples:

- Recommend seating modifications for small group of struggling students
- Collaborate with teacher to develop interventions to support students who are struggling with handwriting.

Tier III: Intensive, Individual Interventions

At this level the focus is on individual students. This may involve intensive, small group or individual instruction, typically comprised of 1-3 students and one interventionist (classroom teacher, specialist, instructional aide, tutor, or paraeducator). Students are grouped by the same skill deficits. Intervention location may be the general education classroom or other service location.

- Review data collected by general education teacher
- Assist team in determining if the child has a suspected disability
- Evaluate, if necessary, in accordance with state requirements
- Present professional development workshops

Examples:

- Recommend strategies for a specific child, as needed (sensory strategies, organizational strategies)

System 3: School-wide Supports

Occupational therapy practitioners work with school administrative teams to identify and address topics related to special and general education. They have a distinct knowledge that supports various school-wide initiatives that promote student participation, efficiency, and excellence within the school community. Some examples of this include:

- ◆ Administrative/Management
 - Time studies for budgeting and staffing
 - Department meetings (special and/or general education)
 - Professional committees and task forces
- ◆ Participation in and development of SRBI processes
- ◆ Development of school-wide movement programs
- ◆ Whole grade instruction in content areas (See Interventions chapter of this document)
- ◆ Development and training for a school-wide handwriting curriculum
- ◆ Assistive Technology-See [Connecticut AT Guidelines](#) (SDE, 2014)
- ◆ Behavior Systems/Programming
- ◆ Review and contribution to research-based instruction and interventions
- ◆ Professional Development (e.g.: in service, mentorship/coaching) in professional issues, childhood development, specific diagnoses, interventions.

System 4: District-wide Supports

Occupational therapy practitioners can contribute to and influence teams, committees, and task forces that address global issues in education. The following initiatives can benefit from the expertise of an occupational therapy practitioner.

- ◆ Preschool/Early childhood evaluation teams
- ◆ Kindergarten screenings
- ◆ Development of evaluation/screening procedures
- ◆ Universal design and accessibility
- ◆ Environmental and ergonomic design (e.g.: recommendations for materials, furniture, equipment, building and playground design)
- ◆ Parent groups and training in specific content areas
- ◆ Violence and bullying prevention programs
- ◆ Health/Wellness and Mental health task forces
- ◆ Obesity prevention task force
- ◆ Assistive Technology-See [Connecticut AT Guidelines](#) (SDE, 2014)
- ◆ Handwriting curriculum
- ◆ Preschool curriculum development and review
- ◆ Transition programs
- ◆ Feeding and swallowing teams-See [Feeding and Swallowing Guidelines](#) (SDE, 2008a)
- ◆ Professional supervisory and/or peer review

Workload Considerations for Collaboration

Effective collaborative teaming requires substantial time for planning, implementation, review, and documentation. Occupational therapy practitioners and school districts must work together to determine sufficient means to manage and carry out collaboration efforts within the workday. Workload time, outside of the specific time devoted to caseload demands mandated by IEP, 504, and SRBI, should be accounted for when determining appropriate levels of staffing. This amount of time may differ between districts, and schools within a district, depending on the utilization of occupational therapy practitioners. Please refer to the Interventions chapter regarding “Workload versus Caseload.” Also, teams may consider using the following form to determine workload.

Worksheet 3.4A.: School Workload: Collaborative Roles Review (Hanft & Shepherd, 2008)

Documentation for Collaboration

All forms of professional service should be clearly documented (AOTA, 2013). This defines content generated by the participants, records the outcomes, and illustrates the value of the service. Please refer to the Documentation chapter. The following forms can be used as guidelines for occupational therapy practitioners and school districts when engaging in collaborative teaming at various levels.

Worksheet 2.2A.: Observation of the School Environment (Hanft & Shepherd, 2008)

Worksheet 2.3A.: Reflection on Team Support Role (Hanft & Shepherd, 2008)

Worksheet 2.4A.: Faces, Spaces, and Paces (Hanft & Shepherd, 2008)

Worksheet 3.3A.: Collaborative Team Meeting Worksheet (Snell & Janney, 2005)

Worksheet 3.4A.: Action Plan for Collaboration (Hanft & Shepherd, 2008)

References

- American Occupational Therapy Association [AOTA]. (2010). Scope of practice. [*American Journal of Occupational Therapy*](#).
- American Occupational Therapy Association [AOTA]. (2012). [AOTA practice advisory on occupational therapy in response to intervention](#).
- American Occupational Therapy Association [AOTA]. (2013). Guidelines for documentation of occupational therapy. *American Journal of Occupational Therapy*, 67(Suppl.).
- American Occupational Therapy Association [AOTA]. (2015). [Occupational therapy code of ethics](#). *American Journal of Occupational Therapy*.
- Connecticut State Department of Education [SDE]. (2008a). [Guidelines for feeding and swallowing programs in school](#).
- Connecticut State Department of Education [SDE]. (2008b). [Using scientific research-based interventions: Improving education for all students](#).

Connecticut State Department of Education [SDE]. (2014). [Connecticut assistive technology guidelines](#).

Hanft, B. & Shepherd, J. (2008). 2...4...6...8...How do you collaborate. In B. Hanft & J. Shepherd (Eds.), *Collaborating for student success: A guide for school-based occupational therapy*. (pp. 1-33). Bethesda: AOTA Press.

Snell, M. E. & Janney, R. (2005). Collaborative team meeting worksheet. In M.E. Snell & R. Janney (Eds.), *Collaborative teaming* (2nd ed., Appendix, p. 50). Baltimore: Brookes.

Resources

American Occupational Therapy Association. (2011). [Definition of occupational therapy practice for the AOTA Model Practice Act](#).

American Occupational Therapy Association (2015). FAQ: Response to intervention for school-based OTs and OTAs. Retrieved from <http://www.aota.org/-/media/Corporate/Files/Secure/Practice/Children/FAQ-School-based-Revised-09-2014.PDF>

American Occupational Therapy Association (2015). [Response to intervention](#).

Orentlicher, M. L., Handley-More, D. Ehrenberg, R. Frenkel, M. & Markowitz, L. (2014, June). Interprofessional collaboration in schools: A review of current evidence. *Early Intervention & School Special Interest Section Quarterly*, 21(2), 1-3. Retrieved from <http://www.aota.org/-/media/Corporate/Files/Secure/Publications/SIS-Quarterly-Newsletters/EIS/EISSIS-June-2014.pdf>

DOCUMENTATION IN SCHOOLS

Section 6

Learning Objectives

Readers will gain a better understanding of:

- ◆ Documentation expectations across workload clusters;
- ◆ Key laws, regulations, and practices that influence school therapy documentation;
- ◆ Common types of school therapy documentation; and
- ◆ Legal, professional, and administrative considerations specific to school therapy documentation

Documentation across Workload Clusters

School practitioners frequently engage in a variety of services and activities (see Figure 1) all of which require some form of documentation. In some instances, these documents may be created solely by the practitioner and become part of a student's educational file, therapist's working folder, or classroom's student support materials. In other cases, practitioners may contribute to the development of a document as a member of an educational team for the purposes of designing an IEP, implementing programming, or collecting data.

Outlined within AOTA's Guidelines for Documentation (2013), practitioners complete documentation to:

- Relay information about a client (e.g., student, classroom, district) from the occupational therapy perspective.
- Reflect occupational therapy practitioner's clinical reasoning and the relationship to improved student outcomes.
- Articulate the rationale for recommendations to the educational team.
- Provide a chronological record of client status, services provided, response to therapeutic intervention, and improved outcomes.

Workload Clusters

Direct Services

- Observations
- Screenings
- Evaluations
- Implement IEPs
- Establish student skills

Indirect Activities

- Pre-referral strategies
- Adapt task demands
- Modify environment
- Prevent anticipated problems
- Alter context to support student
- Create opportunities

Indirect Services

- Contribute to IEP development
 - Design intervention plans
- Coordinate with community providers
 - Plan & prepare intervention
 - Provide staff development
 - Train teachers & staff
 - Consultations
 - Attend meetings

Compliance Activities

- Collect & analyze data
- Compliance paperwork
- Contact logs
- Parent communication logs
- IEP documentation
- Supplemental reports
- 3rd party billing activities
- Write LMN for equipment
- OTA supervision

A sampling of occupational therapy services and activities that require either formal or informal documentation. Concept of workload clusters adopted from ASHA (2002) guidelines.

Levels that Influence Documentation

Many levels (or layers) influence documentation of occupational therapy services from federal laws, to national standards, state regulations, district policies, school practices, and provider expertise. The school district and therapy practitioner should be familiar with each of these levels. By understanding them, actions steps can be applied to promote best practice, produce meaningful documentation, and positively impact student outcomes.

Federal Level

Special Education Law: IDEA, 2004

- ◆ Student focused-optimize student learning and participation
- ◆ Defines the following:
 - Observation: child observed in “learning environment to document... academic performance and behavior in area of difficulty” (§ 300.310)
 - Screening: “to determine appropriate instructional strategies for curriculum implementation” (§ 300.302)
 - Evaluation: “use a variety of assessment tools and strategies to gather relevant functional, developmental, and academic information about the child” (§ 300.304)
 - Progress reporting: “periodic reports on the progress the child is making toward meeting the annual goals” (§ 300.320(a)(3)(ii))
- ◆ Identifies required IEP components (§ 300.320)
- ◆ Establishes meaning of personally identifiable information (§ 300.32)

Federal Level (continued)

Civil Rights Law: Section 504 of the Rehabilitation Act, 2008

- ◆ School focused—provide fairness and equal access to education
- ◆ Defines evaluation and placement procedures: “information from a variety of sources... is documented” (34 CFR § 104.35(c))

Civil Rights Law: American with Disabilities Act (ADA), 2009

- ◆ Community focused—guarantee equal opportunity in public accommodations, employment, transportation, and telecommunications

Privacy Law: Family Educational Rights and Privacy Act (FERPA)

- ◆ Education focused—protect the privacy of students’ education records
- ◆ Defines education records as those records that are: (a) directly related to a student and (b) maintained by an educational agency or institution or by a party acting for the agency or institution. (§ 99.3)
- ◆ Outlines that the term education records do not include: (a) Records that are kept in the sole possession of the maker, (b) are used only as a personal memory aid, and (c) are not accessible or revealed to any other person except a temporary substitute for the maker of the record. (§ 99.3)
- ◆ Defines personally identifiable information (§ 99.3)

Privacy Law: Health Insurance Portability and Accountability Act (HIPAA), 1996

- ◆ Health focused—protect the privacy and security of individually identifiable health information
- ◆ Health care providers who bill Medicaid are subject to HIPAA requirements (e.g., obtain parental consent in order to disclose Medicaid billing information about a service provided to a student [34 CFR §99.30])

National Level

Professional Association: AOTA

- ◆ Guidelines for evaluation, screening, intervention plans, service contacts, progress report, transition plan, and discontinuation report (AOTA, 2013)
- ◆ Code of Ethics: record and report in an accurate and timely manner (AOTA, 2015)

Credentialing Agency: NBCOT

- ◆ Code of Conduct: accurate, truthful, and complete (NBCOT, 2015)
- ◆ Post-nominal initials: must maintain credentialing with NBCOT to use OTR (occupational therapist *registered*) or COTA (*certified* occupational therapy assistant) initials

State-Federal Level

Entitlement Program: School Based Child Health and Medicaid

- ◆ Districts may opt to pursue Medicaid funding for Medicaid-eligible children receiving school health services listed in an IEP. Parent consent is required along with documentation to submit claims.
- ◆ District must maintain a permanent service record (paper or electronic format).
- ◆ Documentation often includes the following service information: dates, units of time, provider, service type, setting, description, and monthly progress summaries, along with a signature of the qualified health care provider performing the service.
- ◆ Retention of all records must be maintained for a minimum of six years (Connecticut Department of Social Services, 2015).

State Level

CT State Department of Education: Bureau of Special Education

- ◆ Provide IEP Manual and Forms “to help insure compliance with the statutory requirements of IDEA and State law.” (CT SDE:BSE, 2015)
- ◆ Establishes guidelines for occupational therapy services in educational settings.

State Library: Education Records

- ◆ Establish retention disposition schedules for education records.

Professional Licensure: Department of Public Health

- ◆ Post-nominal initials: must maintain licensing with DPH to maintain practice and use OT/L (occupational therapist/*licensed*) or OTA/L (occupational therapy assistant/*licensed*) initials

District Level

Policies, procedures, & practices

- ◆ Establish policies, procedures, and/or practices for documentation (e.g., formats, dissemination, compliance, confidentiality, tips, and storage)
- ◆ May use web-based software or an electronic system for documentation
- ◆ Formally support time requirements, provide access to technology, and identify supervision or peer review practices for documentation

School Level

Practices

- ◆ Dependent on the mission, organizational structure, or operations of the school or educational program, documentation practices, flow of information, site-specific terminology, or focus may vary
 - ◆ Dependent on experience of team(s) and collaborative skills sets, documentation practices may vary
 - ◆ Dependent on philosophy and history of therapy services, variations along the continuum of the educational model may exist and influence documentation content
-

Provider Level

Knowledge, skills, & values

- ◆ Dependent on practitioner's specialized knowledge and practice in school therapy services, variations may exist in documentation of critical reasoning
- ◆ Dependent on written communication skills and practices, variation may exist in writing styles

Therapy Specific Documentation

Listed in this section are common types of occupational therapy reports in the school setting. This should not be considered an exhaustive list but rather a guide for meeting specific documentation needs.

Screening

Distinct levels of screening exist and require different considerations when documenting.

Universal Screening. This service may be requested as part of a district's adopted procedures or Connecticut's SRBI tiered system. Occupational therapists may fully conduct or participate in some aspect of district, school, grade, class, or small group screenings (e.g., developmental screenings for preschoolers, handwriting screenings for kindergartners, ecological screenings of classrooms, screenings of group routines). Screening outcomes might include the identification of students who are struggling and need additional instruction, practice, or support; recommendations for professional development; or ideas for modifying classroom environments or routines to facilitate student learning and participation. In this capacity, the occupational therapist's expertise can be accessed to guide the educator or team in selecting a universal, school-wide, classroom, and/or small group strategy to promote inclusive practices. Under the Protection of Pupil Rights Amendment (20 USC § 1232h; 34 CFR Part 98), districts are required to notify parents of universal screenings and offer them an opportunity ahead of time to opt out (i.e., remove their child) from participation. Obtaining district agreement in the universal screening tool and procedure that will be used to gather and record relevant information will be critical.

For more information specific to occupational therapy services and SRBI, please see the [CSDE](#) web site and/or the [AOTA](#) web site.

Individual Screening. An occupational therapy screening may be requested to capture a closer look at an individual student's performance and participation in comparison to classroom peers.

The following outcomes may result from an individual screening:

- Focused instructional strategies, program accommodations, and/or data collection methods to be considered by the classroom teacher, special educator, other faculty or staff, and/or parents.
- Recommendations to the educational team for a follow-up screening (e.g., check in on a quarterly basis). This might be helpful for those students who receive clinic

based therapy services for rehabilitation or habilitation but do not demonstrate educational concerns or needs in the context of their school setting.

- Recommendations to the educational team for a formal occupational therapy evaluation or another service to help identify those areas that facilitate or inhibit student participation and/or access to learning and school activities.

As defined by IDEA (2004) a screening would not be used for determining special education eligibility or related services. As best practice, parent(s) should be notified of this special request and given the opportunity to decline this service.

An individual screening may consist of a file review, student work review, interview with teacher and/or parent, and observation of student in context of the school day in the area of difficulty. No assessment measures or tools would be individually administered at the screening level.

Suggested content

1. General information: name, date of birth, district, school
2. Referral information: date of report, service provider's name, reason for referral, questions to answer through screening
3. Sources of information: file review, student work review, interview with teacher, observation of student in context of school day
4. Performance area: brief observation summary
5. Impressions and recommendations for team to consider: clinical reasoning regarding focused instructional strategies, program accommodations, and/or data collection methods to document progress—all to be carried out by another educational provider and/or need for formal occupational therapy evaluation
6. Therapy provider: name and credentials

Evaluation/Re-evaluation

An occupational therapy evaluation may be requested as part of (a) an initial special education eligibility evaluation, (b) a diagnostic placement, (c) once the child is determined a child with an educational disability under IDEA, or (d) when determining whether a child remains a child with an educational disability and requires occupational therapy services to benefit from special education.

The occupational therapist evaluates areas of need in which he or she is qualified to gather information regarding a child's ability to participate in and gain access to the general education curriculum in various contexts throughout the day. The intent is to evaluate a child in all areas of a suspected disability using relevant assessment tools and observing the student in the area of difficulty. Information gathered would help the team identify the child's present level of performance including those areas that facilitate or restrict learning and participation.

For more information specific to evaluations, please refer to *Section Four: Evaluation* in this document.

Suggested content

1. General information: student name, date of birth, district, school
2. Referral information: date of report, service provider's name, reason for referral, questions to answer through evaluation
3. Student and therapy profile: brief statement about history of services; student perspective of his or her performance or participation; school, classroom, grade, or curriculum expectations that are challenging or meaningful to note
4. Sources of information: file review, student work review, interview with teacher, observation of student in context of school day, assessment tools and measures administered
5. Occupational performance: direct observations; results from school-related performance tests and tools; changes in student performance with trialed environmental adaptations, modifications, or equipment
6. Learning and participation implications: synthesized data collected and description of potential impact on student learning and/or participation in school activities, critical reasoning related to the student's educational needs
7. Preliminary recommendations to the team: educational needs and concerns revealed through the evaluation, discussion points for determining needed accommodations, modifications, or support so child can benefit from his or her special education program
8. Therapy provider: name and credentials

IEP

Therapy practitioners contribute, in collaboration with a student's educational team, to the development of an IEP. As the team develops a student's IEP, practitioners need to be mindful that educational goals and objectives would be discipline-free (e.g., focused on educational outcomes versus therapeutic outcomes). After all, there is only one IEP for each child not an IEP for each related service. The IEP should not be confused with an Intervention Plan.

For more information specific to IEPs, please refer to *Section Two: Laws and Policies* in this document.

Intervention Plan

An intervention plan is a helpful tool for focusing the approaches and direction of the course of therapy services. When applicable, the plan can be used to collaborate with the occupational therapy assistant. It should not be confused with an IEP. While the educational team develops an IEP, the occupational therapist develops an intervention plan, which outlines therapeutic goals and objectives. The plan can be modified based on student progress and anticipation of meeting the IEP goals and objectives. In collaboration with the occupational therapist, the assistant can modify the intervention plan. The plan would become part of the therapist's working folder.

Suggested content

1. General information: student name, date of birth, school, service provider, precautions or contraindications, date of document and review dates
2. Student information: presenting concerns and what the student wants or needs to do (e.g., IEP goals and objectives in brief form)
3. Intervention: baseline of student performance, intervention approaches (e.g., establish, restore, alter, adapt, modify, prevent, or create)
4. Service model: individual, integrated, group, consult, or other
5. Additional information: data collection method, follow-up activities, or compliance tasks
6. Plan for discontinuation: outline points for discussion with educational team to help determine when to discontinue therapy services
7. Therapy provider: name and credentials

Service Contact Notes

Service contact notes serve as personal memory aids to the person writing the note.

Therapy practitioners “may maintain personal notes on students separate from the official student record as a personal memory aid when the following conditions are met:

- the notes are in the sole possession of the practitioner; and
- the notes are not accessible nor the content revealed to any other person.

If the content of the notes is discussed with others, the notes lose their “sole possession” status and they become part of the student’s permanent record. As with all confidential materials, personal notes should be kept in a secure location.” (Connecticut State Department of Education, 2013, p. 11).

Suggested content

1. General information: student name, date of birth, school, teacher, year, IEP’d service frequency and model, IEP goals and objectives in brief form
2. Notes: date, skilled intervention or activity (e.g., training, phone call, meeting), outcomes

Progress Summary

IDEA (2004) identifies that the IEP must include “a description of when periodic reports on the child’s progress toward meeting the annual goals will be provided” (Section 300.320(a)(3)(ii) 614(d)(1)(A)(i)(III)). In Connecticut, the IEP document may allow sufficient space to briefly summarize the student’s progress on goals and objectives, as well as involvement and progress in the general education curriculum (or preschool activities). Some districts and schools may require a formal progress summary to supplement the IEP summary.

Suggested content

1. General information: student name, date of birth, district, school
2. Summary of services provided: frequency and duration; interventions and strategies used; measurable progress; environmental or task modifications; adaptive

equipment or orthotics; pertinent updates; trainings provided to student, staff, or family

3. Recommendations to the team: student strengths (those areas that facilitate participation) and student needs/concerns (those areas that may restrict or inhibit full participation)

Transition Plan

Students, throughout their school career, may transition from programs, schools, grade levels, service providers, and more. In many instances there are formal practices in place to ensure a smooth transition (e.g., updated IEP, summary of performance plan, entry level IEP meeting summary).

Transition goals and objectives at age 15 years. When a student is bridging from school to adulthood, the educational team will draft a summary of performance as part of a transition plan. The occupational therapy practitioner can assist in the content required for this document.

Please see the [Connecticut's Summary of Performance](#) document for more specific information.

Transition to another practitioner. On occasion, a child may transition and benefit from having additional information shared with the next service provider. A transition plan summary may assist with this process to relay pertinent information for therapy programming.

Suggested content

1. General information: student name, date of birth, originating school and district, date
2. Summary of services: service frequency and location, equipment, special concerns, abilities, intervention ideas, plans for future (if known), pertinent information
3. Therapy provider: name and credentials

Discontinuation Plan

As student's exit from therapy services, summarizing the points that the educational team considered when making such a decision is beneficial to document. This provides a timeline of services and decision-making during the course of a student's schooling. At times, the summary points will be sufficiently outlined in the IEP minutes. On other occasions, a discontinuation plan may be required to supplement the IEP summary and provide a record of change and rationale for that change.

Suggested content

1. General information: student name, date of birth, school, LEA, date.
2. Summary of services: student's present level of performance, strategies, modifications, and accommodations that optimize student learning and participation.
3. Points for the team to consider, for example:
 - a. Goals & objectives requiring therapy have been met. No additional goals requiring therapy services appear to exist.
 - b. Problem ceases to be educationally relevant.
 - c. The student's needs can be met by another educational provider and therapy services are no longer required.

Other Documents

In managing occupational therapy services, districts, schools, or practitioners may already have or look to create documentation forms that are not addressed in the above list. These forms may meet the need for documenting compliance activities (e.g., supervision, parent communication, training logs, 3rd party billing) or other activity. When developing forms, key questions to ponder include the following:

- Is it needed?
- Where will the document be kept?
- Who will the document belong to?
- Should the form be vetted?
- Will the form duplicate processes already in place?
- In using the form, will a reduction in paperwork result?
- What techniques can be applied to decrease time spent on paperwork?

Legal, Professional, and Administrative Considerations

Legal Liability

Education/Special Education Records. Documents within a student's education record must be able to endure a legal review. Special education records often include IEP documentation, three-year evaluation reports, and essential compliance documents. As a member of the IEP team, occupational therapy practitioners must know what information is necessary to include in IEP documentation (e.g., present level of performance, services on behalf of the student, accommodations and modifications, educational goals and objectives, progress reporting, related service summary). The purpose of knowing this information is so practitioners can help in the development of the IEP document. Practitioners also need to know that prior to conducting an evaluation, the school district must obtain written consent of parents for the evaluation procedures recommended. This written consent document would become part of the student's special education record.

For more information specific to IEPs, please see the CSDE's Bureau of Special Education [IEP Manual and Forms](#) and [The IEP Guide Page by Page](#).

Confidentiality. In compliance with FERPA, HIPPA, professional standards, and school/district policies, practitioners must put practices in place to adhere to privacy and security standards to protect confidential student information (i.e., written and electronic).

Records Retention. Schools/districts should have policies and procedures in place for records retention. Some may specifically outline procedures regarding testing protocols (e.g., immediately destroying test protocols upon the transfer of relevant information into a comprehensive report summary). The occupational therapist will need to know and adhere to the district's records retention policies and procedures.

For more information specific to Connecticut's Records Retention Schedule, please see [Connecticut's State Library web site](#).

For more information specific to Connecticut's School Based Child Health and Medicaid documentation retention requirements, please see [Connecticut's Department of Social Services](#) web site.

Professional Practices

While documentation can be viewed as a barrier to getting work done (Yamkovenko, 2014), it is invaluable as practitioners record their clinical reasoning, identify potential concerns and needs, plan interventions, communicate with other members of the team, log student outcomes, and provide evidence of compliance. Putting forth practices that promote quality documentation, stimulate a continuum of learning and up to date knowledge, and incorporate security measures is best.

Quality of Documentation. The following points are posed for practitioners to consider as they aim to improve the quality of their documentation:

- Maintain a mindset that all documentation (i.e., formal and informal) is professional communication.
- Aspire to represent the value of the occupational therapy profession in communications and the unique lens that the practitioner brings to the team.
- Use documentation to inform, explain, and/or clarify the critical reasoning of the practitioner to build understandings and new insights of the situation being discussed.
- Base practice on best evidence available in communications to build credibility, meaningful contributions, and realized outcomes.
- Align documentation with the laws and regulatory bodies that guide school therapy practice to support an educational focus.
- Develop a process for peer review of reports to stimulate professional dialogue, improve communications, and generate new knowledge.

Privacy and Security. In compliance with FERPA, HIPPA, and other privacy laws, practitioners need to use due diligence to keep documentation (i.e., paper and electronic) private and secure. Key points to consider include, but are not limited to:

- Is documentation kept in a secure area?
- Who has access to the documentation?
- Is personally identifiable information secure from public viewing (e.g., schedules, notice board)?
- What data is supplied?
- For electronic documentation, is data encrypted in transit and at rest?
- Do you know who the district's Privacy and Security Officers are for establishing site-specific procedures?

Parent Friendly. While this subheading is titled parent friendly, practitioners should be mindful that every member on the educational team comes from a different discipline and therefore has his or her own set of professional terminology (Rioux, 2012). Each member of the educational team needs to not only talk about and share their areas of expertise, but also translate their profession-specific language so others can understand and support the child. School therapy practitioners are no different and must become skilled in translating the many languages associated with their profession (e.g., medical, theoretical, and professional jargon).

Key points to consider for adopting parent friendly terminology:

- Instead of using acronyms, write out the words (e.g., occupational therapy versus OT)
- Term educational goals based on skills addressed versus the discipline responsible for addressing the goals (e.g., fine motor goals versus occupational therapy goals)
- Adjust and/or translate your profession-specific language so others can understand your message.
- Be cautious about writing in a textbook or explanatory style. This style can disrupt the communication process, hide essential information, and baffle others.
- When possible, embed photographs or scans of student work to relay student outcomes (e.g., grasp before and after intervention) versus writing long narratives to describe change.
- When quantitative data can sufficiently describe change in student outcomes, collect and report those figures.
- When qualitative data can sufficiently describe change in student outcomes, organize data by themes and when possible use bullet points or a table to organize information.

Administrative Considerations

School practitioners and administrators should work together to ensure adequate time, training, equipment, materials, and space exist to complete documentation requirements.

Key points for discussion include, but are not limited to:

- a. Time for documentation requirements (e.g., report writing, parent communications, 3rd party billing, and so on)
- b. Access to working technology, information systems, and supports (e.g., computer, Internet access, printer, electronic IEP systems, and tech support)
- c. Training for electronic management systems (e.g., IEP or Medicaid)

- d. Materials and supplies (e.g., paper, files, locked storage system)
- e. Support for peer review of documentation
- f. Site-specific policies and procedures for documentation

References

- American Occupational Therapy Association (2013). Guidelines for documentation of occupational therapy. *American Journal of Occupational Therapy*, 67(6), S32-S38.
- American Occupational Therapy Association. (in press). Occupational therapy code of ethics (2015). *American Journal of Occupational Therapy*, 69(Suppl. 3)
- American Speech-Language-Hearing Association. (2002). A workload analysis approach for establishing case-load standards in the schools. Guidelines. ASHA Desk Reference (vol. 3). Rockville, MD: Author.
- Americans With Disabilities Amendments Act of 2008, Pub. L. No. 110-325, 42 USC § 12101 (2008).
- Connecticut Department of Social Services. (2015). [Medicaid school based child health program](#). Retrieved on October 20, 2015.
- Connecticut State Department of Education. (2013). [Practice guidelines for delivery of school social work services](#). Retrieved on October 20, 2015.
- Connecticut State Department of Education: Bureau of Special Education (2015). [IEP Manual and Forms](#). Retrieved on October 20, 2015.
- Family Educational Rights and Privacy Act of 1974, 20 U.S.C. § 1232g (1974).
- Health Insurance Portability and Accountability Act of 1996, Pub. L. 114-38, 42 USC § 300gg (1996).
- Individuals with Disabilities Education Improvement Act of 2004, Pub. L. No. 108-446, 20 U.S.C. § 1400 *et seq* (2004).
- National Board for Certification in Occupational Therapy. (2015). [Practice standards/Code of conduct](#). Retrieved on October 20, 2015.
- Protection of Pupil Rights Amendment of 1978, 20 USC § 1232h (1978).
- Rioux, J. (2012). School system occupational therapists: Using language in everyday practice. *Proquest, UMI Dissertations Publishing*, 3507413.
- Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794. (2008).

Yamkovenko, S. (2014). [How to be more effective with documentation: Q&A with Cathy Brennan](#). Retrieved on October 17, 2015.

ADMINISTRATION

Section 7

Learning Objectives

Readers will gain a better understanding of:

- Considerations for employment;
- Supervision of Occupational Therapy Personnel;
- Medicaid Reimbursement: School system Occupational Therapy Services; and
- Workload versus Caseload Considerations

Traditional Employment vs. Contract Staff

Districts have two distinct options to fulfill coverage needs for occupational therapy services. In determining best fit, they should take the time to understand those options and the possibilities within those options of traditional employment and contract staff.

Traditional Employment

Refers to a therapy practitioner employed by the district for a specific duration with set hours, which can be full time with benefits or part time with reduced benefits. In the case of traditional employment, the district is responsible for recruitment, verification of license/credentials, and liability of the practitioner. In addition, the district maintains responsibility for providing adequate assessments tools, materials, supplies, and equipment in order for therapy services to be adequately provided.

Being a *contract* employee (or having an employment contract) should not be confused with being an independent *contractor*. A contract employee is *an employee* who works under contract—a contract quite often generated by the district that outlines condition(s) of employment. Conditions might define that the practitioner will maintain their professional certification through NBCOT and licensure through the Connecticut Department of Health, as well as meet legal and professional practice standards. Districts and practitioners should consult IRS definitions to understand the distinct difference between an employee working under contract versus an independent contractor.

Independent Contractor

The district may enter into a contractual agreement with a business entity (e.g., a private practitioner, agency, corporation). When contracting with (or purchasing services from) an independent contractor, the terms of the contract or agreement typically generated by the business entity would be mutually determined.

A contract for services typically outlines the service to be provided, the hours required, and

the predetermined rate for reimbursement (e.g., hourly, daily, or service specific amount). It is recommended that the attorney for the district and appropriate administration review the contract prior to final approval. Understanding the services being purchased is important to the district's flow of operations. Important points to consider:

- Will the district be provided with a therapy practitioner that possesses and maintains specialty knowledge in school system practice?
- What type of supervision will the therapy practitioner receive from the business entity?
- Who will ensure compliance with state and professional practice standards, as well as background verification?
- What resources (e.g., current assessment tools, equipment, supplies) will the therapy practitioner have at their disposal through the business entity?
- What will happen in the event of a practitioner's leave of absence?

Some agencies provide a package of services while others make a match of personnel. A package of services may include additional supports, such as independent educational evaluations, consultation services for problem solving, and specialty workshops or trainings for district staff.

Lastly, districts that enter into a contractual agreement with a *private practitioner* are strongly recommended to review Connecticut's Independent Contractor Classification to determine whether practitioners meet such eligibility requirements. Districts are responsible to the following regulatory bodies regarding the classification of a worker: IRS, Department of Labor, State Unemployment, Workers Compensation Insurance Agency, State Tax Departments and the National Labor Relations Boards.

For more information specific to Connecticut's Independent Contractor Classification, please see the [Connecticut Department of Labor](#) web site.

Supervision of Occupational Therapy Personnel

The information below has been adapted for the State of Connecticut using the *Model State Regulation for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Service* template adopted by the American Occupational Therapy, Representative Assembly 2005, (RA Charge 2005C181). This template is identified by AOTA to be used by state agencies and occupational therapy regulatory boards when drafting or revising regulations to govern the clinical supervision of occupational therapy assistants, limited permit holders, and paraeducators. The model is intended to help safeguard the public health, safety and welfare by establishing guidelines that are consistent with professional standards and accepted practice in the profession.

Definitions

In this section, the following terms have the meanings indicated.

Paraeducator: a person who is not licensed by the Board and who provides supportive services to occupational therapists and occupational therapy assistants. A paraeducator shall function under the guidance and responsibility of the occupational therapist and may be supervised by the occupational therapist or an occupational therapy assistant for specifically selected routine tasks for which the paraeducator has been trained and has demonstrated competency.

Board: means the State of Connecticut Department of Public Health.

Competence: refers to an individual's capacity to perform job responsibilities.

Competency: refers to an individual's actual performance in a specific situation.

Limited permit holder: means an individual who has completed the academic and fieldwork requirements of this Act for occupational therapists or occupational therapy assistants, has not yet taken or received the results of the entry level certification examination, and has applied for and been granted limited permit status.

Occupational therapist: an occupational therapist that is licensed by the State of Connecticut.

Occupational therapy assistant: means an occupational therapy assistant who is licensed by the Board to provide occupational therapy services under the supervision of and in partnership with a licensed occupational therapist.

Supervision: means a cooperative process in which two or more people participate in a joint effort to establish, maintain, and/or elevate a level of competence and performance. Within the scope of occupational therapy practice, supervision is aimed at ensuring the safe and effective delivery of occupational therapy services and fostering professional competence and development.

Scope of Occupational Therapy Assistant's License

In general - An occupational therapy assistant's license authorizes the licensee to provide occupational therapy services under the supervision of and in partnership with a licensed occupational therapist.

Supervision required - A licensed occupational therapy assistant must practice only under the supervision of an occupational therapist that is authorized to practice occupational therapy in the State of Connecticut.

Supervision of Occupational Therapy Assistants

- Supervision involves guidance and oversight related to the delivery of occupational therapy services and the facilitation of professional growth and competence. It is the responsibility of the occupational therapist and the occupational therapy assistant to

seek the appropriate quality and frequency of supervision to ensure safe and effective occupational therapy service delivery.

- The specific frequency, methods, and content of supervision may vary and are dependent upon the complexity of client needs, number and diversity of clients, skills of the occupational therapist and the occupational therapy assistant, type of practice setting, requirements of the practice setting, and other regulatory requirements.
- More frequent supervision may be necessary when: the needs of the client and the occupational therapy process are complex and changing, the practice setting provides occupational therapy services to a large number of clients with diverse needs, or the occupational therapist and occupational therapy assistant determine that additional supervision is necessary to ensure safe and effective delivery of occupational therapy services.
- A variety of types and methods of supervision may be used. Methods may include direct face-to-face contact and indirect contact. Examples of methods or types of supervision that involve direct face-to-face contact include but are not limited to observation, modeling, co-treatment, discussions, teaching, instruction, and video conferencing. Examples of methods or types of supervision that involve indirect contact include but are not limited to phone conversations, written correspondence, electronic exchanges, and other methods using secure telecommunication technology. All methods should be compliant with confidentiality requirements of government agencies, facilities, employers, or other appropriate bodies.
- Occupational therapists and occupational therapy assistants must document a supervision plan and supervision contacts. Documentation should include frequency of supervisory contact, method(s) or type(s) of supervision; content areas addressed; and names and credentials of the persons participating in the supervisory process.

Supervision of a Limited Permit Holder

An occupational therapist limited permit holder or occupational therapy assistant limited permit holder who has not yet taken or received the results of the entry-level certification examination shall practice under the supervision of an occupational therapist. It is the responsibility of the supervising occupational therapist to provide and the limited permit holder to seek the appropriate quality and frequency of supervision to ensure safe and effective occupational therapy service delivery.

Roles of the OT and OTA

Information within this section was gathered and adapted from the AOTA Standards of Practice (2010), Occupational Therapy Performance Frameworks (2014), AOTA Code of Ethics (2014), AOTA Guidelines for Supervision, Roles, and Responsibilities (2014) and Best Practices for Occupational Therapy in Schools (2014).

	OT	OTA*
Responsibilities		
Occupational Therapy Practice	<ul style="list-style-type: none"> • Graduated from an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) or predecessor organizations • Successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapists that is accredited by ACOTE or predecessor organizations • Passed a nationally recognized entry-level examination for occupational therapists • Fulfills state requirements for licensure, certification, or registration 	<ul style="list-style-type: none"> • Graduated from an occupational therapy assistant program accredited by the Accreditation Council for Occupational Therapy Education (ACOTA) or predecessor organizations • Successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapy assistants that is accredited by ACOTA or predecessor organizations • Passed a nationally recognized entry-level examination for occupational therapy assistants • Fulfills state requirements for licensure, certification, or registration

Responsibilities OT

• OTA*

- Screening**
- Complete file review, observation, gather student work samples, and interview team/teacher
 - If applicable, collaborate with Occupational Therapy Assistant
 - Report recommendations and impressions to the team/teacher relative to universal, school wide, and classroom strategies

- After demonstrating skill competency, as determined by the Occupational Therapist, may complete file review, observation, and gather student work samples
- Report findings to Occupational Therapist

Referral (for Occupational Therapy evaluation)

- Initial IDEA and 504 referral: May be part of the evaluation team to provide data on student participation and learning
- Using clinical reasoning, the Occupational Therapist considers educational data, parental concerns, and challenges related to student performance to determine if a formal Occupational Therapy evaluation is required
- Identifies and selects appropriate and relevant assessment tools

- The OTA is not involved in the referral process

Evaluation

- Responsible for the evaluation process
- Administer, score, and interpret assessments
- Interpret the information provided by the Occupational Therapy Assistant and integrate that information in the evaluation and decision-making process
- Provides input to the team as to whether the child requires Occupational Therapy to benefit from or access to his/her educational program

- After demonstrating skill competency, as determined by the Occupational Therapist, may complete file review, observation, administer and score select portions of standardized assessments, gather student work samples
- Report findings to Occupational Therapist

Responsibilities • OT

• OTA*

PPT and IEP Meetings	<ul style="list-style-type: none">• Serves as a member of the PPT for student's requiring occupational therapy• As a member of the PPT, needs to be invited to IEP meetings specifically when knowledge or special expertise of the student pertaining to occupational therapy is discussed	<ul style="list-style-type: none">• In collaboration with and at the discretion of the Occupational Therapist may serve as a member of the PPT for student's receiving occupational therapy implemented by the assistant• Parents may request the presence and participation of the occupational therapy assistant• Cannot determine consideration/plan for any occupational therapy screen or evaluation without Occupational Therapist direct involvement
Intervention	<ul style="list-style-type: none">• Determines specific service delivery model and intervention approach based on selected theories, frames of reference, and evidence• Provide intervention and review progress towards targeted outcomes• If applicable, monitor and collaborate with Occupational Therapy Assistant	<ul style="list-style-type: none">• Carries out the intervention plan, in collaboration with Occupational Therapist
Outcomes	<ul style="list-style-type: none">• Report progress, verbally and/or written, at least annually or as determined by the IEP or 504 Plan	<ul style="list-style-type: none">• In collaboration with Occupational Therapist, report progress, verbally and/or written, at least annually or as determined by the IEP or 504 Plan
Discontinuation	<ul style="list-style-type: none">• Recommends, to the team, whether discontinuation of services is warranted	<ul style="list-style-type: none">• In collaboration with the Occupational Therapist, recommends, to the team, whether discontinuation of services is warranted
Supervision	<ul style="list-style-type: none">• After minimum of one year in school system practice, may supervise Level I and II Occupational Therapy and Occupational Therapy Assistant Students at all levels	<ul style="list-style-type: none">• After a minimum of one year in school system practice, may supervise Level I and II Occupational Therapy Assistant Students, as well as Level I Occupational Therapy Students• May supervise Occupational Therapy Paraeducators

Responsibilities • OT

Documentation

- Review and sign all formal documentation completed by Occupational Therapy Assistant
- Record Occupational Therapy Assistant supervision
- Provide formal documentation to be reviewed and signed by supervising Occupational Therapist
- Participate in recording of supervision with Occupational Therapist

• OTA*

Note: The term *occupational therapist* used in the column describing the occupational therapy assistant's role means the occupational therapist that *directly supervises* the occupational therapy assistant. In each instance, the supervising occupational therapist has a level of responsibility for those services provided by the occupational therapy assistant.

Supervision of Paraeducators in Occupational Therapy

A paraeducator, as used in occupational therapy practice, is an individual who provides supportive services to the occupational therapist and the occupational therapy assistant.

Occupational Therapy Paraeducators are not primary service providers of occupational therapy, therefore cannot support OT hours on an IEP. Therefore, paraeducators do not provide skilled occupational therapy services.

A paraeducator is trained by an occupational therapist or an occupational therapy assistant to perform specifically delegated tasks that may include collecting data, implementing a maintenance program, taking inventory, assuring overall upkeep and quality of equipment as well as the environment. The occupational therapist is responsible for the overall use and actions of the paraeducator.

A paraeducator first must demonstrate competency to be able to perform the assigned, delegated client and non-client- related tasks.

The occupational therapist must oversee the development, documentation, and implementation of a plan to supervise and routinely assess the ability of the occupational therapy paraeducator to carry out client and non-client-related tasks. The occupational therapy assistant may contribute to the development and documentation of this plan.

- The occupational therapy assistant may supervise the paraeducator.
- Non-client-related tasks include clerical and maintenance activities and preparation of the work area or equipment.
- Client-related tasks are routine tasks during which the paraeducator may interact with the client but does not act as a primary service provider of occupational therapy services. The following factors must be present when an occupational therapist or occupational therapy assistant delegates a selected client-related task to the paraeducator:
 - The outcome anticipated for the delegated task is predictable
 - The situation of the client and the environment is stable and will not require that judgment, interpretations, or adaptations be made by the paraeducator
 - The client has demonstrated some previous performance ability in executing the task
 - The task routine and process have been clearly established
- When performing delegated client-related tasks, the supervisor must ensure that the paraeducator is trained and able to demonstrate competency in carrying out the selected task and using equipment, if appropriate, has been instructed on how to specifically carry out the delegated task with the specific client, and knows the precautions, signs, and symptoms for the particular client that would indicate the need to seek assistance from the occupational therapist or occupational therapy assistant.
- The supervision of the paraeducator must be documented and include information about frequency and methods of supervision used, the content of

supervision, and the names and credentials of all persons participating in the supervisory process.

Coercion Prohibited

No person(s) shall coerce an occupational therapist or occupational therapy assistant into compromising client safety by requiring them to delegate activities or tasks when the occupational therapist or occupational therapy assistant determines that it is inappropriate to do so. Occupational therapists or occupational therapy assistants shall not be subject to disciplinary action by the Board for refusing to delegate or refusing to provide the required training for delegation when the occupational therapist or occupational therapy assistant determines that delegation may compromise client safety.

Medicaid Reimbursement: School Occupational Therapy

Medicaid is a joint state-federal program (Department of Social Services (DSS), no date, para 2). “Since 1988, Medicaid has been required to pay for certain IDEA services that are both educationally related and also medically necessary services under Medicaid” (AOTA, no date, para 1).

School occupational therapy services provided under the IDEA 2004 may be deemed medically necessary under criteria set by the state Medicaid agency and the state educational agency in an interagency agreement and would, therefore, be covered under Medicaid (AOTA, no date, para 2). The interagency agreement also details how school districts can seek reimbursement, including conditions and terms of reimbursement (AOTA, no date, para 9).

In Connecticut, the DSS is the state Medicaid agency. The DSS administers the Medicaid School Based Child Health Program, “the mechanism by which a school district may seek federal Medicaid reimbursement for many of the Medicaid covered services that are provided to an eligible student pursuant to the student's IEP” (DSS, no date, para 2). School occupational therapy is covered under Medicaid in Connecticut. Practitioners, therefore, may be involved in their school district's Medicaid billing. The focus of Medicaid on medically oriented therapy goals, rather than educational goals, however, could create some confusion. Seeking Medicaid reimbursement for school occupational therapy services does not require practitioners to use a medically-based model; practitioners should continue to provide school services and design IEP goals and objectives appropriate for school practice.

For more information on Medicaid reimbursement in Connecticut, please visit the DSS web site, [Medicaid School Based Child Health Program](#).

Medicaid Resources

<p>Federal Medicaid and School Health</p>	<p>http://www.medicaid.gov</p>	<p>A federal managed website regarding the broad guidelines set for Medicaid and school health</p>
<p>National AOTA Medicaid School system Billing FAQs</p>	<p>http://www.coconsortium.org/sites/default/files/AOTA%20Medicaid%20Schoolsystem%20Billing%20FAQs.pdf</p>	<p>The American Occupational Therapy Association's support for answering frequently asked questions pertaining to Medicaid school based billing</p>
<p>State Medicaid School Based Child Health Program</p>	<p>http://www.ct.gov/dss/cwp/view.asp?a=2349&q=526930</p>	<p>In Connecticut, the School Based Child Health Medicaid program (SBCH) is the mechanism by which a Local Educational Agency (LEA) may seek Medicaid reimbursement for Medicaid-related health-care services when provided to an eligible student pursuant to that student's Individualized Education Program (IEP). SBCH also provides a means for LEAs to seek federal reimbursement for expenditures related to administrative activities that are included in the SBCH provider agreement and are related to the state's Medicaid program.</p>
<p>School Based Child Health Parental Consent</p>	<p>http://www.ct.gov/dss/cwp/view.asp?a=2349&q=528684</p>	<p>American Speech and Hearing Association support for understanding Medicaid and 3rd party payments</p>
<p>Other Resources Medicaid and Third Party Payments in the Schools</p>	<p>http://www.asha.org/practice/reimbursement/medicaid/thirdparty-payment/</p>	<p>American Speech and Hearing Association support for understanding Medicaid and 3rd party payments</p>

Workload Versus Caseload

The role of the school therapy practitioner has expanded over the years, which has resulted in an increased demand of time. As discussed earlier, occupational therapists provide a multi-level system of supports (e.g., individual student, classroom, school, and district wide). These supports can range from providing evaluations and interventions at the individual student level, engaging in SRBI at the group or classroom level, delivering trainings and professional development for school staff, and assisting with kindergarten screenings or preschool evaluation teams. This broadening of service has blurred the manner in which workload determinations can be calculated. Basing staffing decisions based only on IEP direct services is no longer reasonable. At present, no specific guidelines exist that clearly delineate what constitutes a reasonable caseload; however, there are several resources that recognize that the more traditional concept of assigning a *caseload* does not fully recognize the potential contribution an occupational therapist can make (AOTA, 2006). Applying a workload approach better ensures compliance with IDEA (2004) requirements, as well as state and local mandates to support all students in the least restrictive environment (LRE) and facilitate participation in the general education curriculum.

According to the AOTA, the concept of workload encompasses all of the work activities therapists perform that benefit the student directly and indirectly, including activities geared toward groups of students, whole classrooms, or school wide populations (AOTA, 2006). “Caseload refers only to the number of children seen by occupational therapy in special education as part of their IEP” (AOTA, 2006). Furthermore, a traditional caseload *counting* approach does not fully appreciate the complexity of the occupational therapists role in current best-practice scenarios.

While coverage needs often vary between schools and districts, taking into account not only direct services but also indirect services, indirect activities associated with those services, and compliance activities for adhering to laws and regulations is important (see the *Section: Documentation* for a figure depicting workload clusters adapted from ASHA). The following services and activities should be considered when determining a reasonable workload and full time equivalency (FTE) calculations.

Direct Service:

Required to implement IEP service with student

- Observations
- Screenings
- Evaluations
- Interventions

Indirect Services:

Required to implement IEP

- Collaboration and consultation with team members
- Committee work (e.g., curriculum development)
- Conferencing with parents/guardians and/or staff
- Coordinating with community providers
- IEP Development
- Intervention planning
- Ordering equipment/materials
- Parent training and information sharing
- Providing staff development
- Attending team meetings

Indirect Activities:

Required to promote LRE & participation in general education

- Pre-referral team/strategies
- Adapting task demands
- Modifying environments
- Preventing anticipated problems
- Altering context to support student
- Creating opportunities
- Involvement in general education initiative/school teams (e.g., SRBI)

Compliance Activities:

Required to adhere to laws and regulations

- Copying reports for parents in preparation for IEP meetings
- Data Collections
- Documentation
- Maintaining supplies and equipment
- Medicaid documentation
- Being mentored
- Trainings and professional development
- Scheduling
- School wide jobs/duties (i.e. bus duty, lunch duty)
- Supervision of occupational therapy assistants and/or occupational therapy interns
- Travel between schools/sites

Other:

Required to sustain productivity & energy levels throughout the day

- Breaks
- Lunch

In addition to the services and activities listed above, other factors that should be taken into consideration:

- Students' primary disabilities and resulting severity
- Volume of consultations and evaluations requested and/or anticipated
- Service delivery model(s) utilized (e.g., high utilization of indirect time)
- Referral rate for evaluations
- Support staff available to assist the practitioner in carrying over individualized programs (e.g., paraeducator) and training time required

In order to determine how a therapy practitioner's time is spent, and, in turn, how to establish staffing needs, time studies that closely examine the various roles and responsibilities required of the occupational therapy practitioner will help to delineate the percentage of time spent on each activity. Quite often, capturing a typical schedule for the week will provide insight into variable activities, such as screenings, evaluations, and meetings. In addition, maintaining and frequently updating an explicit caseload list that includes: student names, service hours (direct and indirect), service location, anticipated PPT dates, and pending assessments will be important.

While there is not a tried and true method and/or formula for determining caseloads, the following is a discussion of some of the recommendations based on literature studies and common practices.

Workload Determination	Components
Caseload Estimate	<ul style="list-style-type: none"> • Reflects flexibility to meet day to day demands • Result of occupational therapist and administration collaboratively planning needs
Calculation Estimate	<ul style="list-style-type: none"> • Formula applied based on direct contact hours, severity of student needs, evaluation load, number of sites, and level of responsibilities (very minimal to very extensive) • Formulas might range from a factor of 1.7 to 2.7 of direct IEP hours (e.g., 1 hour direct x 1.7 = 1.7 total hours).
Ratio Estimate	<ul style="list-style-type: none"> • Maximum coordination of 50 students or 40 preschool students • Ratio determination for a lower caseload would account for additional workload requirements

Note. Information was drawn from the following sources: Connecticut's Guidelines for Occupational Therapy in the Educational Setting (1999), North Carolina's Department of Public Instruction website, Ohio Department of Education website.

In summary, the AOTA in conjunction with the American Physical Therapy Association (APTA) and the American Speech and Hearing Association (ASHA) recognize concerns

regarding staffing based on a caseload approach (AOTA, APTA, & ASHA, 2014). By applying a workload approach many benefits are realized including optimized student outcomes, increase opportunities for collaboration, support of school initiatives, and greater staff recruitment and retention rates.

References

- American Occupational Therapy Association. (2005). [Model state regulation for supervision, roles, and responsibilities during the delivery of occupational therapy service template](#). Retrieved on August 17, 2015.
- American Occupational Therapy Association. (2010). Occupational standards of practice. *American Journal of Occupational Therapy*, 64, (Suppl. 3).
- American Occupational Therapy Association. (2010). Occupational therapy practice framework: Domain and process (3rd ed.). *American Journal of Occupational Therapy*, 68 (Suppl. 1).
- American Occupational Therapy Association Workgroup of Leaders in State Departments of Education. (2013). What is the role of the school system occupational therapy practitioner? Questions & answers for school administrators. Retrieved September 22, 2015 from <http://www.aota.org/-/media/Corporate/Files/Secure/Practice/Children/Workload-fact.pdf>
- American Occupational Therapy Association. (2014). Guidelines for supervision, roles, and responsibilities during the delivery of occupational therapy services. *American Journal of Occupational Therapy*, 68 (Suppl. 3)
- American Occupational Therapy Association. (in press). Occupational therapy code of ethics. (2015). *American Journal of Occupational Therapy*, 69 (Suppl. 3).
- AOTA, APTA, & ASHA (2014). Workload approach: A paradigm shift for positive impact on student outcomes. Retrieved on November 22, 2015 from <http://www.aota.org/-/media/Corporate/Files/Practice/Children/APTA-ASHA-AOTA-Joint-Doc-Workload-Approach-Schools-2014.pdf>
- Frolek Clark, G., & Chandler, B. (2013). Best Practices for Occupational Therapy in Schools. Bethesda, MD: AOTA.
- Jackson, L., Polichino, J., & Potter, K. (2006) [Transforming caseload to workload in school system and early intervention occupational therapy services](#). Bethesda, MD: American Occupational Therapy Association.

Williams, J., & Cecere, S. (2013, April). School system workload: What's the magic formula? Short Course presentation at the American Occupational Therapy Association 93rd Annual Conference & Expo, San Diego, CA.

PROFESSIONAL RESPONSIBILITY

Section 8

Learning Objectives

Readers will gain a better understanding of:

- Professional licensure, national certification, and continuing competency requirements;
- Connecticut Practice Act; and
- AOTA's Code of Ethics and NBCOT's Code of Conduct.

Professional Licensure, Certification and Continuing Competence

State Licensure

The Connecticut Department of Health oversees licensure of healthcare practitioners, which includes occupational therapists and occupational therapy assistants. In order to be eligible for Connecticut licensure, occupational therapy practitioners must meet certain requirements.¹⁵

Occupational Therapist Requirements

- Hold a degree in occupational therapy from a program accredited by the American Occupational Therapy Association.
- Satisfactorily completed at least 24 weeks of supervised fieldwork experience at a recognized educational institution or a training program approved by the educational institution where the academic requirements were met.
- Successfully completed the National Board for Certification in Occupational Therapy certification examination.
- Recent graduates of occupational therapy programs may be eligible for temporary permit status (i.e., up to 120 days) to practice under direct and immediate supervision of a Connecticut licensed occupational therapist.

Occupational Therapy Assistant Requirements

- Hold an associate's degree in occupational therapy assistant from a program accredited by the American Occupational Therapy Association
- Satisfactorily completed at least 8 weeks of supervised field work experience at a recognized educational institution or a training program approved by the educational institution where the academic requirements were met

¹⁵ Language in this section was taken from the Connecticut Department of Public Health website. Retrieved on October 22, 2015 from <http://www.ct.gov/dph/cwp/view.asp?a=3121&q=389442>

- Successfully completed the National Board for Certification in Occupational Therapy certification
- Recent graduates of occupational therapy assistant programs may be eligible for a temporary permit status (i.e., up to 120 days) to practice under the direct and immediate supervision of a Connecticut licensed occupational therapist

Occupational therapy practitioners who practice in Connecticut are expected to hold a valid license through the Department of Public Health. Licenses are renewed every two years for an established fee. Upon renewal, practitioners will attest that, during the preceding two-year period, they have fulfilled the required continuing competency units, that is, 24 contact hours for occupational therapists and 18 contact hours for occupational therapy assistants.

National Certification

While school system occupational therapy practitioners are not eligible for a certification through the Connecticut Department of Education, they are required to pass a national certification exam through the National Board for Certification in Occupational Therapy (NBCOT). Practitioners who pass the exam and maintain their certification are eligible to use the trademark NBCOT credentials: OTR (occupational therapy *registered*) and COTA (*certified* occupational therapy assistant).

To be eligible for initial certification, the OTR or COTA candidate must meet specific eligibility requirements (e.g., graduated from an accredited occupational therapy program, completed all fieldwork requirements, agreed to abide by NBCOT practice and code of conduct standards) To maintain certification, practitioners must attest that, during the preceding three-year period, they have met all certification requirements. This includes fulfillment of 36 professional development units (PDU), that is, 36 units for occupational therapists and occupational therapy assistants alike. PDUs can be acquired through a wide range of professional development activities recognized by NBCOT. Usable charts and resources are located on their Web site.

In addition, to providing certification for the occupational therapy profession, NBCOT works with “state regulatory authorities and employers, providing information on credentials, professional conduct, and regulatory and certification renewal issues” (see NBCOT Web site).

For more information pertaining to NBCOT initial certification and renewal, available resources, and a means to verify an occupational therapy practitioner’s credentials, please go to the [NBCOT](#) Web site.

Continuing Competence

The Connecticut Department of Public Health and the NBCOT mandate continuing education for occupational therapists and occupational therapy assistants to maintain licensure and certification. In doing so, practitioners need to identify their own continuing education needs and pursue professional development that supports those needs. AOTA's Standards for Continuing Competence (2015) can be used as a guide to determine areas of relative strength and areas for ongoing professional development. The standards cover *knowledge, performance skills, interpersonal abilities, critical reasoning, and ethical reasoning skills*. In the school setting, the knowledge standard might translate to understanding (a) conditions that impact a student's occupational engagement (e.g., medical diagnoses, educational disability, environmental demands), (b) contextually based assessments, (c) educationally relevant interventions, and (d) national, state and local education laws and regulations relevant to school practice.

Please see [AOTA's Standards for Continuing Competence](#) for more information.

School or District-Wide Trainings. In Connecticut, school staff members receive annual trainings, some of which are mandatory. Occupational therapy practitioners practicing in schools need to be included in mandatory trainings and should be included in other trainings at the mutual discretion of the district and practitioner. Training topics may include:

- DCF Mandated Reporter
- Infection Control and Standard Precautions specific to blood borne pathogens
- Restraint and Seclusion
- Behavior Management

Restraint and Seclusion. Changes to Public Act 15-141, an Act concerning Seclusion and Restraint in Schools, went into effect on July 1, 2015 and impacts the training occupational therapy practitioners will be required to receive including but not limited to¹⁶:

- An annual overview of relevant laws and regulations regarding the use of physical restraint or seclusion
- Training on the prevention of the use of restraint or seclusion and the proper means of physically restraining or secluding a student should an emergency arise

For more information on the Act concerning Seclusion and Restraint in Schools, please see the [Connecticut General Assembly](#) Web site.

Behavior Management Training. A variety of training courses exist regarding behavior management. A district may choose one course over another dependent on best fit. As

¹⁶ Content in this section was taken from the State of Connecticut document, An Act Concerning Seclusion and Restraint in Schools. Retrieved on December 3, 2015 from <https://www.cga.ct.gov/2015/ACT/pa/pdf/2015PA-00141-R00SB-00927-PA.pdf>

a school staff member, occupational therapy practitioners should be included in district, school, or site-specific trainings pertaining to behavior management. Benefits of this training consist of learning proactive strategies, understanding the system, becoming familiar with the language used, operating as part of the school team, and optimizing student outcomes.

Professional Development Resources. AOTA has a number of job and career resources available for school therapy practitioners, one of which is Specialty Certification in School Systems. This certification is applicable for occupational therapists and occupational therapy assistants who *specialize* specifically in school system practice. It is appropriate for those who work with students ages 3 to 21 who are eligible for education services under federal, state, and local mandates. Services may be provided in preschool, elementary, secondary, transition, and/or post-school environments; and may be delivered in either public or private settings. Practitioners who apply need to have 600 hours specifically in schools with a focus on maximizing educational outcomes for students.

Administrators/Employers can support continuing education in a variety of ways, including but not limited to:

- Providing paid professional leave time
- Supporting a student training program (occupational therapy and occupational therapy assistant students)
- Reimbursing therapy practitioners for continuing education, texts, and/or materials
- Sponsoring/co-sponsoring workshops, courses, and regional pediatric interest groups/consortiums
- Offering in-service training on topics that are pertinent to occupational therapy in the school setting
- Providing tuition reimbursement to pursue higher education or certificate programs in school practice

Please see [Connecticut licensure requirements and/or approved professional development activities](#) under the Connecticut Department of Public Health web site for more information.

Please see [AOTA's Specialty Certification in School Systems](#) for more information.

Connecticut's Occupational Therapy Practice Act

The Connecticut Department of Public Health is the regulatory body for the practice of occupational therapy in the state of Connecticut. Connecticut's Practice Act defines occupational therapy, outlines licensing requirements, and describes potential for disciplinary actions.

Please see [Connecticut's Occupational Therapy Practice Act](#) for more information.

Code of Ethics & Code of Conduct

Occupational Therapy Code of Ethics

AOTA's Ethics Commission "is responsible for developing the Ethics Standards" for the occupational therapy profession (2015). The Occupational Therapy Code of Ethics addresses the core values of the profession, as well as principles and standards of professional conduct. Occupational therapists and occupational therapy assistants would use the Code of Ethics to guide decision-making and comply with ethical actions.

The Core Values of Occupational Therapy as defined in the Code of Ethics consists of (a) altruism, (b) equality, (c) freedom, (d) justice, (e) dignity, (f) truth, and (g) prudence. The principles of professional conduct include (a) beneficence—*prevent harm*, (b) non-maleficence—*do no harm*, (c) autonomy—*respect for self-determination*, (d) justice—*fair, equitable, and appropriate*, (e) veracity—*being truthful*, and (f) fidelity—*maintaining respect*.

For specific definitions and standards of professional conduct, please see the AOTA Code of Ethics at <http://www.aota.org/-/media/Corporate/Files/Practice/Ethics/Code-of-Ethics.pdf>

NBCOT Code of Conduct

As the national credentialing agency for occupational therapy, NBCOT "promotes and maintains standards of professional conduct" (NBCOT, 2015). Those persons seeking, holding, and renewing certification through NBCOT are expected to uphold the agency's Code of Conduct Principles.

For specific details, please see the [NBCOT Code of Conduct](#).

RESOURCES

Section 9

Section One: Introduction

I. Overview of Occupational Therapy

AOTA Web site, [About Occupational Therapy](#)

Frequently Asked Questions Section

[AOTA](#) Web site.

[Connecticut Occupational Therapy Association \(ConnOTA\)](#) Web site

Connecticut DPH Web site, [Occupational Therapist Licensure](#)

Connecticut DPH Web site, [Occupational Therapist Assistant Licensure](#)

AOTA publication, [Occupational Therapy In School Settings](#)

AOTA publication, [Frequently Asked Questions: What Should the Occupational Therapy Practitioner Know About the Common Core State Standards \(CCSS\)?](#)

AOTA publication, [Frequently Asked Questions for Educators Help ALL Students Achieve Greater Success in Academic Performance and Social Participation](#)

AOTA publication, [Occupational Therapy and Universal Design for Learning](#)

AOTA publication, [Occupational Therapy and School Mental Health](#)

AOTA publication, [What Parents Need to Know About School system Occupational Therapy](#)

AOTA publication, [Brochure for Parents: What is the Role of the School system OT Practitioner?](#)

AOTA publication, [AOTA Practice Advisory on Occupational Therapy in Response to Intervention](#)

AOTA publication, [Response to Intervention Consumer Brochure](#)

AOTA publication, [Workload Approach: A Paradigm Shift for Positive Impact on Student Outcomes](#)

[CSDE SRBI Web site](#)

CSDE publication, [Connecticut's Framework for RTI](#)

U.S. Department of Education publication, [Questions and Answers on Serving Children with Disabilities Placed by Their Parents in Private Schools](#)

U.S. Department of Education publication, [Provisions Related to Children With Disabilities Enrolled by Their Parents in Private Schools](#)

Section Two: Laws and Policies - Resources

I. Definitions: Laws and Regulations, Guidance, Policies, and Professional Resources

[CSDE guidance documents specific to special education](#)

[CSDE Web site](#)

AOTA Web page, [School system Practice](#)

II. Laws and Regulations Relevant to School system Practice: General Education

[U.S. DOE ESEA Web site](#)

CSDE [State Performance & Accountability](#) Web site

[SRBI in Connecticut CSDE](#) Web site

CSDE publication, [Connecticut's Framework for RTI](#)

CSDE publication, [A Family Guide: Connecticut's Framework for RTI](#)

OCR publication, [Questions and Answers on the ADA Amendments Act of 2008 for Students with Disabilities Attending Public Elementary and Secondary Schools](#)

OCR publication, [Free Appropriate Public Education for Students With Disabilities: Requirements Under Section 504 of The Rehabilitation Act of 1973](#)

OCR publication, [Protecting Students With Disabilities](#)

[U.S. Department of Justice, Civil Rights Division's Web site](#)

III. Laws and Regulations Relevant to School system Practice: Special Education

OSEP publication, [Questions and Answers On Individualized Education Programs, Evaluations and Reevaluations](#)

OSEP publication, [Questions and Answers on Secondary Transition](#)

CSDE Web site, [Secondary Transition Resources](#)

OSEP publication, [Questions and Answers On Serving Children With Disabilities Placed by Their Parents at Private Schools](#)

OSEP publication, [Questions and Answers On Response to Intervention \(RTI\) and Early Intervening Services \(EIS\)](#)

OSEP publication, [Questions and Answers On Procedural Safeguards and Due Process Procedures For Parents and Children With Disabilities](#)

CSDE publication, [A Parent's Guide to Special Education in Connecticut](#)

IV. Laws and Regulations Relevant to School system Practice: Operational

[U.S. DOE Web site, Family Educational Rights and Privacy Act \(FERPA\)](#)

DSS Web site, [Medicaid School Based Child Health Program](#)

Section Three: Collaboration - Resources

I. Supporting Role of Occupational Therapy in Collaboration

[Scope of Practice](#) (AOTA, 2010)

[Occupational Therapy Code of Ethics and Ethics Standards](#) (AOTA, 2015)

II. Multi-tiered Approach to Collaboration & Role of Practitioner

Assistive Technology-See [Connecticut Assistive Technology Guidelines](#) (SDE, 2014)

[Feeding and Swallowing Guidelines](#) (SDE, 2008a)

III. Workload Considerations for Collaboration

Hanft, B. & Shepherd, J. (2008). 2...4...6...8...How do you collaborate. In B. Hanft & J. Shepherd (Eds.), [Collaborating for student success: A guide for school system occupational therapy](#). (pp. 1-33). Bethesda: AOTA Press.

Worksheet 3.4A.: School Workload: Collaborative Roles Review (Hanft & Shepherd, 2008)

IV. Documentation for Collaboration

Hanft, B. & Shepherd, J. (2008). 2...4...6...8...How do you collaborate. In B. Hanft & J. Shepherd (Eds.), *Collaborating for student success: A guide for school system occupational therapy*. (pp. 1-33). Bethesda: AOTA Press.

Snell, M. E. & Janney, R. (2005). Collaborative team meeting worksheet. In M.E. Snell & R. Janney (Eds.), *Collaborative teaming* (2nd ed., Appendix, p. 50). Baltimore: Brookes.

Worksheet 2.2A.: Observation of the School Environment (Hanft & Shepherd, 2008)

Worksheet 2.3A.: Reflection on Team Support Role (Hanft & Shepherd, 2008)

Worksheet 2.4A.: Faces, Spaces, and Paces (Hanft & Shepherd, 2008)

Worksheet 3.3A.: Collaborative Team Meeting Worksheet (Snell & Janney, 2005)

Worksheet 3.4A.: Action Plan for Collaboration (Hanft & Shepherd, 2008)

Section Four: Evaluation - Resources

I. Requirements for Evaluation

[CSDE Web site](#)

[USDOE publication, IEP guide](#)

II. Sharing Information about Occupational Therapy

AOTA Web site, [School system Practice](#)

AOTA Web site, [OT in Schools](#)

AOTA Web site, [What Parents Need to Know About School system Occupational Therapy](#)

III. Standardized Tools

[Center for Public Education](#) Web site

Occupational Therapy **Evaluation** for Children: A Pocket Guide, Second Edition

Asher's Occupational Therapy Assessment Tools, 4th Edition

[Therapro](#) Web site

[List of Assessment Tools Used in Pediatric Physical Therapy](#) Web site

IV. FAQs

[AOTA document, Standards of Occupational Therapy Practice](#)

[Model of Human Occupation](#) Web site