SUBJECT: Please support HB 2618 (Requires Department of Education to conduct study to identify best methodology for determining appropriate number of students on [caseload] workload for certain school-based health practitioners.)

Message: Dear Representative Sosa] or Senator Sollman,

As a constituent and an occupational therapist, I am asking you to support HB 2618, which would require the ODE to conduct a study to determine best methodology for determining an appropriate workload for school based practitioners.

Approach to educational support services has changed over the time that I've been in practice. Much of this is positive and backed by the AOTA (American Occupational Therapy Association), such as the participation in the use of the MTSS and RTI (Response to Intervention) models. Allowing for a more consultative model rather than a direct intervention and "treatment" model has given us greater opportunities to work with teachers and support staff as a team rather than as separate entities and does better reflect the application of services in support of accessing a child's education in a public school setting. To do this effectively, we need appropriate time to work with the teaching staff and provide any necessary training on a particular strategy or modification. We cannot provide support without this crucial piece.
Meanwhile, workloads have dramatically increased to the point of being unable to ethically and legally provide these services. The minutes set on IEPs and IFSPs are minimums. We can provide more, but we must provide at least that minimum amount of consult time. Since the minutes are lower, it can appear that we don't need more time than that per month or quarter to serve a particular school or student. So, admins can say that they don't see a need to hire more staff. We spend the majority of our time in meetings, collaborating with teachers and support staff, taking calls when children are struggling to participate in classes and then are "eloping" (running out of the room or building), engaging in destructive behaviors, or otherwise being unable to safely participate in school. We are called in to help the behavior support team determine strategies that will help with regulation and participation in a safe, supportive, confidence-building way that encourages self-advocacy and independence.
To effectively do this, we may meet with the team, observe the student in and out of the classroom, meet with the child and/or caregivers, and sometimes explore strategies before recommending them so that we are setting the student and teachers/support staff up for success with the tool. We might model or follow a student in class for a short time up front so that staff can learn from observing us or working with us to support the student. We are providing staff education during professional development days. We are creating modified equipment and collaborating with medical professionals and then interpreting that information so that school team members can provide needed supports. These may be indirectly supporting a student but not reflected on a specific child's IEP or IFSP. We also are the staff who are called in for ensuring safety of students during the school day in terms of mobility (PTs and OTs), toileting, self care, and eating (ideally a team of OT, PT, SLP, RNs).
Caseload numbers alone are not able to determine the actual workload being required.
Our assigned schools and caseloads determine how much travel is required, how many team members are involved, and the type of services needed (for example, complex medical needs vs sensory processing vs safe feeding protocols).
The result of this disparity between the amount of time for consultation with a teacher or other staff member and actual services rendered is that equity is sacrificed, we meet the bare minimums so that we can serve all and end up serving disproportionately and often not even fully to anyone.
School districts must justify additional staffing, and that is not happening, especially with our current system. We need support through legislation to motivate the school districts to action.

Without it, we will continue to have burnout, high turnover, and a lack of desire for OTs to enter or re-enter the school-based services setting.

Please see below for further information on the importance of this bill.

HB 2618, the Workload Study Bill, would require the Oregon Department of Education (ODE) to conduct a study to identify the best methodology for determining the appropriate workload for school-based health practitioners. It is important to differentiate between *workload* and *caseload. Caseload* is simply the number of students with Individualized Education Programs (IEPs), Individualized Family Service Plans (IFSPs), and 504 Plans served by school-based professionals through direct and/or indirect service delivery options. In contrast, *workload* refers to *all* activities required and performed by school-based professionals in the school setting. These school-based health professionals have requirements for collaborating & consulting with school staff & parents as well as community-based professionals, facilitating access and participation in the general education curriculum, providing direct, indirect services, and response to intervention services (RTI) within the student contact day at school. Workload also includes non-therapeutic activities which include, but are not limited to, development and maintenance of adaptive equipment and visual aids, drive time between sites, time-spent in special education meetings, provision of professional development, research on low-incidence disorders and evidence based practices, etcetera. Additionally, they have an increased burden of billing and documentation requirements on top of the Individuals with Disability Education Act (IDEA) mandates.

There are currently no guidelines or requirements for how school-based agencies (birth-21 years of age) determine the workload assigned to occupational therapy practitioners (OTs), physical therapy practitioners (PTs), and speech-language pathology practitioners (SLPs) in Oregon schools. The lack of workload requirements for school-based health practitioners has many potential negative impacts: 1) affect student outcomes and program quality; 2) potentially violate state & federal mandates, including Every Student Succeeds Act (ESSA), IDEA, and Free & Appropriate Public Education (FAPE); 3) may violate professionals' codes of ethics; 4) professionals become overburdened, have less job satisfaction leading to potential burn out. Many school-based health practitioners end up leaving the schools to seek employment in medical-based settings such as hospitals, out-patient clinics, and private practices. These settings typically have measures in place to control workload and offer significantly better compensation than schools provide.

Establishing a methodology, such as a workload calculator, would help school administration understand appropriate workload for school-based practitioners. Appropriate workloads for school-based health practitioners will ensure that these federally mandated services (occupational therapy, physical therapy, speech & language therapy continue to be provided in Oregon schools in an efficacious manner while upholding the professional code of ethics. OTAO, APTA Oregon, and OSHA are eager to work with and support the ODE in their establishment of a workload methodology. Inclusion of our voices in establishing the methodology is pivotal to ensure all aspects are taken into consideration.

I urge you to support HB 2618 during this legislative session. It may be the way back to better supporting our students and helping to create a positive educational experience in our state. Thank you for your consideration.

Sincerely,
Sandra Bigelow, OTR/L