Occupational and Physical Therapy
Policy and Procedure Manual

Piedmont Regional Education Program
2017-2018
Purpose

The Piedmont Regional Education Program (PREP) was established in 1975 in Charlottesville, VA as a public umbrella organization to provide special education programming and related services for low incidence special education students in school districts in the central region of Virginia. Under the Individuals with Disabilities Education Act (IDEA), occupational and physical therapy are considered related services “that may be required to assist a child with a disability to benefit from special education”, and may be implemented in a variety of ways in different school systems to best meet students’ individual academic and functional needs.

This *Occupational and Physical Therapy Policy and Procedure Manual* was created to help define and clarify the roles, responsibilities, procedures and ‘best practice’ guidelines for both the PREP catchment area OT’s and PT’s as well as for the districts we serve.

Information for the completion of this handbook was derived from the sources listed below. Source information is included where appropriate through direct and indirect references.

- The American Occupational Therapy Association, Inc. [http://www.aota.org](http://www.aota.org)
- The American Physical Therapy Association, Inc. [https://www.apta.org](https://www.apta.org)
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Professional Responsibilities
Occupational Therapist

Position Description
The Occupational Therapist (OT) is responsible for assessment, planning, and collaboration on IEP goal development for students at assigned sites. As a related service provider, the OT provides appropriate intervention to meet the individual student’s needs in acquiring independence in functional skills to participate in and benefit from the educational environment. Good communication and interpersonal skills are necessary to collaborate with parents, educators, and other school support staff. Organizational skills and the ability to work independently are necessities. The therapist reports to the Lead Occupational Therapist and the Executive Director.

Qualifications
- Graduation from an accredited occupational therapy program following successful completion of all fieldwork requirements
- Must have passed the Occupational Therapy National Certification Examination and be licensed by the Virginia Board of Medicine
- Must complete at least 20 hours of continuing learning activities biennially as prescribed by the Virginia Board of Medicine to maintain licensure
- Minimum of one year of pediatric work experience is preferred

Physical Requirements
Physical requirements of the position include the abilities to lift a minimum of 30 pounds, walk an average of one mile per day, climb flights of stairs as needed, sit for extended periods of time in a car, and transition from standing to the floor and back during service provision.

Professional Performance Responsibilities
- Complete evaluations, develop measurable goals, plan and implement therapeutic interventions at intervals determined to be educationally relevant
- Communicate results of evaluations and reports to students, parents, educational staff, and when appropriate, other professionals and agencies concerned with the students
- Establish a system of documentation that is professional, efficient, and timely providing proof of accountability that conforms to state and individual agency policy (including Individualized Education Programs, progress reporting, daily documentation, and Medicaid documentation when required)
- Collaborate, consult, teach and monitor professionals and paraprofessionals involved with the implementation of occupational therapy interventions
- Provide consultation to schools and districts regarding students’, staff and system needs
- Attend school team and IEP meetings as appropriate
- Attend PREP staff meetings and in-services
- Supervise, monitor and evaluate the job performance of any assigned occupational therapy assistant or student as required by the Virginia Board of Medicine
- Make recommendations regarding adaptive equipment needs and maintain an inventory of therapy equipment and supplies
Certified Occupational Therapist Assistant

Position Description
Under the direction and supervision of a licensed occupational therapist, the Certified Occupational Therapist Assistant (COTA) provides appropriate intervention services designed to enhance the student’s potential for performing in a variety of learning environments. Good communication and interpersonal skills are essential to assist students and collaborate with the supervising occupational therapist, parents, educators, and other school support staff. The COTA reports to the supervising OT, the Lead OT, and the Executive Director.

Qualifications
● Graduation from an accredited Associate’s degree program following successful completion of all fieldwork requirements
● Must have passed the COTA National Certification Examination and be licensed in the State of Virginia
● Must complete at least 20 hours of continuing learning activities biennially as prescribed by the Virginia Board of Medicine to maintain licensure
● Minimum of one year of pediatric therapy experience is preferred

Physical Requirements
Physical requirements of the position include the abilities to lift a minimum of 30 pounds, walk an average of one mile per day, climb flights of stairs as needed, sit for extended periods of time in a car, and transition from standing to the floor and back during service provision.

Supervision
A COTA is professionally responsible under the direct supervision of a licensed occupational therapist

Professional Performance Responsibilities
● Implementation of therapeutic activities to remediate and/or compensate for difficulties in a student’s fine motor, self-care, sensory motor, visual motor, perceptual, cognitive and/or mobility skills, as deemed appropriate by the supervising occupational therapist
● Document all therapy services including daily documentation, Medicaid notes, and progress reports within the designated time frame prescribed by the supervising occupational therapist
● Collect data to assist the supervising occupational therapist in evaluating the student’s needs and progress towards IEP goals
● Assist the supervising occupational therapist with determination of students’ adaptive equipment needs and in-service training of staff in use of adaptive equipment and therapeutic techniques
● Maintain inventory of equipment and supplies
● Attend PREP staff meetings/ in-services and school team meetings as appropriate
Lead Occupational Therapist

Position Description
The Lead Occupational Therapist is responsible for providing clinical support, supervision, and mentoring for all PREP OT’s and COTA’s. The Lead OT also provides coordination and organization of PREP Therapy and Assistive Technology Services and reports to the Executive Director.

Qualifications
- Graduation from an accredited occupational therapy program following successful completion of all fieldwork requirements
- Must have passed the Occupational Therapy National Certification Examination and be licensed by the Virginia Board of Medicine
- Must complete at least 20 hours of continuing learning activities biennially as prescribed by the Virginia Board of Medicine to maintain licensure
- Minimum of five years of school based pediatric therapy experience is preferred

Physical Requirements
Physical requirements of the position include the abilities to lift a minimum of 30 pounds, walk an average of one mile per day, climb flights of stairs as needed, sit for extended periods of time in a car and transition from standing to the floor and back during service provision.

Professional Performance Responsibilities
- Maintain a student caseload following the professional performance responsibilities as delineated in the OT job description
- Recruit and interview new therapy staff
- Provide orientation and mentoring to new PREP therapists, according to the PREP Mentoring Program guidelines
- Support PREP occupational therapists through direct clinical training and assistance with caseload requirements
- Support supervision of university students, occupational therapy assistants, and occupational therapists with provisional licenses, as needed
- Evaluation of clinical occupational therapy staff
- Support PREP districts’ staffing needs by substituting for occupational therapists when possible during periods of extended absence or when short of staff
- Serve as a liaison between the occupational therapy team and the Executive Director regarding professional and staffing needs within the regional program
- Create continuing education opportunities based upon common areas of need within the therapy department
- Facilitate monthly staff meetings
- Organize/ chair committees required for therapy department and/or Program needs
Lead OT Additional Responsibilities

- Research and ensure clinical best practice standards for the therapy department, as designated by the American Occupational Therapy Association, American Physical Therapy Association, the Virginia Board of Medicine, the Virginia Board of Physical Therapy, and the Virginia Department of Education
- Monitor the effectiveness of therapy service delivery, efficiency, productivity and development of therapists’ clinical skills
- Liaison with universities for student affiliation placements
- Communicate the needs of the therapy department to the Executive Director and district representatives
- Manage monthly OT/PT meetings (including topics, presenters, agenda, and staff notifications to ensure appropriate professional development for therapy staff)
- Track therapy staff CEU’s earned from in-house continuing education
- Schedule and organize the annual PREP OT/PT conference with input from the therapy staff and consultation with the Executive Director
- Order, maintain and establish accountability for therapy equipment, evaluation kits and forms
- Responsible for annual updates to the OT/PT Manual in conjunction with the PREP Comprehensive Plan
- Assistive Technology Team Planner (see AT Handbook for specific responsibilities)
- Coach Assistive Technology Initiative (iCATT) for Ivy Creek School
**Physical Therapist**

**Position Description**
The Physical Therapist (PT) is responsible for assessment, planning, and collaboration on IEP goal development for students at assigned sites. As a related service provider, the PT provides appropriate intervention to meet the individual student’s needs in acquiring independence in functional skills to participate in and benefit from the educational environment. Good communication and interpersonal skills are necessary to collaborate with parents, educators, and other school support staff. Organizational skills and the ability to work independently are necessities. The therapist reports to the Lead Physical Therapist and the Executive Director.

**Qualifications**
- Graduation from an accredited physical therapy program following successful completion of all clinical internship requirements
- Must have passed the Physical Therapy National Certification Examination and be licensed by the Virginia Board of Physical Therapy
- Must complete at least 30 hours of continuing learning activities biennially as prescribed by the Virginia Board of Physical Therapy to maintain licensure
- Minimum of one year of pediatric work experience is preferred

**Physical Requirements**
Physical requirements of the position include the abilities to lift a minimum of 30 pounds, walk an average of one mile per day, climb flights of stairs as needed, sit for extended periods of time in a car, and transition from standing to the floor and back during service provision.

**Professional Performance Responsibilities**
- Complete evaluations, develop measurable goals, plan and implement therapeutic interventions at intervals determined to be educationally relevant
- Communicate results of evaluations and reports to students, parents, educational staff, and when appropriate, other professionals and agencies concerned with the students
- Establish a system of documentation that is professional, efficient, and timely providing proof of accountability that conforms to state and individual agency policy (including Individualized Education Programs, progress reporting, daily documentation, and Medicaid documentation when required)
- Collaborate, consult, teach and monitor professionals and paraprofessionals involved with the implementation of physical therapy interventions
- Provide consultation to schools and districts regarding students’, staff, and system needs
- Attend school team and IEP meetings as appropriate
- Attend PREP staff meeting and in-services
- Supervise, monitor and evaluate the job performance of any assigned physical therapy assistant or student as required by the Virginia Board of Physical Therapy
- Make recommendations regarding adaptive equipment needs and maintain an inventory of therapy equipment and supplies
Physical Therapist Assistant

Position Description:
Under the direction and supervision of a licensed physical therapist, the Physical Therapist Assistant (PTA) provides appropriate intervention services designed to enhance the student’s potential for performing in a variety of learning environments. Good communication and interpersonal skills are essential to assist students and collaborate with the supervising physical therapist, parents, educators, and other school support staff. The PTA reports to the supervising PT, the Lead PT, and the Executive Director.

Qualifications:
• Graduation from an accredited Associate’s degree program following successful completion of all clinical affiliation requirements
• Must have passed the PTA national certification examination and be licensed in the State of Virginia
• Must complete at least 30 hours of continuing learning activities biennially as prescribed by the Virginia Board of Physical Therapy to maintain licensure
• Minimum of one year of pediatric therapy experience is preferred

Physical Requirements:
Physical requirements of the position include the abilities to lift a minimum of 30 pounds, walk an average of one mile per day, climb flights of stairs as needed, sit for extended periods of time in a car, and transition from standing to the floor and back during service provision

Supervision:
A PTA is professionally responsible under the direct supervision of a licensed physical therapist

Professional Performance Responsibilities:
• Implementation of therapeutic activities to remediate and/or compensate for difficulties in a student’s gross motor, sensory motor, balance, tone, strength, range of motion, mobility, gait, self-care, and/or cognitive skills, as deemed appropriate by the supervising physical therapist
• Document all therapy services including daily documentation, Medicaid notes, and progress reports within the designated time frame prescribed by the supervising physical therapist
• Collect data to assist the supervising physical therapist in evaluating students’ needs and progress towards IEP goals
• Assist the supervising physical therapist with determination of students’ adaptive equipment needs and in-service training of staff in use of adaptive equipment and therapeutic techniques
• Maintain inventory of equipment and supplies
• Attend PREP staff meetings/ in-services and school team meetings as appropriate
Lead Physical Therapist

Position Description
The Lead Physical Therapist is responsible for providing clinical support, supervision, and mentoring for all PREP PT’s and PTA’s. The Lead PT reports to the Executive Director.

Qualifications
● Graduation from an accredited physical therapy program following successful completion of all clinical internship requirements
● Must have passed the Physical Therapy National Certification Examination and be licensed by the Virginia Board of Physical Therapy
● Must complete at least 30 hours of continuing learning activities biennially as prescribed by the Virginia Board of Physical Therapy to maintain licensure
● Minimum of five years of school based pediatric therapy experience is preferred

Physical Requirements
Physical requirements of the position include the abilities to lift a minimum of 30 pounds, walk an average of one mile per day, climb flights of stairs as needed, sit for extended periods of time in a car, and transition from standing to the floor and back during service provision.

Professional Performance Responsibilities:
● Maintain a student caseload following the professional performance responsibilities as delineated in the PT job description
● Recruit and interview new therapy staff
● Provide orientation and mentoring to new PREP therapists, according to the PREP Mentoring Program guidelines
● Support PREP physical therapists through direct clinical training and assistance with caseload requirements
● Support supervision of university students, therapy assistants, and physical therapists with provisional licenses, as needed
● Support PREP districts’ staffing needs by substituting for physical therapists when possible during periods of extended absence or when short of staff
● Research and ensure best practice standards for PREP physical therapy staff, as designated by the American Physical Therapy Association as well as the Virginia Board of Physical Therapy, and the Virginia Department of Education
● Evaluation of clinical physical therapy staff
● Serve as a liaison between the physical therapy team and the Executive Director regarding professional and staffing needs within the regional program
● Create continuing education opportunities based upon common areas of need within the therapy department
● Facilitate monthly staff meetings
● Assist in organizing committees required for therapy department and/or Program needs
● Provide input and assistance for annual OT/PT conference
● Collaborate on annual updates of OT/PT Manual in accordance with the PREP Comprehensive Plan
Continuing Education Requirements for OT’s and COTA’s

In 1997, the General Assembly of Virginia passed a law (§ 54.1-2912.1) to ensure the continued competency of occupational therapists and occupational therapy assistants licensed by the Board of Medicine. It directed the Board to include in its regulations continuing education, testing, and/or any other requirement which would address the following: (a) the need to promote ethical practice, (b) an appropriate standard of care, (c) patient safety, (d) application of new medical technology, (e) appropriate communication with patients, and (f) knowledge of the changing health care system. The Virginia Board of Medicine recognizes that the professional responsibility of practitioners requires continuous learning throughout their careers, appropriate to the individual practitioner’s needs. The Board also recognizes that practitioners are responsible for choosing their own continuing education and for evaluating their own learning achievement. The Board regulation is designed to encourage and foster self-directed practitioner participation in education.

Number of Hours Required
In order to renew an active license biennially, the practitioner must complete the Occupational Therapy Continued Competency Activity and Assessment Form (which can be found at: https://www.dhp.virginia.gov/forms/.../ContinuingComp/OT_cc_form.doc) and indicate at least 20 contact hours of continuing learning activities. At least 10 contact hours (each biennium) shall be Type 1, which are activities offered by a sponsor or organization recognized by the profession and may include in-service training, self-study courses, specialty certification or professional workshops. All 20 continued competency hours each biennium may be Type 1 hours.
No more than 10 contact hours (each biennium) shall be Type 2 activities, which may include consultation with another therapist, independent reading or research, preparation for a presentation, fieldwork with students, or other such experiences, which promote continued learning.

Maintenance and Audit of Records
The Continuing Education Log Instructions, and Continuing Education Log and Summary for OT (Appendices A-1 and A-2) can be used for planning and recording continuing learning activities: The practitioner is required to retain in his or her records the completed form with all supporting documentation for a period of six years following the renewal of an active license. Continuing Education Log Instructions, and Continuing Education Log and Summary for OT (Appendices A-1 and A-2) can be used for planning and recording continuing learning activities. The practitioner is required to retain in his or her records the completed form with all supporting documentation for a period of six years following the renewal of an active license.

The Board will periodically conduct a random audit of one to two percent of its active licensees to determine compliance. The practitioners selected for the audit must provide the completed Continued Competency Activity and Assessment Form and any supporting documentation within 30 days of receiving notification of the audit.

If a therapist is interested in a Continuing Education Course, they should fill out the Professional Leave form (located on the PREP website) and attach course information for the Executive Director’s consideration. Continuing Education will be approved based upon educational relevance to the therapist’s caseload and available funds.
Continuing Education Requirements for PT’s and PTA’s

In 2001, the General Assembly of Virginia passed a law requiring regulations to ensure the continued competency of practitioners licensed by the Board of Physical Therapy to address: (a) the need to promote ethical practice, (b) an appropriate standard of care, (c) patient safety, (d) application of new medical technology, (e) appropriate communication with patients, and (f) knowledge of the changing health care system. The Board regulation is designed to encourage and foster self-directed practitioner participation in education.

Maintenance and Audit of Records
As part of the biennial license renewal process (by December 31st in each even numbered year), PT’s and PTA’s must record continuing learning activities using either the FSBPT aPTitude on-line tracking system (which can be found at: https://pt.fsbpt.net/aPTitude) or by utilizing the Virginia Board of Physical Therapy Continued Competency Activity and Assessment Form (which can be found at: http://www.dhp.virginia.gov/PhysicalTherapy/physther_forms.htm). The practitioner is required to retain in his or her records the completed form with all supporting documentation for a period of at least 4 years from the end of the renewal period covered by that form. The Board will periodically conduct a random audit of a percentage of its active licensees to determine compliance. It is possible that the request for a copy of the form occurs after the renewal. Failure to comply within 30 days of receiving notification of the audit may result in disciplinary action.

Numbers and Types of Contact Hours Required
The 2015 revision of the Virginia Board of Physical Therapy Continued Competency Activity and Assessment Form must indicate completion of at least 30 hours of continuing learning activities for physical therapists and physical therapist assistants biennially (to the nearest ½ hour) listed by Type as described below:

- **At least 20 of the hours required for physical therapists and at least 15 of the hours required for physical therapist assistants** shall be **Type 1** continuing learning activities. (All required hours may be Type 1.)
  Type 1 courses are any organized program of study, classroom experience, or similar activity, such as online coursework, webinars, podcasts, face to face workshops, etc. which have been approved or provided by the APTA, VPTA, local/state/federal government agencies, regionally accredited colleges and universities, healthcare organizations granted compliance assurance authority by the Centers for Medicare and Medicaid Services, the American Medical Association, the National Athletic Trainers Association, or the Federation of State Boards for Physical Therapy.

- **No more than 10 of the hours required for physical therapists and no more than 15 of the hours required for physical therapist assistants** may be **Type 2** continuing learning activities.
  Type 2 credits may or may not be offered by an approved organization but must relate to clinical practice. These activities may include consultation with colleagues, independent study/research/journal review, experiential learning opportunities, clinical instruction/supervision activities, etc. PT’s and PTA’s shall qualify and document their own participation on the form.

If a therapist is interested in a Continuing Education Course, they should fill out the Professional Leave form (located on the PREP website) and attach course information for the Executive Director’s consideration. Continuing Education will be approved based upon educational relevance to the therapist’s caseload and available funds.
OT/PT Staff Meetings

- OT/PT Meetings/Events occur monthly from August through April
- Meetings are scheduled for Monday afternoons from 2:15 - 3:45
- Meetings will be held in the PREP office 3rd floor conference room, unless otherwise indicated
- Therapists will receive a schedule of meeting dates and formats for the year at the first mandatory PREP Staff Work Day of the school year

**Staff meeting attendance is considered mandatory** for all full-time therapists. (Part-time therapists may take approved flex time in order to attend.) Therapists are expected to be mindful not to schedule conflicting meetings on these afternoons. Therapists should leave Monday afternoons “flexible” when creating their weekly schedule, so that they can attend the planned staff meetings. (On the Mondays that a meeting is not scheduled, this flexible time block can be used for conducting student evaluations, team meetings, consultations, or to complete paperwork as determined by the individual therapist.)

If a meeting is missed, the therapist will notify the Lead OT who will then email the meeting agenda to the therapist. The therapist will be responsible for all missed information.

A continuing education certificate will be presented at the end of the school year, acknowledging the hours each therapist spent in the *training aspects* of staff meetings.

**Three different meeting formats** may be employed. Check your yearly meeting schedule for which type of meeting is scheduled on a given date:

1. **Combined OT/PT Meetings:** A traditional PREP combined meeting format with topic/speakers relevant to both OT and PT.

2. **Individual OT and PT Meetings:** Separate meetings held on the same day at locations to be decided by the respective groups. The OT’s and PT’s will meet separately to discuss issues specific to their discipline, brainstorm therapeutic approaches, or get topics/speakers specific to the staff’s needs.

3. **Special Interest Groups:** At the initial combined OT/PT meeting of the school year therapy staff may introduce options for special interest groups. Ongoing participation in these groups will be optional. The Special Interest Group members will decide frequency, topics and locations of meetings with the group facilitators. Continuing educations hours will be awarded accordingly.
Annual OT/PT Regional Conference

To maintain professional licensure in Virginia, OT’s, COTA’s, PT’s and PTA’s are required to demonstrate *continued learning* throughout their careers. To assist with this process, PREP sponsors an OT/PT Regional Conference annually, on a topic chosen by the therapy staff deemed relevant for the students they serve. Sponsoring this annual training is beneficial to our community in a variety of ways. Notably, it is cost effective to train the PREP staff together locally. Training several members of a therapy team jointly insures competent use of learned strategies in practice and provides support for incorporating these new skills within the schools. Additionally, it provides a service to community therapists who can attend an annual workshop presented by nationally renowned professionals, at a significantly reduced fee. This further enhances PREP’s reputation for sponsoring quality continuing education within our greater community. Conference attendance by PREP therapy staff is funded by PREP.

*Note:* The annual OT/PT Conference is recognized as a *Type 1* continuing education activity according to the *Virginia Board of Medicine* for occupational therapists. Physical therapists should check annually to assess whether the PREP course will qualify as *Type 1* or *Type 2* continuing education credit under the *Virginia Board of Physical Therapy* guidelines.
Use of PREP Funds / Equipment

Therapists receive an annual monetary allotment for the purchase of needed individual therapy equipment and supplies. Each OT/PT should base their requests on the needs of the student population they serve, or they may pool monies for more expensive purchases or to maximize economies of scale.

Full-time therapists will receive $400.00, and part-time therapists will receive $200.00 per school year.

When placing individual orders, therapist should fill out the Purchase Requisition Form (located on the PREP website), and send the completed form to the Executive Director for approval.


Items bought with PREP money remain the property of PREP once the therapist leaves employment.

Therapists are able to loan out PREP therapy equipment to students on a trial basis. Once efficacy is established, recommendations based upon data collection and monitoring should be made to the district for purchase of the equipment by that LEA. All PREP therapy equipment should be labeled [“PREP”] and kept track of by the issuing therapist.
Liability Insurance

All PREP therapists must maintain individual liability coverage (malpractice insurance). It is the therapist’s responsibility to obtain appropriate coverage prior to the initiation of direct services with students. PREP will reimburse each therapist for their individual expenditures annually, following the first year of employment regardless of full- or part-time status. Reimbursement is attained by turning in proof of coverage along with a Purchase Requisition Form (located on the PREP website) to the Executive Director.
Parent Communication

PREP therapists are encouraged to maintain open lines of communication with the parents/guardians and staff of the students on their caseload. This includes participation in IEP and team meetings whenever possible in order to afford a personal dialogue. Other means of communication with families include phone conversations, adding to a student’s daily log, email, evaluation reports, IEP present levels of performance and goals, and progress reports.

*All documents should be written using language that individuals without a therapy background can understand.*

Beginning of the School Year Letter

In order to initiate communication with the parents/guardians of students on a therapist’s caseload, each therapist is required to send out a *Beginning of School Year Parent Letter* (Appendix B is an example). Therapists may create their own personal letter if preferred, with contact information provided. This initial communication can be sent out via email, for those parents who list an email address on their child’s IEP. **If you are sending out a mass email to parents, be sure to send it out using the “blind copy” (Bcc:) to insure confidentiality of parents’ email addresses.** For those families that don’t list an email address, a hard copy may be sent home in the child’s backpack. This initial letter should be issued to families within the first two weeks of every school year.

Therapist contact information should also be shared with parents of students who have been added to the therapist’s caseload throughout the year.
Confidentiality

PREP therapists must perform their jobs in accordance with their professional Codes of Ethics. This includes the realm of Confidentiality.

In order to maintain confidentiality, therapists must:
- only discuss students by name with individuals necessary to the provision of services, in locations where conversations cannot be overheard
- share “working files” with PREP personnel only and other information gathered regarding the student with ‘essential’ personnel only
- store files in a secure location
- keep charts ‘face down’ so student names are not displayed
- do not leave files open/ unattended
- shred any documents containing the student’s name that are not part of the working file or permanent record

Email correspondences should not include the student’s name either in the subject heading or body. It is recommended that the student’s initials or other identifying information be used instead. Preferably, no more than one student should be referenced per email. Email correspondence regarding students should bear the disclaimer ‘not to be shared’ and should be deleted once read.

University Student Observations

If a therapist has a university student observing them within a school, it is the therapist’s responsibility to have the student sign either the District’s or PREP’s confidentiality agreement prior to initiation of the observation. Forms may be available from your district or you may print out a Confidentiality Statement for Observation form from the PREP website. These signed forms are then maintained by the PREP bookkeeper.

Therapists should check with the specific district that they serve to see if there are additional or alternate confidentiality requirements.
Occupational Therapy Student Affiliation Program

As part of our professional responsibilities to our discipline and as one avenue for recruitment, PREP occupational therapists are offered opportunities to supervise student affiliates. Supervision of a student affiliate is voluntary and supported by the Lead Occupational Therapist.

PREP suggests therapists have a minimum of four years of school-based therapy experience and/or have successfully completed the PREP Mentoring Program in order to be considered for student affiliate supervision.

Types of Fieldwork Experiences

- **Level I Fieldwork**
  The goal of the Level I Fieldwork is to introduce students to the fieldwork experience and develop a basic comfort level with an understanding of the needs of students on your caseload. Level I Fieldwork is not intended to develop independent performance, but to include experiences designed to enrich didactic coursework through directed observation and participation in selected aspects of the therapy process. Each program sets the time requirements for students on Level I Fieldwork. The options are usually a full day per week for one-half a term, full days in alternating weeks for one term, half days for one term or one week.

- **Level II Fieldwork**
  The goal of Level II Fieldwork is to develop competent, entry-level, generalist occupational therapists and occupational therapy assistants. The fieldwork experience is to provide students with the opportunity to integrate academic knowledge with the application of skills in a practice setting. (AOTA, 1999a & b; AOTA, 1996)
  For Level II Fieldwork, the Standards require a minimum of 24 weeks full-time for occupational therapy students and 16 weeks full-time for occupational therapy assistant students. This may be completed on a full-time or part-time basis, but may not be less than half-time, as defined by the fieldwork site. The therapy student’s academic program determines the required time needed to complete II fieldwork in your program.

General Student Affiliate Supervisor Guidelines (prior to student’s start date)

- The supervising therapist should obtain the school’s packet of information from the Lead Therapist and review the contained information prior to the student’s start date. Be sure to review all information including curriculum and expectations for the student.
- Contact the student at least two weeks prior to their start date to confirm start and end dates, business hours, code of conduct, dress code, as well as to make any recommendations for pre-placement literature or assessment review.
Level II Fieldwork Orientation will include the following:

- PREP organizational orientation (conducted cooperatively between Lead and supervising therapists)
- Expectations regarding affiliation assignments/projects
- Student and supervisor’s objectives for the fieldwork
- Assistance with setting student’s personal goals/objectives
- Review of the student’s personal learning style and preferences for receiving feedback
- Review of documentation/record keeping, including student attendance forms, daily progress notes, student evaluations and Medicaid documentation
- Confidentiality expectations
- Establishment of a mutually agreed upon time for weekly feedback/planning meetings, and schedule dates for mid-term and final evaluations

Additional Supervising Therapist Responsibilities:

- The supervising therapist should include information about their student affiliate in the beginning of the year communication with parents of the students on their caseload (see Parent Communication). The parents should be aware that the student affiliate will be working with their child for a designated period of time under direct supervision.
- If the student affiliate will be attending IEP or eligibility meetings, the case manager must be informed in advance, so that the student can be officially invited to the meeting. The child’s parent must give prior approval for the affiliate’s attendance at the meeting. Introduce the affiliate to the team when the meeting initiates.
- Conduct weekly meetings to provide feedback and training.
- Provide the student a midterm and final evaluation using the forms and procedures provided by the school.
- Maintain personal records of weekly meetings with the affiliate and student feedback in the event of problem performance. Contact the Lead Therapist and university Fieldwork Coordinator immediately when there is a concern about a student’s performance.
- Supervising Therapist should make copies of the mid-term and final evaluations. Originals should be sent to the affiliate’s school and a copy sent to the Lead Therapist upon completion of the affiliation.
Physical Therapy Student Affiliation Program

As part of our professional responsibility to our discipline and as one avenue for recruitment, PREP physical therapists are offered opportunities to supervise student affiliates. Supervision of a student affiliate is voluntary and is supported by the Lead Physical Therapist.

Entry level physical therapy programs are now at the doctoral level. The APTA has decided to allow any PT with two years of experience to be a Clinical Instructor (CI). However, PREP suggests therapists have a minimum of four years of school-based therapy experience and/or have successfully completed the PREP Mentoring Program in order to be considered for student affiliate supervision. Although preferred by the APTA, The CI is not required to have a clinical doctorate degree and does not need to be certified through the Clinical Instructor Education and Credentialing Program (CIECP). (Therapists may visit www.APTA.org, and view Therapy Clinical Education Principles for more information on the CIECP program.) The school may require the CI to pass the APTA Clinical Performance Instrument (CPI) web training (available for continuing education credit through the APTA Learning Center).

Types of Clinical Rotations
Despite similarities in PT education programs in various regions of the country, there is no current consensus on length/distributions of clinical affiliations, so the explanations/timelines below are illustrative only and may not match the specific program requirements to which an intern must adhere.

Observations
Individuals applying to Doctorate of Physical Therapy (DPT) programs must complete 40 hours of physical therapy observation prior to acceptance. These individuals often spend part or all of their required observation hours at PREP. The individual is required to sign either a District or PREP confidentiality form and provide any required observation verification documentation (usually online).

Physical Therapist Assistant (PTA) Practicums
PTA students are required to successfully complete [usually three] full-time, hands-on clinical rotations totaling 15-18 weeks, depending on the program.
- The 1st rotation (usually 3 weeks long) is considered introductory. Emphasis is on patient and staff interaction, therapeutic exercise, message and modalities applications, and documentation.
- The 2nd rotation (about 4 weeks in duration) is typically in [medical-surgical based] inpatient or [orthopedic rehabilitation] out-patient setting.
- The 3rd rotation (lasting approximately 8 weeks) falls at the end of the second semester of the second year of study, and is designed to provide the PTA student the opportunity to apply all previously learned and practiced skills in preparation for entry-level practice. The placement choice is usually either rehabilitative (medical-surgical, neurologic or pediatric conditions) or in long-term care.

Doctorate of Physical Therapy (DPT) Affiliations
In the mid-Atlantic region these are often designed as much around the needs of clinical sites as they are around those of the academic institutions and students.
- Integrated Clinical Experiences usually occur during the first two years of academic study and emphasize particular skills associated with didactic courses. They often run concurrently a few hours per semester or one day per week, with the goals of introducing students to the clinical experience, increasing basic comfort levels through directed observation, and encouraging participation in selected aspects of the therapy process. They are not intended to develop independent performance.
• **Full time Rotations** may last as little as four weeks or up to one year (usually 4-16 weeks), after which students return to academic coursework. These clinical experiences provide students opportunities to integrate academic knowledge with the application of skills in practice settings. The goal is the development of competent, entry-level, generalist physical therapists.

• **Clinical Internships** usually run 8-16 weeks in length. The longer rotations occur in the 3rd year of study after all didactic work is complete, and are usually reserved for specialty settings/fields of interest. Longer internships may extend beyond graduation and continue as post licensure experiences. These are designed to ensure the graduate’s ability to practice independently in the medical field.

**General Clinical Instructor Guidelines** (prior to student’s start date)

- The supervising therapist should obtain the school’s packet of information from the Lead PT and review the contained information prior to the student’s start date. Pay particular attention to didactic coursework schedule and expectations for the student.
- Contact the student at least two weeks prior to their start date to confirm start and end dates, business hours, code of conduct, dress code, as well as to make any recommendations for pre-placement literature or assessment review.

**Student Orientation should include the following:**

- PREP organizational orientation (conducted cooperatively between Lead and supervising therapists)
- Expectations regarding affiliation assignments/projects
- Student and supervisor’s objectives for the clinical practicum or internship
- Assistance with setting student’s personal goals/objectives
- Review of the student’s personal learning style and preferences for receiving feedback
- Review of documentation/record keeping, including student attendance forms, daily progress notes, and Medicaid documentation
- Confidentiality expectations
- Establishment of a mutually agreed upon time for weekly feedback/planning meetings, and schedule dates for mid-term and final evaluations

**Additional Clinical Instructor Responsibilities**

- The CI should include information about their student affiliate in a communication with parents of the students on their caseload (e.g. Parent Letter, Appendix C). The parents should be aware that the student affiliate will be working with their child for a designated period of time under direct supervision.
- If the student affiliate will be attending IEP or eligibility meetings, the case manager must be informed in advance, so that the student can be officially invited to the meeting. The child’s parent must give prior approval for the affiliate’s attendance at the meeting. Introduce the affiliate to the team at the initiation of the meeting.
- Conduct weekly meetings to provide feedback and training
- Provide the student a midterm and final evaluation, as applicable, using the forms and procedures provided by the school
- Maintain personal records of weekly meetings with the affiliate along with their feedback in the event of problem performance. Contact the Lead Therapist and school Academic Coordinator of Clinical Education immediately when there is a concern about a student’s performance.
- The CI should make copies of any mid-term and final evaluations. Originals should be sent to the affiliate’s school and the copy sent to the Lead PT upon completion of the affiliation.
Service Delivery
Workload vs. Caseload Framework

According to the American Occupational Therapy association, in their “Practice Tips for Occupational Therapists and Occupational Therapy Assistants” (AOTA, 2006), the concept of *workload* encompasses all of the work activities a therapist performs that benefits students directly and indirectly. The term *caseload* refers only to the number of children seen by an OT or PT as part of the individualized education program. This traditional caseload “counting” approach does not fully appreciate the complexity of the OT’s or PT’s role in current best-practice scenarios. Pull-out services built around a clinical model of predictable, routine “appointments” have limited support in the educational literature and do not necessarily promote the generalization of skills to the classroom or other appropriate settings. To meet the needs of children, parents, teachers, and school programs, a workload approach for OT’s and PT’s helps in the development of work patterns that optimize effectiveness and impact. Practitioners must redesign their work patterns so they are able to serve students in their least restrictive environment and at the same time support their functional performance needs (e.g. in language arts, during restroom break, lunch, on the playground, during PE, getting on/off the bus). Practitioners must also have time in their workday for collaborative teamwork, data collection and documentation. A workload approach allows therapist the flexibility to be wherever children need them whether they are needed for applying strategies and techniques to the classroom or for school activities and tasks. Virginia Department of Education, as well as other state DOE’s and professional organizations have advocated this approach.

It is recommended that each full-time PREP therapist serve 5 to 8 students per day. An average full-time therapist’s caseload would then be between 25-40 students. The appropriate amount of students that can be served is determined based upon the factors listed below:

- total number of students on caseload
- the number of students that have weekly or biweekly sessions
- number of students that have “flexible weekly sessions” (for example, each week a different student with consult services would be served in the same weekly timeslot)
- complexity of student and equipment needs vs. experience of teaching staff
- the number of schools/locations
- the number of students per school
- the number of locations per day
- distance between schools
• students’ schedule flexibility
• IEP/Team Meetings
• planning and set-up time
• documentation (requested observations, daily progress notes, Medicaid paperwork, interim notes, progress reports, IEP’s)
• lunch (30 minutes per day)
• student evaluations (based on district averages)

In order to best serve the district’s changing demographics, it is essential that therapists have time built into their schedules for the addition of new students. A typical therapy evaluation from initial referral to eligibility can take between 8-12 hours due to the following required components:

• chart review
• consult with case manager
• classroom/ school observations (playground, specials, bus, etc.)
• scheduled evaluation session(s) – these can be multiple based on the child’s age, intelligence, severity of disability, distractibility/ amount of time they are able to tolerate assessment tasks, the amount of standardized tests required, the complexity of equipment and/or assistive technology needs, etc.
• scoring/ interpreting standardized tests
• writing the evaluation report
• Medicaid documentation for the evaluation (if eligible)
• attendance at team meeting(s) to determine eligibility for services
• writing the IEP goals
• Medicaid Plan of Care (if the team determines that services are warranted and child is eligible)
School-Based Therapy Services

The following are key considerations for the delivery of OT and PT services in the public school setting. These considerations are based on current research and are recommended by the Virginia Department of Education as delineated in the *Handbook for Occupational and Physical Therapy in Virginia Public Schools, 2010.*

Inclusive Practice Philosophy

- All students can learn in the general education environment
- Special education is a service rather than a placement
- Effective inclusive practice focuses on maximizing the amount of time students with disabilities receive academic instruction in the general education environment

Services are provided to enable the student to benefit from his/her special education program and facilitate access to the general curriculum

- Strategies should be integrated into the school environment as well as the classroom to support learning of curriculum content
- Interventions should support skills that are needed for graduation with a diploma

Services are provided in the context of the student’s daily educational routine

- Skills should be taught across all educational settings in naturally occurring environments
- Therapeutic activities should occur throughout the school day and can be implemented by instructional staff in collaboration with therapists
- Skills should be generalized across different school settings, not in isolated areas solely with the treating therapist

Services are provided through a team approach

- Educational strategies and interventions should be developed and implemented jointly by the IEP team members including the student when appropriate
- Team members should share information, strategies, and techniques to assure continuity of services
- Regular team meetings should be held to facilitate communication of information regarding activities, instruction, and outcomes that occur throughout the day in the classroom, home and community
Service provision may be through a variety of delivery models
- Service delivery models include monitoring, consulting and working directly with the student
- Effective therapy services generally include a combination of models to meet the unique needs of each student
- Effective therapy services also include:
  a. School staff training in activities and accommodations that can be implemented throughout the student’s day
  b. Observing and critically analyzing student performance and responses that prevent the student from benefiting from his or her educational program
  c. Identifying, selecting, and adapting special materials and equipment
  d. Collaborating and coordinating with the student’s family, teachers, and private medical providers on any needed changes to instruction, the learning environment, and/or adaptive equipment
  e. Consulting with students, parents, school staff, and medical providers

A student’s need for OT and/or PT services may vary over time.
- Therapy needs may differ in intensity and/or focus over the course of a students’ school years
- Fluctuations are reflected in IFSP, IEP, or 504 plans which should remain fluid and flexible, based on pertinent educational needs at any given time during the student’s course of study
- Consideration of changes in services may be especially warranted during periods of transition between schools or into community activities, or when significant changes in educational or medical transitions occur
School-Based Therapy Service Models

The service delivery model a student receives therapy services under is listed in the Related Services section of the Child’s IEP. (See Individualized Education Program (IEP) and Progress Reporting section of this Handbook.)

Students attend school for the primary purpose of learning. While medical conditions or disabilities may be present, school-based therapy services are not required unless the disability impacts the student’s ability to benefit from his/her special education program. Issues can be addressed through a variety of intervention models which may include direct therapy with the child, consultation with the teacher, modification of the environment, provision of adaptive equipment, staff training, etc.

(Adapted by Albemarle Co. from Chapel Hill-Carrboro City Schools; http:www2.chccs.k12.nc.us/education/components/scrapbook)

Guidelines to consider when determining the most effective service delivery model for a student:

Direct student services are merited if “hands-on”, skilled intervention is required on a regular basis in order to make progress towards the student’s educational goals and access the school environment.

Consultative service is the appropriate model if the student’s goals can be accomplished by making recommendations to the teacher, training staff, and/or adapting/ adjusting equipment within the classroom throughout the year as situations occur.

Effective therapy services generally include a combination of models to meet the unique needs of each student.

If a therapist determines that direct service is merited, it is recommended whenever possible to add “Direct/Consult” for the service delivery model on the student’s IEP. Under the direct model, the consultative time with teachers/staff that is required for best practice, will then officially be considered a viable part of the services the therapist provides. In districts where this combined service delivery model is not utilized, you may add a time allotment for “Direct” service as well as a separate time designation for “Consult” service. IEP goals under consultative services may be embedded collaboratively or stand alone as allowed by the district.

Therapists should refer to the student’s local school division regarding how this should be listed on the IEP.
Service Delivery to a Student with a 504 Plan

There may be students who are not eligible for services under the IDEA who may qualify under Section 504 for accommodations, modifications and related services to access the general education curriculum. Similar to IDEA, Section 504 regulations ensure that students with disabilities be placed with nondisabled peers to the maximum extent appropriate. It further requires that the student be placed in the “regular environment” unless it is established that a satisfactory education cannot be achieved with supplementary aids and services.

Section 504 does not require an IEP, but it does require its functional equivalent, which may be termed a 504 Plan. Team members are those knowledgeable about the child, the meaning of evaluation data, and placement options. By regulation, the parents are not required members; however, best practice supports their involvement. Under a 504 Plan, a free and appropriate public education (FAPE), guarantees the student access to regular or special education services (as needed), and the related aids, services, and environmental adaptations necessary to ensure that individual education needs of persons with disabilities are met as adequately as those of nondisabled persons. Students who receive PT under 504 plans are required to have a physician’s referral, unlike students served under an IEP. OT services do not carry this same requirement under a 504 plan.

Under a 504 Plan, therapists may have a variety of roles and responsibilities including but not limited to:

1. evaluation
2. participation in the development of the student’s 504 plan
3. adaptive equipment evaluation, procurement, monitoring
4. modification of the educational environment
5. observation and consultation
6. provision of direct services

If needed by the student, services, accommodations, and/or modifications must be provided in both academic and nonacademic settings, including extracurricular activities. 

Therapists should refer to their local school division’s procedures for guidance.
Therapist’s Roles in Response To Intervention

Response to Intervention (RTI) is a multi-tiered, evidence based instructional framework that allows early identification of struggling learners in an effort to eliminate “wait to fail” situations. Mandated by the 2004 IDEA Improvement Act, with no single, commonly accepted model, each state, district and school was allowed freedom in program implementation toward accountability.

In a common three-tiered approach students' progress is closely monitored at each stage of intervention to determine the need for further instruction and/or intervention in general education, special education, or both.

**Tier 1**: High-Quality Classroom Instruction, Screening, and Group Interventions

**Tier 2**: Targeted Interventions

**Tier 3**: Intensive Interventions and a Comprehensive Evaluation which could result in the student becoming eligible for Special Education Services and then possibly Related Services.

Therapists can assist their school division with students who are receiving services within Tier 1 and 2 (not identified for special education evaluation), by providing the following support as members of the school team:

- **OT or PT Student Observation Feedback** (See Student Observation Procedure in the Documentation and Procedures section of this Handbook, and Appendices C and D.)
- Consultation and general recommendations to the classroom teacher concerning:
  - normal development
  - environmental adaptations
  - diversified instructional techniques
  - behavioral/sensory strategies
  - low tech. adaptive technology/materials/equipment
  - Universal Design for Learning

Therapists do not perform the following tasks as part of RTI:

- standardized testing
- formal evaluations/ reports
- direct intervention
- equipment monitoring
- meetings with parents

If a student reaches Tier 3, he/she may be evaluated for Special Education services with parental consent. Once found eligible, the IEP team may request related service evaluations. Parental consent would be required prior to the initiation of a therapy evaluation.
Related Services in Alternative Placements

According to the Virginia Department of Education, a school division’s responsibilities differ depending on the reason for a parent’s or school’s placement decision, and on the location of the placement. Local education agencies (LEA’s) are mandated to locate, identify, and evaluate children who are home-based, home-schooled, or placed in private schools within their division just as they would for students with disabilities within [their] public schools’ as part of Child Find activities, but subsequently they have demonstrated a wide variety of service offerings.

- If a student is found eligible for SPED services, but the parent waives the right to a free and appropriate public education (FAPE) for educational reasons (i.e., home-schooled or privately placed within the child’s home district): the student does not have the same rights to receive some or all of the special education and related services that public school children would receive (Parent’s Guide to Special Education, pg. 35). In this case the LEA, in consultation with the private school and/or parent, would develop an Individualized Service Plan describing what, if any, services would be provided, including the Instructional Setting for those services. If the decision is made to provide therapy services, the parent or designee would bring the student to the public school where the child would normally have been enrolled to receive services within designated school hours, as arranged by the parent and therapist. If the Service Plan designates the instructional setting as the private school, then the LEA must contract a therapist not affiliated with PREP to provide the service. If the child attends a private school located in another school division, that division is responsible for the development of the Individualized Service Plan and provision of services.

- If a preschool-age child is identified as eligible for SPED services, but attends a private preschool he/she might have attended as a child without a disability, an IEP will guide both case management and any required related services. This might include consultative or direct service offered in the private setting or in the public school as specified under Instructional Setting under Related Services in the IEP.

- Students who are home-bound for medical reasons will receive services at home or at a suitable instructional setting convenient for the student, family, and service provider as determined by the IEP team.

- If a student becomes home-based for behavioral concerns, suspensions or expulsions, the IEP team shall determine if a new home-based IEP is required. This new IEP would delineate changes to instructional setting, service delivery model and/or duration of services. If the student remains on the school-based IEP, then the therapist should only provide services according to the Instructional Setting designated under Related Services in the child’s current IEP.
Extended School Year Services

Most students who qualify for related services receive OT/PT during the 10-month school year only. In some instances, a student may require “extended school year” (ESY) services in order to prevent substantial regression during the summer. The determination of substantial regression is based on documentation of student performance before and after other school breaks (i.e., weekends, holidays, vacations) and the amount of time it takes to regain previously mastered skills. ESY services are also considered if the student is demonstrating an emerging life skill that might otherwise be delayed. ESY services are not provided for the purpose of maximizing a student’s educational opportunities. The school district has great discretion in how, where, and for how long ESY services are delivered. Goals are culled from the previous year’s IEP, and may or may not include any of the student’s related service goals.

If the district chooses to provide related services for a particular student under ESY, the district will contract for those services with providers outside of their PREP contract. PREP therapists are contracted for a 10-month school year through PREP, but may contract privately with the districts PREP serves to cover ESY services.
Make Up Policy for Therapy Sessions Missed

When PREP therapists are unable to provide service time as per a student’s IEP, therapists are expected to make up that designated time.

Therapists will not be expected to make up sessions for students under the following circumstances:

- the student is absent or unavailable at the time of the scheduled session (e.g. field trips, testing, assemblies)
- when school is not in session due to holidays
- when school is closed due to inclement weather

The therapist should note on the child’s attendance record the circumstance of all missed sessions.

Recommended methods to provide a therapist with more flexibility for making up missed sessions are as follows:

- Whenever possible, frequency of services on the IEP should be stated in a manner that would indicate flexibility in a variety of educational settings. For example, scheduling services for 2 hours per month might be more beneficial than 30 minutes per week. (Check with your district SPED Director to see if this method of writing frequency on the IEP is approved.)
- If allowed on your district’s IEP software, therapists could list their service delivery method in the Related Service section as Direct/Consult. This is a true reflection of best practice, in order to integrate services throughout the child’s day. Direct/consult also allows the therapist to count time required for consultation with school staff, parents, meetings and fabrication of equipment or therapy materials. When this combined service delivery designation is not used in a district, the therapist may list direct and consult time separately on the Related Service page of the IEP.
- If a therapist anticipates a change in schedule that will result in missed sessions, she/he can “bank time” by seeing students a few minutes longer per session before or after the missed session. (Remember this is for the purpose of IEP required time, as Medicaid visits are on a per session basis and not determined on the number of minutes.) The therapist should document all time spent with the student on the daily attendance record.
Documentation and Procedures
Student Observation ("Screening") Procedure

If a student is eligible for Special Education services:
A student observation may be requested by a teacher when she/he seeks assistance for instructional strategies for a specific student. VDOE states that an observation may be part of a “…screening of a student by a teacher or specialist to determine appropriate instructional strategies for curriculum implementation (8VAC20-81-10). If the intent of the related service provider is to observe the student solely to provide suggestions for the teacher for support of instruction/learning, then Prior Written Notice (PWN) and parental consent is not required.

If a student is suspected of requiring OT or PT services to make progress, a referral for evaluation should be made by the IEP team. Following the review of existing data, and stating the need for additional information, parental consent is required for the related service evaluation to proceed. Observations of students participating in school environments and activities are one of a number of standard components of a comprehensive therapy evaluation, and as such are required to have (PWN) and parental consent. (8VAC20-81-10).

The requirement for parental consent depends on the purpose of the observation and use of the data. The decision to refer a student for a therapy evaluation is always an IEP Team decision and always requires parental consent.

If a student is not eligible for Special Education services, then the therapist may conduct an observation only as part of the school’s Response to Intervention (RTI) plan for the student, once an official referral from the RTI Team has been received.

When a therapist conducts a Screening she/he should:
● meet with the teacher to assess areas of concern and what interventions have been tried
● observe the student in the daily school routine and environment in which he/she is normally conducting the activities of stated concern
● conduct the screening globally within the natural environment, without singling out a child or removing them from the class activity
● use the discipline specific OT or PT Student Screening Feedback form (Appendices C and D, respectively) to record observations and make recommendations for the teacher and/or RTI Team. (The parent does not receive a copy of the form, this is provided as a reference for the referring teacher only.)
● Following the screening, the therapist should meet with the teacher to review the information on the form and to brainstorm possible interventions. Therapist may include differentiated learning activities, transition options and school environmental adaptations based upon a Universal Design to Learning (UDL) frame of reference.
● The therapist is not required to meet directly with the RTI team or parents following the screening. The referring teacher will report suggestions to the team and implement suggestions as appropriate. The related service provider will not follow up with this student unless another referral is made by the team.
Therapy Evaluation Referral Procedure

The decision to conduct an occupational and/or physical therapy evaluation should be made by the student’s IEP team or 504 plan committee following the determination of the child’s eligibility for Special Education or 504 Services.

Case managers referring a student for an occupational and/or physical therapy evaluation should implement the following steps, in accordance with the local school division’s procedures:

● Provide PWN to the parent, and obtain written parental consent for the evaluation.

● The parents should be provided with a copy of *Virginia Special Education Procedural Safeguard Requirements under the Individuals with Disabilities Education Act*. To comply with Section 504, the LEA may use the IDEA procedural safeguard document or use a document developed by the LEA to address only 504 procedural safeguard requirements.

● Notification of a new referral should be sent to the therapist’s email address within a day of receiving signed parental consent. The district’s referral form or student’s IEP is then shared with the therapist with educational concerns listed. PREP therapists’ email addresses are available on the PREP Website ([http://www.prepivycreek.org](http://www.prepivycreek.org)) under the PREP Staff tab on the Contacts dropdown menu.
**Therapy Evaluation Content**

The nature of the evaluation and the selection of evaluation tools are determined by the therapist’s professional judgment. Assessment tools used by occupational and physical therapists in schools should be carefully chosen to evaluate the student’s ability to perform in the educational setting. See Appendix E - Assessment Tools in the *Handbook for Occupational and Physical Therapy in Public Schools in Virginia 2010, VDOE*, for a list of norm-referenced, criterion-referenced and judgment-based assessment tools commonly used by school based therapists.

School-based therapists are expected to evaluate the student’s performance within the educational environment to determine the student’s strengths and weaknesses unless the student is homebound or awaiting placement. Occasionally, sufficient data are available from therapy evaluations conducted within a different school system or agency. Select data from these evaluations may be incorporated into the therapist’s report, if the prior therapy evaluation was conducted by a licensed therapist within six months of the current assessment process.

**Evaluations typically include the following:**

- Review of pertinent medical and educational records including current IEP or 504 Plan, if appropriate
- Interviews with the student, teacher(s) and paraprofessionals
- Observations in a variety of student contexts or environments (e.g., classroom, cafeteria, PE, playground, job training site)
- Evaluation of activity demands that impact educational performance
- Administration of informal evaluation tools, such as self-care, functional, sensory and behavioral checklists
- Administration of standardized assessments
- Summary and recommendations based on the evaluation findings for IEP team consideration

A written report must be completed at the end of each evaluation. Educators and parents find it helpful to have OT and PT evaluations and findings reported in layperson terms. Medical terms should be explained by definition and application to the educational setting. It is also beneficial for the therapist to reiterate that the evaluation addresses the student’s ability to participate in functional, educationally relevant activities. See Appendix F- *OT/PT Evaluation Template* for recommended evaluation format.

The goals of evaluation are to:

- Identify functional skills and impairments that impact the student’s access to his educational program and/or his educational environment
- Assist the educational planning committee with service determination, goals, objectives, and other suggestions (e.g., equipment, modifications, and referral to other disciplines)

Evidence of a delay or impairment does not necessarily mandate therapy services. Therapists offer specialized information and recommendations to support an IEP or 504 Plan team decision rather than make a unilateral decision.

*Source: Handbook for Occupational and Physical Therapy in Virginia Public Schools 2010, VDOE*
Completed Evaluation Policy

Eligibility for special education or related services must be determined within **65 business days** after the special education administrator receives the referral for evaluation, unless the parent and the eligibility group agree in writing to extend the 65 business day timeline to obtain additional data that cannot be obtained during the initial 65 business days.

*Source: Parent’s Guide to Special Education 2010 Edition Pg.21 VDOE*

Therapists will make every effort to complete evaluations as quickly as possible (recommended within 30-45 days). Therapists should notify the case manager if there are extenuating circumstances which may require the full 65 days.

**It is the therapist’s responsibility to notify the case manager when the student’s evaluation is completed.**

Copies of the therapy evaluation should be sent to the following locations:
- The district’s Central Special Education Office
- The student’s personal information [green] folder within his/her school office
- The student’s case manager

The therapy evaluation must be available in these locations **at least two (2) business days before the planned meeting to determine eligibility for a related service**, in order for the parents and other team members to view the document.

The student’s case manager is responsible for notifying the parents and scheduling the meeting with the IEP team to review the therapy evaluation and determine the child’s eligibility for therapy services. Therapists should provide the case manager with possible dates and times that they will be available to meet.

The therapist should make every effort to attend the scheduled meeting, in order to review the evaluation with the child’s parents/IEP team, answer questions and make recommendations concerning intervention.
Individualized Education Program (IEP) and Progress Reporting

The IEP is a written plan that describes the unique educational needs of a student with a disability and identifies special education and related services required to meet those needs.

An IEP must be in effect before special education and related services are provided to an individual student.

Plans are developed, reviewed, and revised during annual IEP team meetings. An OT/PT evaluation may be requested at an IEP meeting. Decisions about the need for and the amount of OT and/or PT services are made by the IEP team.

Under the current IDEA regulations, the core team members are required to be at all IEP meetings. Related services personnel are not considered part of the core team. It is recommended that therapists attend as many meetings as possible, however, this is not always feasible. If a therapist has conflicting meetings, they should try to prioritize based on where their input is most essential to the team. A therapist should provide a draft of the Present Level of Educational Performance (PLOP), goals and recommendations regarding therapy amount/frequency to the case manager in advance. If unable to attend, the therapist should inform the case manager that they will not be able to attend the meeting and provide a method (email address or phone number) for the parents to contact them.

Therapists have a professional obligation to provide input regarding the decision concerning therapy services.

All of the districts within the Piedmont Regional Education Program create their IEP’s using a web accessed program. These on-line programs allow team members to access this information from any internet device simultaneously. The IEP programs used by the districts may vary slightly. Trainings are available at the beginning of each school year for district staff. Therapists should contact their Lead Therapists if not familiar with the program that the district is using.

IEP Content

Present Level of Educational Performance

The Present Level of Educational Performance (PLOP) is a written passage describing how the disability affects the student’s participation and progress in the general curriculum and the educational needs that result from the disability. This section reports baseline measurements and levels of functional skills in objective and measurable terms. The present level of performance should be an integrated summary that relates directly to the child’s performance on the current IEP’s goals and their function within the school. Any data not easily understood needs to be explained. The Present Level of Educational Performance should provide a rationale for the other components of the IEP. Generally, OT and PT comments, the date, and the therapist’s name or initials, should be put in the Non-Academic section of the PLP if the IEP is not fully integrated.
**IEP Goals**
The IEP must state measurable annual goals for the student. Goals must relate to the needs of the student resulting from the disability and help the student be involved and progress in the general education curriculum.

Therapy goals should be integrated into the class/school routine and relate directly to the student’s educational goals. Whenever possible, therapists should create goals in conjunction with the student’s special education teacher. When writing goals, the section “person responsible” should always include the therapist, the special education case manager and any other person on the team that could also work on that goal. In a school based practice, the therapist should not be working on a goal in isolation. As educational team members, therapists work closely with teachers, families, and the student (when appropriate) to identify solutions and implement strategies that help students participate in appropriate educational programs.

**Measurement of Goals**
The IEP must include measureable annual educational goals for the student. The child’s need for benchmarks or short term objectives must be considered by the IEP team. Parental consent is not required before the administration of a test or other data collection method that is used to measure progress on the child’s IEP goals. However, the intent to use these measures should be stated in the IEP and the IEP must state how progress towards the annual goals will be measured.

**Accommodations**
Therapists’ contributions to the Accommodations section of the IEP are valuable to the team. Accommodations can assist in the child’s success in school goals. Accommodations may include but are not limited to:
- daily range of motion conducted by classroom staff, (trained by therapists) in preparation for functional tasks such as switch use, or standing in a stander for a group cooking activity
- equipment needed, described *without naming specific brands* (e.g. portable word processor with word prediction software, *not* a NEO)
- level of assistance required for a functional task, such as help carrying cafeteria tray
- additional materials needed, such as copies of class notes
- increased time for completing tasks or leaving class 5 minutes early for navigation through the halls
- environmental modifications/equipment adaptations, e.g. sensory diet, accessibility needs, preferential seating, cushions or type of chair suggested, slant to keyboard, etc.
- visual strategies, such as a picture schedule, visual timer, etc.

**Amount and Frequency of Related Service**
The student’s needs, as identified by the PLOP and IEP goals, are the driving force for service determination. Decisions regarding the type and frequency of therapy service are made by the IEP team. The team should consider how therapy will affect the student’s participation with nondisabled peers and in the general education curriculum. In an integrative model, the typical amount of time a PREP therapist would see an individual student directly is 30 to 60 minutes per week. The therapist should additionally instruct the school team on how to carry out therapy recommendations and strategies as part of the child’s school routine. *(See School Based Therapy Service Models)*
Therapists should consider stating related service amounts in ‘block time’ (monthly or quarterly vs. weekly) on the IEP if allowed by the District/IEP program. This allows for greater flexibility and often more realistic service delivery.

**Progress Reports**
Parents of students with Special Education services must be informed of progress as often as parents of children without disabilities are informed. Therefore [IEP] Progress Reports will go out whenever the school district issues [General Education] report cards to their student body. Therapists should be aware of their district’s policy on report card distribution. This is typically on a 9 week cycle, but may be bi-annually for younger students, or include interim reports for older students. Progress Reports are completed by the team using the District’s chosen on-line IEP program. The student’s case manager is responsible for distribution of the progress reports to the parents/guardians once all team members have added their information.

Individualized Education Programs and Progress Reports will become part of the student’s permanent school record within their LEA.
Therapy Documentation: Daily Records

PREP Therapy files for every student served should include the following:

**Daily Attendance Record**
At the beginning of the school year a daily Attendance Record form will be provided by PREP that corresponds to the district calendar(s) in which the therapist works. Therapists will maintain a yearly Attendance Record for each of their students in order to mark the amount of therapy time spent per session. In addition to time spent in direct services, the therapist should also indicate time spent in consultation, staff trainings, meetings and creating materials used directly to ensure the student’s access to the educational curricula and environment. The daily note for that session should indicate how the time was utilized. A coding system is listed on the form to indicate student absences, snow days, therapist absences, if the student was unavailable or if the session was a “Make-Up” session. If the Make-Up code is utilized, the therapist should indicate the date and time of the scheduled session that was being made-up.

This Attendance Record provides evidence of how and when the related service time was provided as per the student’s IEP.

**Daily Documentation**
Daily Documentation is required for all therapy intervention with students and should include the following information:
- date of service
- educational goal or school activity and environment
- therapeutic intervention(s), accommodations, assistive technology or strategies utilized
- measureable outcomes, with respect to the initial goal(s)
- other pertinent information to guide future sessions
- consultation or training of staff
- equipment issued
- any contact with parent/guardian, physician, private therapists, etc.

**Documentation Forms**
Therapists should use the Medicaid Progress Notes form (DMAS 48 [OT] or 36 [PT]), located on the PREP website (under the Medicaid section as OT or PT Progress Notes) for students who receive Medicaid services. Non-Medicaid covered student notes may also be recorded on Medicaid Progress Notes forms, or the therapist may choose to use the 9 wk. Progress Note form (Appendix F) to document each student’s daily progress towards therapy goals. Plans of Care (POC) and additional Medicaid documentation are not required for non-Medicaid students, nor will their chosen progress note forms be turned into the office monthly.
Documentation for Medicaid

At the beginning of every school year individual therapists will receive an email requesting caseload information. This should be recorded using the *Caseload Form* (located on the PREP website) and sent to the PREP Medicaid Coordinator and appropriate Lead Therapist. (If therapy services are being provided to students by a COTA or PTA, see *Caseload Recording Procedure for COTA’s/PTA’s and Supervising Therapists* section regarding how the *Caseload Form* is specifically to be filled out.) Following receipt, the Medicaid Coordinator will then send each therapist a list of the students on their caseload who are eligible for Medicaid billing. This list should be regarded as highly confidential.

All Medicaid forms are located on the PREP website (www.prepvycreek.org), under the *Medicaid* section > *forms*. It is suggested that therapists retain copies of Medicaid paperwork until the Medicaid Coordinator finishes billing for the school year.

**Note:**

- The Medicaid Coordinator does not need original documentation as the forms are scanned to DMAS; however, copies need to be legible.
- Medicaid does not permit the use of correction fluid on any Medicaid/medical forms. When correcting Medicaid/medical forms, the error should be marked through with a single line, and an initial and date for each correction.
- Medicaid documentation may be hand-delivered, sent via FAX or inter-office mail, or may be emailed in encrypted or password protected form to the Medicaid Coordinator. *Google docs versions are not HIPPA compliant and may not be forwarded/shared.*

For students who receive Medicaid services the following documentation is required:

**Therapy Request for Assessment** (DMAS 51) form must be filled out for any Medicaid eligible student who has received an OT or PT evaluation. This form is completed regardless of whether the student is found eligible for related services by the team. The therapist should attach a copy of the competed evaluation to this form. Medicaid will reimburse for an evaluation under the following circumstances:

- Student is being evaluated to determine eligibility for special education and related services and an assessment/evaluation is necessary.
- Student has been undergoing therapy and a significant change in condition/status affecting function has invalidated the most recent evaluation, so a new assessment/evaluation is necessary.

**Note:** *Triennial evaluations are not reimbursable*

**Therapy Plan of Care (POC)** (DMAS 42) will be completed by the therapist one time each calendar year for every Medicaid eligible student. The date of implementation must ‘match’ the date on the *Long Term Goal(s)*. Implementation can coincide with the student's IEP start and finish dates or be created routinely at the initiation of each school year for the term of that year. The POC must be completed and signed before Medicaid billing can begin. The POC must be signed and dated by the
therapist's hand. When listing Specific Interventions, it is recommended that the therapist refer to the list of therapy specific Activities on the Progress Note form (DMAS 48 or 36) that are appropriate for the student. Frequency of Sessions should be written in a range, such as 1-2 times per week. This allows the therapist flexibility if two shorter sessions are required to attain the goals or make-up sessions are needed. Medicaid billing is compiled per session, not by the amount of time the student spent in therapy. See the POC directions at the end of the form for any questions regarding completing the document.

Therapy Plan of Care Addendum (DMAS 33) is completed by the therapist if a change in the original Therapy Plan of Care (DMAS 42) is required before the end date. Changes may also be noted within the Therapy Progress Note (DMAS 48 or 36) in lieu of filling out DMAS 33.

Reasons for this addendum are as follows:

- The Long Term Goal(s) need to be updated
- The student’s IEP is being amended with a significant change to the duration of the plan

Occupational Therapy (DMAS 48) or Physical Therapy (DMAS 36) Progress Notes are records of each scheduled therapy session. Each treatment period should be accounted for. (For example, a child seen 2x/wk. would have two notes for that week; if the student was unavailable, the session fell on a snow day or holiday, or the therapist was absent, each missed session would be dated and have a corresponding code). If a treatment session was provided for make-up purposes, indicate when the session was made up both on the student’s attendance record and Therapy Progress Note, and include the scheduled date the session was replacing in addition to the appropriate make-up code.

The session notes are compiled on the Therapy Progress Note forms and turned in at the end of every month. Therapists may combine two months onto one form when there are only one or two weeks within any given month, as in the beginning or end of the school year (August/September or May/June). The month(s) for the Progress Note must be listed at the top of each page.

Medicaid requires that the therapist document the Students’ response to treatment by measurably listing:

- Therapeutic Activity
- The child’s progress (in percentages) towards established goals
- Responses to treatment that are goal related
- The therapist’s interpretation of the child’s response to treatment

Note: Discharge from Medicaid billable services is notated on the final Progress Note (DMAS 48 or 36). Indicate whether therapy changed from direct to consultative services or the student was discharged from services completely.

Note: The Supervision Visit box at the end of the Medicaid form is filled out by the supervising therapist only if a COTA or PTA is working directly with a student.
Caseload Recording Procedure for COTA’s/PTA’s and Supervising Therapists

Licensed assistants (COTA’s and PTA’s) who are providing direct therapy services to students are required by law to receive monthly supervision from a licensed therapist. In addition, supervising therapist’s are required to perform an initial evaluation, establish Medicaid POC and therapy goals, and provide supervision of documentation and intervention.

To avoid confusion when reporting student caseloads and billable [IEP/Medicaid] time, the procedure detailed below will be followed when filling out the Therapist Caseload Form found on the PREP website.

Therapy Assistants will fill out their Caseload Form, listing all of the students that they provide services to with the amount of direct treatment time they provide the student. The student’s exact IEP time should be listed unless actual treatment time is split with the supervising therapist. In that case, list only the time personally provided to the student. For example, if a student’s IEP time is 60 minutes of direct intervention per week, and the supervising therapist is seeing the student for 30 minute per week, the assistant would list “30 minutes per week” in the time column on their caseload form.

Supervising Therapists will fill out their Caseload Form by typing “Direct Students” in Column A, leaving the other columns in that row blank. On the subsequent rows, all of the students for whom the therapist provides the entirety of their direct IEP service time are listed, along with the full amount of that time.

The therapist will then skip a row line and write “Direct and Supervision” in Column A, with the rest of the columns in that row left blank. This will be followed by the list of students for whom direct therapy coverage is split with the therapy assistant. In the Time Column, list your direct intervention as a weekly measure (i.e., 30 minutes per week), and your supervisory time (30 minutes per month) separately. (Thirty minutes per month is the estimated supervisory time that will be used for bookkeeping purposes.)

Following another blank row, lastly list in Column A, “Supervised Students” followed by the list of those students for whom the therapy assistant provides all of the direct intervention. For these remaining students on the therapist’s caseload, “30 minutes per month” listed in the time column will indicate the approximate time expected to be spent on supervision.
Eligibility/ Triennial Meetings

Occupational and Physical Therapists, as related service providers in the schools are not members of the initial eligibility or triennial teams. Related service providers do not determine educational eligibility for Special Education Services and are not routinely involved in eligibility assessments or meetings.

When a student is suspected of having a disability and is initially referred for comprehensive evaluation, the eligibility committee reviews the assessments and any pertinent information to determine if the child has a disability that requires special education. If a student is found eligible for special education under IDEA, decisions about the need for related service evaluations are made by the IEP team based on assessments and/or other relevant data. After eligibility is established, the IEP team determines if related services are needed to help the student benefit from his educational program or access the general curriculum.

Source: Handbook for OT and PT Services in the Public Schools of Virginia 2010, VDOE

Therapists can provide an evaluation for the eligibility team, if assessment information is essential in determining that the child has a disability that requires special education.

If a student is receiving OT or PT services during his/her triennial year, the team may ask the related service provider for an update on the child’s status from the therapist’s perspective. In this instance, the therapist may give the child’s case manager the most recent progress report or a summary of performance to share with the team, in lieu of attending the meeting.
Termination from Therapy Services

The IEP team, which includes the therapist, makes the decision concerning the continued need for OT and/or PT services. When a therapist determines that a student has mastered all of his/her therapy goals and is functional within the school setting, they may recommend discharge from OT or PT services. The therapist should discuss this plan with the child’s case manager and parents prior to the IEP meeting, where discharge from services will be recommended to the full team. The child’s Present Level of Performance (PLOP) must reflect his/her ability to function within the school setting and explain why the therapist believes services are no longer warranted.

Parental consent is necessary for termination of OT and/or PT services, and the IEP must be amended to reflect this change.

If the parent does not consent to termination, the district’s special education department will mediate the resolution of the dispute. Therapy services must continue as written in the current IEP, until the team comes to a consensus.

Current literature recommends the use of the less stigmatizing term “graduation”. Graduation from therapy services is a positive indication of the student’s progress and achievement of goals to the maximum extent possible. Consider using the word graduation vs. discharge or termination whenever possible.
**Records Management**

PREP working files are not part of the student’s official records. They still are, however, considered *Educational Records*, and as such fall under the Freedom of Information Act. Once a student is discharged from service, the procedures below are followed to guarantee that the file is properly secured. Only the information listed below which is unique to the therapist’s working records are maintained. All other therapy notes that were maintained while the child was actively receiving therapy services have already been summarized in the child’s IEP or progress reports, which are available in the student’s permanent record. If the child is picked up again for services in the future, the new therapist will have access to information related to previous interventions in the permanent record.

**This culling process for students discharged from therapy services should be done at the end of every school year to prevent a backup or loss of records.**

**Procedure:**
When a student is discharged from therapy services for any reason (i.e., mastered goals, moved out of district, graduated, deceased), the therapist should:

- **Keep only test protocols (booklets) and service delivery attendance records.**
  Working files will be cleaned of all daily notes and other data used to support summary reports (which are maintained in the student’s permanent record in his/her school district). Information removed from the files will be treated as confidential material and shredded.

- **Once the file is cleaned, the date 5 years after the child turns 18 will be written on the outside of the folder.** (For example, if a student turns 18 in 2017, the year “2022” will be written on the outside of his/her folder.)

- **The folder is then given to the PREP secretary, who will file it under the appropriate year in the PREP discharged records file. An annual date will be set when these discharged working files (which have reached the 5 year mark) will be destroyed. Official notification in a regional newspaper will be made two (2) weeks prior to destruction.**
Performance Guidelines and Review
New Therapist Mentoring Program and Suggested Schedule

The mentoring calendar outlined below is followed through the first year of employment with PREP. Once that criterion has been met, the therapist will be evaluated via the Experienced Therapist Protocol.

The format of the contact can be discussions with questions and answers, working together with a student, observation and consultation, assistance with evaluations and documentation, an in-service on a chosen topic, or any method deemed collaboratively instructive.

- New Graduates or therapists with less than 3 years prior experience will have contact with the Lead Therapist 1-3 times per month or as needed.
- Therapists new to PREP with more than 3 years prior experience will have contact with the Lead therapist at least one time per month as determined collaboratively.

The School Year Timeline Will Include the Following Expectations

August
- Initial Orientation to PREP
- Medicaid training

September
- Complete OT/PT Orientation Skill Rating (Appendix G) and discuss optimal learning/supervisory style
- Review specific caseload/equipment needs
- Schedule date/time/location for first observation in October and post-observation feedback meeting

October
- Establish yearly (SMART) goal based on the Skill Rating and guided by SMART Goal Components (Appendix H), and develop collaborative plan to attain goal
- Provide Lead Therapist the therapeutic goals of the student who will be observed, one week prior to observation
- First scheduled observation
- Post-observation meeting held with feedback
- Review daily progress notes and Medicaid documentation
November
- Review an evaluation written by the new therapist using the OT/PT Evaluation Template (Appendix E) and the Peer Review of a Therapy Evaluation Report (Appendix I)

December
- Meet with Lead Therapist to discuss progress toward annual SMART goal
- Review daily progress notes and Medicaid documentation
- Schedule date/time/location for second observation in January and post-observation feedback meeting

January
- Give Lead Therapist the therapeutic goals of the student who will be observed, one week prior to observation
- Second scheduled observation
- Post-observation meeting held with feedback

February
- Review second evaluation written by the new therapist using the OT/PT Evaluation Template and the Peer Review of a Therapy Evaluation Report
- Review daily progress notes and Medicaid documentation
- Schedule date/time/location for third/last observation in March and post-observation feedback meeting

March
- Give Lead Therapist the therapeutic goals of the student who will be observed, one week prior to observation
- Last scheduled observation
- Post-observation meeting held with feedback

April/May
- Review of the end of the year expectations concerning documentation, meetings, and equipment
- Final evaluation meeting with Lead Therapist and OT/PT Supervisor using feedback from observations, documentation samples, and teacher/team feedback from the Service Delivery Survey (Appendix J) to complete the OT/PT Core Competencies Collaborative Assessment (Appendix K). This collaborative assessment will go into the therapist’s personnel file. Thereafter, the therapist will be evaluated based on the Experienced Therapist Performance Expectations components.
Experienced Therapist Performance Criteria

A therapist is evaluated using the following components after they have completed a successful first year of employment with PREP under the Mentoring Program. A formal performance appraisal will be included in the therapist’s personnel file every third year. The same components will be reviewed with the Lead Therapist in a discussion format at an end-of-year meeting on the other two years of the three year evaluation cycle. A performance improvement plan will be developed if it is determined that the therapist’s performance has not met job expectations. This plan will delineate specific goals and time-frames in which to improve areas of concern.

Components

1. **Attend OT/PT Meetings**
   All full-time therapists are required to attend all OT/PT meetings. Part-time therapists are encouraged to attend meetings and can flex this additional time. If a meeting is missed, the therapist is responsible for any information presented.

2. **SMART Goal**
   All therapists are required to develop an annual professional goal guided by the SMART Goal Components (Appendix H) within the first quarter of the school year. The goal may be either professional or student centered in nature, but focus should remain on improved service delivery and student outcomes. These will be shared with the Lead Therapist and Executive Director once formulated. Progress on this goal will be discussed at the therapist’s annual review meeting.

3. **Direct Clinical Observation and Documentation Review**
   The Lead Therapist will do one direct clinical observation and documentation review per year on each experienced therapist. The PREP Executive Director or her designee will also attend during Formal Evaluation years.
   **Procedure**
   - At a designated time in the school year, an observation will be scheduled with the Lead Therapist.
   - The therapist should have his/her student goals, daily progress notes and one recent student evaluation available for review.
   - A post-observation feedback meeting will be held with the Lead directly following the observation session or at a mutually agreed upon date.

4. **Service Delivery Survey** (Appendix J)
   In order to obtain feedback from district staff, information will be gathered from each therapist’s teachers, case managers, and/or designated team members in January annually. Therapists will receive the survey results at the therapist’s annual review meeting with the Lead Therapist and OT/PT Supervisor in the spring.
Experienced PT’s and OT’s will meet with their respective Leads annually to review accomplishment of the above components. Experienced COTA’s and PTA’s will review the above components with their supervising therapists annually. In addition to review of the above components, at the end of the third year formal performance appraisal cycle, OT’s and PT’s will meet with their respective Leads to collaboratively fill out and review the Core Competencies Assessment. COTA’s and PTA’s will meet with both their supervising therapist and respective Lead to review their Core Competencies.

**OT/PT Core Competency Collaborative Assessment Review**

*OT/PT Core Competencies Collaborative Assessment* (Appendix K) is an assessment of various clinical skills and professional behaviors. This measure assesses therapists using the VDOEs recommended seven *Performance Standards*. This assessment will synthesize all of the components, including district staff survey information, and is collaboratively reviewed with the Lead Therapist. COTA/PTA competencies will be assessed with their supervising therapist(s), using the *COTA/PTA Core Competencies Assessment* (Appendix M).

Therapists receive a rating for each *Performance Indicator* as follows: *Unacceptable* (therapist has not conducted themselves up to professional standards on the designated indicator), *Developing* (this category is appropriate for new therapists or those new to a school based practice), *Proficient* (the therapist is meeting professional expectations for an experienced staff member), or *Exemplary* (this category is designated for therapists who go beyond expectations in an area). Therapists may disagree with the performance appraisal findings. Points of disagreement may be noted on page 11 of the *OT/PT Core Competencies Assessment* or on page 3 of the *COTA/PTA Core Competencies Assessment*, or clearly delineated in a separate letter to be attached to the form. Competencies Assessments will be collaboratively reviewed every three years, as part of the formal evaluation procedure.
Guidelines for the Supervision of Certified Occupational Therapy Assistants

The following guidelines are based upon American Occupational Therapy Association (AOTA) national recommendations, VDOE guidelines, the Virginia Board of Medicine, and the Center for Medicaid Services requirements.

In the AOTA guidelines, supervision is viewed as a cooperative process in which the OTR and COTA participate in a joint effort to establish, maintain, and or elevate a level of competence and professional performance. Supervision is based on mutual understanding between the supervisor and the supervisee about each other’s competence, experience, education, and credentials.

**Supervision**

A Variety of Types and Methods of Supervision should be used
Methods may include “Direct” such as observation, modeling, co-treatment, discussions, teaching and instruction or “Indirect” methods such as phone conversations, written correspondence or e-mails.

**Amount of Clinical Supervision**
According to Virginia Board of Medicine regulations, the OTR providing supervision must meet with the COTA to review and evaluate treatment and progress of each individual student at least once every tenth treatment session or 30 calendar days, whichever occurs first.
A supervising OTR should provide direct supervision at least once per month and indirect supervision more frequently, as required to ensure safe and skilled therapeutic intervention. The OTR must also review all written documentation (on both Medicaid and non-Medicaid students) and co-sign notes at least monthly.

**Documentation of Supervision must be maintained**
Utilize the COTA/PTA Supervision Documentation Record (Appendix L) or a comparable form to record all supervisory contacts. COTA supervision for Medicaid students can be documented monthly, by using the section on the last page of the Occupational Therapy Progress Notes (DMAS 48) form (located on the PREP website under Employee Forms).

**Roles and Responsibilities:**

**Student Evaluations**
The OTR initiates and directs the evaluation, interprets the data, writes the report and develops the intervention plan.
The COTA may assist with data collection, provided the OT has established the COTA’s competency. The OT must be confident that the assessments will be administered in the standardized method by the COTA, and that the results will be gathered safely and effectively. The decision regarding which assessments are appropriate for the student would be determined solely by the OT or collaboratively with the COTA.

**Intervention Planning**
The OTR is responsible for the development of the initial intervention plan which includes the student’s goals, objectives, and frequency of service.
The COTA is responsible for being knowledgeable about evaluation results and for providing input into the intervention plan, based on student needs and responses.
**Intervention Implementation**
The OTR has overall responsibility for implementing interventions, and training and supervising the COTA. The COTA selects, implements, and makes modifications to therapeutic activities and interventions that are consistent with demonstrated competency levels, student’s goals, and the requirements of the curriculum.

**Intervention Review**
The OTR is responsible for determining the need for continuing, modifying, or discontinuing OT services. The COTA contributes to this process by exchanging information with and providing data/documentation to the OTR about the student’s responses during intervention.

**Documentation**

**OTR Responsibilities:**
- initial evaluation/report
- establish goals, objectives and frequency for IEP
- assemble forms to record attendance, document student interventions and collect data
- Medicaid Plan Of Care (POC)
- ensure Medicaid Occupational Therapy Progress Notes are completed, cosigned and turned in at the end of each month
- Medicaid Discharge planning/documentation
- documentation of COTA supervision
- review and co-sign all documentation written by COTA
- review all student information prior to COTA attending a team or IEP meeting
- keep records of overall caseload data and turn in to PREP upon request

**COTA Responsibilities:**
- conduct and score specific standardized assessments as determined by OTR after training
- document daily student attendance and progress on forms provided by OTR (for both Medicaid and non-Medicaid students)
- write student Progress Reports (report cards) in consultation with OTR as prescribed by District (i.e., quarterly)
- notify OTR of evaluation referrals and meeting requests
- attend team or IEP meetings after review of information with OTR
- keep records of caseload data and turn in to PREP upon request
- keep supervising OTR(s) updated in regard to any student/caseload changes.

**Performance Review**
The supervising OT will meet with the COTA to conduct an annual performance review according to the guidelines set forth under either the Mentoring Program or Experienced Therapist Performance Criteria sections of this manual.
Guidelines for the Supervision of Physical Therapist Assistants

The following policies are based on American Physical Therapy Association (APTA) national recommendations, Virginia Department of Education guidelines, Virginia Department of Health Professions regulations, and the Center for Medicaid Services requirements. According to the APTA, direction and [at least general] supervision of the PTA are essential to the provision of quality physical therapy services. At PREP supervision is viewed as a cooperative process in which the PT and PTA participate in a joint effort to establish, maintain, and/ or elevate a level of competence and performance. Supervision is based on mutual understanding between the supervisor and the supervisee about each other’s competence, experience, education, and credentials.

Supervision

A Variety of Types and Methods of Supervision should be used
Methods may include “Direct” where the PT is immediately available (on-site, observing, modeling/instructing, co-treating, discussing) or “General” where the PT is available for consultation (i.e., phone conversations, written correspondence or e-mails).

Amount of Clinical Supervision
The PT providing supervision must meet with the PTA to review and evaluate treatment and progress of each individual student at least once every 30 calendar days or within 12 student visits, whichever occurs first.
A supervising PT should provide direct supervision at least once per month and indirect more frequently, as required to ensure safe and skilled therapeutic intervention. The PT must also review all written documentation (on Medicaid and non-Medicaid students) and co-sign notes at least monthly.

Documentation of Supervision must be maintained
Utilize the COTA/PTA Supervision Documentation Record (Appendix L) or a comparable form to record all supervisory contacts. PT supervision for Medicaid students can be documented monthly using the section on the last page of the Physical Therapy Progress Notes (DMAS 36) form (located on the PREP website under Employee Forms).

Roles and Responsibilities

Student Evaluations
The PT performs the initial student evaluation, interprets the data, writes the report and develops the intervention plan which includes the student’s goals, objectives, and frequency of service.
The PTA’s scope of practice excludes initial evaluation of students, initiation of new treatments or alterations to the intervention plan.

Intervention Planning
The PT is responsible for the development of the initial intervention plan and any subsequent alterations to the plan or therapeutic activities.
The PTA is responsible for being knowledgeable about the evaluation results and intervention plan, including goals and objectives, and treatment frequency. The PTA may provide input based on student needs and responses to assist the PT in intervention planning.
**Intervention Implementation**
The PT has overall responsibility for implementing interventions, and training and supervising the PTA. The PTA selects, implements, and makes modifications to therapeutic activities and interventions consistent with PT guidance, demonstrated PTA competency levels, student’s goals, and the requirements of the curriculum.

**Intervention Review**
The PT is responsible for determining the need for continuing, modifying, or discontinuing PT services. The PTA contributes to this process by exchanging information with and providing documentation to the PT about the student’s responses during intervention. The PTA may also assist with data collection, provided the PT has trained the PTA and established the PTA’s competency to do so.

**Documentation Responsibilities**

**PT Responsibilities:**
- initial Student Evaluation/ report
- establish goals, objectives and frequency for IEP
- assemble forms to record attendance, document student interventions, and collect data
- Medicaid Plan of Care (POC)
- ensure Medicaid PT Progress Notes are completed, co-signed, and turned in at the end of each month
- Medicaid Discharge planning/ documentation
- documentation of PTA supervision
- review and co-sign all documentation written by PTA
- review all student information prior to PTA attending a team or IEP meeting
- Keep records of overall caseload data and turn in to PREP upon request

**PTA Responsibilities:**
- document daily student attendance and progress on forms provided by PT (for both Medicaid and non-Medicaid students)
- provide assistance in data collection (as determined by PT)
- write student Progress Reports (report cards) in consultation with PT as prescribed by District (i.e., quarterly)
- notify PT of evaluation referrals and meeting requests
- attend team or IEP meetings after review of information with PT
- keep records of caseload data and turn in to PREP upon request
- keep supervising PT updated in regard to any student/ caseload changes

**Performance Review**
The supervising PT will meet with the PTA to conduct an annual performance review according to the guidelines set forth under either the *Mentoring Program* or *Experienced Therapist Performance Criteria* sections of this manual.
Appendices
Appendix A-1: Continuing Education Log Instructions for OT

Instructions for Completing the Continued Competency Activity and Assessment Form for OT’s and COTA’s

**Part A: Activity**

Learning Activity, Resources, Strategies & Experiences - List resources, strategies & experiences that you used to develop or maintain the selected knowledge or skill listed in Part B (e.g., conferences, continuing education courses, specialty certification, in-service workshops, consultations, discussions with colleagues, self-study courses, research in preparation for teaching, reading peer reviewed journals and textbooks, and self-instructional media).

Date(s) of Activities - List the date(s) that you were engaged in the learning activity.

**Part B: Assessment**

Knowledge or Skills Maintained or Developed - Think about questions or problems encountered in your practice. Describe the knowledge or skills you addressed during the learning activity listed in Part A. Consider ethics, standards of care, patient safety, new medical technology, communication with patients, the changing health care system, and other topics influencing your practice.

Number of Hours

Hours Actually Spent in Learning Activity - List the hours actually spent in the learning activity to nearest ½ hour. Total hours should be at least 20 hours biennially. (1 semester hour = 15 contact hours, 1CEU = 10 contact hours)

Types of Activities - List the type of activity from the categories described below:

**Type 1 continuing learning activities**
10 hours required biennially
Must be offered by a sponsor or organization which is recognized by the profession and which provides documentation of hours to the practitioner. These activities may include formal course work, in-service training, continuing education classes, or specialty certification.

**Type 2 continuing learning activities**
10 hours required biennially
May or may not be approved by a sponsor or organization but shall be activities considered by the learner to be beneficial to practice or to continuing learning; occupational therapists document their own participation on the attached form. Type 2 activities may include independent reading or research, consultation with another therapist, preparation for a presentation, or self-study through multi-media.

**Part C: Outcome**

Outcome - Indicate whether you will: a) make a change in your practice, b) not make a change in your practice, and/or c) need additional information on this topic. *(You may include personal notes regarding the outcome of participating in this activity, e.g., learning activities you plan for the future, questions you need to answer or barriers to change.)*
# Appendix A-2: Continuing Education Log for OT

## OCCUPATIONAL THERAPY CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM
(Maintain a copy of this record and all supporting documentation for a period of six (6) years.)

<table>
<thead>
<tr>
<th>PART A: ACTIVITY</th>
<th>Date</th>
<th>PART B: ASSESSMENT</th>
<th>Number of Hours</th>
<th>Number of Hours</th>
<th>PART C: OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Activity, Resources, Strategies &amp; Experiences; e.g. conferences, consultations, self-study courses, peer-reviewed journals, continuing education courses, specialty certification.</td>
<td></td>
<td>Knowledge or Skills You Maintained or Developed. What questions or problems encountered in your practice were addressed by this learning activity?</td>
<td>Type 1 (10 hours) Sponsored by a professional organization</td>
<td>Type 2 (10 hours) Learner approved</td>
<td>Outcome: Indicate whether you will: a) make a change in your practice, b) not make a change in your practice, and/or c) need additional information on this topic.</td>
</tr>
</tbody>
</table>
CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM: SUMMARY AND VERIFICATION

This page should be completed at the end of your two year renewal cycle and inserted as the final page of your OCCUPATIONAL THERAPY CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM

Record at least 20 contact hours of continuing learning activities you completed during the preceding two-year period of professional license. Recorded hours should indicate a minimum of 10 hours (all 20 hours can be Type 1) of Type 1 activities offered by a sponsor or organization recognized by the profession to designate learning activities for credit or other value. A maximum of 10 hours can be Type 2 educational activities you consider to be beneficial to your career development that may or may not be approved for credit by a sponsor or organization recognized by the profession. The CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM and all documentation should be maintained in your records for six years.

As you consider your completed CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM, please reflect upon your career and in the space below identify problems or questions you expect to address during the next biennial period of medical license renewal.

________________________________________________________________________________________

______________________________________________________________________________________

As required by law and regulation, I certify that I have completed the CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM and have participated in 20 hours of continuing education or learning activities as required for renewal of occupational therapy licensure in the Commonwealth of Virginia.

_________________________________________  ___________________
Signature                                      Date
Appendix B: Beginning of School Year Parent Letter

Piedmont Regional Education Program
1434 Rolkin Court, Suite 201, Charlottesville, VA 22911
(434) 975-9400 (PH) – (434) 975-9401 (FX)

Date:

Dear Parents,

I would like to introduce myself: I am __________________, and I will be your child’s Occupational/Physical Therapist throughout the 2016-2017 school year. I look forward to working with your child and helping him/her have a successful and enjoyable school experience. I will additionally be consulting with your child’s teachers and will attend team meetings as available. Please feel free to contact me with any questions or concerns you have related to your child’s occupational/physical therapy services. You may reach me either by email __________________, or by leaving a message on my cell phone (_____) ________.

Sincerely,
Appendix C: Occupational Therapy Student Screening Feedback

This document is not to be used for evaluative purposes. The intent of this observation is to provide information to the classroom teacher for instructional purposes only.

Student Name _________________________ DOB __________
School ____________________________ Teacher __________________ Grade____
Reason for Therapy Screening Request:

Date/time and School Environment(s) in which the student was observed:

Assistive Devices Being Used:

| Observations (If two options are listed [i.e., avoids/seeks], circle the appropriate one) |
|---------------------------------|---------------------------------|---------------------------------|
| **Behavior**                   | **Desk/Chair**                  | **Pencil Use**                 |
| □ age appropriate              | □ appropriate                   | □ age appropriate              |
| □ not attending to lesson      | □ desk too low                  | □ fisted grasp                 |
| □ fidgeting                    | □ desk too high                 | □ thumb wrap                   |
| □ disruptive behavior          | □ desk orientation poor         | □ tripod                       |
| □ mouthing objects            | □ chair inappropriate           | □ pressure too light           |
| □ avoids touch/sensory input   | □ other                        | □ pressure too heavy           |
| □ other ______________________|                                 | □ other ______________________|

<table>
<thead>
<tr>
<th><strong>Activities of Daily (ADL's)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ age appropriate</td>
</tr>
</tbody>
</table>

Student has difficulty with the following:

| □ opening containers          |
| □ tying shoes                 |
| □ putting on coat             |
| □ taking off coat             |
| □ clothes, fasteners          |
| □ other ______________________|

<table>
<thead>
<tr>
<th><strong>Writing Posture</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ age appropriate</td>
</tr>
<tr>
<td>□ slouching</td>
</tr>
<tr>
<td>□ lying on the desk</td>
</tr>
<tr>
<td>□ not supporting paper</td>
</tr>
<tr>
<td>□ not visually attending</td>
</tr>
<tr>
<td>□ other ______________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Hand Dominance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ age appropriate</td>
</tr>
<tr>
<td>□ right</td>
</tr>
<tr>
<td>□ left</td>
</tr>
<tr>
<td>□ switches hands</td>
</tr>
<tr>
<td>□ not supporting objects</td>
</tr>
<tr>
<td>□ does not cross midline</td>
</tr>
<tr>
<td>□ other ______________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Writing Sample</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ legible/ age appropriate</td>
</tr>
<tr>
<td>□ spacing inappropriate</td>
</tr>
<tr>
<td>□ alignment inappropriate</td>
</tr>
<tr>
<td>□ capital/lower case letter confusion</td>
</tr>
<tr>
<td>□ reversals</td>
</tr>
<tr>
<td>□ other ______________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Scissor Skills</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ age appropriate</td>
</tr>
<tr>
<td>□ right dominant</td>
</tr>
<tr>
<td>□ left dominant</td>
</tr>
<tr>
<td>□ thumb up position</td>
</tr>
<tr>
<td>□ doesn’t support/rotate paper</td>
</tr>
<tr>
<td>□ wrist position</td>
</tr>
<tr>
<td>□ other ______________________</td>
</tr>
</tbody>
</table>

Additional Observations:

Recommendations:

Therapist Signature__________________________ Date __________

Date: 61
Appendix D: Physical Therapy Student Screening Feedback

This document is not to be used for evaluative purposes. The intent of this observation is to provide information to the classroom teacher for instructional purposes only.

Student Name ________________________________ DOB __________
School ________________________________ Teacher ________________________________ Grade ______

Reason for Therapy Screening Request:

Date/time and School Environment(s) in which the student was observed:

Observations (If two options are listed [i.e., avoids/seeks], circle the appropriate one)

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Management of Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>age appropriate</td>
<td>not observed</td>
</tr>
<tr>
<td>not attending/ following directions</td>
<td>drops heavy materials</td>
</tr>
<tr>
<td>fidgeting</td>
<td>difficulty with materials while walking/negotiating stairs</td>
</tr>
<tr>
<td>disruptive behavior</td>
<td>difficulty managing backpack/clothing</td>
</tr>
<tr>
<td>mouthing objects/ drooling</td>
<td></td>
</tr>
<tr>
<td>avoids/seeks sensory input</td>
<td></td>
</tr>
</tbody>
</table>

Posture

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>appropriate</td>
<td></td>
</tr>
<tr>
<td>slouched/ leans on desk (seated)</td>
<td></td>
</tr>
<tr>
<td>rounded shoulders/back</td>
<td></td>
</tr>
<tr>
<td>falls from chair reported/observed</td>
<td></td>
</tr>
<tr>
<td>increased lordosis/protruding abdomen</td>
<td></td>
</tr>
<tr>
<td>cannot maintain stable standing posture</td>
<td></td>
</tr>
<tr>
<td>locks knees/ crouched in standing;</td>
<td></td>
</tr>
<tr>
<td>asymmetries:</td>
<td></td>
</tr>
<tr>
<td>other</td>
<td></td>
</tr>
</tbody>
</table>

Mobility/Travel

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>trips/falls reported/observed</td>
<td></td>
</tr>
<tr>
<td>bumps into others/objects</td>
<td></td>
</tr>
<tr>
<td>needs assistance to rise from floor</td>
<td></td>
</tr>
<tr>
<td>age appropriate/abnormal gait pattern</td>
<td></td>
</tr>
<tr>
<td>uses assistive device(s) (type?)</td>
<td></td>
</tr>
<tr>
<td>high guard posturing/ other balance issues</td>
<td></td>
</tr>
<tr>
<td>inadequate speed in line with peers</td>
<td></td>
</tr>
<tr>
<td>runs with appropriate speed/agility</td>
<td></td>
</tr>
<tr>
<td>balance/ coordination/ speed issues at run</td>
<td></td>
</tr>
<tr>
<td>unsafe/ immature patterns on stairs/ curbs</td>
<td></td>
</tr>
<tr>
<td>difficulty on/off bus</td>
<td></td>
</tr>
<tr>
<td>other</td>
<td></td>
</tr>
</tbody>
</table>

Additional Observations

Recommendations:

Therapist Signature_________________________________________________________ Date ___________
Appendix E: OT/PT Evaluation Template

Physical/Occupational Therapy Evaluation

Student Name:
Birthdate:
School: Program/ Grade:
Date(s) of Evaluation:
Therapist:

Background Information -- May include:
- Medical (diagnosis, precautions, vision/hearing concerns)
  - Developmental (birth history, milestones)
  - Previous therapies; other related svc’s currently received
  - Adaptive equipment
- Reason for referral (parent/teacher/student educational concerns)
- Educational Info (SPED Designation, placement, academic performance, IQ, etc.)
- Pertinent environmental/ personal factors
- Student strengths, activity preferences/limitations

Evaluations Used (with brief description of assessment tools and norms in lay person terms)

Evaluation Results -- May include:
- assessment(s) results
- skin, soft tissue and general characteristics
- range of motion/ strength/ muscle tone/ joint integrity
- posture; posturing
- balance reactions/ righting reactions/ protective reactions
- functional mobility in the school environment; transfers
- visual perceptual skills; visual motor skills
- fine motor skills/ school tool use (writing, cutting, containers)
- in hand manipulation skills; hand dominance
- school related self-help abilities/ difficulties
- sensory Processing abilities/ concerns
- attention/ organizational skills

Summary/Recommendations
- Should include a summary of findings as they relate to the student’s access to and participation
  in the educational program. May also include recommendations for improved access to the
  school environment and curricula.

Note: The following sentence should be included in every evaluation:
This evaluation will be used by the IEP Committee to determine if PT/OT services are needed to
achieve educational goals and objectives.

Signature______________________________________________ Date___________
Appendix F: 9 Week Progress Note

9 Week Progress Note

Student______________________________________________ Date ______

Therapist______________________________________________

Grading Period:  1   2   3   4

<table>
<thead>
<tr>
<th>Goals</th>
<th>Wk 1</th>
<th>Wk 2</th>
<th>Wk 3</th>
<th>Wk 4</th>
<th>Wk 5</th>
<th>Wk 6</th>
<th>Wk 7</th>
<th>Wk 8</th>
<th>Wk 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td>Criteria:</td>
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<td>Criteria:</td>
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<tr>
<td>Criteria:</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS**

Week 1

Week 2

Week 3

Week 4

Week 5

Week 6

Week 7

Week 8

Week 9
Appendix G: OT/PT Orientation Skill Rating

OT/PT Orientation Skill Rating

**PART I:** Rate your experience/comfort level with each of the following disability groups and therapeutic interventions as follows:

<table>
<thead>
<tr>
<th>Use of</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory Strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior Management Strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual Aids/ Strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistive Technology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sign Language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fine Motor/Hand Skill Development (OT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Handwriting Programs (OT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual Perceptual/Motor Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing Techniques</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeding Techniques</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental Adaptations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NDT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positioning/Handling Techniques</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body Mechanics/Transfers Techniques</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gait Training (PT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional Mobility Equipment (PT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Splinting, Orthotics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengthening Programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yoga, Pilates, other exercise programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PART II

1. Some of my professional successes and/or goals fulfilled this school year include:

2. What are my current strengths?

3. What areas do I need to improve to meet the requirements of my current role?

4. What areas/goals do I want to develop for future growth?

5. What are my ideas on how to implement these goals?

6. List any applicable workshops, courses, etc. that you have attended.

_______________________ ____________________________
Employee Signature Supervisor Signature Date
Appendix H: S.M.A.R.T. Goal Development Sheet

S.M.A.R.T. Goal Components

Therapist’s Name _______________________________  School Year ______________

1. Goal Statement

2. How is this goal important to student outcome?

3. What method(s) of data collection will be used to determine if the goal has been attained?  *(Include baseline and any clarifying operational definitions.)*

4. My action plan for this goal attainment is:

SMART Goal Checklist

Is the goal:

☐  Specific
☐  Measurable
☐  Achievable
☐  Relevant
☐  Time-Bound
Appendix I: Peer Review of Therapy Evaluation Report

Peer Review of Therapy Evaluation Report

Mark each question with Yes or No, or use N/A if the question does not apply to the evaluation.

<table>
<thead>
<tr>
<th>Y / N or N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal Information includes</strong></td>
</tr>
<tr>
<td>Birth Date/ Age</td>
</tr>
<tr>
<td>Grade of student</td>
</tr>
<tr>
<td>Date of Evaluation</td>
</tr>
<tr>
<td><strong>Background information includes</strong></td>
</tr>
<tr>
<td>Reason for referral</td>
</tr>
<tr>
<td>Developmental (birth history, milestones, etc.)</td>
</tr>
<tr>
<td>Assistive Technology; Communication methods</td>
</tr>
<tr>
<td>Adaptive Equipment</td>
</tr>
<tr>
<td>Environment in which the equipment is used</td>
</tr>
<tr>
<td>Educational (placement, other related services currently received, previous therapies)</td>
</tr>
<tr>
<td><strong>Evaluations Used</strong></td>
</tr>
<tr>
<td><strong>Evaluation Results</strong></td>
</tr>
<tr>
<td>Behavior during observation and evaluation</td>
</tr>
<tr>
<td>Observations in other settings</td>
</tr>
<tr>
<td>Function is addressed (ADL’s, mobility, etc.)</td>
</tr>
<tr>
<td>Are the chosen assessments adequately explained (brief)</td>
</tr>
<tr>
<td>Scores/Results are presented in an understandable format</td>
</tr>
<tr>
<td><strong>Summary</strong></td>
</tr>
<tr>
<td>Summary of results are given</td>
</tr>
<tr>
<td>Recommendations are made for teachers and parents</td>
</tr>
</tbody>
</table>
Is the evaluation easy to read?  Yes  No

Is language used that parents will understand?  Yes  No

Are abbreviations/acronyms used defined?  Yes  No

Are there spelling/grammatical errors?  Yes  No

Is the statement “This evaluation will be used by the IEP Committee to determine if OT/PT services are needed to achieve educational goals and objectives” included in the evaluation?  Yes  No

Did the therapist allow the IEP team to determine the child’s eligibility for therapy services?  Yes  No

Were appropriate assessments utilized?  Yes  No

Comments:

Are there additional assessments you could recommend? Why?  Yes  No

Suggestions:

What is one thing you learned or could use from this evaluation?  Comments:

Additional Comments or Suggestions:
Appendix J: Service Delivery Survey

Service Delivery Survey

These six questions, along with space to accommodate comments, are sent to all case managers in a Google Form Survey to help assess the delivery of services we provide:

1. Is the therapist meeting the student’s required time/sessions as per the IEP?

2. Does the therapist provide written and verbal communication in a professional and understandable format in the following situations?
   - IEP or team meetings
   - Student Evaluations
   - Progress Reports

3. Does the therapist provide documentation and/or attendance within the designated time frame in the following situations?
   - IEP or team meetings
   - Student Evaluations
   - Progress Reports

4. Does the therapist work as an effective educational team member?

5. Are suggestions/recommendations made by the therapist reasonable and practical for implementation in the classroom?

6. Do you have additional recommendations regarding how the therapist could provide additional support within the classroom setting and/or school environment?
Appendix K: OT/PT Core Competencies Collaborative Assessment

Occupational and Physical Therapy Core Competencies Collaborative Assessment

Name___________________________________ School Year________________

Performance Standard 1: Professional Knowledge

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Unacceptable</th>
<th>Developing</th>
<th>Proficient</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Demonstrates a knowledge of federal, state and local educational legislation and mandates for related service provision in the school system</td>
<td>[ ] Does not demonstrate an understanding of the educational model of therapy service delivery</td>
<td>[ ] Demonstrates knowledge of the special education process</td>
<td>[ ] Applies understanding of educational legislation for related service provision when making decisions as part of a team</td>
<td>[ ] Provides guidance on developments in health care, VDOE legislation and LEA requirements, concerning the provision of therapy in the school system</td>
</tr>
<tr>
<td>1.2 Demonstrates an understanding of the developmental, medical and learning characteristics of students and the research skills to obtain pertinent information</td>
<td>[ ] Does not demonstrate an adequate knowledge of developmental stages, medical and learning needs of the student and does not research required information</td>
<td>[ ] Demonstrates knowledge and the ability to research childhood development, disabilities, illnesses &amp; environmental/ socio-cultural factors in implementation of services</td>
<td>[ ] Applies knowledge about childhood development, disabilities, illnesses &amp; environmental/ socio-cultural factors in implementation of services</td>
<td>[ ] Is able to communicate knowledge about the developmental, medical &amp; learning characteristics of students to administrators, the IEP team and other therapists</td>
</tr>
</tbody>
</table>
Performance Standard 1: Professional Knowledge

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Unacceptable</th>
<th>Developing</th>
<th>Proficient</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3 Demonstrates familiarity with current research related to child development, pediatric occupational and physical therapy practices and educational services</td>
<td>[ ] Understands the importance of research, but does not demonstrate application</td>
<td>[ ] Reflects on how research can guide practice</td>
<td>[ ] Assesses and uses evidence to design and implement interventions</td>
<td>[ ] Critically appraises published research and provides training on evidence based practice</td>
</tr>
</tbody>
</table>
## Performance Standard 2: Professionalism

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Unacceptable</th>
<th>Developing</th>
<th>Proficient</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.1 Adheres to the school division’s, AOTA/APTA’s Professional Code of Ethics and Virginia Practice Acts</strong></td>
<td>[ ] Is unfamiliar with the tenets of the professional code of ethics and practice acts</td>
<td>[ ] Can identify the basic tenets of the professional code of ethics and practice acts</td>
<td>[ ] Consistently demonstrates professional behavior and competencies related to school based services</td>
<td>[ ] Engages in a continuous self-evaluative process of professionalism and improvement of school therapy services</td>
</tr>
<tr>
<td><strong>2.2 Maintains positive professional behavior (e.g. demeanor, appearance, attendance and punctuality)</strong></td>
<td>[ ] Does not consistently demonstrate professional behavior</td>
<td>[ ] Developing consistent positive professional behaviors, confidence, and skills</td>
<td>[ ] Consistently demonstrates positive professional behavior and is a respected team member</td>
<td>[ ] Is a model of positive professional behavior, and is an exemplary organizational representative</td>
</tr>
<tr>
<td><strong>2.3 Performs assigned duties and documentation within the designated timeframes</strong></td>
<td>[ ] Does not perform duties and documentation within the designated timeframes</td>
<td>[ ] Inconsistently performs and documents within the designated timeframes</td>
<td>[ ] Demonstrates effective scheduling and time management skills for student visits, meetings, and documentation</td>
<td>[ ] Assists others with documentation and time management strategies</td>
</tr>
</tbody>
</table>
### Performance Standard 2: Professionalism

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Unacceptable</th>
<th>Developing</th>
<th>Proficient</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4 Respects and maintains confidentiality</td>
<td>[ ] Does not maintain confidentiality</td>
<td>[ ] Is inconsistent in the application of maintaining confidentiality, as designated by the LEA and professional code of ethics</td>
<td>[ ] Consistently maintains all aspects of confidentiality as designated by the LEA and professional code of ethics</td>
<td>[ ] Mentors, trains and/or supports colleagues in all aspects of records management and confidentiality as designated by the LEA and professional code of ethics</td>
</tr>
<tr>
<td>2.5 Participates in professional growth activities (including attendance at OT/PT meetings) and contributes to the overall functioning of the therapy program</td>
<td>[ ] Less than half of the required meetings attended and minimal contribution to the overall functioning of the PREP therapy program</td>
<td>[ ] Regularly attends and participates in required meetings and meets minimal continuing ed. requirements for licensure</td>
<td>[ ] Regularly attends required meeting and consistently contributes to the improvement of the therapy program, as well as meeting continuing ed. requirements for licensure</td>
<td>[ ] Contributes to the therapy department's knowledge base and volunteers for roles which lead to improved services, and additionally exceeds the continuing ed. requirements for licensure</td>
</tr>
<tr>
<td>Performance Standard 3: Communication and Collaboration</td>
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<tr>
<td><strong>Performance Indicators</strong></td>
<td><strong>Unacceptable</strong></td>
<td><strong>Developing</strong></td>
<td><strong>Proficient</strong></td>
<td><strong>Exemplary</strong></td>
</tr>
<tr>
<td>3.1 Uses effective written, verbal and nonverbal communication skills</td>
<td>[ ] Does not communicate effectively in a way that is professional and understandable to all parties</td>
<td>[ ] Communicates professionally and reflects on methods to adjust information to various parties</td>
<td>[ ] Communicates professionally in written and verbal formats and is able to adjust information to various parties</td>
<td>[ ] Serves as a role model to other therapists regarding written and verbal communication</td>
</tr>
<tr>
<td>3.2 Works collaboratively and cooperatively with colleagues, school staff, administrators, families and community representatives to design, implement and/or support services for specific learner or program needs</td>
<td>[ ] Does not consistently work collaboratively and cooperatively with all parties</td>
<td>[ ] Is learning how to work cooperatively as a team member and considers this in goal writing</td>
<td>[ ] Consistently serves as an effective and cooperative team member and written notes indicate that collaboration has occurred</td>
<td>[ ] Encourages and supports other team members and community representatives in collaborative goal setting and integration of therapy services</td>
</tr>
<tr>
<td>3.3 Responds promptly and appropriately to student, family and educational staff needs and concerns</td>
<td>[ ] Does not respond promptly and/or appropriately in a consistent manner</td>
<td>[ ] Identifies the importance of prompt and professional responses to inquiries or needs</td>
<td>[ ] Consistently responds in a prompt and professional manner, and assists others with obtaining relevant information</td>
<td>[ ] Consistently responds in professional and prompt manner, attempts to anticipate needs/provide others with relevant information</td>
</tr>
</tbody>
</table>
### Performance Standard 4: Program Planning

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Unacceptable</th>
<th>Developing</th>
<th>Proficient</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Demonstrates an understanding and alignment of the theoretical foundations of school occupational therapy or physical therapy, curriculum and students’ needs in the planning process</td>
<td>[ ] Therapist does not integrate therapy services with curriculum/ student needs within the planning process</td>
<td>[ ] Identifies relationships between educational, medical, and psycho-social theories and student needs within the school environment</td>
<td>[ ] Selects, modifies and applies appropriate theories, models of practice and methods to meet student needs</td>
<td>[ ] Aligns educational, behavioral and learning theories with therapeutic best practices and in-services others</td>
</tr>
<tr>
<td>4.2 Uses student data to guide practice and actively participates in the development of the IEP</td>
<td>[ ] Does not use data to plan goals, or modify interventions (student goals are created in isolation)</td>
<td>[ ] Develops goals with school curricula and settings taken into account, and measures student outcomes</td>
<td>[ ] Integrates goals in collaboration with the IEP team, and uses data collection to modify goals and interventions</td>
<td>[ ] Develops and trains others in data collection techniques and collaboration methods</td>
</tr>
</tbody>
</table>

Pg. 6 of 11
### Performance Standard 5: Therapy Services Delivery

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Unacceptable</th>
<th>Developing</th>
<th>Proficient</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Imbeds therapy interventions into the context of the student’s natural activities and routines</td>
<td>[ ] Routinely provides therapy services in isolation</td>
<td>[ ] Seeks to integrate therapy activities into the student’s daily routine</td>
<td>[ ] Collaborates with teachers to create a therapeutic school environment</td>
<td>[ ] Develops school/district wide interventions to enhance student participation and success</td>
</tr>
<tr>
<td>5.2 Uses various types and methods of service provision for individualized student interventions to engage and maintain active learning</td>
<td>[ ] Limited repertoire of therapeutic activities/interventions</td>
<td>[ ] Identifies alternatives for service delivery, but tends to utilize one predominant method</td>
<td>[ ] Analyzes the most effective service delivery method (integrated vs. pull out, individual or small group sessions)</td>
<td>[ ] Extension and enrichment activities researched/provided to student, family, teacher and/or school</td>
</tr>
</tbody>
</table>

Pg. 7 of 11
## Performance Standard 5: Therapy Services Delivery

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Unacceptable</th>
<th>Developing</th>
<th>Proficient</th>
<th>Exemplary</th>
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</thead>
<tbody>
<tr>
<td><strong>5.3</strong> Uses and modifies appropriate strategies during individual or group therapy sessions based upon student response and outcomes</td>
<td>[ ] Does not attend to the student’s response to therapeutic intervention</td>
<td>[ ] Is aware of the need to modify intervention but has a limited repertoire of alternatives</td>
<td>[ ] Is responsive to student’s reactions during therapy and modifies activities appropriately</td>
<td>[ ] Is continuously monitoring the student’s response and demonstrates a variety of effective interventions</td>
</tr>
<tr>
<td><strong>5.4</strong> Demonstrates a system of maintaining daily documentation and data collection</td>
<td>[ ] Does not have a method for daily documentation or data collection</td>
<td>[ ] Creates a system for daily documentation and data collection</td>
<td>[ ] Consistently uses a method of collecting relevant data and daily notes to inform practice</td>
<td>[ ] Critically appraises data, modifies treatment and documents daily and objectively</td>
</tr>
<tr>
<td><strong>5.5</strong> Incorporates assistive technology, therapy equipment, and environmental adaptations as needed to enhance the student’s function</td>
<td>[ ] Unfamiliar with when assistive technology or adaptations are required to attain student goals</td>
<td>[ ] Limited knowledge of assistive technology, adaptive equipment alternatives, and/or environmental adaptations</td>
<td>[ ] Seeks and utilizes assistive technology, adaptive equipment, and/or environmental adaptations to attain student goals</td>
<td>[ ] Shares knowledge with the school team regarding assistive technology, adaptive equipment, and environmental adaptations</td>
</tr>
</tbody>
</table>
## Performance Standard 6: Assessment

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Unacceptable</th>
<th>Developing</th>
<th>Proficient</th>
<th>Exemplary</th>
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</thead>
<tbody>
<tr>
<td>6.1 Demonstrates proficiency in administering, scoring, evaluating and interpreting data from instruments or records</td>
<td>[ ] Lacks skill in appropriate evaluation techniques and interpretation</td>
<td>[ ] Developing skills in appropriate evaluation techniques and interpretation</td>
<td>[ ] Skilled in appropriate tool selection using a variety of evaluation measures, and interprets data effectively</td>
<td>[ ] Trains colleagues in appropriate tool selection, scoring, and interpretation of data</td>
</tr>
<tr>
<td>6.2 Provides accurate and understandable interpretation to learners, families, and school staff on assessment results</td>
<td>[ ] Does not effectively explain evaluation findings to the IEP team</td>
<td>[ ] Learning to explain assessment results so that various individuals can understand</td>
<td>[ ] Consistently explains assessment results so that various individuals can understand</td>
<td>[ ] Accurately synthesizes and interprets a variety of assessments and can present them understandably in an educationally relevant perspective</td>
</tr>
<tr>
<td>6.3 Uses assessment information in making recommendations or decisions that are in the best interest of the learner/school/district</td>
<td>[ ] Does not effectively coordinate evaluation information with recommendations and goals</td>
<td>[ ] Assessment recommendations including level of service are inconsistently aligned with school based practice</td>
<td>[ ] Assessment recommendations including level of service are consistently aligned with school based practice</td>
<td>[ ] Effectively coordinates evaluation information, and recommendations that are evidence based and aligned with a school based model</td>
</tr>
</tbody>
</table>

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### Performance Standard 7: Student Progress

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Unacceptable</th>
<th>Developing</th>
<th>Proficient</th>
<th>Exemplary</th>
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</thead>
<tbody>
<tr>
<td>7.1 Sets measurable and appropriate educational goals based on baseline data</td>
<td>[ ] Goals are not measurable and/or attainable within the school setting</td>
<td>[ ] Creates goals that are inconsistently appropriate for the school setting or that are inconsistently measurable</td>
<td>[ ] Creates goals appropriate for the school setting that are consistently measurable</td>
<td>[ ] Creates goals appropriate for the school setting that are measurable and aligned with data collection methods</td>
</tr>
<tr>
<td>7.2 Monitors student progress through functional measures, assessments, and/or data collection</td>
<td>[ ] Does not monitor student progress using appropriate measures</td>
<td>[ ] Inconsistently monitors/records student progress related to goals</td>
<td>[ ] Consistently monitors and records student progress towards goals</td>
<td>[ ] Creates an efficient and effective system of data collection which reflects student progress</td>
</tr>
<tr>
<td>7.3 Identifies and establishes additional means of support to increase student progress</td>
<td>[ ] Does not adapt therapy methods over time based upon student’s level of progress</td>
<td>[ ] Understands the need to adapt intervention secondary to lack of progress towards goals, but has limited repertoire of alternative methods</td>
<td>[ ] Identifies and adapts interventions to ensure optimal student outcome</td>
<td>[ ] Identifies and adapts interventions collaboratively with the school team to ensure optimal student outcome</td>
</tr>
</tbody>
</table>

Adapted from:

*Virginia Uniform Performance Standards and Evaluation Criteria for Occupational and Physical Therapy Core Competency*

*Self-Assessment* developed by Patricia Laverdure, OTD, OTR/L, BCP

*Other Instructional Personnel Performance Evaluation 2013-2104*, Fluvanna County Public Schools
Evaluator's Comments:

Employee's Comments:

Evaluator Signature______________________________________________ Date____________________

Employee Signature______________________________________________ Date____________________

(The employee's signature indicates that he/she and the evaluator have discussed this evaluation and does not necessarily indicate agreement with this evaluation.)
Appendix L: COTA/PTA Supervision Documentation Record

## COTA/PTA Supervision Documentation Record

<table>
<thead>
<tr>
<th>DATE &amp; AMT. OF TIME</th>
<th>METHOD OR TYPE OF SUPERVISION</th>
<th>CONTENT AREAS ADDRESSED</th>
<th>INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
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</table>
Appendix M: COTA/PTA Core Competencies Assessment

COTA/PTA Core Competencies Assessment

Name_________________________________________________   School Year________________________________________

Supervising Therapist(s) ____________________________________________________________

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Unacceptable</th>
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<th>Proficient</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student Evaluation Process</strong></td>
<td>[ ] Does not effectively assist the therapist with data collection</td>
<td>[ ] Understands the importance of data collection to guide goals and treatment implementation, but is inconsistent and/or has limited experience to do so</td>
<td>[ ] Uses prescribed data collection to assist therapist with designated measures and progress reporting in a timely fashion</td>
<td>[ ] Uses data collection to assist therapist with designated measures and progress reporting in a timely fashion, and continuously learns new measures to support therapist</td>
</tr>
<tr>
<td>Assistance with Data Collection</td>
<td>[ ] Does not effectively assist the therapist with data collection</td>
<td>[ ] Understands the importance of data collection to guide goals and treatment implementation, but is inconsistent and/or has limited experience to do so</td>
<td>[ ] Uses prescribed data collection to assist therapist with designated measures and progress reporting in a timely fashion</td>
<td>[ ] Uses data collection to assist therapist with designated measures and progress reporting in a timely fashion, and continuously learns new measures to support therapist</td>
</tr>
<tr>
<td><strong>Assists in Intervention Planning</strong></td>
<td>[ ] Does not provide input based on data to assist with goal suggestions or modify intervention activities</td>
<td>[ ] Provides some limited input to therapist concerning goals and intervention activities/ methods</td>
<td>[ ] Provides consistent and appropriate input to therapist concerning goals and intervention activities/ methods</td>
<td>[ ] Provides consistent and valuable input to therapist about goals and interventions, and can effectively share information with the team</td>
</tr>
</tbody>
</table>

Pg. 1 of 3
<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Unacceptable</th>
<th>Developing</th>
<th>Proficient</th>
<th>Exemplary</th>
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</thead>
</table>
| **Intervention Implementation**  
Selects, implements, and makes modifications to therapeutic activities and interventions that are consistent with demonstrated competency levels, students' goals, curriculum requirements, and supervising therapist’s directions | [ ] Does not consistently attend to student response to therapeutic activities, or does not carry out therapist’s directives | [ ] Is aware of the need to modify intervention activities but has a limited repertoire of alternatives | [ ] Is responsive to student’s reactions during therapy and modifies activities appropriately | [ ] Is continuously monitoring the student’s response and demonstrates a variety of effective interventions toward both functional and educational goal attainment |
| **Documentation Responsibilities**  
Documents daily student attendance and progress for both Medicaid and non-Medicaid students; writes student progress reports in consultation with therapist; attends team or IEP meetings after review of information with the supervising therapist. | [ ] Does not perform documentation duties appropriately or within the designated timeframes | [ ] The method and/or timeliness of documentation is inconsistent with therapist input or organizational guidelines | [ ] Displays effective time management skills for scheduling student visits, meetings, documentation; documentation is completed professionally and in accordance with therapist input and organizational guidelines | [ ] Assists others with time management strategies/ methods for documentation in accordance with therapist directives, student/staff needs; demonstrates solid knowledge base in team meetings |
| **Professionalism**  
Relates to children, teachers and staff in a positive manner; functions as an effective team member; dresses and behaves professionally; communicates effectively in written format and meeting situations | [ ] Does not consistently demonstrate professional behavior | [ ] Developing consistent positive professional behaviors, but may lack confidence and/or skills | [ ] Consistently demonstrates positive professional behavior and is a respected team member | [ ] Is a model of positive professional behavior and is an exemplary organizational representative |
Supervising Therapist’s Comments:

COTA/PTA’s Comments:

Supervising Therapist Signature__________________________ Date____________________

COTA/PTA Signature____________________________________________ Date____________________

(The employee’s signature indicates that he/she and the evaluator have discussed this evaluation and does not necessarily indicate agreement with this evaluation.)