



PHYSICAL THERAPY IN  
CONNECTICUT SCHOOLS

*Best Practices and Resources*



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***in***  
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***Best Practices and Resources***

**2018**

## **Acknowledgements**

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# Introduction

## Purpose

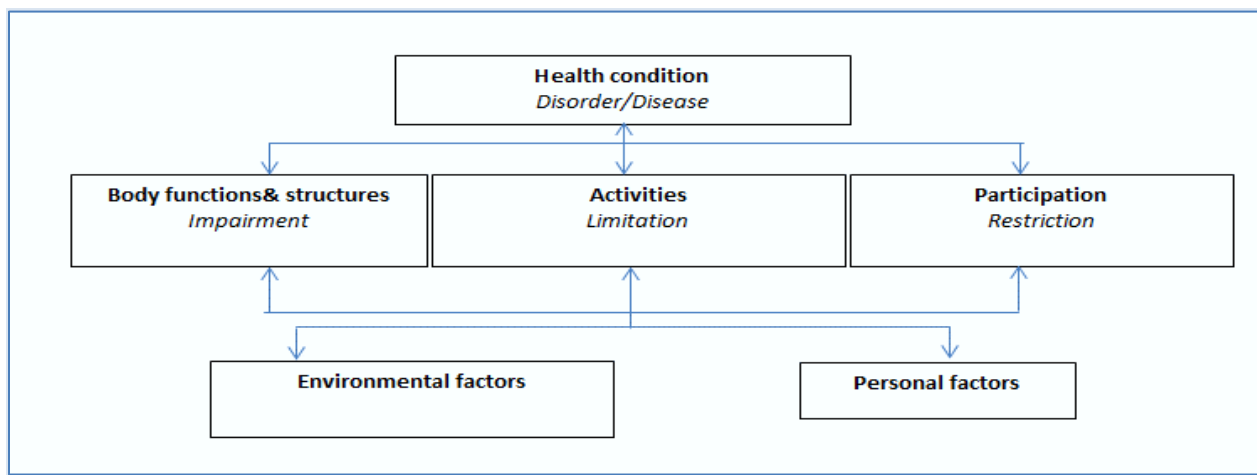
This document has been developed to replace the State of Connecticut Department of Education's *Guidelines for Physical Therapy in the Educational Setting* published as a working draft in 1999. Information contained in this revised document has been compiled using the most up to date resources available at the time of publication to integrate theory, evidence, legislation, and professional guidelines. The document represents a compilation of resources and presents information to allow stakeholders to interpret and integrate educational and physical therapy legislation, policy, and guidelines with the intent of assisting the educational team to provide best practice in the educational setting.

## Document Framework

### *International Classification of Functioning, Disability, and Health for Children and Youth (ICF-CY)*

The World Health Organization's (WHO) introduced a framework for describing and organizing information about function and disability called the International Classification of Functioning, Disability, and Health for Children and Youth (ICF-CY). This document will use the ICF-CY model to provide a common language and a conceptual basis for considering children's health and disability as it applies to physical therapy services in the school setting (WHO, 2007).

### ICF- CY Model of Concept Interactions (WHO, 2007, p.17)



Physical therapy services are provided to individuals in order to rehabilitate, habilitate, maintain health and function, prevent functional decline, and enhance performance with attention to multiple aspects of the ICF-CY model (APTA, Principles of Patient and Client Management, 2014). Physical therapy services address impairments of function and body structure (i.e., range of motion, muscle tone, strength, respiratory capacity, etc.), activity limitations (i.e., mobility,

balance, endurance, etc.), and participation restrictions (i.e., integration into community settings including a child's school program).

Movement is an important means through which children learn. Physical therapists evaluate and provide interventions that address the 'movement system' which is comprised of the body's combined musculoskeletal, neurological, cardiovascular, pulmonary, endocrine, and integumentary systems (APTA, Movement System, 2016).

As a profession, pediatric physical therapists have the responsibility to address the multiple interconnecting aspects of the WHO's ICF- CY model; body functions and structure, activity, and participation. The provision of physical therapy in clinical settings may look different than that provided in educational settings relative to the focus areas and goals of the intervention. Physical therapy in the school setting is provided to support the student's access and participation in the educational program as mandated in federal educational legislation. While participation is the focus, school-based physical therapists consider those body and structure impairments and activity restrictions that impact the student's access and engagement in the school environment. The student may present with needs that require both medically oriented and educationally related physical therapy intervention.

For more information about how physical therapy may enhance educational programming for children with disabilities, please refer to the following fact sheet, *Physical Therapy for Educational Benefit*, published by the APTA: <http://pediatricapta.org/includes/fact-sheets/pdfs/15%20PT%20for%20Educational%20Benefit.pdf>

### *Evidence-based Practice*

Physical therapists practice in many settings including, but not limited to hospitals, clinics, rehabilitation centers, sports facilities, and school systems. Those physical therapists practicing in school systems are in the unique situation of infusing health-related services into educational programming. Physical therapists, along with professionals in the educational field, recognize the importance of using evidence-based practice (EBP) as a means of guiding decision-making. Best practice integrates use of the highest quality research along with clinical judgment to develop and provide intervention. Physical therapists have an ethical responsibility to provide only services that are necessary, supported by evidence, and in the student's best interest, as determined by integrating objective data, the therapist's independent clinical reasoning, and available literature (APTA, Integrity in Practice, 2016). Readers can apply this information to their unique situations to assist in decision-making and to guide practice.

Information about EBP relative to the physical therapy field can be found at:  
<http://www.apta.org/EvidenceResearch/>

The PTNow portal provides access to article searches, clinical summaries, tests, clinical practice guidelines, and Cochrane Reviews. This can be accessed at:  
<https://www.ptnow.org/ArticleSearch>



The journal dedicated to physical therapy services for children, *Pediatric Physical Therapy*, can be accessed at:

<http://journals.lww.com/pedpt/Pages/aboutthejournal.aspx>

## ***Professional Standards and Legislation***

School-based physical therapists must function under legislation relating to both the physical therapy profession and that pertaining to the educational system. All physical therapists are required to adhere to their professional standards and state practice acts in any of the settings in which they may practice. The standards of the physical therapy profession are set by the American Physical Therapy Association (APTA) on a national level. The APTA maintains and updates guidelines for physical therapy practice such as APTA Standards of Practice and Code of Ethics. The APTA also offers specific information for physical therapists practicing in schools. The professional scope of practice is based on the profession's unique body of knowledge of the movement system and is supported by specific educational preparation overseen by the Commission on Accreditation in Physical Therapy Education (CAPTE).

*The Guide to Physical Therapist Practice* can be found at:

<http://www.apta.org/Guide/>

*APTA Criteria for Standards of Practice for Physical Therapy*

[http://www.apta.org/uploadedFiles/APTAorg/About\\_Us/Policies/Practice/CriteriaStandardsPractice.pdf](http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/CriteriaStandardsPractice.pdf)

*APTA Code of Ethics*

[https://www.apta.org/uploadedFiles/APTAorg/About\\_Us/Policies/Ethics/CodeofEthics.pdf](https://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/CodeofEthics.pdf)

Each state is responsible for establishing the scope of practice for physical therapy within its borders through legislative and regulatory action as defined by the state's practice act.

The Connecticut State Practice Act can be found under 'Practice Act' located on the Department of Public Health's Physical Therapist Licensure website at:

<http://portal.ct.gov/DPH/Practitioner-Licensing--Investigations/Physicaltherapist/Physical-Therapist-Licensure>

The physical therapist's personal scope of practice consists of those activities for which an individual is educated, trained, and is competent to perform (APTA, Scope of Practice, 2017). Massachusetts has developed a flow chart that may assist in helping physical therapists to determine when an activity falls in or outside of their individualized personal scope of practice (MA Allied Health Board, Scope of Practice Decision-making Guide).

This chart can be found at:

<http://www.mass.gov/ocabr/docs/dpl/boards/ah/scope.pdf>

In addition to the practice legislation, physical therapists practicing in educational settings as related service providers must adhere to the federally mandated educational legislation, including the Individuals with Disability Education Improvement Act (IDEA). Part B of this legislation focuses on students' rights and the responsibilities of public schools to children with disabilities between the ages of 3 and 21 years of age. The following principles serve as the foundational tenets of IDEA:

- Free Appropriate Public Education (FAPE) with a zero rejection philosophy regardless of severity or nature of disability;
- Appropriate evaluation;
- Individualized Education Plan (IEP);
- Least Restrictive Environment (LRE);
- Parent participation; and
- Procedural safeguards including the due process procedure if parents disagree with the school's recommendations.

A full description of IDEA legislation can be found at:

<https://sites.ed.gov/idea/>

Under IDEA, physical therapists are considered to be related service providers along with other disciplines including speech-language pathologists, occupational therapists, psychologists, nurses, social workers, and transportation providers. Related service providers support the student to advance toward annual goals established as part of their IEP, make progress in the general educational curriculum, and participate in extracurricular and other non-academic activities (IDEA, Related Services, §300.320(a)(4), 2004).

Students with health-related issues, who do not receive special education services under IDEA, may also receive physical therapy under civil rights legislation Section 504 of the federally mandated Rehabilitation Act of 1973 (US Dept. of Education, Protecting Students with Disabilities). Specific Section 504 amendments assure that students with disabilities are provided with related aids and services that afford equal access when compared to students without disabilities (Office of Civil Rights, Part 104, 1973).

For more information regarding Section 504, please see *Protecting Students with Disabilities: Frequently Asked Questions about Section 504 and the Education of Children with Disabilities* at:

<https://www2.ed.gov/about/offices/list/ocr/504faq.html>

Under the Every Student Succeeds Act (USDE, ESSA, 2015), school-based physical therapists assist the educational team in supporting struggling students who are part of the regular education programming. In Connecticut, this process is referred to as Scientific Research Based Intervention (SRBI).

More information regarding ESSA can be found at:

<https://www.ed.gov/essa?src=rn>

In addition to federal legislation, state education legislation also guides physical therapy practice in the school setting. The Connecticut State Department of Education develops standards for educators that physical therapists have the opportunity to support through their programming (CSDE, Core Standards). Connecticut state laws and local education agencies (LEA's) may set policies that are more stringent and specific than the federal legislation.

*“Connecticut’s special education laws and regulations essentially mirror the provisions of the IDEA. Notable exceptions are the use of the term planning and placement team (PPT) that is synonymous with individualized education program team (IEP team); the composition of the PPT/IEP team and member attendance requirements that supplement IDEA requirements; and the timelines for conducting activities related to referrals, evaluations, and IEP implementation.”*  
(CSDE, Connecticut Assistive Technology Guidelines, 2013)

Specific state statutes relating to special education in Connecticut can be found at:

<https://eregulations.ct.gov/eRegsPortal/Browse/RCSA/%7B209BE155-0B00-C059-8535-2744B98A6144%7D>

Legislation is subject to changes, varied interpretations, and updates and it is the therapist's responsibility to remain current on those requirements. Additionally, LEA's may interpret elements of the federal and state legislation, create policy, and implement practice based on their unique perspectives, experience, school climate, and demands within the local system. Physical therapists practicing in schools are required to adhere to local policy, state physical therapy and educational practice acts, and federal education legislation. It is suggested that readers contact their LEA for the most current state and local policies.

This document is meant to assist in navigating the complex and interconnecting legislation, standards, and guidelines of both the physical therapy profession and the educational system. This document attempts to answer the most commonly asked questions, and serve as a resource that represents current best practices. *Physical Therapy in Connecticut Schools- Best Practices and Resources* is intended to assist physical therapists, school administrators, parents, students, and others to better understand school-based physical therapy practice.

A variety of fact sheets and resources specific to school-based physical therapy are available for public access through the Academy of Pediatric Physical Therapy portal at:

<https://pediatricapta.org/fact-sheets/>

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# Chapter 1. Legislation Relating to Physical Therapy in Connecticut Schools

## *What is Physical Therapy and Who Provides It?*

Connecticut General Statutes, Chapter 376 provides definitions of physical therapy, physical therapist, and physical therapist assistant.

*“Physical therapy’ means the evaluation and treatment of any person by the employment of the effective properties of physical measures, the performance of tests and measurements as an aid to evaluation of function and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting or alleviating a physical or mental disability. ‘Physical therapy’ includes the establishment and modification of physical therapy programs, treatment planning, instruction, wellness care, peer review, [and] consultative services” (Connecticut General Assembly - Public Health Committee, Chapter 376)*

Connecticut General Statutes Chapter 376 defines a ‘physical therapist’ as *“a person licensed to practice physical therapy in this state”*.

Physical therapists have completed an accredited program and may hold a Bachelor, Masters, or Doctorate degree in physical therapy depending on education requirements at the time of their licensure exam. Some physical therapists have pursued higher levels of education that exceed entry level licensure requirements. A physical therapist must have a current Connecticut license, which must be renewed every year, to maintain his/her ability to practice physical therapy in Connecticut. Physical therapists licensed in the state of Connecticut are required to attend 20 hours of continuing education every year to maintain licensure. Each person licensed to practice physical therapy under Connecticut’s General Statutes (Chapter 376) who provides direct care services shall maintain professional liability insurance as specified in the state’s practice act (Connecticut General Assembly - Public Health Committee, Chapter 376).

Within the state of Connecticut physical therapists practice with direct access with restrictions. This means that persons can request, and physical therapists can initiate, physical therapy services without first having written permission of another medical professional. For continued provision of intervention, however, stipulations (including communication with the primary care provider or health care provider of record) must be met to allow continued access (Connecticut General Assembly - Public Health Committee, Chapter 376).

The Connecticut Physical Therapy Practice Act refers to people receiving physical therapy as ‘patients’. In the case of school-based physical therapy, the service recipients are students. The

following sections of the Practice Act pertain to provision of physical therapy in schools as well as other medical facilities:

*(b) (1) The treatment of human ailments by physical therapy shall only be performed by a person licensed under the provisions of this chapter as a physical therapist or physical therapist assistant. Except as otherwise provided in subdivisions (2) and (3) of this subsection, such treatment may be performed by a licensed physical therapist without an oral or written referral by a person licensed in this state to practice medicine and surgery, podiatry, naturopathy, chiropractic or dentistry, or an advanced practice registered nurse licensed to prescribe in accordance with section 20-94a or a physician assistant licensed to prescribe in accordance with section 20-12d, provided the licensed physical therapist*

*(A) was admitted to a bachelor's degree program prior to January 1, 1998, and has practiced physical therapy for at least four out of the most recent six years of his or her clinical practice, or earned a master's degree or higher in physical therapy from an accredited institution of higher education*

*(B) requires any person receiving such treatment to disclose or affirmatively confirm the identity of such person's primary care provider or health care provider of record upon each initial visit for treatment without an oral or written referral,*

*(C) provides information to any person seeking such treatment regarding the need to consult with such person's primary care provider or health care provider of record regarding such person's underlying medical condition if the condition is prolonged, does not improve within a thirty-day period, or continues to require ongoing continuous treatment, and*

*(D) refers any person receiving such treatment to an appropriate licensed practitioner of the healing arts if, upon examination or reexamination, the same condition for which the person sought physical therapy does not demonstrate objective, measurable, functional improvement in a period of thirty consecutive days or at the end of six visits, whichever is earlier."*

(Connecticut General Assembly - Public Health Committee, Chapter 376 § 20-73)

For more information about direct access please refer to:

[https://www.cga.ct.gov/2015/pub/Chap\\_376.htm#sec\\_20-73](https://www.cga.ct.gov/2015/pub/Chap_376.htm#sec_20-73)

Physical therapists practicing in any setting, including schools, must adhere to the Connecticut Physical Therapy Practice Act. The Connecticut Physical Therapy Practice Act in its entirety can be found at:

[https://www.cga.ct.gov/2015/pub/Chap\\_376.htm](https://www.cga.ct.gov/2015/pub/Chap_376.htm)

Physical therapist assistants (PTAs) may also be involved in providing therapeutic intervention. The state of Connecticut provides a definition of this role.

*"Physical therapist assistant' means a person licensed to assist in the practice of physical therapy in this state under the supervision of a physical therapist. 'Supervision' means the overseeing of or the participation in the work of a physical therapist assistant by a licensed physical therapist, including, but not limited to: (A) Continuous availability of direct communication between the physical therapist assistant and a licensed physical therapist; (B) availability of a licensed physical therapist on a regularly scheduled basis to (i) review the practice of the physical therapist assistant, and (ii) support the physical therapist assistant in the performance of the physical therapist assistant's services; and (C) a predetermined plan for emergency situations, including the designation of an alternate licensed physical therapist in the absence of the regular licensed physical therapist;*

*'Assist in the practice of physical therapy' means the treatment of any person by the employment of the effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting or alleviating a physical or mental disability, but does not include the interpretation of referrals, initial or discharge evaluation or assessment, or determination or modification of treatment or discharge plans."*

(Connecticut General Assembly - Public Health Committee, Chapter 376)

Physical therapist assistants work under the supervision of a physical therapist. There are limitations to the elements of care that physical therapist assistants are licensed to provide. For example, a physical therapist has the responsibility for conducting evaluations and developing programs, and a physical therapist assistant can implement those programs established by the physical therapist under the physical therapist's supervision in any setting, including schools.

According to a policy statement issued by the APTA (2018), when the physical therapist supervises the physical therapist assistant in any offsite setting, the following requirements must be observed:

- 1. A physical therapist must be accessible by telecommunication to the physical therapist assistant at all times while the physical therapist assistant is providing services to patients and clients.*
- 2. There must be regularly scheduled and documented conferences with the physical therapist assistant regarding patients and clients, the frequency of which is determined by the needs of the patient or client and the needs of the physical therapist assistant.*
- 3. In situations in which a physical therapist assistant is involved in the care of a patient or client, a supervisory visit by the physical therapist:*
  - a. Shall be made upon the physical therapist assistant's request for a reexamination, when a change in the plan of care is needed, prior to any planned conclusion of the episode of care, and in response to a change in the patient's or client's medical status*



- b. *Shall be made at least once a month, or at a higher frequency when established by the physical therapist, in accordance with the needs of the patient or client*
  - c. *Shall include:*
    - i. *An onsite reexamination of the patient or client*
    - ii. *Onsite review of the plan of care with appropriate revision or termination*
    - iii. *Evaluation of need and recommendation for utilization of outside resources*
- (APTA, 2018)

For more details regarding physical therapist assistant practice and restrictions please reference:  
 The Connecticut Physical Therapy Practice Act, and  
[https://www.cga.ct.gov/2015/pub/Chap\\_376.htm#sec\\_20-66](https://www.cga.ct.gov/2015/pub/Chap_376.htm#sec_20-66)

American Physical Therapy Association House of Delegates Position Statement  
*Direction and Supervision of the Physical Therapist Assistant*  
[www.apta.org/uploadedFiles/APTAorg/About\\_Us/Policies/Practice/DirectionSupervisionPTA.pdf#search="DIRECTION%20SUPERVISION%20OF%20THE%20PHYSICAL%20THERAPIST%20ASSISTANT%20HOD%20P06-18-28-35](http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/DirectionSupervisionPTA.pdf#search=)

In the school system, physical therapy services can only be provided by a licensed physical therapist or physical therapist assistant. While other members of the educational team cannot perform ‘physical therapy’, they are able to carry out motor-related and functional activities delegated by and under the monitoring and/or guidance of a physical therapist.

### ***What Legislation Applies to Physical Therapy in Schools?***

In addition to the general statutes relating to physical therapy, the provision of physical therapy specifically in the school setting is regulated by federal educational and civil rights legislation, as well as state level educational statutes. The school-based physical therapist functions as part of teams that serve students receiving special education as well as regular education programming.

#### ***IDEA***

Part B of the Individuals with Disability Education Improvement Act (IDEA) is the federal educational legislation that provides access to free appropriate education for children with disabilities between the ages of 3 and 21. This legislation ensures special education programming and related services, including physical therapy that supports the student’s participation in the educational program. Students with sensorimotor delays and functional limitations associated with movement may require the expertise of a school based physical therapist as part of their special education program under IDEA (IDEA, 2004). IDEA (Part C) describes physical therapy as a related service in the following manner:

*“Physical therapy includes services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development,*

*cardiopulmonary status, and effective environmental adaptation. These services include—*

*(i) Screening, evaluation, and assessment of children to identify movement dysfunction;*

*(ii) Obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems; and*

*(iii) Providing individual and group services or treatment to prevent, alleviate, or compensate for, movement dysfunction and related functional problems” (IDEA, 2004).*

Physical therapists practicing in the schools most commonly function under IDEA where they are a member of the Individualized Education Program (IEP) team along with the student, parents, and educational staff. As a team member, the physical therapist is involved in developing, reviewing, and revising the student’s IEP. The Connecticut’s State Department of Education refers to the IEP team as the Planning and Placement Team (PPT), and refers to the IEP meeting as the PPT (CSDE, Individualized Education Program (IEP) - Planning and Placement Team (PPT), 2018). These terms will be used interchangeably in this document. The IEP team meetings are the forum for sharing evaluation results, discussing issues related to the student, adjusting individual programs and developing future plans (CSDE, A Parent’s Guide to Special Education in Connecticut, 2007).

More information about IEP team meetings can be found at:

<http://portal.ct.gov/SDE/Special-Education/Special-Education-Resources-for-Families>

The school-based physical therapist makes valuable contributions to the IEP team meeting as an individual who can present and interpret evaluation results relating to movement, function, and sensorimotor development that may affect the student’s access and participation in educational programming (IDEA, IEP Team, 2004). A physical therapist may be invited to an IEP team meeting if the team has concerns relating to movement, function, and/or sensorimotor development. When the school-based physical therapist is already part of a student’s IEP team, that therapist must be invited to the IEP team meetings and is expected to attend the meeting unless the parent/guardian excuses the therapist in writing (CSDE, IEP Guide Page by Page, 2015). If the physical therapist cannot attend, then the parent/guardian may excuse the therapist using the *Planning and Placement Team Attendance* Form ED633 found at the following link:

<https://portal.ct.gov/SDE/Special-Education/Planning-and-Placement-Team-PPT-Process-and-Individualized-Education-Program-IEP-Forms/Documents>

In the cases where the therapist has been excused from attendance, the physical therapist is responsible for providing written input into the development of the IEP prior to the meeting (IDEA, IEP Team Attendance, 2014). While scheduling IEP team meetings is handled differently depending on LEA policy, IEP team meetings must be held at least once annually for a student receiving special education services (IDEA, Development, Review, and Revision of the IEP, 2004).

IEP team meetings can be held for a variety of reasons including:

- reviewing a referral to special education and considering/planning an evaluation;
- reviewing evaluation results and determining eligibility for special education;
- developing, reviewing or revising the IEP;
- conducting an Annual Review; and
- considering transition needs/services – transition planning.

The reason for holding the PPT meeting must be stated as part of the Notice of PPT Meeting (Connecticut form ED623).

Forms relating to the IEP team meeting may be found in the Connecticut State Department of Education IEP Manual located at:

<https://portal.ct.gov/-/media/SDE/Special-Education/IEP-Manual-REVISED-July-2018.pdf?la=en> and

<https://portal.ct.gov/SDE/Special-Education/Planning-and-Placement-Team-PPT-Process-and-Individualized-Education-Program-IEP-Forms/Documents>

### *Section 504*

Physical therapists may also contribute in the educational setting under civil rights legislation, Section 504 of the Rehabilitation Act of 1973 which prohibits discrimination of students in federally funded programs based on health status. Section 504 assures that knowledgeable persons evaluate students and create plans that allow the student's participation in the educational program to the same extent as their peers (OCR, Protecting Students with Disabilities). Consequently, physical therapists may lend their expertise in cases where students have health impairments that compromise the student's function within the educational program. Please see Chapter 3 for more details.

### *Every Student Succeeds Act*

Similarly, physical therapists may lend their expertise in consulting with educational teams about students in the regular education programs as part of The Every Student Succeeds Act (ESSA) of 2015 (USDE, ESSA, 2015; Office of Special Education Programs, 2018). This legislation assures that a multi-tiered system is in place to support struggling students within the regular educational program. Physical therapists may be helpful in educating the team and in proposing strategies that can be attempted as part of the multi-tiered intervention system. This is explained in more detail in Chapter 3.

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## Chapter 2. Roles and Responsibilities of the School-based Physical Therapist

### *Knowledge and Skill Set of the School-Based Physical Therapist*

The physical therapist plays an important role as a member of the educational team by contributing unique expertise in children's movement, function, and sensorimotor development especially in relation to the musculoskeletal and neuromuscular systems. In addition to knowledge about the individual, physical therapists also have expertise in task modification, and environmental adaptations which may include evaluation, prescription, and management of adaptive equipment to promote students' participation in educational programming. (Effgen, Chiarello, & Milbourne, 2007; APTA, Physical Therapy in School Settings, 2016)

Physical therapists in the school setting must develop competencies in pediatric physical therapy, knowledge of federal and state education legislation, and skills required to work in the schools. The implementation of student-centered programming that incorporates the student's and family's cultural considerations, needs, and values helps to assure best practice. Effective communication is essential for collaboration with all educational team members, including parents, for the purpose of enhancing the student's educational experience (Effgen, Chiarello, & Milbourne, 2007).

For more information, please see the article describing competencies for school-based physical therapists at:

[http://journals.lww.com/pedpt/Fulltext/2007/01940/Updated\\_Competencies\\_for\\_Physical\\_Therapists.2.aspx](http://journals.lww.com/pedpt/Fulltext/2007/01940/Updated_Competencies_for_Physical_Therapists.2.aspx)

Specific roles and responsibilities of the school-based physical therapist identified by the APTA include:

- *“Gathering appropriate information from students, parents, and other team members regarding the child's functional motor performance in school settings;*
- *Selecting, administering and interpreting a variety of screening instruments and standardized measurement tools;*
- *Examining and evaluating eligible students' strengths and needs to establish their ability to participate in meaningful school activities and routines with or without assistance;*
- *Participating in team meetings, including parent conferences;*
- *Participating in the IEP/504 process, including collaboratively determining the need for physical therapy as a related service (IDEA) or as a reasonable accommodation (504);*
- *Forming partnerships and working with other team members in the school setting to promote an effective physical therapy plan of care;*
- *Coordinating physical therapy interventions within the school program;*

- *Adapting environments to facilitate student access and participation in the educational program;*
- *Functioning as a consultant to other school personnel, parents, and students to coordinate the provision of physical therapy services, which may include:*
  - *Interpretation of assessments and recommendations;*
  - *Explanation of the potential impact of developmental, medical and/or sensorimotor problems on school performance;*
  - *Instruction of other caregivers in the physical management of students, such as safe lifting, positioning, assisted ambulation, gross motor programs, vocational tasks, leisure activities, and/or equipment use;*
  - *Setting realistic expectations for student performance in school; and*
  - *Selecting, modifying, or customizing adaptive equipment and assistive technology.*
- *Educating school personnel and families to promote inclusion of students within the educational experience by developing, demonstrating, training, and monitoring the effectiveness of strategies and intervention activities, using data to make decisions. This includes the use of assistive technology for access and participant in the general education curriculum;*
- *Supporting the safe transportation of students;*
- *Referring students to other related services personnel and to healthcare providers as appropriate; and*
- *Serving as a liaison among school, medical personnel, and medical equipment vendors.” (APTA, Therapy in the School Setting, 2016)*

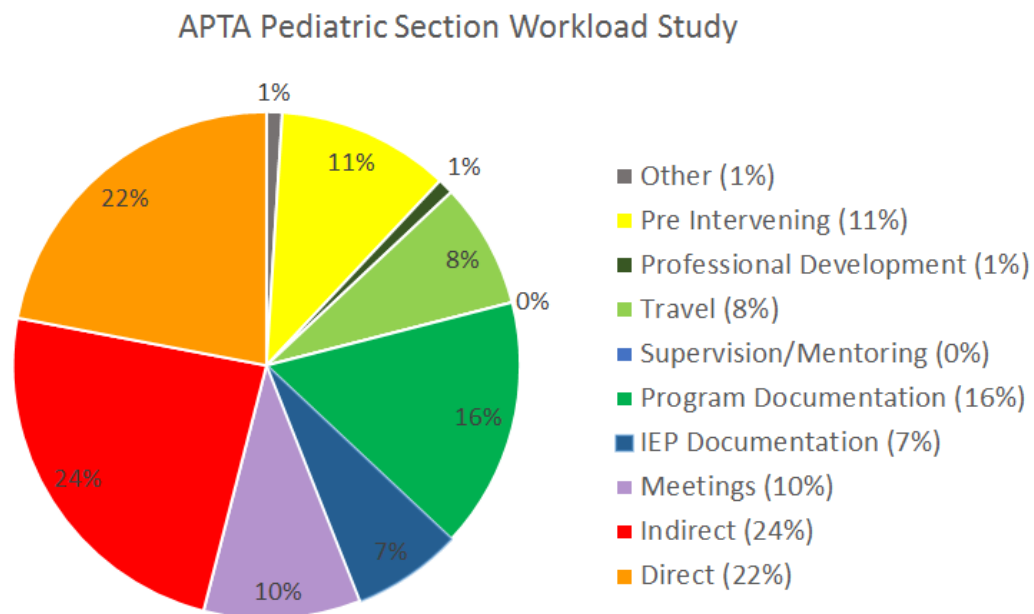
### ***Physical Therapy Workload and Caseload***

The most effective services occur when the physical therapist is an active and integral part of the educational team (Effgen, 2005; McEwen, 2009). The amount of time the LEA needs from physical therapy personnel is based on several factors. Physical therapy service hours identified on the IEP’s of students receiving special education services are just one piece of a therapist’s responsibilities. The therapist’s caseload includes all students for whom the therapist provides services within the school setting. A therapist’s overall workload is more than the sum of direct service hours for the student caseload. The therapist’s workload includes direct services, as well as other activities including evaluating, planning, documenting, billing, consulting, meeting, analyzing data, recommending and monitoring adaptive equipment, traveling between sites, participating in school wide activities, recommending safety procedures, training and supervising staff, as well as communicating with other agencies, parents, physicians and school staff. While time allocation may vary by geographic region, a study by Cecere et al (2008), identified that less than half of the therapist’s time is spent on direct service (Cecere 2008; Williams & Cecere, 2013). The following are examples of activities within the categories that comprise a therapist’s workload:

<b>Direct Intervention</b>	Providing face to face hands-on physical therapy (evaluation, intervention, instruction) to a student for the number of minutes listed in an IEP or 504 plan
<b>Indirect Intervention</b>	Including but not limited to monitoring equipment, adjusting equipment, establishing and monitoring routines and procedures delegated to other staff, researching treatment strategies and service provided on behalf of a student
<b>Meetings</b>	Participating in the IEP team, Child Find process, departmental meetings, parent meetings etc.
<b>Program Documentation</b>	Providing written documentation for licensure, progress monitoring, report cards, physician communication, visit/encounter notes, communication logs, Medicaid billing, evaluations etc.
<b>Travel</b>	Traveling in and out of district, between schools, or within a school district, to obtain adaptive equipment, and to attend medical appointments and to conduct home visits.
<b>Professional Development</b>	Attending and conducting training. Professional development is a licensure requirement for Connecticut physical therapists. The time required to attend may occur during school hours.
<b>Supervision/ Mentoring</b>	Supervising physical therapist assistants and physical therapy students. Consulting with para-educators, teachers, co-workers. Working with school staff and family members to provide education about the student's needs and care and monitor carry over.
<b>IEP Documentation</b>	Contributing information to a student's IEP as part of the IEP team with updated and current information regarding present levels of progress, goals, level of service, modifications, equipment, etc.
<b>Pre-Intervention</b>	Consulting with school staff, participating in pre-referral activities, observing programs.
<b>Other</b>	Developing school wide programs, campus safety and access, program planning, and budget recommendations.



The chart below represents the distribution of workload responsibilities found in the APTA Pediatric Section Workload Study (Williams & Cecere, 2013).



A consensus statement developed collectively by the national associations for physical therapists, occupational therapists, and speech-language-hearing therapists highlights the importance of activities outside of direct intervention as being essential elements of service provision and ultimate student success. Therefore these associations jointly endorse a *workload model* as opposed to a *caseload model*. (APTA-ASHA-AOTA, Workload Approach; A Paradigm Shift for Positive Impact on Student Outcomes, 2014).

For more information regarding the APTA workload study, please refer to:

School-based Workload: What's the Magic Formula? (Williams & Cecere, 2013):

<http://archives.marylandpublicschools.org/MSDE/divisions/earlyinterv/commission/docs/04162014/Materials/11%20Williams%20&%20Cecere%20AOTA%202013.pdf>

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<http://www.aota.org/~media/Corporate/Files/Practice/Children/APTA-ASHA-AOTA-Joint-Doc-Workload-Approach-Schools-2014.>

## ***Employment Models Found in the School Setting***

Several different models of employment may be utilized to bring physical therapists into the school setting. The LEA may hire the physical therapist as a staff member or as a consultant. The LEA may also contract with an agency or an individual to provide physical therapy services. The employment model has implications for payment, billable components of services, types of services provided, and supervision. Connecticut's State Department of Education (CSDE) recognizes that while physical therapists are not certified by the CSDE, they are valuable team members. The CSDE currently does not require physical therapists to be evaluated using Connecticut's System for Educator Evaluation and Development (SEED) model, but leaves the implementation of evaluation of physical therapists to the LEA's discretion (CSDE, Navigating Connecticut's Evaluation and Support Systems for SESS, 2015)

For more information about support service evaluation please refer to:

[https://portal.ct.gov/-/media/SDE/SEED/Navigating\\_Connecticuts\\_Eval\\_and\\_Support\\_Systems\\_for\\_SESS.pdf](https://portal.ct.gov/-/media/SDE/SEED/Navigating_Connecticuts_Eval_and_Support_Systems_for_SESS.pdf)

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## Chapter 3. Physical Therapy Services as a Component of the General Education Program

While the primary role of physical therapists in the school setting is defined by the Individuals with Disability Improvement Act (IDEA, 2004), physical therapists can promote the academic success of *all* students by contributing their expertise in the areas of child development, motor proficiency, health, wellness, fitness, and injury prevention. School-based physical therapists can influence general school programs, routines, and curriculum (Academy of Pediatric Physical Therapy, *The Role of School-based Physical Therapy; Successful Participation for All Students*, 2012).

### *Health Promotion and Wellness*

Physical therapists can share their expertise in body systems and function to promote wellness in the school community (CSDE, Connecticut's Framework for RtI, 2008). Wellness care in the Connecticut Physical Therapy Practice Act is defined as "*services related to conditioning, strength training, fitness, workplace ergonomics or injury prevention.*" The Connecticut Physical Therapy Practice Act further states that "*Nothing ... shall prevent a physical therapist from providing wellness care within the scope of physical therapy practice to asymptomatic persons without a referral*" (Connecticut General Assembly - Public Health Committee, Chapter 376). Physical therapists are equipped to provide expertise in the design and implementation of health promotion and fitness programs for students with and without disabilities in the school setting. These programs are important to promote active, healthy lifestyles and reduce secondary problems associated with sedentary lifestyles. Physical therapists can incorporate fitness strategies and health promotion into their practice through aerobic activities and strengthening for muscles and bones (US Department of Health and Human Services, 2008). Examples of physical therapy recommendations may include backpack safety programs, walking programs, and recommendations to optimize learning through movement and positioning.

The APTA has developed Fact Sheets for activities for young children and fitness-related family resources which can be found respectively at:

- *Resources on Fitness for Young Children*  
<http://pediatricapta.org/includes/fact-sheets/pdfs/Toddler%20Fitness%20Websites.pdf>
- *Family Resources for Fun with Physical Activity and Young Children*  
<https://pediatricapta.org/includes/fact-sheets/pdfs/16%20Family%20Resources%20for%20Fun%20with%20Phys%20Activity%200916.pdf>

## **Section 504**

Physical therapists may lend their expertise for students within the general education program under Section 504 of the Rehabilitation Act of 1973, a civil rights statute that prohibits discrimination of persons with disabilities in programs receiving federal funding including public schools.

*“To be protected under Section 504, a student must be determined to: (1) have a physical or mental impairment that substantially limits one or more major life activities; or (2) have a record of such an impairment; or (3) be regarded as having such an impairment. Section 504 requires that school districts provide a free appropriate public education (FAPE) to qualified students in their jurisdictions who have a physical or mental impairment that substantially limits one or more major life activities.”* (Section 504 of the Rehabilitation Act, 1973)

Students qualify for modifications, accommodations, and/or related services in their educational programming under Section 504 if they have physiologic conditions, disfigurement, or anatomical loss in the various body systems (e.g., neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine).

*“Major life activities, as defined in the Section 504 regulations at 34 C.F.R. 104.3(j)(2)(ii), include functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. .... Congress provided additional examples of general activities that are major life activities, including eating, sleeping, standing, lifting, bending, reading, concentrating, thinking, and communicating”* (US Dept. of Ed., Office of Civil Rights, 2018).

School districts establish standards and procedures for initial evaluations and reevaluations as specified in Section 504 (CFR 104.35). Evaluation results are reviewed and a plan is developed by a multidisciplinary committee made up of persons knowledgeable about the student, evaluation data, and intervention options. Physical therapy, along with other related services, may be part of the 504 plan “designed to meet the individual needs of such students to the same extent as the needs of students without disabilities are met” (US Dept. of Ed., Office of Civil Rights, 2018).

## **Scientific Research-based Interventions (SRBI)**

Physical therapists work with staff to problem solve and make recommendations for differentiated instruction for students participating in the regular education curriculum. Following the enactment of the No Child Left Behind Act (NCLB) of 2001 (United States Department of Education, NCLB, 2001), school districts began using a process known as Response to Intervention (RtI) as a way to promote research-based interventions to facilitate

success for all students, monitor student progress, make decisions about differentiated instruction, and identify students with learning disabilities (CSDE, Connecticut’s Framework for RTI, 2008). The more recent Every Student Succeeds Act (ESSA) of 2015 uses the term Multi-tiered System of Supports (MTSS) as a means of supporting struggling students, improving social and emotional development for all students, and addressing school climate. Positive Behavior Intervention and Support (PBIS) and Response to Intervention (RtI) fall under the MTSS umbrella (USDE, ESSA, 2015; Office of Special Education Programs, 2018).

The Connecticut State Department of Education (CSDE) currently refers to the RtI process within MTSS as Scientific Research-based Interventions (SRBI) (CSDE, Topical Brief 3; Addressing the Whole Child, 2011). The SRBI process emphasizes the role of general education in addressing students’ needs, and stresses the importance of using scientifically based practices, monitoring progress frequently, and collecting data to make informed decisions. In 2010, the Connecticut State Board of Education Position statement on Student Support Services suggested that the SRBI model was an appropriate ....

*“process to address the needs of the whole child to remove non-academic barriers to academic achievement and to ensure that students achieve their full potential.”*

(CSDE, Topical Brief 3; Addressing the Whole Child, 2011).

Variations of the SRBI process exist, often being in the form of a three-tiered model of addressing students’ needs with successive levels that provide increasingly intensive forms of intervention for students in pre-K through grade 12. The specific model and methods of monitoring student progress vary based on LEA practice. Teams of educators (often referred to as data teams) are formed within each school to review student achievement. The regular members of these teams include general education teachers, administrators, school psychologists, speech-language pathologists, English as a Second Language (ESL) teachers, special educators, reading and math consultants, and counselors (CSDE, Topical Brief 3; Addressing the Whole Child, 2011; Johnson, Mellard, Fuchs, McKnight, 2006).

Physical therapists may be called upon to serve as a resource to provide general recommendations to minimize barriers for students’ participation in educational programming. These barriers may include weaknesses in a student’s movement, function, and/or sensorimotor abilities. A student may be challenged in many areas including but not limited to safety, posture, mobility, body structure and function, endurance, sensory processing. The team will collaboratively determine whether or not these weaknesses are impacting the student’s educational achievement. The school-based physical therapist can provide strategies that the educational staff can implement with students. Within the SRBI process, the therapist provides consultation to the school personnel and does not provide direct physical therapy intervention for a specific student.

### *SRBI Tier I (Universal Intervention)*

Tier 1 refers to the general education core curriculum, school climate, and behavioral supports for all students (CSDE, Topical Brief 3; Addressing the Whole Child, 2011). Universal common

assessments in the key academic areas are used to establish whether or not students are meeting targeted benchmarks periodically throughout the year. Approximately 80% of all students are expected to succeed in the general academic curriculum which includes physical education (CSDE, Topical Brief 3; Addressing the Whole Child, 2011). Physical therapists may contribute input regarding students' motor development that will lead to their academic success. The therapist may be involved in providing input about the students' participation in other non-academic areas that afford opportunities for physical activity including recess, before- or after-school programs, physically active learning, environmental supports/modifications, ergonomics, and navigation of the school environment.

The physical therapist may contribute to the development of prevention, fitness, and wellness activities as part of the universally designed programs for all students. Therapists may make recommendations for school-wide programs (transportation, backpack safety, screenings, evacuation, etc.) and environmental design (entry/exit, playgrounds, bathrooms, seating). According to the Pediatrics APTA *Fact Sheet, FAQ's on Response to Intervention (RtI) for School-based Physical Therapists* (APTA, 2011), physical therapists can contribute to the Tier I process when they:

- *“Provide in-services to teachers on typical development and indicators of academic readiness;*
- *Assist with environmental design to reduce barriers and enhance performance;*
- *Provide in-services to administrators, teachers, and other staff members on strategies to promote alertness through incorporation of movement activities;*
- *Provide in-services to teachers and staff on possible environmental modifications that can maximize posture to enhance learning and participation;*
- *Provide in-services to administration on benefits of including recess in the students' school day; and*
- *Provide in-services to staff on PTs' role in RtI and provide resources and equipment guides.” (APTA, 2011).*

### *SRBI Tier II (Targeted Intervention)*

Students who are not achieving the desired benchmarks of success after the staff's attempt to implement Tier I recommendations may be referred for Tier II consideration. Recommendations made as part of Tier II SRBI tend to be targeted instruction for a specific skill or learning strategy over a short duration of time. Data collection is an integral part of monitoring a student's progress in response to the implementation of the SRBI team's intervention plan.

For example, the SRBI process can be applied to the universal concern for students' safety on the stairs. The teacher may have an explicit policy for all children to hold the handrail (Tier I intervention). Tier II targeted suggestions for improving a specific student's safety while on the stairs may include purposefully positioning the student in line relative to his peers and/or performing the task when fewer children are on the stairs.

Principles of SRBI may also be applied to promote physical activity and wellness. For example, SRBI principles may be applied to physical education to allow small groups of students to perform alternative activities, or to meet with the physical educator for pre-teaching, reinforcement, individualizing modifications or skill practice, goal-setting and progress-monitoring (CSDE, Topical Brief 3; Addressing the Whole Child, 2011).

Therapists may observe students in classrooms and other settings in the school in order to assist teachers and parents to understand and to plan for students who are struggling. As a consultant to the general education team, the physical therapist may suggest activities, practice, instructional strategies/approaches, extra-curricular activities, and community resources. As a team contributor to Tier II interventions, physical therapists may:

- *“Participate in building level problem-solving process at grade/class subgroup level;*
- *Suggest alternative materials to promote participation and performance for remediation and enrichment;*
- *Explore environmental triggers for behaviors in daily routines; and*
- *Suggest purposeful activities for classroom and leisure time.”* (APTA, 2011).

### *SRBI Tier III (Intensive Intervention)*

Students not making progress despite Tier II interventions may be referred for Tier III consideration. Tier III provides the most intensive level of intervention. Tier III interventions are research based, usually occur daily, consist of individual or small group models, and require more frequent progress monitoring than was recommended in previous levels of the SRBI process. Interventions continue to be short-term, remain part of the general education system, and supplement core instruction. Adapted strategies in physical education may be considered a Tier III intervention (CSDE, Topical Brief 3; Addressing the Whole Child, 2011).

Physical therapists involved in Tier III of the SRBI process may continue to participate in problem-solving at the individual student level. Observation and/or screening may lead to the therapist’s better understanding of the student and his/her interaction with the school environment. The therapist may consult with classroom teachers and/or parent on a regular basis to monitor the recommended supports and accommodations and to adjust these as needed. Physical therapists are uniquely qualified to collaborate with physical education teachers regarding individual student’s participation, strategies, physical fitness profiles and assessments (APTA, 2011).

The principles of SRBI are often thought of as early intervening strategies that occur prior to referral for special education or individualized related service. However, a referral for a comprehensive evaluation, possibly including a physical therapy evaluation, can occur at any time by requesting a PPT meeting to determine eligibility for special education or 504 services. Referral for evaluation most often occurs when:



- 1) The student is not achieving the desired level of progress in Tier III;
- 2) The parents request a formal evaluation to determine special education eligibility (CSDE, Connecticut's Framework for RTI, 2008; APTA, 2011); or
- 3) The educational team members determine the need to refer the student for a full evaluation based on observations, data collection, input from teachers/ parents/ medical personnel, etc.

A sample of a form for gathering information from teachers that is supported by the APTA School Special Interest Group can be found at:

[https://pediatricapta.org/special-interest-groups/SB/pdfs/WI\\_schools\\_checklist.pdf](https://pediatricapta.org/special-interest-groups/SB/pdfs/WI_schools_checklist.pdf)

For more information about physical therapy's contribution to the SRBI process, please access:

<http://pediatricapta.org/includes/fact-sheets/pdfs/11%20FAQs%20for%20School%20PTs.pdf>

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## Chapter 4. Referral, Observation, Screening, and Evaluation

### *Child Find*

Each state is required through the Child Find component of IDEA to develop a system to identify, locate and evaluate all children with disabilities ages birth through 21 who are in need of special education and related services (CPAC, Child-find, 2018). Local education agencies (LEA) handle the 'Child Find' process in a variety of ways resulting in students being referred for school-based physical therapy through various mechanisms. Referrals may come from professionals working with students already in the school district or from people outside of the school district. Examples of outside referrals include those from parents, Birth-to-Three service providers, and private or parochial school educators. Once the referral is received, the educational team meets and determines which evaluations are warranted. (USDE, Provisions Related to Children With Disabilities Enrolled by Their Parents in Private Schools, 2011).

### *Transition from Birth to Three*

Children who receive Birth-to-Three services may be eligible to receive special education in the school setting upon turning three years of age. Timelines are established to facilitate transition into the school system. The notification for transition to school-based services is mandated to begin within 9 months prior, and no later than 90 days prior, to the child's third birthday (IDEA, Section 303.209/c/1, 2004). The Birth to Three provider is responsible for gaining permission from the parents to send information to notify the LEA. The Birth to Three provider is also responsible for completing the Birth to Three forms requesting an evaluation by the school district to determine eligibility (CT Birth to Three, 2013). An Individual Family Service Plan transition conference is scheduled by Birth to Three, up to 9 months before but no later than 90-days before the child has his/her third birthday. The LEA representatives are mandated to attend this conference, and the school-based physical therapist may attend when the child is having difficulty in the areas of function, movement, or sensorimotor development. At the transition IEP team meeting the team discusses the referral, reviews available information and parent concerns, and determines whether or not evaluation is needed.

The LEA may use existing information from Birth to Three to assist in determining eligibility and programming within the school setting. If the LEA needs additional or more current data and chooses to conduct their own initial evaluation, then the LEA must obtain written consent from the parents for an "initial evaluation" (IDEA, Evaluation Procedures, 2004). School-based physical therapists may be called upon to participate in the comprehensive team evaluation that identifies whether the child has a disability and recommends an appropriate educational program for the child (IDEA, Evaluation Procedures, 2004). If a child is found to be eligible for special education and related services, then an IEP will be developed and services will begin by the first school day that is on or after the child's third birthday (CT Birth to Three, 2013).

It is important to note that if the LEA is using existing information from Birth to Three to determine the need for physical therapy, a physical therapist must have been included in the Birth to Three transdisciplinary team that is providing the information. An evaluation must be completed by a physical therapist prior to determining the need for school-based physical therapy services and developing a physical therapy plan of care in the school. According to the Guide to Physical Therapist Practice

*“A physical therapist examination must be conducted during the initial session with the individual prior to establishing a physical therapist plan of care”.*

(APTA, Defensible Documentation Elements: Initial Examination and Evaluation, 2018)

The APTA, Section on Pediatrics has developed a worksheet to assist therapists in the transition process. The worksheet is available at:

<https://pediatricapta.org/includes/fact-sheets/pdfs/14%20EI-SB%20Transition%20Worksheet%20for%20Ped%20PTs.pdf>

### ***Students Transferring From Another District***

For students transitioning from other schools with an existing IEP, the therapist must utilize the existing IEP from the previous LEA to provide physical therapy until the PPT accepts, updates, or develops a new IEP. The LEA must also make reasonable attempts to obtain the previous LEA’s records regarding the provision of special education and related services (USDE, IDEA-When IEP’s must be in effect, 2004). Therapists should check with their LEA about specific timelines, policies and procedures.

### ***Referrals for Students within the School District***

For students already enrolled in the public school, educational team members, including parents, may make referrals through the SRBI, Section 504, or special education processes. If the educational team members recognize that the student is experiencing movement, function, or sensorimotor challenges and is having difficulty accessing or participating in school activities, then a physical therapist may be able to share his/her expertise to assist the team in better understanding that student. Any member of the educational team can initiate the process to involve a physical therapist to further assess areas of concern for the student.

### ***Ways to Gather Information about a Student***

A therapist can gather information about a student’s performance in a variety of ways depending on the team’s concerns and the information needed to satisfy the referral question. Therapists can observe a student in typical educational situations, screen the student’s performance of specific tasks, or perform more comprehensive testing as part of a formal evaluation.

Sometimes school staff or parents may request that a physical therapist ‘take a look’ at a student to see whether or not the student is functioning in a manner similar to his/her peers or to

determine whether or not additional testing is indicated. To meet this request, physical therapists will conduct an *observation* of the student in the natural setting as a means of providing information to the PPT to assist with decision-making. A physical therapist's *observation* includes watching or monitoring a student when the student is engaged in motor-based educational activities as part of the typical routine. A member of the educational team should communicate with the student's parents about the observation.

Findings from observation may help a therapist to:

- Identify the student's general level of participation relative to peers;
- Recommend general strategies to facilitate the student's participation;
- Determine if further testing is indicated; and
- Suggest that the team and parents consider involving other professionals when there appears to be a concern outside of the physical therapist's scope of practice.

*Screening* is another means of gathering information about a student who is experiencing challenges and who is not currently receiving physical therapy services. In a *screening*, a physical therapist focuses on a particular area of concern and systematically collects and analyzes data in order to determine a future course of action (APTA, Introduction to the Guide to Physical Therapist Practice, 2014). The therapist may ask the student to perform specific tasks as a means of obtaining specific information about areas of potential challenges. Parental consent is required prior to conducting the screening (IDEA, Sec. 303.320(a)(1)(ii), 2004).

According to IDEA:

*“The screening of a student by a teacher or specialist to determine appropriate instructional strategies for curriculum implementation shall not be considered to be an evaluation for eligibility for special education and related services. “* (IDEA, Sec. 300.302).

Findings from screening may help a therapist to:

- Make recommendations to the team to improve the student's participation;
- Indicate the need for further physical therapy examination, and/ or
- Refer to appropriate disciplines when findings indicate issues outside of the scope of physical therapy practice (APTA, Introduction to the Guide to PT Practice, 2014).

A referral for a physical therapy evaluation occurs as a recommendation from the PPT or the 504 team. Signed written parent or guardian consent is necessary to begin the physical therapy evaluation (IDEA, Parental Consent, 2008). While physician referral for physical therapy evaluation is not necessary in the state of Connecticut (Connecticut General Assembly - Public Health Committee, Chapter 376 § 20-73), a physical therapist may consult with medical personnel to gain helpful information to focus the evaluation and ensure the appropriate level of challenge during the evaluation process.

The physical therapy evaluation may occur in order to:

- Contribute to the understanding of the student’s function, movement, and sensorimotor abilities as part of a comprehensive evaluation by the special education team to create an appropriate educational program;
- Assist in identifying and documenting areas of strengths and concerns in function, movement, and sensorimotor areas for a student suspected of having a disability;
- Contribute to the understanding of a student who is already receiving special education services and for whom function, movement, and sensorimotor issues have been raised by the team;
- Assist in setting appropriate expectations for the student; and/or
- Determine modifications and accommodations in order to promote student success.

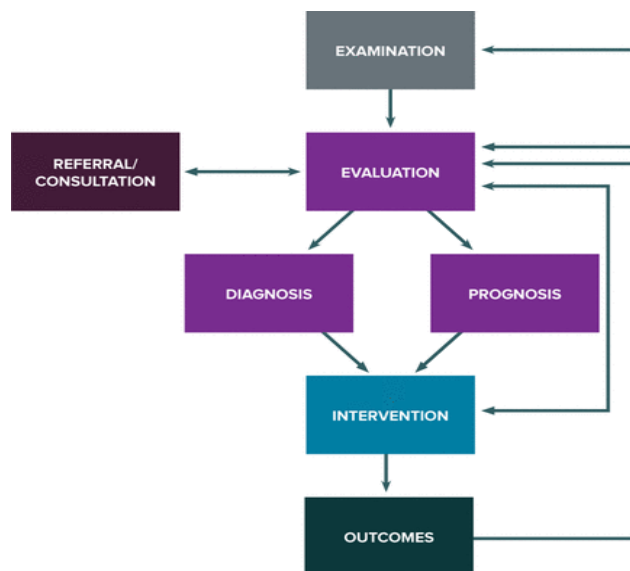
An initial evaluation must be completed within the time frame identified in section 10-76d-13 of the Connecticut Regulations of State Agencies. Current time frames set by the state can be found at:

<http://www.portal.ct.gov/-/media/SDE/Performance/Data-Collection/Help-Sites/Evaluation-Timelines/EvaluationTimelinesUserGuide.pdf>

Because some local school districts have set shorter timelines than state requirements, therapists should check with their LEA to ensure compliance.

### *Defining the Evaluation Process*

The APTA provides specific definitions of terms used in gathering information in their Client Management Model. The terms and the interactions of the components are depicted in the figure below.



(APTA, Principles of Physical Therapist Patient and Client Management, 2014)

*Examination* includes obtaining a history, performing relevant systems review, and administering specific tests and measures. *Evaluation* involves making clinical judgments using the data gathered during the examination (APTA, Fact Sheet: Using APTA’s Guide to Physical Therapist Practice in Pediatric Settings, 2003). Evaluation is the process by which physical therapists determine a *Diagnosis* amenable to physical therapy intervention (APTA, Principles of Physical Therapist Patient and Client Management, 2014). While the school-based physical therapist does not make a medical diagnosis, the therapist will identify elements within the movement system that negatively affect the student’s performance in the educational setting that will become the focus of physical therapy intervention (APTA, Principles of Physical Therapist Patient and Client Management, 2014). The physical therapy diagnosis also differs from the broader IDEA educational categories used to qualify students for special education (i.e., Autism, Learning Disability, Intellectual Disability, and Other Health Impairment). The evaluation also includes the process of determining the *Prognosis*, the expected optimal level of progress and the time needed to reach that level. The *Intervention* describes the interaction of the therapist with the student and other individuals involved with the student’s educational program including the student instruction and specific therapeutic methods or techniques. *Outcomes* are identified as a means of measuring the effectiveness of the intervention and monitoring student progress. The APTA identifies the *Plan of Care* as the culmination of the examination, diagnostic, and prognostic processes. The *Plan of Care* includes “the goals, predicted level of optimal improvement, interventions to be used and proposed duration and frequency of the interventions” (APTA, Principles of Physical Therapist Patient and Client Management, 2014).

### ***The Evaluation Process in Schools***

The school-based physical therapist uses a participation-based approach beginning with identifying the student’s strengths and areas of functional challenge within the entire educational program including the student’s meaningful participation in school-wide, extracurricular, and educationally related community activities.

*“The first step in a school-based evaluation is for the team to identify the functional limitations and participation restrictions affecting the student. This information will guide the physical therapist in the choice of examination, observation, and assessment tools.”*

(Academy of Pediatric PT, Fact Sheet; Practice Recommendations, 2014).

Observations of the student’s functional performance in natural environments can provide information regarding strengths, expectations, and barriers to the student’s access and participation in educational programming. Natural educational environments may include, but are not limited to classrooms, cafeterias, hallways, libraries, gymnasiums, bathrooms, art/music rooms, playgrounds, exterior school property, work sites, community-based instruction locations, and buses or other modes of transportation. These observations will help the therapist to focus the evaluation and identify the appropriate assessment tools.

The *Examination* component of the physical therapy evaluation includes a *History* section. The school-based physical therapist may include the following information in this section; medical and educational program history, reason for referral including concerns expressed by the student, staff and/or parents, information pertaining to the student's school day, and expectations. It is also important to include information about therapeutic services outside of the school as well as the student's participation in community activities. Sources of information for the history that are available to the school-based physical therapist may include parent/student interview, educational staff interviews, questionnaires, nursing and health records, cumulative files, special education files, prior Individualized Family Service Plans (IFSP) or IEPs, and physical education testing results. In addition, it may be appropriate and helpful to consult with community-based medical providers (physicians, therapists, home health agencies) to obtain important information about the student. Written consent from the parents or guardians is required to obtain/share necessary information with outside providers such as physicians, clinical therapists, home health agencies, etc. (USDE, FERPA, 2018).

As part of the *Examination*, school-based therapists are responsible for conducting a *Systems Review*. This review consists of a brief, abbreviated assessment of musculoskeletal, neuromuscular, cardiopulmonary, integumentary (skin) systems in order to determine specific testing needs. This review also considers communication, cognition, and learning preferences. Additional areas to consider when assessing students might include nutrition, behavior/attention, and self-determination. *Systems Review* is necessary to provide information regarding conditions that may contribute to the areas of concern and reason for referral. The comprehensive nature of the *Systems Review* can help delineate areas of concern which may be outside the scope of physical therapy practice and guide the therapist towards an outside referral when warranted (APTA, Defensible Documentation; Elements of Documentation within the Patient/Client Management Model, 2018).

*Tests and measures*, as part of the *Examination*, can be used to determine the baseline of the student's performance. The therapist should have specific rationale for the tests and measures chosen. Student's performance should be assessed using valid and reliable measures. Criterion referenced measures may be used to compare a student's performance against described criteria and to quantify changes in successive performances of that individual student. Norm referenced instruments may also be used in some cases when a comparison is needed between the individual student's performance and that of same age peers. When using standardized assessments physical therapists are expected to adhere to administration protocol and report any deviation from the recommended methods for testing administration or use outside of protocol. Standardized norm referenced tests may not be sensitive to the effects of therapy or instruction and may not consider specific task analysis needed within the educational setting (Long & Toscano, 2002). Findings of tests and measures, along with a description of the student's specific performance, can provide baseline status and allow monitoring of student progress toward predicted goals over time (APTA, Measures and Outcomes, 2017).

The school-based physical therapist plays a unique role on the educational team as the individual who can assess the student from the multiple perspectives presented in the ICF-CY model. A therapist is trained to take into account the dynamic interaction of the student's health, body



function and structure, environmental factors, and personal factors as they affect the student's ability to engage in activities and participate in the educational program.

The examination considers all elements of the ICF-CY Model including **body structures** (anatomical parts of the body such as organs, limbs and their components) and **body function** (physiological functions of body systems including psychological functions) (WHO, 2007). Consideration of the **body structures and function** aspect of the ICF-CY Model may include measurement of cardiopulmonary function, body mass, structural alignment, joint mobility, strength, muscle tone, coordination, endurance, posture, balance, pain, etc. Additionally, school-based physical therapists may assess vestibular function, proprioceptive function, visual-motor coordination, body awareness, and spatial awareness (Fact Sheet: Practice Recommendations, 2014). Examples of tests and measures used to assess **body structures and function** may include but are not limited to vital signs, energy expenditure index, Modified Ashworth Scale, Pediatric Balance Scale, Clinical Observation of Posture and Movement (COMPS). (APTA, List of Pediatric Assessment Tools Categorized by ICF Model, 2012).

Consideration is also given to the **activity** aspect of the ICF-CY model (the execution of a task, skill, or action by an individual). **Activity** that occurs throughout the student's day includes gross motor skills (e.g., running, kicking, jumping, ball play), functional mobility (e.g., ambulation, wheelchair use, transfers, stair climbing), play (e.g., climbing, swinging, floor play), and the execution of school-related tasks (e.g., lifting a backpack, using the bathroom, standing on tiptoes to reach an object). Assessment in this area includes observations in natural environments, ecological inventories and checklists. Some examples of tools used to assess the **activity** level may include, but are not limited to Timed Up and Go (TUG), Timed Up and Down Stairs Test, Peabody Developmental Motor Scales (PDMS-2), Test of Gross Motor Development (TGMD-2), and Gross Motor Function Measure (GMFM) (APTA, List of Pediatric Assessment Tools Categorized by ICF Model, 2012).

Assessment tools are also available to quantify the student's **participation** (involvement in a life situation). Examples of **participation** with peers may include transitioning between classes, managing the lunch routine, playing at recess, and getting on and off the school bus. Such assessments consider environmental factors, task demands, and expectations. Some examples of tools used to assess the child's **participation** may include, but are not limited to the School Function Assessment (SFA), Quality of Life Scales, and Pediatric Quality of Life Inventory (APTA, List of Pediatric Assessment Tools Categorized by ICF Model, 2012).

For additional resources about specific tests and measures categorized by the ICF Model, please refer to the APTA publication:

Fact Sheet: List of Pediatric Assessment Tools Categorized by ICF Model.

<http://pediatricapta.org/includes/fact-sheets/pdfs/13%20Assessment&screening%20tools.pdf>

For a comprehensive list of pediatric assessment tools with descriptions please refer to:

List of Assessment Tools Used in Pediatric Physical Therapy.

<https://www.scribd.com/doc/142428792/Lists-of-Assessment-Tools-Used-in-Pediatric-Physical-Therapy>

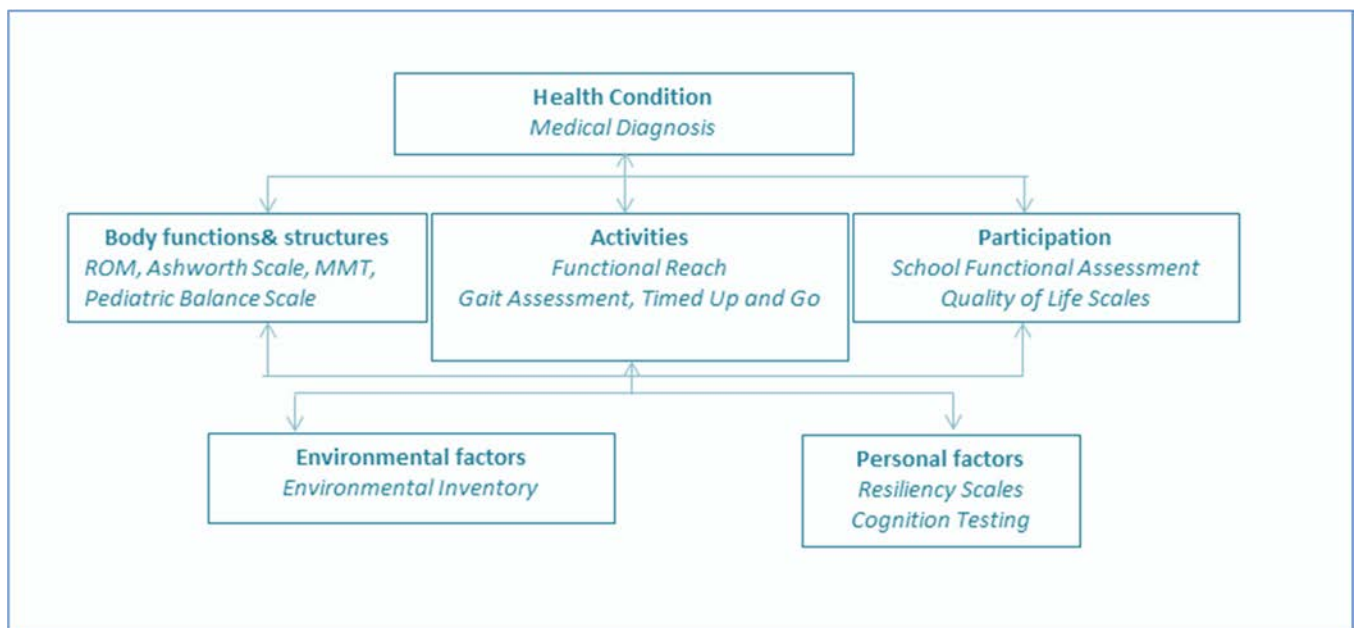
Many students in the school setting can best be assessed in the area of participation by direct observation in the natural environment. A sample observational assessment of participation is included in Practice Recommendations for the School-Based Physical Therapy Evaluation of Children with Autism Spectrum Disorder, which can be found at: :

<http://pediatricapta.org/includes/factsheets/pdfs/14%20Prac%20Rec%20for%20Schools%20for%20Eval%20of%20Autism.pdf>

While this observational assessment tool was designed for children with Autism, the format can be used for students with a variety of conditions.

Physical therapists identify environmental barriers to a student's access and participation and suggest ways to provide environmental supports to enhance participation and independent access. A student's personal factors (interests, motivation, cognition, awareness, maturity, cultural beliefs) are also considered as part of the evaluation process. Some tools used to assess personal factors include Children's Assessment of Participation and Enjoyment (CAPE), Perceived Efficacy and Goal Setting (PEGS), and Participation and Environment Measure for Children and Youth (PEM-CY).

Below is an example of some tests and measures options that may be selected in accordance with the elements of the ICF-CY model (WHO, 2007).

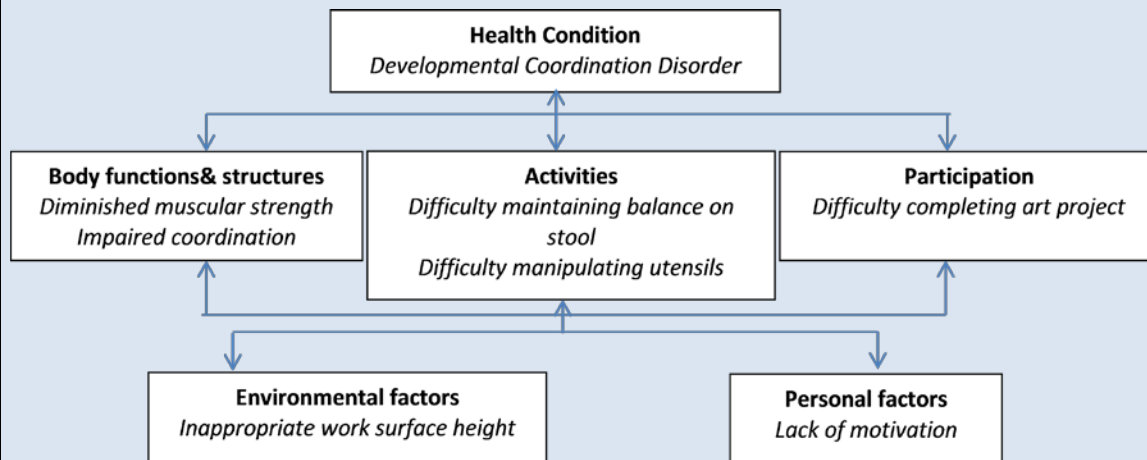


## Case Study Illustrating the Physical Therapy Evaluation Process

The following case study illustrates the evaluation process applying the ICF-CY model.

The IEP team requested that the physical therapist assess an 8-year-old male student with developmental coordination disorder who was having difficulty completing art projects. The parent provided written consent for a physical therapy evaluation. To begin the evaluation of the student's participation, the therapist observed the student in the natural setting keeping in mind the ICF-CY framework. Through the observation of the student in art class, the therapist noted that the child had challenges completing his art project. His posture and movements suggested that he may have underlying strength and coordination impairments, diminished balance, and difficulty with fine motor skills. The art table was relatively high and the stool lacked back support. The student expressed frustration and required adult encouragement to continue the project.

The chart below represents how observation findings can be categorized within the ICF-CY model:



The therapist's observation served to guide the selection of specific tests and outcome measures to include in the examination of each of the ICF-CY areas. Within the **body functions and structures** category, the therapist chose to administer coordination sub-tests of the Bruininks-Oseretsky Test of Motor Proficiency -2, and strength tests (APTA, Strength Testing in Pediatric PT, 2011). Activity restrictions were quantified using the Functional Reach Test and Pediatric Balance Scale. The School Function Assessment (SFA) was used to quantify the student's object manipulation and positioning in this situation and his performance throughout the general school routine.

The physical therapy examination findings indicated below age-expected performance on:

- Supine flexion, prone extension;
- Grip strength;
- Bilateral coordination subtest of the BOT-2;
- Pediatric Balance Scale;
- Functional Reach; and
- SFA subtests - Using Materials, Manipulation with Movement, Recreational Movement, and Maintaining and Changing Positions.

The school therapist interpreted and integrated examination information (evaluation) and made the determination that the student's impairments and activity limitations (physical therapy diagnosis) restricted the student's participation in the school setting. The student demonstrated potential for improved participation and his needs fell within the scope of physical therapy practice (prognosis). The results of the therapist's evaluation were presented orally and in written form at the PPT meeting, including a suggestion for the team to consider a referral for an evaluation by an occupational therapist.

Another example of a comprehensive case study using the ICF-CY model, please refer to the APTA Section on Pediatrics published case study which can be found at:

<http://www.pediatricapta.org/consumer-patient-information/pdfs/GuideFactSheetCase.pdf>

### ***Determining Need for Physical Therapy Services***

The physical therapist interprets and integrates examination information to determine the student's physical therapy diagnosis and prognosis, and discusses the results of the evaluation with the PPT. Using the information provided by the physical therapist, the team collaboratively determines the need for physical therapy services. Since physical therapy services are considered "related services" the team determines whether the student's needs can be addressed by the school personnel or if the addition of skilled physical therapy services is needed for the student to benefit from his/her special education program (IDEA, Sec. 300.34, Related Services, 2004). The team must also consider whether or not the student's performance would be adversely affected were these services not provided. In addition to the physical therapy evaluation, the team may consider information from outside clinic-based evaluations and physician prescriptions. It is the IEP team members' decision to determine the relevance of the recommendations as they pertain to student access and participation in the school environment. The school-based physical therapist, along with the team members, should consider the following questions during the decision-making process:

1. *Are the student's disabilities or performance limitations adversely affecting his/her education?*
2. *Is the student's physical therapy need educational, and not only medical?*
3. *Is physical therapy necessary for the student to benefit from his/her education?*
4. *Does the student have potential to improve access to his/her education, and achieve educational goals with physical therapy intervention?*
5. *Does the student require the level of expertise of a physical therapist to achieve educational goals?"* (Vialu and Doyle, 2017)

### ***Physical Therapy Plan of Care in the Schools***

The physical therapy plan of care includes a list of goals, description of interventions, projection of service frequency and duration, and discharge plans (APTA, Principles of Physical /Therapist Patient and Client Management, 2014). In the more traditional medically oriented setting, the

plan of care is completed as part of the physical therapy evaluation. In the educational setting, elements of the plan of care will need to be described in multiple documents. Once the need for physical therapy services has been established, the IEP team determines the goals, frequency and duration of physical therapy and documents their decisions in the written IEP to serve as the foundation for intervention (McEwen, 2009, p.42). The physical therapist is responsible for determining and documenting the planned interventions including clinical reasoning based on the student's prognosis. All elements of the plan of care need to be documented as part of the physical therapy evaluation (APTA, Defensible Documentation Elements; Initial Examination & Evaluation, 2018). More information about documenting the *Plan of Care* can be found in **Chapter 7. Documentation of Physical Therapy in the Educational Setting.**

### ***Triennial Reevaluation***

Three years after the initiation of special education including related services, a Triennial Review is held to establish continued eligibility for special education services. The team will review existing data and decide the specific evaluations/assessments to be conducted in the areas of the student's disability prior to the Triennial Review. School-based physical therapists use their clinical judgment to recommend the components of an evaluation that are most helpful in assisting the educational team to understand the movement, function, and sensorimotor abilities of the student. Written parent or guardian consent is needed to conduct these evaluations using form ED27-Notice and Consent to Conduct a Reevaluation.

*"In school based practice, comprehensive team reexamination, reevaluation and reassessment for the integrated educational assessment are performed every three years or as mandated by state and federal regulations (Individuals with Disability Education Improvement Act 2004). This is a minimal requirement and may be done more frequently as indicated either by child's change of status, parent request and team decision or any requirements of individual state practice acts."*

(APTA, Defensible Documentation:  
Reexamination and Reevaluation, 2018).

Triennial Reviews are held on three year intervals or in certain circumstances dispensed with when the student's parents and the public agency agree that a reevaluation is unnecessary for determining eligibility as permitted by Sec 300.303 (B)(2) of IDEA. While educational legislation may allow waiver of this evaluation, and the Connecticut Practice Act does not mandate reevaluation, physical therapists must be mindful of their professional guidelines relative to reevaluating and documenting progress. The APTA guidelines recommend that a reevaluation with a written report should be performed if the student is not responding to intervention as expected or the need for a new plan of care is indicated (APTA, Defensible Documentation: Reexamination and reevaluation, 2018).

## *Discontinuation of Services*

The IEP team, including the physical therapist, considers the student's status on a regular basis as part of the progress monitoring process (Please see Chapter 5). Based on an analysis of the student's performance relative to identified outcomes, the IEP team may decide that physical therapy services are no longer needed to achieve educational goals and improve access and participation within the school setting. If discontinuation of physical therapy services is decided upon by the IEP team, the therapist will review the student's progress, describe the student's current status, and provide a rationale for discontinuing services (APTA, Defensible Documentation. Setting-Specific Considerations, 2018). (Please see Chapter 7 for a description of the documentation associated with discontinuation from physical therapy services.)

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## Chapter 5. Goals and Objectives as Part of the Plan of Care in the School Setting

### *Plan of Care*

The physical therapy plan of care includes a list of goals/objectives, prognosis/clinical reasoning, description of interventions, projection of service frequency and duration, and discharge plans/discontinuation of services (APTA, Principles of Physical Therapist Patient and Client Management, 2014). Some elements of the plan of care are represented as required items within the IEP form (goals, frequency and duration, episode of care), and other elements of the plan of care (prognosis, description of intervention, and the discharge plan) are typically not designated within the IEP form, but are, nonetheless, important for the provision of therapy services.

### *Developing Goals and Objectives*

One way school-based physical therapists contribute to the development of the student's IEP is by working with the educational team to establish annual student goals and objectives. Student IEP goals and objectives are written by the PPT to address the identified concerns and project what the student can reasonably accomplish in a designated amount of time (usually in a year) based on his or her current level of performance. Educationally relevant goals and objectives are written to be measurable and reflect functional performance requirements in the school setting.

*“Specified annual goals and objectives should align with the grade level general education curriculum standards, functional performance requirements and the Connecticut Frameworks: Curricular Goals K-12 and the Connecticut Preschool Frameworks.”* (Connecticut State Department of Education, IEP Manual and Forms, 2018).

Annual goals estimate the outcomes that are expected to be achieved prior to the student's next annual review. Goals are based on the student's present levels of performance and the expected prognosis. Goals indicate what the *student* will accomplish, not what the therapist or educational staff will do. Goals in the school setting are discipline free and are designed to allow a collaborative effort to promote the student's achievement (McEwen, 2009, p. 42).

Physical therapists are uniquely qualified to contribute information relating to students accessing the educational environment, executing sensorimotor based activities, and participating in the physical aspects of school programs. While the school-based physical therapist may recommend and be responsible for monitoring the student's performance relating to the goal, school staff can assist with goal achievement by working on activities throughout the day.

According to the Connecticut State Department of Education *IEP Manual*,

*“Goals are written for instructional/educational outcomes for students, not for services per se. Theoretically, a number of services could satisfy any particular instructional goal,”* (CSDE, IEP Manual and Forms, 2018).

It is important for physical therapists to collaborate with all team members to exchange information about the student’s goals. Physical therapists can contribute information regarding non-motor areas of development observed during therapy sessions (e.g., behavior, level of interest, communication). Conversely the therapist may ask school staff to collect data about goal-related motor performance throughout the school day. The student’s participation in the educational program is multi-faceted and best achieved when the educational team adopts a collaborative approach to both setting student goals and collecting data/monitoring progress.

Short term objectives and benchmarks describe meaningful intermediate and measurable outcomes between the student’s current performance level and the realistic projected annual goal. It is important that goals and objectives be educationally relevant, specific, measurable, and to the extent appropriate, relate to the student’s achievement in the appropriate preschool activities, general education curriculum, or transition programming (CSDE, IEP Manual and Forms, 2018). Measurability can be achieved by using objective measures that have been established as valid and acceptable measurement tools or by establishing specific criteria for achievement (distance, time, level of assistance, etc.) (Dole, 2003; CSDE, IEP Manual and Forms, 2018). Objectives may target student function within all aspects of school programming and are written to allow ease of understanding by all persons involved in the student’s program.

Originally developed in the business field, SMART goal writing has been applied to the educational setting (Doran, Miller & Cunningham, 1981). The acronym of SMART goals has been coined to help educators include the correct components within goals as described in the chart below.

<b>Specific</b>	Designate who will perform, what will be done, where the activity will occur, when and how in the school routine the activity will be done
<b>Measurable</b>	Describe how much, how many, and how to determine when it is accomplished
<b>Achievable, agreed upon, appropriate</b>	Consider the ability to be accomplished in the school setting, the importance relative to the student’s educational program, and the support given by the entire team
<b>Relevant, realistic</b>	Consider the value to the student’s participation in the educational program, along with the ability to be accomplished in the educational program
<b>Time specific</b>	Identify the time period in which the goal can be accomplished, establish interval times to assess progress

(Franklin Public Schools, 2012)

To continue the example of the eight-year old student who had difficulty completing art projects, the following goals and objectives could be included on the IEP, with purposeful variation in wording to illustrate possible ways to represent SMART goal writing criteria:

Goal 1: The student will increase strength, balance, and coordination in order to improve participation in art activities in a similar manner to peers as evidenced by meeting the following objectives:

Objectives may include:

1. Provided with a stool with a back, the student will demonstrate proper sitting position and maintain sitting balance for 20 minutes using his hands to complete the art project.  
(Baseline: Student sits for 5 minutes after which upper body support is needed)
2. From a seated position, the student will improve from requiring upper extremity support to being able to reach forward to obtain utensils and materials placed in the center of the art table without loss of balance 80% of given opportunities over a two week period.

On the IEP, evaluation procedures are specified for each annual goal and short term objective, and may include pre-and post-baseline data, criterion referenced assessments, and standardized assessments. Performance criteria is specified for each short term objective and for the annual goal(s) and may include frequency, level of assistance, trials, job performance, etc. depending on the task demand. Achievement of the short term objectives may be used as the evaluation procedure for assessing the advancement toward the student's annual goal. If the PPT determines that progress or lack of progress toward goals warrants a change in the education plan, (e.g., increased/decreased frequency or duration or change in location of service) then parents must be informed of the proposed changes in programming prior to implementation (CSDE, Parent's Guide to Special Education in CT, 2007).

### ***Monitoring Progress***

As part of ongoing monitoring of student progress, school-based physical therapists are continually assessing the effectiveness of their interventions. In the school system, therapists are often collecting and sharing data at appropriate intervals to monitor progress toward achievement of the student's annual goals and objectives. The plan for monitoring progress for each goal and objective is established at the PPT meeting. This is documented in the IEP in the Evaluation Procedures and Performance Criteria sections (CSDE, 2018, p.13). This reporting is established at designated times during the school year and is often concurrent with the issuance of report cards of the general school population (IDEA, Sec. 300.320(a), 2004).

A tool for progress monitoring called the Goal Attainment Scaling (GAS) has been developed to assist therapists in collecting data and assessing progress toward goals and objectives (Palisano, 1993). The GAS is a criterion-referenced tool that can be individualized to the student and measure change by defining a range of outcomes using a 5-point scale reflecting functional change. A PT COUNTS study by Chiarello, Effgen, Jeffries, McCoy and Bush (2016) found that

“GAS was responsive to changes that individual students made and support its use as a meaningful outcome in school-based physical therapy practice,” (Chiarello, et al, 2016).

The following chart presents a sample of how the GAS can be applied to a student who has emerging walking skills and is able to crawl throughout the classroom and independently pull to stand to play with toys.

Attainment Level	Score	Description
Baseline	-2	The student independently pulls to stand to play with a desired object
Less than expected outcome	-1	The student cruises 1-3 feet along a stable surface to play with a desired object
Expected outcome	0	The student cruises 3-5 feet along a stable surface to play with a desired object
Greater than expected outcome	+1	The student takes 1-5 steps independently away from the stable surface
Much greater than expected outcome	+2	The student takes > 5 steps independently away from the stable surface

(APTA, Performance Appraisal of School-Based Physical Therapists, 2013)

Many more examples of ways to use GAS can be found in the APTA Fact Sheet: Performance Appraisal of School-Based Physical Therapists at:  
<https://pediatricapta.org/includes/fact-sheets/pdfs/15%20PT%20Performance%20Appraisal.pdf>

### ***Annual Review***

The IEP team “reviews the child’s IEP periodically, but not less than annually, to determine whether the annual goals for the child are being achieved” (IDEA, Sec. 300.324, 2004). This is typically referred to as the Annual Review. Progress toward goals and objectives is assessed using identified evaluation procedures and performance criteria as specified in the student’s IEP. This progress is reported at the Annual Review PPT meeting following the initiation of physical therapy. The IEP cycle (as identified by the dates on the IEP document) typically serves as the episode of care in the educational setting (APTA, Dosage Considerations, 2014; APTA, A Pediatric Case Example, 2004).

Based on the student’s progress toward outcomes identified on the IEP, the IEP team will determine if the physical therapy services continue to be needed. The physical therapist, in collaboration with the IEP team will revise existing goals, develop new goals and objectives, and revise the plan of care (APTA, Defensible Documentation Elements: Initial Examination and Evaluation, 2018).

## *Criteria for Discontinuing Service*

Discontinuing physical therapy services for a student is determined on the basis of the individual student's status. Physical therapy services may be discontinued if the student is no longer eligible for special education or Section 504 services due to change in status, graduation, or surpassing age of eligibility (i.e., 21 years of age). Physical therapy services can be discontinued when the therapist, in collaboration with other team members, concludes that the student no longer requires the unique expertise and/or licensure of the physical therapist to achieve educational benefit from his/her special education program. In some cases it may be appropriate to discontinue direct services and maintain a consultative role to monitor the effects of discontinuing direct intervention (Effgen, 2000).

According to Effgen (2000), discontinuing physical therapy services may occur when:

- The student has met all established functional goals;
- The student's areas of concern are no longer interfering with his/her ability to function within the educational program;
- The student has learned appropriate strategies to compensate for his/her disability;
- Effective strategies to manage the student's areas of concern have been developed and can be implemented safely and independently by the current educational team through classroom accommodations and/or modifications;
- Adaptive equipment is in place and is effective in enhancing safety, participation and independence;
- The parent revokes consent for services;
- The student no longer requires a related service in order to access and/or participate in the general curriculum;
- The student's needs can be managed effectively by another service provider on the educational team, and the expertise of the current therapist is no longer necessary.

As the student reaches the ultimate discharge criteria,

*“the physical therapist measures the global outcomes of the services provided. . . In consultation with appropriate individuals, the physical therapist plans for the conclusion of care and provides for appropriate follow-up or referral.”* (APTA, Patient and Client Management, 2014)

The APTA maintains that documentation is required at the conclusion of an episode of physical therapist care. Information on specific documentation requirements can be found in Chapter 7.

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## Chapter 6. Interventions as Part of the Plan of Care in the School Setting

### *Using Clinical Reasoning to Select Interventions*

Once the educational team establishes the student’s goals, the physical therapist uses knowledge of the student, the student’s condition, and clinical expertise to continue developing the plan of care. Physical therapists’ utilize clinical reasoning, their reflective thinking and decision-making skills, to integrate their knowledge of student-specific variables with available evidence to propose a plan of care specific to that student (APTA, Clinical Reasoning in Pediatric Physical Therapist Practice, 2013). Therapists are responsible for implementing best practice using a variety of interventions that integrate current motor learning and motor control theory and techniques supported by research whenever possible (APTA, Evidence-based Practice in Pediatric Physical Therapy, 2007). Many databases are available to reference and research the most current evidence to support decisions relating to intervention selection and implementation.

For more information on finding relevant databases, follow this link:

<http://pediatricapta.org/includes/fact-sheets/pdfs/Evidence-based%20Practice%20Fact%20Sheet.pdf>

When designing a physical therapy program in the school setting, the therapist must consider many factors. The Section on Pediatrics of the APTA have identified important factors to consider when determining the plan of care in the school setting as identified in the chart below.

<b>Level of participation</b>	The student’s functional abilities and/or skills (strengths and challenges) that impact his/her ability to access and engage in the educational program
<b>Chronological age/readiness for skill acquisition</b>	The student’s potential for skill acquisition during a critical period of development and the student’s intrinsic desire to participate
<b>Educational support</b>	The expertise/competency of the staff in a specific area of need, or the availability of other school-based providers to meet the needs
<b>Transitions</b>	The student’s level of performance in a new program, placement or environment
<b>Need for physical therapy expertise</b>	The need for problem solving, decision-making, and expertise from a skilled physical therapist.
<b>Previous therapy</b>	The student’s response to previous physical therapy interventions and the principles of evidence based practice
<b>Health condition</b>	Changes in the student’s medical status and health condition at various times throughout the educational experience
<b>Assistive technology (AT)</b>	The access and use of adaptive equipment to increase, maintain, or improve the student’s participation

(APTA, Dosage Considerations, 2014).

More detailed information about factors relative to determining elements of the plan of care can be found in *Dosage Considerations: Recommending School-Based Physical Therapy Intervention under IDEA Resource Manual* located at:

<http://pediatricapta.org/includes/fact-sheets/pdfs/15%20Dosage%20Consideration%20Resource%20Manual.pdf>

Tools such as the *Considerations for Educationally Relevant Therapy* (CERT) have been developed to assist the therapist in determining the need for educationally relevant therapy and appropriate time required to support the IEP goals/objectives. The CERT provides an organizational structure to consider student performance, history, progress, and prognosis. This tool may assist the IEP team in determining the level and intensity of physical therapy services along a continuum from simple adaptations and consultation to intensive therapy.

*“Best practice is to use the CERT with evaluations and reevaluations at a minimum. ... The CERT may be a valuable tool in leading the discussion or assisting in consensus of the team.”* (Florida Department of Education, 2006).

For information on the CERT follow this link:

<http://www.fldoe.org/core/fileparse.php/7590/urlt/0068975-cert-script.pdf>

Although services are most often specified over the course of the year in the IEP, it may be necessary to alter these services to meet the specific needs of the student on an ongoing basis.

*“Individuals with lifelong conditions receive health services on multiple occasions over their lifespan. Each episode is for a defined period and specific need. Children with lifelong conditions, such as cerebral palsy, developmental coordination disorder, and pervasive developmental disorder, may benefit from several episodes of therapy during childhood and adolescence. Outcomes for each episode should be meaningful to the child and family. The concept of an episode of therapy is in contrast to the perspective that children should continuously receive therapy services based on having a lifelong developmental or health condition.”*

(Palisano & Murr, 2009).

The IEP is intended to be a responsive document that is able to be modified based on the student’s presentation and needs at any given time. Depending on the policies of the school district, this can be done with an IEP amendment or by calling for a Program Review PPT meeting. The DoSES Model provides suggestions for ways to build flexibility within the IEP. For example, more frequent physical therapy services at the beginning of a school year (“front-loading”) can be recommended when a child transitions to a new school or program when it may be necessary to provide therapy services weekly for the beginning of the school year and then reduce to once monthly. In other cases, there may be a need for short bursts of more intensive intervention during the school year. This increase might occur when new equipment is being

introduced, or when practicing a functional skill such as walking across the stage for graduation (APTA, Dosage Considerations, 2014).

The following questions may guide the school-based therapist's clinical decision-making:

- What specific interventions will support the student's skill acquisition and participation in the educational program?;
- Where should the intervention take place?;
- How should the physical therapy service be provided?;
- How often should intervention be provided and for how long?; and
- How can changing demands in the school setting influence interventions over time?

***Selecting Interventions and Therapeutic Techniques** - What interventions do school-based therapists use to support the student's skill acquisition and participation in the educational program?*

When choosing intervention options the therapist considers current models relating to general health as well as theories specific to motor control and motor learning. Along with the ICF-CY model, the Dynamic Systems Theory may be used as a foundation for choosing and implementing the specific interventions. The Dynamic Systems Theory proposes that movement is produced from the interaction of the person, the task, and the environment (Thelen 1989; Thelen, Kelso, & Fogel, 1987; Sauve & Bartlett, 2010). When the school-based therapist creates an intervention plan, consideration may be given to those three main areas; (1) the student, (2) the educationally-related tasks, and (3) the natural environments in which the child participates as part of his/her educational program. While all three areas may be addressed in the interventions, one area may be emphasized more than another.

When the characteristics of the **student** are the focus of the intervention, the physical therapist works through the neuromuscular, musculoskeletal, cardio-pulmonary, and sensory systems of the student. Below is a list of intervention techniques that the APTA has recognized as being used with children in various settings. This list is not all inclusive and should not preclude physical therapists from utilizing techniques that fall within the physical therapy scope of practice but are not listed here.

- Pain management through non-pharmaceutical means;
- Positioning to promote health and function;
- Orthotic and prosthetic assessment and management;
- Functional training;
- Developmental training;
- Modalities;
- Manual therapy techniques;
- Postural training;
- Balance training;
- Perceptual training and sensory regulation activities;
- Gait training;

- Therapeutic exercise for strength and endurance;
- Flexibility activities;
- Neuromuscular education/re-education;
- Relaxation activities; and
- Student education to promote participation in the educational program  
(APTA, Principles of Patient and Client Management, 2014).

The specific intervention plan may need to focus on **task** performance when the student experiences difficulty in fully accessing and safely participating in educational activities in a manner similar to peers. Therapeutic intervention relating to **task** may include instruction about how to perform common tasks, or modifications of tasks that would promote the student's independence. Common tasks requiring intervention include:

- Indoor functional mobility such as negotiating stairs, ramps, doorways, elevators, etc.;
- Outdoor functional mobility including negotiating curbs, hills, uneven surfaces, and transportation access;
- Functional life skills including toileting, pressure relief/skin management, hygiene;
- Use of assistive devices such as wheelchairs, walkers, canes;
- Performance of physical education and recreation activities;
- Use of playground equipment;
- Use of assistive technology; and
- Student, staff, and family education about task performance.  
(NYC Department of Education, 2011).

Changes to the task may be required when attempts to address student characteristics have not yet been effective or when immediate need for task performance is necessary. In the school setting, these changes are referred to as modifications. Modifications are changes to the content standards or performance expectations that changes *what a child learns* (CSDE, IEP Manual, 2018, p. 17). Physical therapists may make modifications in duration, frequency, speed, and method of performing tasks. Tasks may need to be frequently modified to provide the appropriate level of challenge based on the student's skill and successful participation. For example, a child with cerebral palsy who has limited endurance may be excused from the mile-run requirement in physical education. A physical therapist may be involved in planning alternative activities. As endurance improves recommendations to participate or increase independence may be adjusted. Modification to task performance should be noted in the IEP on the *Program Accommodation and Modifications* page (CSDE, IEP Manual, 2018, p. 19).

Another focus of the physical therapy intervention may be on the **environment** when physical barriers to task performance exist. Recommendations to adapt the environment may be made when access to the environment is not possible and when the student is unlikely to achieve the skills necessary to perform a task without environmental changes (e.g. ramps to enter, installation of bathroom grab bars, etc.) (NYC Department of Education, 2011). In the school setting, environmental adaptations are referred to as *Accommodations*. Accommodations are also changes to instruction that changes *how* a child learns. Accommodations may include use of adaptive equipment and assistive technology (e.g., use of a walker, stander, communication device, etc.) (CSDE, IEP Manual, 2018, p.17). Physical therapists may be involved in the

prescription, application, and modification of assistive technology and adaptive equipment (APTA, 2014). Additional resources relating to assistive technology can be found at:

*Connecticut Assistive Technology Guidelines.*

<https://portal.ct.gov/-/media/SDE/Publications/atguide/atguide.pdf>

## ***Special Considerations***

There are specific situations for which school-based physical therapists commonly lend their expertise in considering the integration of the student's abilities, the task demands, and the environmental characteristics. Therapists often give advisement relating to a student's participation in physical education, transportation, and unique educational experiences that irregularly occur (e.g., emergency drills, field trips, and extra-curricular activities).

### ***Interventions Related to Adaptive Physical Education***

Physical education is the component of the education curriculum that provides students with the opportunity to develop fitness, wellness, and motor skills. Adapted physical education (APE) is a direct, specifically designed instructional service specified in the IEP, and provides physical education curriculum that can meet the unique needs of a student with a disability. The definition of APE is described in IDEA Section 33A 300.39 a 1 ii (IDEA, Special Education, 2004). Physical therapists often work closely as related service providers with APE teachers. While roles overlap, adapted physical education and physical therapy are two separate disciplines. The role of the physical therapist is defined in Section 300.34 of IDEA (IDEA, Related Services, 2004). Physical therapists, as related service providers, may provide consultation to physical education instructors about improving the student's performance, enhancing participation, setting specific student goals relating to the physical education curriculum, and monitoring student progress. Physical therapy is not a substitute for physical education or APE (CSDE, Guidelines for Adapted PE, 2018), and APE is not a substitute for physical therapy (Academy of Pediatric Physical Therapy, 2016). The Academy of Pediatric Physical Therapy has recently published a Fact Sheet, *APE & SBPT Collaborating for Student Success* that helps to clarify the roles of APE and physical therapy in the academic setting. This document is available at:

<https://pediatricapta.org/includes/fact-sheets/pdfs/17%20APE%20SBPT%20resource.pdf>

Detailed information on Connecticut's Guidelines for APE can be found at:

<http://portal.ct.gov/SDE/Publications/Guidelines-for-Adapted-Physical-Education/Defining-APE-Best-Practice-for-Connecticut-Schools>

Specific APE assessment tools and modifications can be found within Connecticut's Guidelines for APE at:

<https://portal.ct.gov/SDE/Publications/Guidelines-for-Adapted-Physical-Education/Appendixes>

The PE Central website has a great deal of information on APE lessons, adapted assessment tools and IEP development. This information can be found at:

<https://www.pecentral.org/adapted/adaptedmenu.html>

The United States Department of Health and Human Services' *Physical Activity Guidelines for Americans* can be found at: <https://health.gov/paguidelines/pdf/paguide.pdf>.

Information regarding the role of related services and APE is available at: <http://portal.ct.gov/SDE/Publications/Guidelines-for-Adapted-Physical-Education/Defining-APE-Best-Practice-for-Connecticut-Schools#relatedServices>.

Children with disabilities often have fewer opportunities for general fitness activities than typically developing peers and consequently children with disabilities may develop secondary complications associated with sedentary lifestyles, including obesity (APTA, 2012). The APTA section on Pediatrics Task Force on Health Promotion, Fitness and Wellness has produced a Fact Sheet that can guide therapists in designing wellness programs for students without disabilities, for students with obesity, and for students with five conditions for which pediatric physical therapy is commonly provided; Cerebral Palsy, Down's Syndrome, Spina Bifida, Duchenne's Muscular Dystrophy, and Autism Spectrum Disorder (APTA, 2012).

The Fact Sheet titled *The Role and Scope of Pediatric Physical Therapy in Fitness, Wellness, Health Promotion, and Prevention* can be found at: <https://pediatricapta.org/includes/fact-sheets/pdfs/12%20Role%20and%20Scope%20in%20Fitness%20Health%20Promo.pdf>

### *Interventions Related to Transportation*

Transportation is a related service under IDEA (IDEA, 2004). If the IEP team identifies that the student has special needs associated with transportation, then the physical therapist as an IEP team member may provide information about resources and adaptive equipment, and may educate staff about student specific needs. Physical therapists may perform direct interventions related to transportation when students are working toward independently getting on and off school vehicles and public transportation, as well as opening doors, securing and releasing seat belts, and transferring on and off the vehicle seat. It's important for therapists to stay current with legislation relating to transportation (McEwen, 2009 p. 141-144). Specific information concerning transportation can be found at the following locations:

Connecticut Car Seat Laws and resources regarding car seat regulations can be found at:

<https://newcarseatlaws.com/connecticut/>

Information relating to transporting children with special healthcare needs can be found at several sites:

<http://pediatrics.aappublications.org/content/104/4/988>

<http://pediatrics.aappublications.org/content/108/2/516>

<http://wc-transportation-safety.umtri.umich.edu/home>

[https://sites.ed.gov/idea/files/OMB\\_08-0101\\_Transportation-11-4-09\\_FINAL-1.pdf](https://sites.ed.gov/idea/files/OMB_08-0101_Transportation-11-4-09_FINAL-1.pdf)

A resource designed to educate transportation personnel can be found at:

<http://www.schoolbusfleet.com/article/611958/involving-physical-therapists-in-pupil-transportation>

### *Interventions Related to Safety and Accessibility*

Two of the primary objectives of involving a physical therapist in a student's program are to ensure safety and to maximize participation, thereby ensuring all students can access all school activities and functions. The physical therapist may recommend equipment or approaches that may be of benefit for both student and staff safety. Collaboration with the student's educational team is needed when planning for emergency drills, field trips, extracurricular activities, and activities not part of the regular routine. Oftentimes training of the staff who support students may be required. Therapists may also provide direct interventions related to safety and accessibility. These interventions may occur in short intense bursts if the situation is occurring infrequently during the school year, as in the case of field trips or an extracurricular activity. In many cases, the physical therapist is able to help pre-plan for maximizing student safety and participation.

### *Location of Physical Therapy Services - Where should the intervention take place?*

After goals are determined, the therapist, along with other team members, identifies the Least Restrictive Environment (LRE) in which the goals can be met. IDEA states that

*“To the maximum extent appropriate, children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are non-disabled; and special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.”*

(IDEA, Sec. 300.114, 2004)

In other words, therapists must provide services in the same location as typically developing peers to the maximum extent appropriate. Services provided within the school routine result in less separation of the student from class activities than services provided out of the context of the educational routine. It is important, when possible, to structure therapy so that it is consistent with the school routine to maximize the student's interaction with his/her classroom peers and thus increase participation. Applying interventions within the natural environment can allow the student to practice skills with peers and increase the opportunity to generalize newly acquired skills into their functional context (CSDE, Promoting School Success for Your Child with a Disability). Therefore, therapy may take place in a variety of locations including, but not limited

to classrooms, hallways, stairs, gymnasiums, playgrounds, lunchrooms, buses or vans, bathroom, music and art rooms. Depending on the educational program, students may require services in community settings and work training sites as part of postsecondary transition planning.

When therapy is provided within the educational routine, it is often referred to as “push-in services.” The “push-in” model increases the likelihood of skills being integrated into activities and generalized throughout the student’s day (Sekerak, 2003; Palisano & Murr, 2009). Successfully providing physical therapy in the classroom during integrated routines is influenced by several factors that include the:

- Individual student’s ability level;
- Professional interaction skills of all team members;
- Amount and arrangement of classroom space;
- Amount and type of distractions in the room;
- Classroom schedule; and
- Student’s optimal time of day for learning motor tasks (Sekerak, 2003).

Current research supports the concept of an inclusive physical therapy model for several reasons. Sekerak (2003) found that motor gains for preschool students receiving inclusive push-in services equaled those of students involved with pull-out services. The push-in physical therapy model provides benefit when the physical therapist presents the educational staff with an opportunity to gain additional knowledge of typical motor development and become familiar with the individual student's motor goals. The push-in model helps teachers to learn about motor skill acquisition and therefore assists teachers in planning general classroom motor activities that address similar needs of all students. A third advantage of inclusive physical therapy services in the classroom is the benefit of modeling focused motor-related activities for all students, not just those with identified needs (Sekerak, 2003).

Services provided away from school routines and peers, in a controlled environment are often referred to as “pull-out services”. Students with disabilities should not be removed from the regular educational environment unless the severity of the disability is such that education in regular classes cannot be satisfactorily achieved. Pull-out therapy may be done when intervention strategies cannot be carried out appropriately in the classroom setting due to concerns that include but are not limited to safety, privacy, or space. (Effgen & Kaminker, 2014)

### ***Service Delivery Models - How should the physical therapy service be provided?***

Physical therapy intervention can be delivered through both a direct service delivery model and an indirect service delivery model. **Direct service** occurs when the therapist provides face to face intervention that emphasizes acquisition of a new skill. **Indirect service** occurs when the therapist is performing activities on behalf of a student, but the student may not be present. A combination of approaches is often used when designing an intervention plan. Delivery details are individualized based on the unique needs of the student and educational team, and are documented on the IEP. The continuum of physical therapy services range from indirect consultation only to direct individual intervention based on the student’s unique needs. It is



likely that a combination of models may be best to meet the changing needs of the student and educational team (Effgen and Kaminker, 2014).

*Direct therapy* should be considered when the expertise of the physical therapist is required to safely provide the recommended intervention. Additionally, the student's readiness for skill acquisition influences the choice of models.

*“Readiness pertains to the concepts of sensitive period and dynamic systems. Readiness not only applies to body functions and structures but also to the child’s motivation and interests, family systems, and relevant aspects of the child’s physical, social, and attitudinal environment . . . During periods of readiness, a child may benefit from an intense episode of direct individual therapy. Similarly, a child who has recently had a surgical or pharmacological intervention that has changed one or more body systems may benefit from an intense episode of direct individual therapy. An episode of direct individual therapy also may be indicated when a child experiences secondary impairments in body functions and structures that adversely affect activity and participation.”*

(Palisano & Murr, 2009)

Direct service could include, but is not limited to facilitating movement and sensorimotor skill development, instructing students in compensatory strategies, providing opportunities for motor learning and skill acquisition under therapist direction, demonstrating exercise programs or activities to remediate deficits in body structure and function, and conducting trials with adaptive equipment.

The physical therapist may interact directly with students on a one-on-one basis or in small groups. According to a survey of practices conducted by LaForme-Fiss, and Effgen (2007), group intervention may be a way to allow students to apply new skills in a social context and may be a bridge to generalizing skills in other settings thereby promoting participation in the educational program. Group intervention may be done by combining students with disabilities with peers who are typically developing, thus providing an opportunity for peer modeling and promoting participation. Task-specific and developmental activities are often incorporated into group settings. The group setting provides the opportunity for practice, repetition, social engagement and motivation (Palisano & Murr, 2009). Group intervention may be used as an adjunct to individual intervention or as a primary means of providing recommended services.

*Indirect* physical therapy services may be delivered in many ways. For example, physical therapists may use their knowledge and skills to help students by teaching people who have frequent direct contact with the student. Through collaboration with family, home-based caregivers, para-educators, teachers, behaviorists, physical education teachers, nurses, and other school personnel, the physical therapist recommends ways for students to practice and integrate skills into school and home routines. School personnel and family members can incorporate positioning and use of adaptive equipment throughout the student's day. Training through the indirect model promotes generalization of the student's use of skills and extends the effects of intervention across school environments (Palisano & Murr, 2009; Effgen & Kaminker, 2014).

Another form of indirect service is monitoring the student's performance.

*“Monitoring involves periodic assessment to prevent problems that might adversely affect activity and participation. Maintenance refers to a child's ability to perform an activity and participate successfully without the need for ongoing therapy. The aim of monitoring is to maintain skill level by identification of problems before they adversely affect the child's activity and participation. Over time, children with developmental conditions may experience changes in body functions and structures. Task demands and environmental conditions also change over time”*

(Palisano and Murr, 2009)

Indirect service may also include, but is not limited to monitoring equipment, adjusting equipment, establishing routines and procedures carried out by other staff, and researching treatment strategies and service provided on behalf of a student (Williams & Cecere, 2013). Assessing the success of indirect services often requires observations and collaboration with the staff who implements the program as a means of tracking student progress. When this type of indirect service monitoring is done, the therapist remains responsible for the student outcomes (Giangreco, 2001; Thomason & Wilmarth, 2015).

Consultative services may be a form of indirect service. Consultation involves planned communication about the student(s), the environment, the tasks or the educational program in general. Consultation requires the consultant to have familiarity with the student and planfully collaborate with other members of the education team (Giangreco, 2001). During the collaboration process therapists may educate staff about specific medical diagnoses and the potential impact the conditions may have upon school activities. Consultation may include technical assistance and training, service coordination, and administrative advisement. Monitoring students and their equipment may also be done through a consultative model (McEwen, 2009, p. 116). Legislation in Connecticut supports the provision of consultation among the educational team members.

*“(b) Consultation. Time shall be scheduled during the school day for personnel who provide special education and related services or general education to consult with each other, other personnel and parents.”*

(CSDE, Sec. 10-76d-2, 2015).

Consultation can occur in a variety of ways. Consultation may be done during scheduled meetings with other team members. Observations and interactions may also occur in natural settings (e.g., classrooms, community work sites). The consultant may work directly with a student to model an intervention that will be carried out by others to promote generalization to the natural environment and to problem-solve during novel situations (Palisano & Murr, 2009). The ways in which consultation is carried out should always take into account the privacy, dignity, preferences and needs of the student. Consultation services can be provided to persons who work directly with a student, including parents, caregivers, school staff, other related service

providers, and healthcare providers. When a student is receiving therapeutic services outside of the educational setting, it is important for the school-based therapist to communicate, collaborate, and coordinate with the other providers. Others who may not work directly with the student, such as transportation providers, administrators and general school staff, may also benefit from consultation with the physical therapist. The school-based physical therapist may also be the liaison with healthcare providers outside of the school to help coordinate educational and medical effort to address the needs of the whole child (Giangreco, 2001).

Consultants may or may not directly supervise people working with the student, but effective consultative collaboration requires a shared responsibility for implementing recommendations and working toward the common goals (Giangreco, 2001; McEwen, 2009). Under consultative indirect service, members of the educational team are responsible for implementing the recommended strategies and monitoring the outcomes.

***Frequency and Duration of Physical Therapy Services - How often should intervention be provided and for how long?***

Frequency and duration of physical therapy services must be determined by the PPT and identified on the IEP. Typically, the PPT relies upon a recommendation from the school-based physical therapist. There is not clear evidence in the literature at this time as to recommendations for frequency of physical therapy services and practice varies (Palisano & Murr, 2009). The APTA Section on Pediatrics has compiled a resource manual for dosage considerations. While this information may guide recommendations for frequency and duration, it is important for the IEP team, including the physical therapist, to individualize recommendations based on student needs and the proposed goals. The Dosage of Services in the Educational Setting Model (DoSES), for school-based physical therapy identifies four levels of intervention frequency described in the chart below that can serve as a general framework to assist clinical decision-making.

Intensive	Weekly or twice weekly sessions of 45 minute
Frequent	Weekly or bi-monthly sessions lasting less than 45 minutes
Periodic	Regularly throughout the school year for 1-2 times per quarter for 20 minute sessions
Intermittent	Irregularly throughout the school year for 2-5 times per year for a total of 60 minutes

(APTA, Dosage Considerations, 2014).

***Need for Extended School Year Services (ESY)***

Students receiving special education may be eligible for services (including physical therapy services) that extend beyond the typical school year. This is referred to as Extended School Year (ESY). Both regression and non-regression criteria are used to determine a child’s eligibility for

ESY service. When deciding whether or not ESY services are warranted, the CSDE recommends that the following considerations be taken into account:

- *“The nature or severity of the student’s disability (non-regression);*
- *The student is likely to lose critical skills or fail to recover these skills within a reasonable time as compared to typical students (regression/recoupment);*
- *The student’s progress in the areas of learning crucial to attaining self-sufficiency and independence from caretakers (non-regression);*
- *The student’s stereotypic, ritualistic, aggressive or self-injurious interfering behaviors prevent the student from receiving some educational benefit from the program during the school year (non-regression);*
- *Other special circumstances identified by the IEP team such as: the ability of the student to interact with other non-disabled students; the areas of the student’s curriculum that need continuous attention; the student’s vocational needs; or the availability of alternative resources”*

(CSDE, Topic Brief - ESY Services, 2007).

It is important to note that *“the provision of ESY is the exception and not the rule for students receiving special education and related services”* (CSDE, Topic Brief - ESY Services, 2007). All decisions regarding a child’s eligibility for ESY services are made on an individual basis depending on the unique needs of the child, and are determined by all members of the IEP team. The determination of whether or not a child is or will be eligible for an ESY program is a PPT decision and is discussed at the annual review for the child. The extent of ESY services, including the frequency, location, and goals of physical therapy during the ESY are also discussed at that time. Documentation of the student’s performance before and after school breaks is helpful in determining whether or not the the student regresses when therapy services are interrupted. Additionally, noting the amount of time it takes to regain skills previously mastered is another factor to consider when determining the need for ESY as this can impact the child’s performance in school (McEwen, 2009, p. 127-129).

### ***Responding to Changing Demands - How can changing demands in the school setting influence intervention over time?***

As students grow and develop, their capacity to respond to intervention and their needs may change. Therefore, the types of interventions, the delivery model, and frequency of intervention may vary. While every situation is unique, some predictable elements of development and curricular demands occur within grade level grouping.

In preschool, there is usually a strong focus on social and motor skills. Connecticut uses the Early Learning and Development Standards (ELDS) as a guide for preschool achievement.

*“Connecticut’s Early Learning and Development Standards are statements of what children should know and be able to do from birth to age 5. These guidelines are intended to inform families, teachers, caregivers and other professionals about common developmental and learning progressions, so*

*that they can work together to better support children's early learning and growth. These standards are intended to serve as a guide for considering the steps in children's development and to plan ways to support children in continued growth."*

(Connecticut Office of Early Childhood, 2014).

There is usually considerable movement and changes in activities as part of the preschool classroom routine with transitions from floor to stand, variable sitting postures on floor and chairs, play, movement throughout the room, use of play equipment, etc. Preschoolers are gaining body awareness and self-control. They are learning about basic self-care and utensil management. Physical therapy can contribute to the development of many of these skills and can fit well within the flow of classroom routine. Physical therapy at the preschool level typically focuses on foundational developmental motor skills.

Academic demands increase as a student moves through the elementary school grade levels with students spending greater amounts of time in seated learning activities. In addition, students are expected to navigate larger and more diverse environments, including but not limited to the cafeteria, playscapes, art and music rooms, library, and vehicles. Transportation modes often change from car seats in vans to school buses. Students are expected to manage with progressively more independence during transitions between classes, when performing errands, and when using the restroom. As children age, they participate in activities with increasing complexity, cognitive challenge, and motoric demands. The school day and expected time on academic tasks usually increases in length with less times for rest. Consequently, a child's endurance may be challenged. The focus of physical therapy may continue to be on development or remediation of the student's skills with emphasis on these new and upcoming demands. The school-based physical therapist may also consider task and environmental adaptations to promote the student's participation.

As students enter the middle school setting, they experience many physical changes as they approach puberty including growth spurts, onset of menses, and weight changes. These changes may affect body structure and function by impacting joint flexibility, activity level, endurance, balance, coordination, and mobility. Students may also require medication changes, surgical interventions, and adapted equipment changes. Increased academic demands continue as the student enters middle school. The middle school environment can be dramatically different from elementary school with greater numbers of teachers, classroom changes, and demands for increasing transitions and independence. Responsibilities for navigating through the school, transporting materials, and meeting timelines typically increase and shift to the student. Opportunities for participation in extracurricular activities usually increase at this stage. Some students may be participating in pre-vocational and life-skill programs in order to reach their post-secondary goals. Physical therapists consider the unique changes for this age group as well as the new functional demands (e.g., self-determination, endurance, and independence) placed on the student by the middle school environment. During the transition to middle school, the physical therapist may need to consult with the staff as most staff may be unfamiliar with the student.

The high school years mark the time to complete planning for students to transition into adulthood. For some students who will go on to pursue further education, there is a high academic demand. The physical therapist should consider the student schedule and needs for optimal participation as the student approaches graduation. The programs for other students may prioritize pre-vocational, extra-curricular activities, and life-skill programs in order to reach their post-secondary goals. Physical therapists may contribute to the student's educational programming at locations outside the school grounds such as work sites, community recreation facilities, grocery stores, and public transportation. Therapy services may focus on skills needed for transition to adulthood with an emphasis on task and environmental adaptations as well as self-help skills. The physical therapist may be helpful in recommending appropriate community-based resources as students transition to adulthood.

### ***Preparing for the Transition Beyond School***

According to Section 300.43 of the IDEA 2004, transition services are defined as:

*“a coordinated set of activities for a child, with a disability, that: (1) is designed within a results-oriented process that is focused on improving the academic and functional achievement of the child with a disability to facilitate the child’s movement from school to post-school activities, including postsecondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation; (2) is based on the individual child’s needs, taking into account the child’s strengths, preferences, and interests - and includes instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and, if appropriate, acquisition of daily living skills and functional vocational evaluation.”*

(IDEA, 2004)

Planning for the student's transition begins in the early part of high school years. Connecticut requires that Individual Transition Plans (ITP's) be developed no later than the annual review meeting following a student's 15th birthday (CSDE, IEP Manual - Transition Planning, 2018, p. 10). The transition component of the IEP must address three targeted post-secondary outcomes mandated under IDEA; postsecondary education/training, employment, and independent living/community participation (Office of Special Education and Rehabilitative Services, USDE, 2017). The physical therapist can play an important role in preparing the student for non-academic transition activities as the student approaches the age of 21, after which time the student will no longer be eligible for special education services through the school district.

The physical therapist may contribute to the transition plan with other team members by:

- Developing goals for after high school;

- Participating in the development of the high school course of study for achieving those goals;
- Participating in an assessment of the student's strengths, interests and preferences;
- Developing transition activities; and
- Coordinating with outside agencies (NSTTAC, 2015).

While students with disabilities may or may not be receiving direct physical therapy by the time of transition, establishing or re-instituting physical therapy services may be necessary in assisting the Transition Planning Team (NSTTAC, 2015). The post-secondary situations present new environment and task demands that may warrant a physical therapist's expertise. As a contributor to the transition process, a school-based physical therapist evaluates barriers to safe and independent participation in a variety of post-secondary environments. The physical therapist plays an important role in developing self-determination and independent functional mobility skills at job sites, post-secondary education settings, and independent living settings. The physical therapist can also investigate the feasibility of using public transportation and can determine architectural barriers to independence. Older students may need to develop improved stamina and endurance for community participation and independence with life skills. Physical therapists educate students and caregivers about community wellness opportunities to promote a healthy active lifestyle, and assist students with disabilities in preferred leisure pursuits. Therapists also have a role in educating students and family regarding protections under Section 504 and the Americans with Disabilities Act that will continue to assure the young adult's civil rights following graduation (APTA, Fact Sheet: Transition, 2006).

For more information about the role of the physical therapist in post-secondary transition, please refer the APTA Fact Sheet: *Intervention for Youth Who are in Transition from School to Adult Life*:

<http://pediatricapta.org/includes/fact-sheets/pdfs/Transition%20Fact%20Sheet.pdf>

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## Chapter 7. Documentation of Physical Therapy Services in the School Setting

Documentation within the school setting serves many purposes. Documentation serves to note progress, communicate with other medical professionals, satisfy billing requirements, communicate with school staff and parents, monitor attendance, as well as satisfy licensure and practice requirements. Physical therapists within the school setting are required to not only comply with documentation which meets school standards, but to satisfy physical therapy professional standards and licensure requirements as well. When completing documentation, the school-based physical therapist must consider the requirements of the educational field (IDEA, Connecticut educational law, individualized LEA policy and procedures), the physical therapy profession (Connecticut Physical Therapy Practice Act; Guide to Physical Therapist Practice; APTA Defensible Documentation Guidelines), and when applicable, Connecticut's Medicaid policy for LEA reimbursement.

Documentation is expected for all students receiving skilled physical therapy services. This may include those who receive physical therapy under IDEA, those who receive direct service and/or accommodations with a 504 plan, and those who receive physical therapy consultation as part of the Scientific Research Based Interventions (SRBI) process. If skilled physical therapy services are provided for an individual student, then the therapist should document to support decision making. Documentation also includes written report of any communication with school staff, healthcare providers, and families. Regardless of mode of documentation (electronic or paper), all documentation must meet standards of confidentiality (APTA, Setting Specific Considerations in Documentation, 2018).

Confidentiality is addressed through federal legislation in both healthcare settings (Health Insurance Portability and Accountability Act) and educational settings (Family Education Rights and Privacy Act).

The Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996 to

*“improve the efficiency and effectiveness of the health care system through the establishment of national standards and requirements for electronic health care transactions and to protect the privacy and security of individually identifiable health information”*

(USDH & USDE, 2008).

The Family Education Rights and Privacy Act (FERPA) addresses the privacy of and access to educational records (USDE, FERPA, 2018). Educational records as defined in FERPA include

*“records that are (1) directly related to a student, and (2) maintained by an educational agency or institution or by a party acting for the agency or institution.”*

(USDH & USDE, 2008)

The documentation required for physical therapy in the public school setting under IDEA is considered a part of the educational record. Maintenance, confidentiality, and access should be in compliance with FERPA, with physical therapists keeping records safe and confidential (APTA, Risk Management, 2018). Additionally, there are circumstances in which a school acts as a billing agency for health-related services and can be considered a ‘HIPAA covered entity’ thus requiring compliance of HIPAA privacy and confidentiality standards. Below is a description of how HIPAA may apply in the school setting.

*“...if a public high school employs a health care provider that bills Medicaid electronically for services provided to a student under the IDEA, the school is a HIPAA covered entity and would be subject to the HIPAA requirements concerning transactions. However, if the school’s provider maintains health information only in what are education records under FERPA, the school is not required to comply with the HIPAA Privacy Rule. Rather, the school would have to comply with FERPA’s privacy requirements with respect to its education records...”*

(USDH & USDE, 2008)

It is important that the school-based physical therapist understand both HIPAA and FERPA as they apply to confidentiality requirements of physical therapy documentation and transmission of information within the school setting. A resource which can be helpful to understand the difference and overlap between FERPA and HIPAA within the school setting can be found at:

*Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records*

<https://www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipaa-guidance.pdf>

More detailed information regarding HIPAA can be found at:

<https://www.hhs.gov/hipaa/index.html>

More detailed information regarding FERPA can be found at:

<https://www2.ed.gov/policy/gen/guid/fpco/index.html>

Measures should be taken to protect the documents with respect to location and access by others. Physical therapists may consider using personal computers for documentation.

*“If you use a personal computer for documentation of services, you must comply with all federal and state regulations regarding confidentiality, such as password access, encryption, and other security and privacy measures”*

(APTA, Risk Management, 2018).

Physical therapists are often working collaboratively with outside medical providers (primary physicians, private physical therapists, medical specialists and anyone who is not part of the PPT). In accordance with FERPA, parental permission is required in order to share information

with outside providers regarding students. Please reference the following US Department of Education link for information regarding FERPA:  
<https://ed.gov/policy/gen/guid/fpco/ferpa/index.html>.

### ***Blending Physical Therapy Guidelines for Documentation with Educational Practice***

Physical therapists in all settings are expected to complete initial evaluations, progress notes, visit or encounter documentation, reassessments (reexaminations), and discharge reports (APTA, Guidelines: Physical Therapy Documentation of Patient/Client Management, 2014). Beyond these professional requirements, the school system has documentation requirements based on IDEA legislation which may or may not correspond with the physical therapy requirements. The APTA recognizes the unique documentation needs of the educational setting (APTA, Setting Specific Considerations in Documentation, 2018). While IDEA requires evaluation, IEP and progress updates, there may be differences in format or timelines when compared to more traditional clinical practice. In many cases the APTA Guidelines for documentation exceed the documentation requirements of the educational setting. The physical therapist in the school setting must meet the requirements of both the physical therapy field as well as the educational setting. Local preferences and policy may influence the documentation format. While the recommended physical therapy guideline terminology may differ from the terminology used in the educational setting, the same type of information should be contained in the documentation in some manner. The IDEA recommends that information be conveyed in a parent-friendly manner, i.e., in language understandable to the general public and the native language of the parent. Unlike, the medical field, educational documentation is designed to be shared with family members (APTA, Setting Specific Considerations in Documentation, 2018). The timelines for submission of documentation and implementation of proposed plans are outlined in Section 10-76d-13 of the Connecticut State Regulations at:

<http://www.portal.ct.gov/-/media/SDE/Performance/Data-Collection/Help-Sites/Evaluation-Timelines/EvaluationTimelinesUserGuide.pdf>

Because some local school districts may require shorter timelines that exceed state requirements, therapists should check with their local education agencies to assure compliance.

### ***Documentation Used in the School Setting***

Some of the documentation used in the school setting includes:

- Parental consent;
- Release of information;
- Communication with medical personnel;
- Evaluation including plan of care;
- Individualized Education Program;
- Visit notes;
- Progress reports;
- Re-examination;
- Discharge/discontinuation summary;

- Summary of performance; and
- Medicaid claims for reimbursement.

## ***Parental Consent***

The importance of student and parental involvement is well recognized in early intervention and school based settings (McEwen, 2009; CSDE, A Parent’s Guide to Special Education in CT, 2007). As active members of the team, students and parents contribute and work towards common goals that can lead to the child’s greater successes. At various points in physical therapy plan development and implementation, written parental consent is required by IDEA, state legislation, and/or FERPA. For example, parent permission is necessary for students to receive an initial physical therapy evaluation, reevaluations, and initial receipt of related services (CSDE, A Parent’s Guide to Special Education in CT, 2007). Parental consent is also indicated for screenings (IDEA, Sec. 303.320(a)(1)(ii), 2014). Connecticut legislation is more restrictive than that of IDEA as it pertains to parental consent. According to the *State of Connecticut Regulation of Department of Education Concerning Special Education*:

*(b) **Written consent.** The board of education shall obtain written parental consent, in accordance with the provisions of the IDEA, for initial evaluation, reevaluation and initial receipt of special education and related services. The failure of the parent to respond to a request from the board for consent to conduct an initial evaluation, reevaluation or for the initial receipt of special education and related services within ten days from the date of the notice to the parent shall be construed as parental refusal of consent.*

(Connecticut Regulations, Sec. 10-76d-8, Notice and Consent, 2015)

Connecticut’s consent forms required for initial evaluation can be found at the following link:  
<http://portal.ct.gov/-/media/SDE/Special-Education/ED625.pdf>

Connecticut’s consent forms for reevaluation can be found at the following link:  
<http://portal.ct.gov/-/media/SDE/Special-Education/ED627.pdf>

The LEA is responsible for attempting to obtain parental permission for initial evaluation and reevaluation. There may be rare occasions in which obtaining parental consent is not possible. (IDEA, 2004; CSDE, A Parent’s Guide to Special Education in CT, p. 5, 2007). The school-based physical therapist should consult with the LEA regarding difficulties obtaining parental consents to ensure compliance with LEA, CT, and IDEA policies and procedures. If parents refuse permission, then a therapist may not evaluate or treat a child. Therapists should be aware

of the specific school district's policies addressing this matter. The following links may be helpful to obtain additional information regarding specific circumstances relating to consent.

Information in IDEA relating to 'Consent' can be found at:

<https://sites.ed.gov/idea/statute-chapter-33/subchapter-II/1414/a/1/D>

Information relating to 'Consent' in Connecticut educational statutes can be found at:

<https://eregulations.ct.gov/eRegsPortal/Browse/RCSA?id=Title%2010|10-76|10-76d-8|10-76d-8>

### ***Release of Information***

Physical therapists communicate with medical professionals outside of the school setting. Physical therapists can act as a liaison between school personnel and the medical community. In order to share information with personnel outside the school setting the physical therapist must obtain parent/ guardian permission as required by FERPA (USDE, FERPA, 2018). This legislation requires parental permission to release identifiable information to persons or agencies who are not part of the PPT. Parents can also revoke consent at any time, limit information exchange, and require a copy of all communication be provided to parents (USDE, FERPA, 2018). Local educational agencies may develop their own forms for release of information.

### ***Documentation of Communication for Compliance with Legislation***

The Connecticut Physical Therapy Practice Act describes the physician/healthcare provider communication that is required for the physical therapist to provide intervention regardless of setting (refer to Chapter 1 of this document for specific Practice Act language). While the Practice Act outlines the time frame and criteria for mandatory communication, a physical therapist may choose to exceed the minimum communication with medical personnel in particular instances, e.g., when a child is recovering from surgery, when there has been a change in the child's health status, when referral to other providers is warranted, or when clarification is indicated.

What does the implementation of this Practice Act look like in the schools? Physical therapists need to obtain the contact information from the parents/guardians regarding the child's physician(s) along with respective permission to release information in order to communicate with the healthcare provider (USDE, FERPA, 2018).

While the Practice Act requires a physical therapist to communicate with a student's medical provider as specified in Chapter 1, a therapist may opt to communicate with a provider earlier or more frequently than required by law. The APTA highlights the importance of communication and recommends that physical therapists:



*“Document all communications related to the attempts to contact referral sources and payment sources such as insurers. In addition, document any communication with anyone.”*

(APTA, Risk Management, 2018)

One way to comply with this legislation is to implement a standard procedure of communication to inform a student’s medical provider of the recommended services and plan of care. How a physical therapist meets the requirements of the Practice Act can vary to a certain degree; however, it is important for the physical therapist to demonstrate how his/her practice meets the requirements of the Practice Act through appropriate documentation of the communication with the student’s medical personnel.

Sample forms for communication with parents and physicians (and other healthcare providers) are available at the end of this guide. While districts may handle the documentation requirement differently from one another, it is the physical therapist’s responsibility to meet the state practice guidelines.

### ***Evaluation***

An initial evaluation is required to determine eligibility and to initiate physical therapy services within the school setting in accordance with practice standards. The APTA’s *Guidelines: Physical Therapy Documentation in Patient/Client Management* suggest that “physical therapy examination, evaluation, diagnosis, prognosis, and plan of care should be documented, dated and authenticated by the therapist who performs the service” (APTA, 2014).

Please reference the section on physical therapy evaluation for more in depth explanations of each area:

[http://www.apta.org/uploadedFiles/APTAorg/About\\_Us/Policies/Practice/DocumentationPatientClientManagement.pdf](http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/DocumentationPatientClientManagement.pdf)

The written document should link these evaluation elements to the student’s function in the educational program. The LEA may have input as to the preferred format for the district. Throughout the documented physical therapy evaluation the school-based physical therapist includes test results and findings using language that is understandable to the educational team, including family members (APTA, Setting Specific Considerations in Documentation, 2018).

Please refer to **Chapter 4: Referral, Observation, Screening, and Evaluation** for more detailed information about the process associated with each section of the evaluation. The *Examination* section of the physical therapy evaluation documents the data and information obtained in the student’s *History, System’s Review, and Tests and Measures*. The physical therapist considers student’s *Examination* findings to guide documentation of impairments, limitations and restrictions in body structure and function, activities, and participation respectively.

The *Evaluation* section of the report includes the synthesis of information obtained in the examination findings along with the therapist’s clinical judgment. These may be documented in

the form of a problem list or narrative summary (APTA, Defensible Documentation Elements: Initial Examination and Evaluation, 2018). The following describes the *Evaluation* section as it relates to children:

*“Consistent with family-centered care, the documentation of the evaluation reflects a strength-based approach. An evaluation would typically include the pediatric patient's strengths, readiness to learn a new skill, and areas of concern, priority, or need. Areas of need would include the patient's participation restrictions in the home, school, and community; activity limitations; and body structure and function impairments. The evaluation should also note characteristics of both the patient and his or her environment hypothesized to be facilitators or barriers to his or her activity and participation.”*

(APTA, Defensible Documentation Elements: Initial Examination and Evaluation, 2018).

The *Evaluation* process also lends itself to determining the student’s physical *Diagnosis* and *Prognosis* (APTA: Defensible Documentation Elements: Initial Examination and Evaluation). In the Physical Therapy Evaluation, the physical therapy *Diagnosis* is determined based on the information presented in the *Examination* and *Evaluation* sections. The physical therapy *Diagnosis* is “typically made at the impairment, activity, and participation levels” and can be documented in different formats (APTA: Defensible Documentation Elements: Initial Examination and Evaluation, 2018). The physical therapy *Diagnosis* is not to be confused with the categories under IDEA or the medical diagnosis (APTA: Defensible Documentation Elements: Initial Examination and Evaluation, 2018). For example, a student may have a medical diagnosis of Down Syndrome, the IDEA categorization of Intellectual Disability, and the physical therapy diagnosis of balance impairment and endurance limitation.

Once the diagnosis is established the physical therapist determines the *Prognosis*. The *Prognosis* conveys the projected level of improvement that is supported by the school-based physical therapist’s clinical reasoning (APTA: Defensible Documentation Elements: Initial Examination and Evaluation, 2018). An example of documented Prognosis provided in APTA: Defensible Documentation Elements: Initial Examination and Evaluation (2018) is as follows:

*“The child's prognosis for independent walking is positive secondary to the child presenting with a Gross Motor Functional Classification System level of I and a supportive family who provide appropriate movement opportunities.”*  
(APTA, 2018)

### ***The Documented Plan of Care***

“A *Plan of Care* is based on the data gathered from the Examination....., Diagnosis, and Prognosis established by the physical therapist” (APTA: Defensible Documentation Elements:

Initial Examination and Evaluation, 2018). A comprehensively documented *Plan of Care* includes goals, frequency and duration of physical therapy, intervention, and discharge plans. The APTA supports that a plan of care is developed through a collaborative process as is noted in the *APTA Criteria for Standards of Practice for Physical Therapy*.

*“The physical therapist involves the patient/client and appropriate others in the planning, implementation, and assessment of the plan of care.”*

(APTA, Criteria for Standards of Practice for Physical Therapy, 2012)

In the school setting the physical therapist shares the evaluation findings and the educational team collaboratively develops a plan that describes the student’s goals, the services needed, and the service frequency/duration (APTA, Setting Specific Considerations in Documentation, 2018). These components of the *Plan of Care* are documented in the IEP.

Other components of the *Plan of Care* including intervention strategies, and discharge plans are not typically included in the IEP. While the APTA supports documenting aspects of the plan in accordance with the educational formatting of the IEP, they also recognize that the documentation of the *Plan of Care* should be in accordance with the professional guidelines and the state practice act (APTA, School-based Physical Therapy: Conflicts Between Individuals With IDEA and Legal Requirements of State Practice Acts and Regulations, 2014; APTA, Setting Specific Considerations in Documentation, 2018). While the Connecticut Physical Therapy Practice Act does not specify regulations related to this area, the APTA states that a documented *Plan of Care* should describe the interventions recommended by the physical therapist.

*“For pediatric patients and clients:*

*The physical therapist plan of care in early intervention and school-based practice is often incorporated into the pediatric patient's general team intervention plan provided in the IFSP or IEP, respectively. The general plan may also include general methods or strategies that the team will use to assist the patient and family in early intervention or the student in school-based practice in meeting their goals. More specific details regarding the intervention strategies are contained in the PT's supplemental intervention plan or daily visit documentation notes.”*

(APTA, Defensible Documentation Elements, 2018)

This information, combined with the team-developed IEP contains a comprehensive *Plan of Care* necessary for service provision that is in compliance with professional best practice.

### ***The Individualized Education Program (IEP)***

The IEP is the legal document that operationalizes the requirements of IDEA for a child receiving special education services. The IEP describes the child’s present level of performance, the child’s learning needs, the services needed, and who will provide the services. The IEP is the main form of documentation utilized by special education personnel. Both electronic and paper

forms of the IEP are available and the physical therapist must use the appropriate format to meet the district’s special education requirements (CSDE, IEP Manual, 2018).

While school-based physical therapists participate in the overall IEP development, they most often provide input to the movement, functional, and sensorimotor development areas as described in the Gross-motor, Fine-motor, Activities of Daily Living, and Health and development sections of the IEP. The therapist will note the evaluation findings in the appropriate ‘Present Levels of Academic Achievement and Functional Performance’. Body structure and function impairments, activity limitations, and participation restrictions that are collaboratively identified and prioritized by the education team are noted in the ‘Concern/Needs’ section. The ‘Concerns/Needs’ may reflect challenges that have a marked impact on the child’s educational performance, require specialized instruction, and correspond to annual goals/objectives (CSDE, IEP manual, 2018).

For details, please refer to Sections 4 and 5 of the IEP Manual at:

<https://portal.ct.gov/-/media/SDE/Special-Education/IEP-Manual-REVISED-July-2018.pdf?la=en>

An example of Present Levels of Academic Achievement and Functional Performance for a kindergarten student with identified motor limitations may be documented on the IEP in the following manner:

Area: Fine and Gross Motor examples

Age appropriate: <input checked="" type="radio"/> Yes or <input type="radio"/> X No
Current Performance: PDMS-2= 78. School Functional Assessment Travel Domain = 60%, Pediatric Balance Scale = 30/54. Student requires hand held assistance with all transfers, ambulation with hand-held assistance up to 50 feet in the classroom.
Strengths: Student enjoys modified games with peers, physical activity, and demonstrates good strength and endurance, and is highly motivated.
Concerns/Needs: Balance deficits, frequent falls with attempts at unsupported ambulation, requires assistance for mobility, difficulty with transitioning sit to stand and higher level gross motor activities.
Impact of Student’s Disability: Due to the student’s delayed gross motor skills and balance deficits, the student is unable to safely travel throughout the school and participate in motor tasks with peers without specialized instructions and accommodations.

While goals and objectives are developed and finalized at the PPT meeting, therapists can draft goals and objectives in preparation for the PPT meeting to serve as a framework for discussion by the educational team, including the family. (Specific tips for goal and objective writing can be found in Chapter 4). According to the CSDE IEP Manual, “The goals and objectives are directly related to concerns and build on strengths”. The CSDE Section 7 of the IEP Manual provides detailed instructions for completing the goal page of the IEP and can be found at:

<https://portal.ct.gov/-/media/SDE/Special-Education/IEP-Manual-REVISED-July-2018.pdf?la=en>

The *IEP Guide Page-by-Page* can be found at:  
[http://www.ct.gov/dds/lib/dds/family/iep\\_guide\\_page\\_by\\_page.pdf](http://www.ct.gov/dds/lib/dds/family/iep_guide_page_by_page.pdf)

To continue the kindergarten student example from above, examples of goals and objectives could be written as:

**Goal 1.** The student will ambulate with close supervision from desk to bathroom (approximately 50 feet) 80% of observed trials as recorded on his data sheet. (Baseline: Student ambulates with hand-held assist from desk to bathroom).

**Objective 1:** The student will demonstrate improved standing balance by progressing from standing with upper extremity support, to standing unsupported, during the pledge of allegiance, 4 out of 5 mornings per week.

**Objective 2:** The student will ambulate 25' with close supervision from classroom door to bathroom 80% of observed trials as recorded on his data sheet. (Baseline: Student ambulates with hand-held assist from desk to bathroom)

**Goal 2.** The student will throw a playground sized ball 5 feet to a peer while maintaining balance in 4 out of 5 trials in ball play opportunities.

**Objective 1.** The student will bend down to pick up a playground sized ball from the floor and assume stance while maintaining his balance with supervision during a ball activity with his peers.

**Objective 2.** The student will throw a playground sized ball 3 feet to a peer while maintaining balance in 4 out of 5 trials during ball play with his peers. (Baseline: student loses balance and places hands on the floor after releasing the ball)

As part of goal development, therapists will also identify the method of monitoring progress using the options indicated on the IEP form. In addition to describing present levels of performance and writing goals, therapists can also contribute to the IEP by describing training, monitoring, recommended environmental changes and supports in the *Program Accommodations and Modifications* section.

Indirect physical therapy services, including consultation, provided on behalf of a student receiving special education are documented in the IEP on the *Program Accommodation and Modifications* page of the IEP under *Frequency and Duration of Supports Required for School*

*Personnel to Implement this IEP* (CSDE, IEP Manual, 2018). The amount of time, frequency, and duration of consultative services are specified on this page. For details, please refer to Section 8 of the IEP Manual at: <https://portal.ct.gov/-/media/SDE/Special-Education/IEP-Manual-REVISED-July-2018.pdf?la=en>

The *Summary: Special Education, Related Services, and Regular Education* page specifies information regarding the provision of **direct** special education and related services (frequency, number of hours, service delivery model, setting, start and end dates, and responsible staff). “The amount of time each implementer will work directly with the child should be specified under *Description of Instructional Service Delivery*” (CSDE, IEP Manual, 2018). It is important to remember that the only responsible staff for physical therapy services is the physical therapist, and the only service implementers for ‘physical therapy’ are the physical therapist or the physical therapist assistant. If a physical therapist assistant is going to be providing any portion of the services, that must be indicated in the IEP, and the responsible staff member, for purposes of implementing the goals and objectives, is the physical therapist.

According to the Connecticut Physical Therapy Practice Act, “*physical therapy shall only be performed by a person licensed under the provisions of this chapter as a physical therapist or physical therapist assistant*”. Therefore, the carry-over activities provided by educational staff other than the physical therapist or physical therapist assistant cannot be considered ‘physical therapy’.

When a para-educator is being utilized to carry out a program developed by a physical therapist, this service should be recorded under the Special Education Service or Related Services heading, as appropriate, on *The Summary: Special Education, Related Services, and Regular Education*. When the para-educator service time is reported here, the title of the certified or licensed staff member who is supervising the provision of these services must be included in the *Staff Responsible* field. The *Service Implementer* field would be the para-educator and the certified staff person. The amount of time each implementer will work directly with the child should be specified under *Description of Instructional Service Delivery* (CSDE, IEP Manual, 2018).

The *Summary* page is also the location in the IEP to document recommendations for Extended School Year services. Criteria for Extended School Year can be found in Chapter 6 of this document. Several examples of the summary page grid can be found in Section 11 of the IEP Manual at: <https://portal.ct.gov/-/media/SDE/Special-Education/IEP-Manual-REVISED-July-2018.pdf?la=en>

### ***Visit/Encounter Documentation***

According to the APTA guidelines for documentation, physical therapists are expected to document every encounter. (APTA, Guidelines: PT Documentation, 2014; APTA, Defensible Documentation, 2018). Visit/encounter documentation should describe interventions, responses, progress, and change in status. Visit notes may also include plans for next visit, equipment used, and subjective information (APTA, Guidelines: PT Documentation, 2014).

*“In pediatrics, especially school-based practice, there may be some misconception that daily notes are not required. However, skilled physical therapist intervention should be documented for each visit..... However, it is best practice for clinicians to have a system in place to track what skilled interventions were provided in daily treatments and why those treatments required the skills of a physical therapist or physical therapist assistant, so that when the weekly note or progress report is written, there is enough evidence to complete the documentation efficiently and completely.”*

(APTA, Defensible Documentation, Conveying Medical Necessity, 2018).

In addition to documenting the physical therapy services, a physical therapist documents communications, training, staff education, parent conversations, and other interactions that occur as part of the provision of services for a student (APTA, Defensible Documentation-Setting Specific Considerations, 2018). Flow/data sheets can be a useful tool to aid in documenting current program and progress. However; these types of forms may not represent adequate information to justify the need for skilled intervention, plans for ongoing care, and the student’s status. Therefore, data forms may not be consistent with the documentation requirements for visit or encounter notes when used by themselves, but require additional documentation of the therapist’s assessment of the student’s performance and the need for specific therapeutic intervention (APTA, Defensible Documentation, 2018).

### ***Progress Reports/Updates***

For students receiving services under special education, progress reports toward annual goals and objectives are required to be provided at designated intervals and often align with report card issuance to the general education peers (Connecticut General Assembly, 2012). This typically occurs at the time of report cards, but may be customized based on the recommendations of the IEP team. Physical therapists consult with team members as appropriate to determine and document level of progress towards IEP goals and objectives. Progress can be indicated using the codes outlined on the IEP form (e.g., Mastered, Satisfactory, Unsatisfactory, Not Introduced, or Other) (CSDE, IEP Manual, 2018). The therapist may also be able to enter specific explanatory comments in the IEP formats.

### ***Annual Review***

Documentation requirement for the Annual Review includes an update of progress toward IEP goals and the student’s present levels of performance. The reporting of this information may vary by district. During the Annual Review, a new IEP is written as described above. The Annual Review may be considered to be the conclusion of an episode of care, in which case associated documentation is indicated (APTA, Dosage Considerations, 2014; APTA, A Pediatric Case Example, 2004).

## ***Reevaluation***

The reevaluation “is the process of performing selected tests and measures after the initial examination to evaluate progress and to modify or redirect interventions” (APTA, Defensible Documentation- Elements of Documentation, 2018). Based on the reevaluation findings, programs may be adjusted and/or the IEP may be amended. The Triennial Evaluation, a specific type of reevaluation in the school setting, represents an extensive form of documentation similar to that of an initial evaluation along with an updated history including a description of the physical therapy interventions. The APTA recognizes that the Triennial Evaluation is consistent with the physical therapy definition of reevaluation and should be completed at least every three years in accordance with education legislation (APTA, Defensible Documentation - Setting Specific, 2018).

Beyond the scheduled Triennial Evaluation, a reevaluation may be indicated when there is a change in the student’s health status, with parent request, upon team decision, or to be in accordance with requirements of the individual state’s Practice Act (APTA, Defensible Documentation - Elements of Documentation, 2018). Currently Connecticut Practice Act does not mandate reassessment or associated documentation (Connecticut General Assembly - Public Health Committee, Chapter 376).

## ***Discharge Report/Discontinuation Summary***

The IEP team, including the physical therapist, determines when physical therapy services are no longer needed to achieve educational goals and improve access and participation within the school setting.

*“Although the discontinuation of physical therapy services would be noted in the IEP document, the physical therapist needs to summarize the student’s current status as part of a final summary to close the current episode of care.”*

(APTA, Defensible Documentation.  
Setting-Specific Considerations, 2018).

This documentation may be referred to as the discharge report in medical settings, and as a discontinuation summary in the educational setting. The APTA recommends that the following information be included in the discontinuation summary:

- A summary of the student’s progress;
- The student’s current status;
- The rationale for discontinuing services; and
- Recommendations for community resources to support the student’s continued health, fitness, development, and well-being

(APTA, Defensible Documentation. Elements of Documentation, 2018).



## ***Summary of Performance (SOP)***

When students whose eligibility under special education terminates due to graduation with a regular diploma, or due to exceeding the age of eligibility (21 years of age), they are still entitled to reasonable accommodations and supports in post-secondary settings per the American with Disability Act and Section 504 of the Rehabilitation Act (ADA, 1990; USDOL, Sec 504; CSDE, Summary of Performance, 2011). At the time of transition from the special education program, the local education agency is required under IDEA to provide a *Summary of Performance*. This document summarizes the student's academic achievement and functional performance and proposes recommendations on how to assist the individual in meeting his/her postsecondary goals (IDEA, 2004; CSDE, Summary of Performance, 2011). The SOP is a document that represents multidisciplinary input summarizing current levels of performance along with accommodations being used in the educational setting. The information provided in the SOP helps to establish a student's eligibility for reasonable and successful postsecondary accommodations or supports.

The SOP can guide accommodations that may be needed upon graduation and can assist in determining eligibility and programming for the Bureau of Rehabilitation Services (BRS), the Department of Developmental Services (DDS) or any agency that requires documentation to provide services and/or reasonable accommodations for the individual. Physical therapists have the unique expertise to assist the team in the completion of the *Functional Areas Section* of the SOP. Access the following link for the *Summary of Performance* document:

<http://portal.ct.gov/-/media/SDE/Special-Education/ED635.pdf>

## ***Billing/ Medicaid Reimbursement Documentation***

According to IDEA districts may use Medicaid or other public benefits to fund services provided under IDEA as permitted by their benefits program. Physical therapy is considered one of the services that is eligible for Medicaid reimbursement (IDEA, Sec 300.154.).

In Connecticut the program designated for Medicaid reimbursement in schools is called Medicaid School Based Child Health Program (SBCH) and is administered by the Department of Social Services. SBCH reimbursement not only reimburses services provided under IDEA, but also includes services provided as part of 504 plans. Connecticut legislation requires school districts to participate in the SBCH as detailed below:

*“10-76d (a) (2) Not later than December 1, 2017, each local and regional board of education shall (A) enroll as a provider in the state medical assistance program, (B) participate in the Medicaid School Based Child Health Program administered by the Department of Social Services, and (C) submit billable service information electronically to the Department of Social Services, or its billing agent.”*

(CGA, General Assembly Amendment, 2018)

Parental permission is required in order for a district to release personally identifiable information needed for reimbursement services and to access the child's public benefits in order to pay for these services (IDEA Sec 300.154) (CDSS, 2018).

The following link contains information pertaining to SBCH:

<https://portal.ct.gov/DSS/Health-And-Home-Care/School-Based-Health-Care-Program/School-Based-Child-Health---SBCH>

Medicaid has requirements for service reimbursement; including service documentation in the student's IEP or 504 plan, medical necessity of the services, and appropriate provider qualifications. Reimbursement may be provided contingent on the therapist's documentation including visit notes and monthly progress reports.

The user guide for the Medicaid School Based Child Health Program including information related to documentation requirements can be found at:

[https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/Reimbursement/School-Based-Healthcare-Program/SBCH\\_User\\_Guide\\_updated\\_2017.pdf?la=en](https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/Reimbursement/School-Based-Healthcare-Program/SBCH_User_Guide_updated_2017.pdf?la=en)

SBCH requires records be retained for at least 6 years. Please reference the following link for specific documents which are to be retained under SBCH requirements:

<http://portal.ct.gov/DSS/Health-And-Home-Care/School-Based-Health-Care-Program/School-Based-Child-Health---SBCH/Related-Resources>

## ***Record Retention***

The APTA recognizes that physical therapy documentation in the school setting is considered to be a part of the student's educational record (APTA, Defensible Documentation - Risk Management, 2018). Connecticut has a policy regarding archiving of educational records. Local educational agencies may have their own policies that at a minimum meet the state's requirement. In accordance with Connecticut General Statutes Section 11-8, the Office of Public Records Administrator within the Connecticut State Library oversees the record retention schedule. The Public Records Administration Municipal Records Retention Schedule describes the requirements for educational record retention. According to the state requirements, special education documents, including those of related services, must be retained for 6 years after a student leaves the district. While physical therapy notes are not specifically identified, case notes of other service providers such as social workers and speech language pathologists are required to be retained for a minimum of 6 years after the student leaves the district.

For more detailed information regarding record retention requirements reference record retention schedules at the following link:

<https://ctstatelibrary.org/wp-content/uploads/2015/07/M8.pdf>

Therapists are employed in school districts through various models (e.g., through agencies, private consultation, and direct employment by the LEA). Therapists must be cognizant of the record retention requirements for educational, medical, and business systems. The APTA recognizes the multiplicity of variables, and defers to state laws that govern how long medical records are to be retained. In addition, some states have legal requirements for retention of business records that may include medical records.

Information about Connecticut's licensing requirements, specific to medical record retention, can be found under "Medical Records" at Connecticut's Board of Examiners - Physical Therapists website:

<http://www.portal.ct.gov/DPH/Public-Health-Hearing-Office/Board-of-Examiners-for-Physical-Therapists/Board-of-Examiners-for-Physical-Therapists>

The following regulations pertain to healthcare providers:

Regulation 19a-14-42. Retention Schedule states that:

*"Unless specified otherwise herein, all parts of a medical record shall be retained for a period of seven (7) years from the last date of treatment, or, upon the death of the patient, for three (3) years."*

Regulation 19a-14-43. Exceptions specifies the following exceptions for medical record retention:

*"Nothing in these regulations shall prevent a practitioner from retaining records longer than the prescribed minimum. When medical records for a patient are retained by a healthcare facility or organization, the individual practitioner shall not be required to maintain duplicate records and the retention schedules of the facility or organization shall apply to the records. If a claim of malpractice, unprofessional conduct, or negligence with respect to a particular patient has been made, or if litigation has been commenced, then all records for that patient must be retained until the matter is resolved. A consulting health care provider need not retain records if they are sent to the referring provider, who must retain them. If a patient requests his records to be transferred to another provider who then becomes the primary provider to the patient, then the first provider is no longer required to retain that patient's records."*

Funding sources may also have specific record retention requirements. For example, Medicaid School Based Child Health Program (SBCH) requires records to be retained for 6 years following service. Medicaid record retention requirements can be found at the following link:

<http://portal.ct.gov/DSS/Health-And-Home-Care/School-Based-Health-Care-Program/School-Based-Child-Health---SBCH/Related-Resources>

Beyond these resources, school-based physical therapists should consult with their LEA administrator regarding record retention protocol that may exceed state and Medicaid requirements. Therapists practicing in the schools must meet the record retention requirements of legal mandates, the profession, their employer, and the setting in which they practice.

### ***Documentation Resources***

The APTA presents guidelines for best practice relating to general physical therapy documentation. Below is a list of references which provide guidelines for general physical therapy documentation requirements.

- *Guide to Physical Therapist Practice (3.0); Principles of Physical Therapist Patient and Client Management.*  
<http://guidetoptpractice.apta.org>
- *APTA Criteria for Standards of Practice for Physical Therapy*  
[http://www.apta.org/uploadedFiles/APTAorg/About\\_Us/Policies/Practice/CriteriaStandardsPractice.pdf](http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/CriteriaStandardsPractice.pdf)
- *APTA Guidelines: Physical Therapy Documentation of Patient/Client Management*  
[http://www.apta.org/uploadedFiles/APTAorg/About\\_Us/Policies/Practice/DocumentationPatientClientManagement.pdf](http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/DocumentationPatientClientManagement.pdf)
- *APTA Defensible Documentation*  
<http://www.apta.org/DefensibleDocumentation/>

Below are documents which provide information regarding physical therapy documentation specifically within the school setting:

- *Section on Pediatrics. School-Based Physical Therapy: Conflicts Between Individuals with Disabilities Education Act (IDEA) and Legal Requirements of State Practice Acts and Regulations fact sheet.*  
<https://pediatricapta.org/includes/fact-sheets/pdfs/14%20State%20Practice%20Acts%20IDEA.pdf>
- *Section on Pediatrics. Providing Physical Therapy in Schools Under IDEA 2004 fact sheet.* <https://pediatricapta.org/includes/fact-sheets/pdfs/09%20IDEA%20Schools.pdf>

- *CT State Department of Education IEP Manual and Forms. Revised 2018*  
<https://portal.ct.gov/-/media/SDE/Special-Education/IEP-Manual-REVISED-July-2018.pdf?la=en>
- *State of CT Department of Social Services Medicaid SBCH Program User Guide , October 2017.* [http://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/Reimbursement/School-Based-Healthcare-Program/SBCH User Guide updated 2017.pdf?la=en](http://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/Reimbursement/School-Based-Healthcare-Program/SBCH_User_Guide_updated_2017.pdf?la=en)

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## Conclusion

Physical therapy services in the school setting represents the blending of two fields - medical and educational. The school-based physical therapist has the unique opportunity to incorporate health related perspectives and interventions with educational programming in the student's natural educational environment.

This guide is a compilation of multiple resources that provide additional, more in-depth information that can help guide decision-making. The information presented in this document may assist school-based physical therapists and other educational stakeholders in gaining a better understanding of physical therapy in the educational setting.

*Physical Therapy in Connecticut Schools; Best Practices and Resources* is intended to synthesize the most current information relating to educational legislation, physical therapy professional legislation, and best practice guidelines. The process of service provision is constantly evolving as laws change and new research yields evidence relating to best practice. This guide is a working document that will require continuous updating to provide optimal benefit to school based physical therapy practice.

## **Supplemental Forms**

**Parental Consent Form**

Date

Dear \_\_\_\_\_  
Parent/Guardian

Your child, \_\_\_\_\_, DOB: \_\_\_\_\_,  
Student Name

is to receive Physical Therapy Services as is stated in his/her Individualized Education Program/ 504 Plan. In accordance with the Connecticut Physical Therapy Practice Act, I am requesting that you provide the name of your child's Primary Care Provider/Health Care Provider. As a Physical Therapist, I am required to consult with your child's Primary Care Provider/Health Care Provider in order for your child to receive physical therapy services on an ongoing basis for the 2014-2015 school year and extended school year if applicable.

In addition, because \_\_\_\_\_ has a condition that may  
Student Name  
be prolonged, may not improve within 30 days, and/or may require ongoing continuous treatment, state law requires that I suggest that you consult a physician about this condition.

Please complete the following information and sign below indicating that you have read the above and provide consent for physical therapy services within the school setting.

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone #: \_\_\_\_\_

Parent/Guardian  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for your attention to this matter. Please feel free to contact me directly with questions or concerns.

*School-based Physical Therapist PT*  
[schoolpt@localschooldistrict](mailto:schoolpt@localschooldistrict)  
000-000-0000

**Physician Communication for Physical Therapy Services**

Dr. Doctor  
1 Doctor drive  
Some city, CT 00000

Regarding: \_\_\_\_\_ Student \_\_\_\_\_ DOB: \_\_\_\_\_ x-x-xx \_\_\_\_\_  
Student Name

Dear Dr. Doctor,

This letter is to inform you that your patient, student, will be receiving physical therapy services at Local School District according to his/her Individualized Education Program/504 Plan during the \_\_\_\_\_ academic year. In accordance with the Connecticut Physical Therapy Practice Act, a physical therapist is required to consult with student's Primary Care Provider/Health Care Provider if physical therapy services are ongoing and continuous. I expect this student to receive physical therapy services on an ongoing basis according to his/her Individualized Education Program. This letter will serve as consultation regarding the ongoing nature of the physical therapy services. Physical therapy services for the \_\_\_\_\_ school year and extended school year (if applicable) will include:

\_\_\_\_\_

**Please complete the information below, sign, and return via fax to School-based Physical Therapist, PT at 000-000-0000.**

**Diagnosis:** \_\_\_\_\_

**Pertinent Medical History:** \_\_\_\_\_

**Medications:** \_\_\_\_\_

—

**Precautions/Contraindications:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Physician Signature:**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**Please feel free to contact me directly regarding questions or concerns with physical therapy program, medical updates, or considerations regarding ongoing physical therapy service during the \_\_\_\_\_ school year including summer school if applicable.**

School-Based Physical Therapist, PT  
[schooltherapist@localdistrict.org](mailto:schooltherapist@localdistrict.org)

000-000-0000

**PHYSICIAN COMMUNICATION FORM**

**PHYSICAL THERAPY SERVICES \_\_\_\_\_ PUBLIC SCHOOLS**

Date: \_\_\_\_\_

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Medical History: \_\_\_\_\_

Precautions/Contraindications: \_\_\_\_\_

Dear Dr. \_\_\_\_\_,

The PPT/504 process at \_\_\_\_\_ Public Schools has recommended Physical Therapy services for \_\_\_\_\_, for whom you are the primary care provider. In accordance with the State of Connecticut Physical Therapy Practice Act, a physical therapist is required to consult with the student's Primary Health Care Provider if the physical therapy services are expected to be prolonged and continuous. I expect this student to receive physical therapy services from XX/XX/XX until the next scheduled Annual Review on XX/XX/XX.

The physical therapy assessment has determined the following areas of concern to be addressed by physical therapy intervention:

Attached is a copy of the physical therapy evaluation, goals and objectives that will be addressed by **direct physical therapy for \_\_\_ hour(s) per week**. Services will include:

Please sign below and return:

(Signature) Dr \_\_\_\_\_ (Date) \_\_\_\_\_

Please add any additional information, precautions or contraindications:

Please contact me if you have questions or concerns. Thank you in advance for your prompt reply.

\_\_\_\_\_, PT

Phone: XXX-XXX-XXX, FAX: XXX-XXX-XXXX