Personnel Issues in School-Based Physical Therapy: Supply and Demand, Professional Preparation, Certification and Licensure

Prepared for the Center on Personnel Studies in Special Education

EXECUTIVE SUMMARY

by
Mary Jane K. Rapport
University of Colorado Health Sciences Center
JFK Partners

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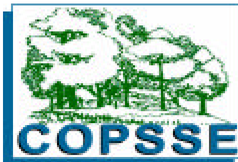

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COPSSE research is focused on the preparation of special education professionals and its impact on beginning teacher quality and student outcomes. Our research is intended to inform scholars and policymakers about advantages and disadvantages of preparation alternatives and the effective use of public funds in addressing personnel shortages.

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COPSSE Project
P.O. Box 117050
University of Florida
Gainesville, FL 32611
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352-392-2655 (Fax)

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INTRODUCTION

This paper reviews personnel issues pertaining to the delivery of physical therapy (PT) services in school settings. Physical therapists (PTs) have been involved in the education of children with disabilities almost since the profession began in the early part of the 20th century. In addition, PTs have continued to be involved in the prevention of disabilities and the promotion of health as well as their role in the rehabilitation or restorative health care process.

DEFINITIONS

PTs work in schools and provide *related services* under Part B of the Individuals with Disabilities Act (IDEA). *Physical therapy* means services provided by a qualified PT (34 CFR 300.24(b)(8)). While the federal regulations do not provide more specific detail, practice tells us that these PT services are intended to address a child's posture, muscle strength, mobility, and organization of movement in an educational environment. PTs focus on particular skills required to achieve independence, including motor control and movement.

According to IDEA, the role of PTs in schools is defined by the need to provide children with disabilities some educational benefit in the least restrictive environment. PT is provided for children with disabilities who need therapy services to assist the child to benefit from special education. Even so, there is nothing in the law or regulations about how therapy services are to be delivered. *Direct services* usually involve face-to-face interactions between the therapist and the child/student. *Indirect services* involve the therapist interacting with other adults (professionals, paraprofessionals, teachers, parents) so that they can appropriately carry out the intervention.

SERVICE DELIVERY METHODS

The *traditional method* of service delivery by PTs in schools has been through direct therapy using a *pull-out model*. Under this arrangement, therapy takes place in a separate room outside of the classroom with little collaboration or consultation with teachers or parents. Recognizing that this isolated approach had many limitations, researchers in the early 1990s emphasized the need to expand therapeutic input to children through everyday routines at home and at school. The *consultative model* gained in popularity, and therapists were increasingly called upon to design the child's intervention program and then teach the skills needed to implement the program on a regular basis to paraprofessionals, classroom teachers, or parents. In addition to the consultative model of service delivery, direct, integrated, monitoring, and collaborative models are also used. In the *direct model*, the therapist is the primary service provider to the individual child. In the *integrated model*, the therapist is in contact with the teacher, paraprofessional, and family in addition to having direct contact with the child. The *monitoring model* is provided when the therapist instructs and monitors the efforts of the team toward meeting specific outcomes of an intervention. The *collaborative model* is a combination of transdisciplinary team interaction and integrated service delivery where services are provided by all team members.

SUPPLY AND DEMAND

The supply of PTs has been relatively low compared with the ever-increasing demand throughout the 20th century. The number of PTs grew exponentially during that period. The American Physical Therapy Association (APTA) estimates that there are currently 120,000 PTs, 90,000 of whom are either employed or seeking employment as PTs. Their study predicted a 20-30% surplus of PTs by 2005-2007. However, this work force study by the APTA preceded the Balanced Budget Act (BBA) of 1997. This federal legislation had a significant impact on the health care system, particularly for persons dependent on receiving services under the Medicare and Medicaid programs and the health care providers upon whom they relied for their care. The legislation led to changes in the level, systems, and provisions of health care under these federal health care programs. For the first time in the history of the profession, unemployment grew during the period following the BBA. As this situation continues, it is likely that increasing

numbers of PTs may seek employment in the schools despite lacking the specific knowledge required to be a successful provider of related services in educational settings.

Work Settings

Among PTs who identify themselves with the specialty of pediatrics, schools appear to be the most prominent employment setting. An APTA survey in 1993 found that approximately 10% of its members specialized in pediatrics, and almost half of those reported the schools as their primary employment setting. A recent survey of APTA members and nonmembers (n=36,498) conducted in spring 2001 revealed that 5.5% (about 2,000) were practicing in schools.

Personnel

Physical therapists. Data reported in the *23rd Annual Report to Congress* (USDOE, 2002) indicates there were 5,457 fully certified PTs and 53 PTs licensed to practice but not certified within the educational system of their state employed to provide related services for children and youth with disabilities aged 3-21. IDEA requires related services to be provided by qualified personnel. It is up to each state to determine qualifications for personnel providing special education and related services. State law also determines whether paraprofessionals and assistants can be used to assist in the provision of special education and related services.

Physical therapy assistants (PTAs). PTAs are trained at the associate degree level and must work under the direction of a PT. PTAs may implement treatment programs and provide interventions. Initial evaluations and assessments, as well as follow-up evaluations, cannot be delegated and are considered the responsibility of the PT. PTs are also responsible for the design and modification of treatment programs and interventions.

Paraprofessionals. In addition to PTs and PTAs, paraprofessionals may assist in the provision of related services under the IDEA. Although limited in the scope of their services, appropriately trained, continually monitored, and supervised paraprofessionals are able to carry out interventions designed by PTs.

Level of services. The effectiveness of services provided by a paraprofessional will be determined in large part by the skill of the PT who has delegated these tasks. However, it is clear that the involvement and expertise of the PT in therapeutic interventions and the associated decision-making processes continue to be critical elements in the delivery of this related service in schools. When PTAs, paraprofessionals, and other educational team members share the responsibilities of intervention, it is important to insure that the delivery of services using a model other than direct service is not misrepresented to parents, school districts contracting for services, or third-party insurance payers. All parties should be clear about the level of professional providing any related service and what that service entails.

Job Satisfaction

Schools tend to offer PTs lower salaries than they might receive in hospitals, clinics, and other medical or health care settings, even though most school-based employment offers a 10-month period of employment with summers off. Other factors that have been linked to job dissatisfaction among related service professionals in school settings include inadequate work/office space, inadequate equipment/materials, excessive caseloads, limited staff development, isolation from colleagues, excessive paper work, and lack of a career ladder.

PROFESSIONAL PREPARATION

Programs

The Commission on Accreditation in Physical Therapy Education (CAPTE) makes autonomous decisions concerning the accreditation status of education programs. Institutions offering PT preparation programs voluntarily seek accreditation from CAPTE to demonstrate that the program

has met accepted standards and upholds a certain level of quality. In the U. S., graduation from an accredited program is one requirement for PT licensure (ATPA, 2000). However, there is no specific relationship between PT accreditation and the attainment of all skills necessary for satisfactory performance as a school-based PT. As of 2002, all entry-level PT programs are at masters or doctoral levels, rather than bachelors.

Curriculum

All PT education programs must offer a curriculum in basic and applied sciences and PT methods across the life span; however, the skills and knowledge necessary to treat children are not always the same skills and knowledge used to treat adults. The paper reviews literature pointing out the need for more specific pediatric training for PTs.

Profiles

According to APTA, there were 20,279 students enrolled in 193 accredited and 19 developing (not yet accredited) programs during 1999-2000. The average PT program was located at a public institution (51.4%) in the Middle Atlantic region (NJ, NY, PA, 20.4%) and included a class size (cohort group) of approximately 40 students. Over half of the PT students were women (65.7%), and 12.9% of the students were considered to be in the ethnic/racial minority. There were slightly more than 2,200 full-time and part-time core faculty members preparing these future PTs, and 49 vacant faculty positions needed to be filled. The core faculty was predominantly female (60.8%), 40-49 years of age (44.9%), and Caucasian (93.1%). There were 108 programs with no minority representation among their faculty. The majority (51.3%) of all core faculty held a Master's degree, while 10.6% held a professional doctorate, and 33.8% a Ph.D. (*APTA Fact Sheet*, 2000).

Degrees

Of the 7,411 PT graduates in 1999, the most common degree awarded was the Master's of Physical Therapy, or MPT (47.3%). There were 5,687 post-baccalaureate degrees conferred by the accredited PT education programs in 1999. A look at the number of accredited programs in March 2002, showed a total of 0 baccalaureate, 157 Masters of Science/MS/MPT, and 42 doctoral programs (Doctor of Physical Therapy/DPT). Seven (7) MS/MPT and 4 DPT programs were in the process of seeking accreditation. In addition, there was 1 Canadian and 2 international programs accredited by CAPTE.

CERTIFICATION AND LICENSURE

State criteria. PT licensure is granted by state boards and is mandated by state legislation. Each state has its own rules and criteria regarding PT licensure and practice. This generally includes graduation from an accredited program, an acceptable score on the national licensure examination along with evidence of competence in making decisions. The licensed practice of PT may be provided through direct access to PT services (34 states), or access to these services may be contingent on receiving a prescription or referral from a physician indicating the need for PT. States also have licensure requirements for PTAs and requirements for PTs educated outside of the U. S.

Specialist certification. Pediatrics is one of seven areas in which a PT may receive formal recognition from the American Board of Physical Therapy Specialties. In 2001 there were 3,618 certified clinical specialists, with 440 of those PTs recognized as Pediatric Clinical Specialists (PCS).

Residency and fellowship programs. In addition to traditional graduate education programs, PTs may continue their clinical education through a clinical residency or fellowship program.

Continuing education. Even with many options for pursuing educational programs beyond the entry-level PT preparation program, some states do not require continuing education to maintain licensure. Some states have additional requirements for PTs who are either employed by or

contracted to work within the public education system. These additional requirements include special educational certifications granted by the state department of education, which note that the PT is licensed in the state and is acceptable for employment in the schools. These generally are issued pending approval of professional licensure. Some certifications require proof of continuing education for renewal.

RECOMMENDATIONS

In entry-level professional programs, PTs receive limited preparation for employment in a school-based setting. PT education does not have a strong focus on the area of pediatrics, and little time in the overall professional preparation curriculum is devoted to the provision of PT as a related service under the IDEA. However, requiring pediatric or school-related experience for obtaining a job as a PT in the schools would further reduce the already limited pool of qualified PTs available for employment. It will be necessary to change personnel preparation to increase both the number of available pediatric PTs and the quality of the professional skills with which a PT enters employment as a related service provider. These changes include:

- more emphasis on pediatric content in the initial PT professional preparation program
- more mentoring opportunities for PTs who are considering or entering employment in educational, or school-based, settings
- more school-based clinical sites and access to these sites for PT students interested in clinical experience in a school-based setting
- more appropriate continuing education and post-graduate course work in pediatrics and delivery of intervention services in educational environments.

RESEARCH NEEDED

The paper suggests research questions on topics related to school-based PT and the following issues:

- IEP requirements
- use of alternate personnel
- Medicaid
- degree levels
- aging of the PT field.