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A Preliminary Study to Develop a Collaborative Tiered School-Based Physical Therapy Service Delivery Model: Results from an International Delphi Consultation

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ABSTRACT

Background: Physical therapy (PT) is increasingly provided at schools to help students participate in educational activities. Recent rehabilitation models emphasized the benefits of using collaborative tiered services for service provision, yet no model is available to guide how these services should be delivered. Therefore, this study aims to determine the core attributes and PT interventions of a collaborative tiered school-based PT model that could guide how PT services are delivered in schools worldwide.

Methods: A modified Delphi method was used to identify the core attributes and the PT interventions that would be part of the model. An introductory webinar followed by three Delphi rounds with 24 international experts was conducted. Similar ideas generated in Round 1 were combined into statements; the statements reaching the predetermined consensus level in Rounds 2 or 3 were retained. Categories were created to present core attributes and Tiered interventions that were retained.

Results: 41 core attributes were identified and grouped under seven categories. Tiered interventions were grouped under 15 categories which included 37 interventions for Tier 1, 24 interventions for Tier 2, and 60 interventions for Tier 3.

Conclusion: The recommended core attributes and interventions will support the development of an international framework for school-based PT services, fostering health promotion for all children, and supporting those with disabilities.

Keywords: school-based, physical therapy, collaboration, tiered approach.

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INTRODUCTION

The provision of health care services in schools has evolved, and various healthcare professionals are now involved in providing health services to students within their school day or school environment [1]. Physical therapy (PT) is one of the related services provided in school settings to help address the educational needs of students when their impairments interfere with academic performance and daily function [2]. The scope of the services may vary in different countries, yet, most of the school-based PT research literature originates from the USA, where school-based PT is mandated under the Individuals with Disabilities Education Improvement Act (IDEA) [3]. IDEA ensures that all children with disabilities receive public education with an individualized education program that consists of special education and related services, including physical therapy [4]. PT services under IDEA should aim at improving skill acquisition [2]. Though, some issues regarding the accessibility of services and scope of practice remain, especially for children who are experiencing difficulties but are not diagnosed with a disability.

Some general rehabilitation models for pediatric services exist, providing more holistic views to identify the needs of students and proposing ways to support health, healthy lifestyle, quality of life, and school participation. Examples of such models include the multi-tiered system of support [5, 6], the whole-school approach [7], and Partnering for Change [8]. However, these models provide little guidance on the specific role of PT in schools [9], and current caseload models do not support staff to perform these services. Since the service delivery model help translate evidence-based knowledge into clinical practice and support the shifts required within service organizations to embrace new approaches [10], developing such a model to support the implementation of school-based PT services could help the field move forward.

School-based PT models could be informed by other models, especially those at that address the needs of students who do not have a disability but need support. For instance, the Partnering for Change (P4C) service delivery model initially developed for occupational therapy (OT) services [8] is perceived to have the potential to improve all rehabilitation services provided at schools, including PT. P4C may be particularly appealing as a starting point for school-based PT services because it successfully intersects two recent educational frameworks that propose ways to deliver services that are accessible to all children: universal design for learning (UDL) and multi-tiered approaches. UDL is a framework that aims to guide educators and health professionals in promoting in the use of all students in school-related activities using multiple and varied strategies to represent the information, content, and concepts [11]. It is often associated with Response to Intervention, which proposes using a multi-tiered approach to support students with various needs [8].

The multi-tiered approach includes three levels of interventions. Tier 1 includes high-quality and universal activities for all students (Tier 1). The students who are struggling with Tier 1 are gradually provided with more comprehensive interventions (Tier 2 and Tier 3). In P4C, Tier 1 adopts UDL strategies where therapists help teachers design educational materials, instructions, and activities to provide all students with equal access to learning. Activities in UDL strategies are those that can benefit all and essential for some students. When a child needs additional supports, he/she is provided with Tier 2 interventions such as adaptation, modification, motor learning strategies. When a child needs individualized support, then the child is provided with Tier 3 interventions such as one-on-one training and provision of equipment. Considering the needs of a child, a child may start receiving interventions in any level, and be provided with different levels of interventions based on the PT needs in different time points [8].

Using a school-based rehabilitation framework including UDL strategies and multi-tiered approaches could help PTs address the needs of all students for general development, health, fitness, injury prevention, and obesity management needs [12]. Furthermore, using a multi-tiered approach could help PTs identify children with special needs, prevent secondary consequences of health-related issues, and foster skill development and school participation in school. Reflecting on the core principles of these approaches and key intervention strategies of UDL and multi-tiered services would contribute to globally advancing the research knowledge in the field of school-based PT service provision and fill an important evidence gap related to roles and the use of these approaches.

Therefore, the purpose of this study is to identify the core attributes and key interventions that should be included in the future development of a collaborative tiered school-based PT service delivery model. The term "*collaborative*" refers here to partnering and interacting with other stakeholders who are working with the students (e.g., school personnel, families), and "*tiered*" means adopting a multi-level approach.

MATERIAL AND METHODS

Study design

A modified e-Delphi process was constructed based on the steps proposed by Keeney et al. [13]. The study was conducted electronically between October 2020 and March 2021 using the RED Cap software after the research ethics committee of the CIUSSS de l'Estrie-CHUS provided ethical approval (reference number: F9H-38680). Study results are reported using the study elements suggested by Jünger et al. [14] for Delphi studies. This consensus method was chosen since it allows participants from different geographical locations and encourages the independent expressing of the ideas.

Participants

Members of an existing international network of school-based PT (n=38) led by the senior author of this manuscript were invited to participate in this study. Members were all PT clinicians or researchers involved in school-based work from various parts of the world. This network was created following an adjunct meeting during the 2019 World Confederation of Physical Therapy Congress in Geneva. Although a sample of convenience, additional

members were invited using a snowball approach based on recommendations from existing members.

Procedure

The information about the study and a link to the consent form were sent by email to all potential participants. The participants who agreed to participate and acknowledged consent were invited to participate in an introductory webinar followed by three consecutive Delphi rounds as suggested by Chalmers and Armour [15]. Figure 1 presents the flowchart of the Delphi process.
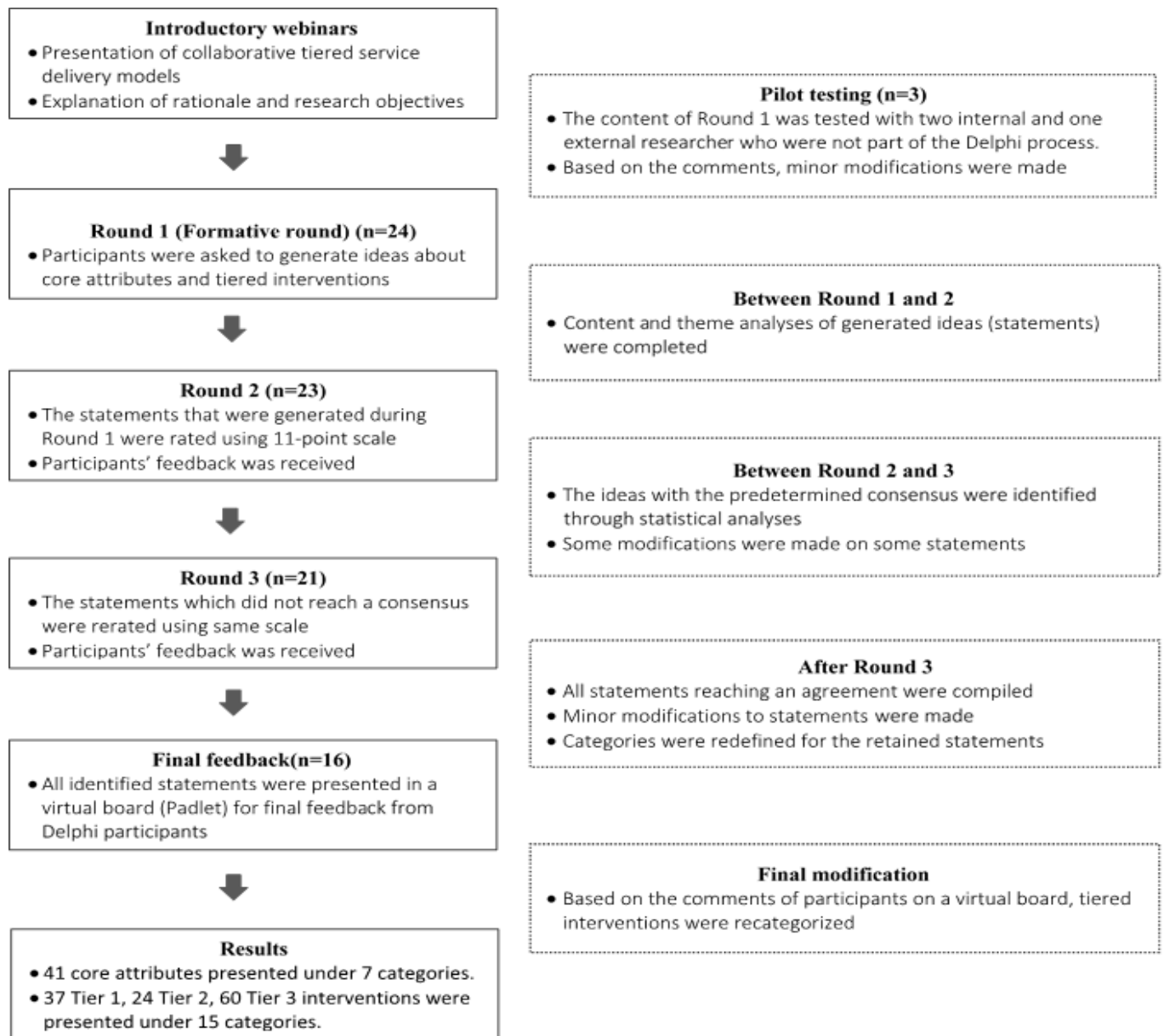
Introductory webinars
- Presentation of collaborative tiered service delivery models
- Explanation of rationale and research objectives

Round 1 (Formative round) (n=24)
- Participants were asked to generate ideas about core attributes and tiered interventions

Round 2 (n=23)
- The statements that were generated during Round 1 were rated using 11-point scale
- Participants' feedback was received

Round 3 (n=21)
- The statements which did not reach a consensus were rerated using same scale
- Participants' feedback was received

Final feedback(n=16)
- All identified statements were presented in a virtual board (Padlet) for final feedback from Delphi participants

Results
- 41 core attributes presented under 7 categories.
- 37 Tier 1, 24 Tier 2, 60 Tier 3 interventions were presented under 15 categories.

Pilot testing (n=3)
- The content of Round 1 was tested with two internal and one external researcher who were not part of the Delphi process.
- Based on the comments, minor modifications were made

Between Round 1 and 2
- Content and theme analyses of generated ideas (statements) were completed

Between Round 2 and 3
- The ideas with the predetermined consensus were identified through statistical analyses
- Some modifications were made on some statements

After Round 3
- All statements reaching an agreement were compiled
- Minor modifications to statements were made
- Categories were redefined for the retained statements

Final modification
- Based on the comments of participants on a virtual board, tiered interventions were recategorized

Figure 1: Flowchart of the Delphi process.

Introductory webinar

Between October 20-27, 2020, four online live introductory webinars, each of lasting approximately one hour, were conducted to accommodate time differences across multiple countries. During each webinar, two research members of this study presented recent evidence on key elements of school-based PT and collaborative tiered school-based PT services. The P4C service delivery model [8] was presented as an example of a service delivery model that could help support the implementation of collaborative tiered school-based PT services. The goals of the study and the research procedure were also presented, and a discussion was facilitated to gather participants' perspectives on the study. Notes were taken during each webinar. The field notes taken during the webinars were then used to improve the clarity of survey questions and organize the process of Delphi rounds.

Delphi rounds

Delphi rounds were conducted using an electronic survey via REDCap software two weeks following the introductory webinar. Before Round 1, a pilot test was done with two internal and one external researchers, and necessary adjustments were made to improve the survey's clarity. In the first section of the Round 1 survey, the constructs of 'core attributes' and 'Tier interventions' were clearly defined (e.g., respectively as 'The guiding principles for the implementation of a collaborative tiered school-based PT services' and 'The actions performed by PTs to deliver services that can encompass a great range of therapy interventions, assessment, strategies, and approaches used to improve function, skills, participation, engagement and health'). To increase participants' understanding of the topic, core attributes of the P4C model and some examples of potential PT interventions for each Tier were

presented. In the second section of the survey, participants were introduced to open-ended questions to generate core attributes for a collaborative tiered school-based PT service delivery model and were provided examples of PT interventions that could be implemented at each Tier.

In Round 2, for information purpose only, participants were provided with the original anonymized statements generated in Round 1 by all participants as well as with an explanation of how they were collapsed and grouped. Participants were then asked to rate how much they agreed with the importance of these core attributes and interventions, using an 11-point Likert scale (0 = strongly disagreed, 5=neutral, and 10= strongly agreed). They were also invited to provide comments on any of these statements. In Round 3, the percent agreements on each statement in Round 2 was provided for participants' information only. Then, participants were asked to rerate the importance of the statements where consensus was not achieved using the same scale. For a statement to be considered as achieving consensus, at least 80% of the participants should score 7 or more on the 11-point scale [16].

As the participants during the webinars requested sufficient time to reflect on the core attributes and interventions they wished to include, they were given four weeks to respond to Round 1, six weeks for Round 2, and three weeks for Round 3. Weekly reminders were provided. At each round, participants were encouraged to provide additional comments.

Analysis and analysis process

Following Round 1, content and theme analyses were completed based on the guideline provided by Keeney et al. [13]. The ideas generated by the participants for core attributes and tiered interventions were expressed as 'statements'. First, similar statements were collapsed into one statement by one researcher, and unique statements were kept as worded as suggested by Elo et al. [17] Secondly, some statements were jointly expressed into a broadly defined statement consisting of multiple sub-statements that would be more specific; for example, assessment for a) *scoliosis (statement 1),* b) *muscle strength (statement 2),* etc". Thirdly, statements for core attributes and tiered interventions were clustered under some categories. Fourthly, a second researcher reviewed all the statements to ensure the merged statements truly reflected the meaning of the original statements, and to review if they belonged where they were originally generated (e.g., if they were a core attribute or related to a specific Tier intervention). A final review of the statements was conducted by two other research members, and the statements were entered in the RedCap software and sent to the participants to measure the extent to which they agree with each statement as core attribute or tiered intervention (Round 2).

After Round 2, the statements on which the predetermined consensus (i.e., 80 % of participant rating 7 or higher on the 11-point Likert scale) was reached were identified and retained. The remaining statements (on which the predetermined consensus was not reached) were moved to Round 3 for rerating. The comments of the participants in Rounds 2 and 3 were carefully reviewed, and minor adjustments were made to the wording of the statements as appropriate or were retained to explain participants' decisions. Some of the comments were briefly presented in the result section. Quantitative responses in Rounds 2 and 3 were analysed via R statistical software using the library "Hmisc" [18].

In the end, all the statements retained were further analysed by the research team to identify the overarching categories representing common perspectives for core attributes and tiered interventions as suggested by Elo et al. [17] and Keeney et al. ([13] as follows:

First, the categories were created by the research team. Any disagreement among research members was resolved through discussion. Secondly, the categories created by the research team and the corresponding statements were entered in a virtual board (Padlet) and a link to the virtual board was sent to Delphi participants for their review (16 of the participants provided feedback on the virtual board). Based on the feedback received from Delphi participants on the virtual board, no change was needed on the categories of the core attributes. However, some modifications were suggested for the categories of tiered interventions to present the interventions considering students` outcomes. Thus, a recent framework on tiered approaches to rehabilitation by VandeKaay et al. [19] proposing different categories aiming different therapy outcomes was used to guide the creation of categories for tiered interventions. The research team also identified additional categories for some interventions that could not be attributed to any of the proposed categories within the guiding framework (e.g., increased quality of life and health). To place the interventions under these categories, at times the same interventions for different stakeholders were expressed in the same statements (e.g., seminars for *school personnel* and *families* regarding physical activity and its benefits). A final review of the categories and corresponding statements were made by all researchers being involved in this study.

RESULTS

Participants

Out of a pool of 38 expert participants who were invited, 24 participated in the study representing 9 countries. Table 1 shows the characteristics of participants.

Table 1: Characteristics of participants (N=24)	N (%)
Age	
20-30 years	1 (4.2)
31-40 years	5 (20.8)
41-50 years	7 (29.2)
51-60 years	7 (29.2)
60-70 years	3 (12.5)
70 and older	1 (4.2)
Country	
Australia	5 (20.8)
Belgium	1 (4.2)
Canada	1 (4.2)
Finland	3 (12.5)
Israel	1 (4.2)

New Zealand	3 (12.5)
Sweden	1 (4.2)
Turkey	1 (4.2)
USA	8 (33.3)
Professional role	
Researcher	10 (41.6)
Clinician	7 (29.2)
Researcher & clinicians	1 (4.2)
Clinical supervisor	1 (4.2)
Policy advisor	1 (4.2)
Physical therapy and rehabilitation teachers	1 (4.2)
Consultant for school-based PT	1 (4.2)
Professor	2 (8.4)
Year of experience in school-based PT	
1-2 years	4 (16.8)
3-4 years	1 (4.2)
6-7 years	2 (8.4)
8-9 years	1 (4.2)
10 or more	16 (66.6)
Participation in webinars	
Live webinar	18 (75)
Recorded webinar	5 (20.8)
Did not watch a webinar	1 (4.2)

Delphi rounds

Round 1

The 24 participants who completed Round 1 survey generated 104 core attributes, and 256 tiered interventions. Of the tiered interventions, the participants generated 91 Tier 1 interventions, 80 Tier 2 interventions, and 85 Tier 3 interventions. Following the initial content analysis, core attributes and tiered interventions were compiled to 53 unique core attributes, and 205 tiered interventions; 74 of which were Tier 1, 62 Tier 2, and 69 Tier 3 interventions (see Appendix 1 for all detailed Round 1 statements).

Round 2

In Round 2, 23 participants completed the survey. Participants agreed on 43 core attributes (81%), 29 Tier 1 interventions (39%), 20 Tier 2 interventions (32%) and 48 Tier 3 interventions (70 %). During this round, participants generated 3 new interventions. 10 interventions were also modified based on participants' comments and added to the interventions for which agreement was not reached. A total of 18 core attributes, 45 Tier 1 interventions, 41 Tier 2 interventions, and 22 Tier 3 interventions were moved to Round 3.

Round 3

In Round 3, 21 participants completed the survey. Participants agreed on 2 additional core attributes (4%), 8 Tier 1 interventions (11%), 4 Tier 2 interventions (7%), and 12 Tier 3 interventions (17%). Following participants' comments, minor adjustments were made to the wording of some of the interventions and core attributes (e.g., using "general" instead of "regular") and the terminology across statements was standardized across statements (e.g., *school personnel* was used to represent educators, teacher aid, etc., and *families* for parents, caregivers, etc.).

Core attributes

Overall, a total of 45 core attributes reached consensus; they were presented as 41 main statements and 4 sub statements under seven categories (see Table 2). An overview of the core attributes generated and retained during Delphi process under seven categories was presented below, along with some of the participants' comments including those that highlight some core attributes that were not kept.

1) Goals, missions and the scope of the practice

The participants agreed that the service goals should be linked to participation in school routine, peer interaction, community involvement, inclusive practices, transition-related needs of students (e.g., transition from primary to secondary education) and improvement of schoolwide health and wellbeing.

2) Key elements of service delivery

There was an agreement that the service should align with curriculum goals and be provided in the school context. PTs are suggested to adopt a learner-centred approach and focus on the students' strengths yet should also include a PT-based diagnosis and assessment.

3) Inclusive and accessible service delivery

It was agreed that the PT service should be responsive to range of school contexts and be culturally sensitive. Particularly, acknowledging the specific needs of indigenous people is fundamental, as expressed by a participant, is even deemed mandatory in some counties (e.g., New Zealand). Using an accessible language for families was perceived to be essential for collaboration.

4) Knowledge and professional development

PTs working in schools are expected to understand school culture, abide by policies and be aware of community-level physical activity opportunities available to students and families, involved in professional developmental activities, and knowledgeable regarding evidence-based practices.

5) Partnership and teamwork

These core attributes of PT practice suggest interdisciplinary and multidisciplinary approaches, in collaboration with students, families, school personnel, healthcare professionals and community to deliver PT services in schools. Participants also agreed that PTs should take some responsibilities for facilitating connections between the education and healthcare systems; yet should not be solely responsible, as expressed by some of the participants.

6) Coaching and knowledge translation

Participants agreed that PTs should build capacity within educators and families as it relates to 1) early identification of at-risk students, 2) prevention the secondary health conditions, 3) the importance of motor skills, and 4) role and expertise of physiotherapy profession. PTs also should coach school personnel in implementing PT-related strategies at schools and follow-up with them regarding the strategies previously trialed.

7) Schoolwide and UDL strategies

The schoolwide approach (e.g., physical activity initiatives for whole school) and UDL strategies (e.g., classroom

movement break) were also identified as core attributes of a collaborative tiered model to address the needs of all students.

Table 2: The core attributes of the model clustered in 7 categories

1) Goal, missions, and the scope of the practice

1) Advocates for school access and inclusive practices
2) Promotes participation in school routine, peer interactions and community involvement
3) Promotes general health and healthy lifestyle for students, school personnel and families
4) Prepares students for transitions especially transition to school, post-secondary education, employment, and independent living in collaboration with school personnel[1] and families
5) Focuses on participation, wellness, and achievement rather than deficit

2) Key elements of service delivery

6) Provides services that are aligned with curriculum goals, and evidence-based teaching strategies
7) Uses general curriculum activities (e.g., physical education, routine mobility) for screening, dynamic assessment, differentiation, or intervention
8) Delivers intervention in context (e.g., classroom, playground, gym)
9) Adopts a learner centre approach
10) Uses a strength-based model of problem solving
11) Offers PT-based diagnosis and assessments
12) Documents all PT-related activities

3) Inclusive and accessible service delivery

13) Provides safe and culturally sensitive practices for all students (e.g., acknowledges the specific needs of Indigenous peoples/First Nations students)
14) Provides services which are flexible and responsive to a range of school contexts and settings
15) Uses language that is accessible when communicating with families (e.g., based on primary language, jargon-free communication, and appropriate reading levels)

4) Knowledge and professional development

16) Introduces and implements evidence-based interventions
17) Demonstrates an understanding of relevant law, policies (e.g., school health and wellbeing policies), ethical standard, and practice guidelines
18) Demonstrates an understanding of the school and classroom culture
19) Is aware of community-level physical activity opportunities and recommends them to students
20) Takes responsibility for continued learning through self-reflection and professional development
21) Is involved in professional activities to train and mentor new physiotherapists and those who are unfamiliar with school-based PT

5) Partnership and teamwork

22) Is committed to interdisciplinary and multidisciplinary approaches to deliver high-quality services to schools and students
23) Collaborates with health care professionals (at primary, secondary and tertiary care services) regarding students' medical issues
24) Takes some responsibilities for being a conduit between the health and education systems
25) Uses a cross-agency service delivery process (e.g., partnerships with the community)
26) Facilitates a student's, family's, and teacher's active partnership and participation in the process
27) Is part of school team and has a role at departmental policy and procedure planning
28) Collaborates with students, families, school personnel and other service providers to identify common needs and goals, and co-create interventions to reach the identified goals
29) Uses a collaborative approach to communication and problem-solving, and demonstrates respect for the expertise of the school personnel and input of each team member (e.g., students, families, school personnel)

6) Coaching and knowledge translation

30) Builds the capacity of school personnel and families regarding[2]
   a) identification of students with atypical development that may be indicative of a health condition
   b) the likelihood and consequence of secondary health conditions
   c) the role and expertise of physiotherapy professional
   d) the importance of well-functioning motor skills and physical activity
31) Supports school personnel to identify changes in performance or function that require physiotherapy support
32) Facilitates the capacity of school personnel and families to generalize successful strategies and implement accommodations
33) Explicitly communicates the rationale for utilizing evidence-based strategies to build the capacity of the school personnel
34) Supports school personnel in differentiating instruction
35) Coaches the school personnel to support the implementation of strategies within the classroom
36) Supports families in the implementation of successful strategies at home, at school, and in the community
37) Follows-up with school personnel and families regarding strategies previously trialed

7) Schoolwide[3] and UDL[4] strategies

38) Is committed to continuous improvement of outcomes for individual students and personnel, and throughout the school
39) Adopts a schoolwide approach for initiatives and interventions to serve all students
40) Modifies the environment in line with UDL principles to benefit all learners
41) Collaborates with school personnel to design educational activities consistent with UDL principles

Categories of tiered interventions

Based on the comments of Delphi participants, Tier 1 interventions were considered as "*universal supports*" accounted for all students, Tier 2 interventions for students in need of "*additional supports*", and Tier 3 interventions for students in need of "*individualized or comprehensive supports*". Agreement was reached for a total of 37 Tier 1 interventions, 24 Tier 2 interventions, and 60 Tier 3 interventions, which were condensed and presented as 13 main statements and 20 sub-statements for Tier 1, 18 main statements and 3 sub-statements for Tier 2, and 47 statements and 4 sub-statements for Tier 3. There were also 4 interventions that were relevant to all Tier levels (see Table 3).

Tiered interventions were grouped under 15 categories according to their end goal, i.e.., what they target. When an intervention targeted more than one goal, they were only placed under one category, i.e., the most relevant targeted goal. An overview of the tiered interventions under 15 categories was presented below, along with the comments of some participants regarding some statements for which agreement was not reached.

1) Earlier and more accurate identification of needs

Participants agreed that PTs should observe students in different school contexts (e.g., school yard, during recess), perform environmental scans and needs assessment (e.g., documenting existing resources and services, identifying funding streams supporting the existing resources, identifying the needs for resources, services, and activities) and screen students' motor competencies (e.g., for balance, developmental delay). Participants chose not to retain some statements as they were considered to potentially fall within the scope of other professionals in some contexts (e.g., scoliosis screening school nurses, back pain by physicians, and sports screening by athletic

therapists in some countries). Tier 2 interventions included the evaluation of at-risk students (e.g., through group activities) and referrals to a physician as needed. However, some participants expressed their concerns regarding their countries/ provinces' policies and legislations which precludes PTs from conducting assessments without a physician`s referral. Workplace assessments and using exercise tracking forms to monitor physical activity were also suggested yet did not reach an agreement as they were considered as interventions that were within the scope of other professionals (e.g., occupational therapists (OTs), and physical education (PE) teachers, respectively). To identify the needs of a student in Tier 3 level, various assessments were agreed upon that consisted of observational assessment, environmental assessment, needs assessment, collaborative assessment (e.g., PTs and OTs together), task analysis, and full assessment of a student. Although yearly assessment was stated as the standards of practice in some countries it did not reach a consensus. Further, participants agreed that PTs should get involved in the assessment and management of children with multiple learning disabilities.

2) Enhanced goal attainment

Interventions included here relate mainly to working collaboratively with school personnel, families, and students for goal setting and how to best address the needs of students. For example, setting educationally relevant goals with families, students, and school personnel, and collaboratively developing a transition plan were examples of Tier 3 interventions. Transition was term used broadly and referred to the transition to schools, from one grade level to another, elementary to secondary, school to work, and school to the community, and it is also sometimes used to express the transition between classrooms or from a classroom to playground.

3) Skill development

Participants agreed upon supporting school personnel in the use of motor learning principles for all Tier levels. Tier 2 additionally included some interventions (e.g., group activities) focused on enhancing functional capacity, problem-solving skills, access, and participation in the school context. One-on-one interventions with students (e.g., stairs training) were also suggested to improve the motor skills of students in schools (Tier 3). Surprisingly, some skill development interventions which were initially proposed were not retained. Some participants commented that these might fall within the scope of other professionals (e.g., backpack strategies or training transportation staff regarding safe transportation of students with disabilities).

4) Increased participation in the school context

No example was generated by the participants or reached a consensus for Tier 1 interventions. The interventions agreed upon by the participants for Tier 2 and 3 were directly related to participation within the school context, such as facilitating movement break in the classroom (Tier 2), or implementing ADL strategies, accommodation, and adaptive activities to improve participation in school activities (Tier 3).

5) Increased participation in everyday context

Assisting students to access community organization and resources (Tier 1), providing advice for families on increasing activity at home (Tier 2) and implementing interventions to address limited community participation (Tier 3) were examples of interventions that participants perceived should be implemented by PTs.

6) Increased physical activity and physical fitness

Interventions included supporting school personnel to implement schoolwide initiatives for physical activity (Tier 1), playground activities (Tier 2), and provision of performance- and health-related physical fitness training (Tier 3). Some participants expressed that sport and leisure time initiatives (Tier 1) are not organized by the schools but addressing this issue may be beyond PTs' role. Participants also disagreed on the inclusion of obesity-related interventions as common practice or clear priority due to inadequate staffing, as expressed by one participant.

7) Increased quality of life and health

Interventions suggested in this category were only provided for Tier 1 and included building the capacity of the school personnel and families as it relates to health promotion, assisting students with their queries and concern regarding health and function, and building collaborative networks with the community to promote health. No suggestion for interventions on Tier 2 and 3 were provided by the participants.

8) Reduced risk of injury

Interventions in this category were related to safety and fall prevention that included collaborating with physical education teachers for access and safety of all students (Tier 1), coaching school personnel for fall prevention strategies and safe manual handling for a specific student (Tier 3), and individualized training for students related to balance strategies (Tier 3). No example was generated by the participants or reached a consensus for Tier 2 interventions.

9) Greater sense of inclusion

Some PT interventions such as schoolwide sporting events (Tier 1) and providing adjustments for inclusive mealtime (Tier 2) reached a consensus to support inclusive practice. No example was generated by the participants or reached a consensus for Tier 3 interventions.

10) Decreased level of impairment

No example was generated by the participants or reached a consensus for Tier 1 and 2 interventions. The examples of impairment-focused interventions were provided for Tier 3. It included training for balance, coordination, and strength to improve participation at schools. Participants emphasized that any training aiming to addressing an impairment should be linked to participating in activities in the educational environment.

11) Improved equipment acquisition and utilization

No example was generated by the participants or reached a consensus for Tier 1 and 2 interventions. Examples for Tier 3 interventions included prescription of an appropriate assistive device, supporting the provision, modification,

and repair of equipment (e.g., developing a relationship with clinics and vendors providing equipment), trialling and adapting mobility equipment, and collaborating with school personnel during these processes.

12) Improved physical environment for learning

Tier 1 interventions included collaborating with the school administrator to improve facility design that enables access for all (e.g., flexibility in space and furniture in a lunchroom considering the needs of students with wheelchairs) and encourages physical activity (e.g., design of playground). Tier 2 interventions focused on modifications needed in the school environment to address the students' needs (e.g., classroom) and developing an environment that promotes motor learning. Similarly, creating stimulating environment (e.g., environment enhancing motor learning, allowing freedom of mobility, providing students with various experiences) was also suggested as Tier 3 intervention. Additionally, Tier 3 included some interventions for seating and mobility in the school setting (e.g., strategies to improve sitting tolerance in those using wheelchairs).

13) Increased knowledge exchange and synergy among service providers

Tier 1 interventions primarily focused on building capacity among school personnel and families regarding physical activity and its benefit, identification of at-risk students (e.g., at risk of motor delay or having coordination disorders), injury prevention, and transition-related needs, as well as that of school administrators regarding improvements to school facilities and students related to physical activity, motor skills development, health lifestyle, and common health conditions for which PT interventions are required. Tier 2 interventions focused on sharing knowledge with school personnel and families about management strategies to cope with motor difficulties, improve participation in leisure and sports activities, and manage ambulation equipment. It also included coaching school personnel to ensure the appropriate delivery of PT-based activities when a PT is not onsite; yet some participants expressed that PT-related activities should be only performed by PTs. Tier 2 interventions also included collaboration with the school nurse to present seminars to the school personnel regarding health-related topics and organizing workshops for other healthcare professionals working in the school regarding specific conditions that could be addressed through Tier 2 interventions. Telerehabilitation was also suggested for all Tiers as a way to share knowledge and strategies with school personnel.

14) Increased self-management skills and physical literacy

Participants agreed that PTs should help all students identify their strengths and needs, create meaningful ways to address their needs (Tier 1) that focuses on empowering students to overcome barriers, develop problem-solving skill and self-determination (Tier 3). No example was generated by the participants or reached a consensus for Tier 2 interventions.

15) Improved curriculum and school policy

Interventions targeting all tiers such as incorporation some

PT interventions into school curriculum and policies, and supporting research in school-based PT were agreed upon by participants.

Table 3: PT interventions[1] by Tiers and categories

1) Earlier and more accurate identification of needs	Tier 1	-Observing all students in the classroom and physical education lesson to identify their needs -Conducting screening in collaboration with school personnel and monitor the changes for a) physical activity b) balance c) motor function d) postural dysfunction e) developmental delay f) developmental coordination disorders -Conducting a school environmental scan and a needs assessment to identify the needs of students at school
	Tier 2	-Evaluating students deemed at risk by school personnel and families, and refer them to a physician if necessary -Referring a student to a physician when motor deficits or medical concerns seen at school exceed the scope of their practice -Providing small group activities for screening and assessment for students
	Tier 3	-Observational assessment of students during class-time, transitions, breaks, PE lessons, sport events, playground, and in the gym -Performing environmental assessment to identify environmental barriers for students including school building, classrooms, bathrooms, playgrounds, transportation system and fire evacuation -Conducting assessment for the need of specific equipment (e.g., walker, stander) at schools -Performing a full assessment of students -Performing individualized assessment by using functional measures -Performing a Task Analysis (e.g., sitting posture) -Performing collaborative assessment (e.g., physical therapy (PT) and occupational therapy assessments together) -Getting involved in the assessments, exercise interventions, and equipment acquisition for students with profound and multiple learning disabilities
2) Enhanced goal attainment	Tier 1	-Collaborating with families to response to the needs of students and families
	Tier 2	*No example was generated by the participants or reached a consensus*
	Tier 3	-Collaborating with school personnel[2], families[3], students to set educationally relevant goals, and collaboratively plan on how to promote the learning and achievement of a student -Developing a transition plan (e.g., transition from primary school to secondary school) for students with the family, student and school personnel -Collaborating with orthotists, outpatient physical therapists (PTs), occupational therapists (OTs) (if applicable) and athletic therapist or trainers (if applicable) to meet the needs of students
3) Skill Developments	Tier 1	-Collaborating with school personnel on certain lessons (upon request) to educate and support them to use motor learning principles
	Tier 2	-Co-creating of activities with school personnel, students, and families to enhance functional capacity of students -Educating PE teachers about motor learning principles to support physical education (PE) lessons -Liaising with other service providers (e.g., occupational therapists, speech therapist) and other school personnel to plan skill training for students -Teaching students some strategies and skills such as problem-solving skills for environmental barriers -Conducting group exercises or training with students who are a) using wheelchair (e.g., wheelchair mobility skills training), b) having gross or fine motor delay or impairment and c) presenting difficulties in playground access and skills
	Tier 3	-Collaborating with or coaching school personnel regarding a) mobility of the students at schools (e.g., classroom, bathroom, playground), b) learning new methods or ways to support a student, and c) compensation strategies -Collaborating with PE teacher on strategies to develop a skill with a specific student -Performing hands-on treatment in early stages of motor skill learning - Providing training for gross motor skills or activity -Providing training of specific skills (e.g., sports skills, strength for sitting) -Providing one-on-one training for motor planning in the context of the student's environment -Providing stair training -Providing gait or walking training -Facilitating the mobility of students as appropriate

	Tier	Example		Tier	Example
4) Increased participation in school context	Tier 1	*No example was generated by the participants or reached a consensus*	**11) Improved equipment acquisition and utilization**	Tier 1	*No example was generated by the participants or reached a consensus*
	Tier 2	Collaborating with school personnel for movement breaks in the classroom for specific student groups		Tier 2	*No example was generated by the participants or reached a consensus*
	Tier 3	-Implementing appropriate ADL strategies into school routine to facilitate access and participation of student in student activities - Implementing interventions to address activity limitations impacting their participation at schools -Implementing accommodations and individualized strategies for a student returning to school after an injury or surgery (return-to-school protocol) -Collaborating with or coaching school personnel regarding adapting activities in a gym or classroom to foster the participation in activities		Tier 3	-Prescribing appropriate assistive devices or technology (e.g., postural support, dynamic orthotics, mobility devices) -Supporting provision of necessary equipment (e.g., standing frames, walking frames, trikes, wheelchairs) -Supporting equipment acquisition, modification, adjustment, and repair to enhance the functioning of a student at school, home and in the community -Developing relationship with clinics providing wheelchair and assistive devices for students throughout the district or region -Trialing, adapting mobility equipment and assistive devices, and monitoring them -Training students for the usage of adaptive equipment or walking aids to use them safely -Collaborating with or coaching school personnel regarding a) adaptive equipment and its use for a student to maximize the functions of students b) equipment acquisition, modification, trails, adjustment, and repair c) orthotic support management d) postural support and positioning of students during school activities (e.g., positioning of a student with dysphagia at lunch or sitting ergonomics
5) Increased participation in everyday context	Tier 1	-Assisting students in accessing community organizations, resources, and activities			
	Tier 2	-Providing families of students with some tips to increase activities at home and the use of transportation			
	Tier 3	-Performing interventions to address activity limitations impacting their participation in the community -Interventions to address impairments and activity limitations impacting their participation at school or in the community			
6) Increased physical activity and physical fitness	Tier 1	-Supporting school personnel to implement a comprehensive schoolwide[4] physical activity program and schoolwide initiatives such as a) recess and lunch activities b) classroom-based physical activity (e.g., physically active lessons and active breaks during class time) c) schoolwide movement activities (e.g., Great Race) d) gross motor skill and fitness activities in the mornings and afternoons e) healthy workplace initiatives for school personnel	**12) Improved physical environment for learning**	Tier 1	-Collaborating with school (e.g., school administrator, school personnel) a) to create a supportive school environment that encourages physical activity b) regarding facility design to support access for all
	Tier 2	-Serving as a coach or consultant to support physical activity and playground activities		Tier 2	-Consulting with school personnel on modifications needed in the classrooms, bathrooms, and playgrounds to meet the needs of the students -Developing environments that promote motor learning in the context
	Tier 3	-Collaborating with or coaching school personnel and families regarding physical activity program of a student -Performance-related physical fitness training -Health-related physical fitness training (e.g., cardiorespiratory fitness, BMI)		Tier 3	-Collaborating with or coaching school personnel regarding creating a maximal stimulating environment -Providing Intervention to facilitate seating and mobility in the classroom, school building and playground
7) Increased quality of life and health	Tier 1	-Building the capacity of school personnel (e.g., seminars, workshops) regarding health promotion -Assisting students with their queries and concerns about issues such as growth, development, functioning, sports, or pain, and sensitively responding to these -Building collaborative networks (e.g., local community organization) that can be partners in promoting students` health and functioning	**13) Increased knowledge exchange and synergy among service providers**	All Tiers	-Providing telerehabilitation support (e.g., preparing e-learning materials) to school personnel
	Tier 2	*No example was generated by the participants or reached a consensus*		Tier 1	-Building the capacity of the school personnel and families (e.g., through seminars, workshops) regarding a) physical activity and its benefits on students' health status and academic achievement b) identification of at-risk students[5] who could benefit from PT interventions c) disease and injury preventions d) transition needs (e.g., transition to schools, from one grade level to another elementary to secondary, school to work, school to community) -Organizing seminars or workshops with school administrators and school personnel regarding how to improve or adapt existing school facilities (e.g., playground) -Organizing seminar, workshops, lectures with students regarding: a) physical activity and its benefits, as well as the importance of a well-functioning motor skills b) health lifestyle c) common health conditions for which physiotherapists provide service in schools (e.g., Cerebral Palsy)
	Tier 3	*No example was generated by the participants or reached a consensus*			
8) Reduced risk of injury	Tier 1	-Working with PE teachers and sports coaches regarding access and safety		Tier 2	-Building the capacity of the school personnel and families (e.g., through seminars, workshops) regarding a) management strategies for motor difficulties b) participation in leisure and sport activities c) usage and management of wheelchairs or ambulation equipment -Collaborating with school nurse to present seminars to school personnel (e.g., on the implications of chronic pain on participation in school to support students with chronic pain) -Organizing workshops to other health professionals working within the school on specific conditions of students that necessitate additional support and potential interventions -Serving as a coach or consultant to ensure the proper delivery of physical therapy (PT) based activities when PT is not onsite (e.g., providing handouts)
	Tier 2	*No example was generated by the participants or reached a consensus*			
	Tier 3	-Collaborating with or coaching school personnel regarding fall prevention strategies, and safe manual handling of a student at school (e.g., in and out of a chair, stander, walker) -One-on-one training for students regarding balance strategies to prevent or decrease fall		Tier 3	*No example was generated by the participants or reached a consensus*
9) Greater sense of inclusion	Tier 1	-Working with PE teachers and sports coaches regarding inclusive activities and schoolwide sporting events	**14) Increased self-management skills and physical literacy**	Tier 1	Promoting students' participation in co-creating meaningful ways to promote health Promoting self-determination in all students, identifying strengths and needs related to their mobility, health-related fitness, and healthy behaviors (e.g., sleep, nutrition, social-emotional strategies)
	Tier 2	-Providing support for accessible and inclusive mealtimes or lunch breaks		Tier 2	*No example was generated by the participants or reached a consensus*
	Tier 3	*No example was generated by the participants or reached a consensus*		Tier 3	-Teaching students how to advocate their own needs (self-advocacy) at school -Strengthening student agency to overcome environmental barriers at school -Teaching students self-management strategies and problem-solving skills (e.g., accessing bus, playground, physical education curriculum, transition between classrooms)
10) Decreased level of impairment	Tier 1	*No example was generated by the participants or reached a consensus*			
	Tier 2	*No example was generated by the participants or reached a consensus*			
	Tier 3	-Collaborating with or coaching school personnel to address the needs of students regarding balance, coordination, and strength -Providing interventions to address impairments impacting their participation at school or in the community -Providing strength training			

15) Improved curriculum and school policy	All Tiers	-Collaborating with the school on the health education curriculum -Collaborating with the school leadership team to enact school policy and programmes (e.g., health and safety policy for manual handling) -Supporting research in school-based PT

[1] *Intervention:* It refers as to actions being done for the management of students which includes assessments, therapies, strategies, approaches used by PTs while providing PT services at schools.
[2] *School personnel:* educators (e.g., teachers, special education teacher, physical education teachers), teacher aids/assistant, learning support team, school administrator, etc. [3] *Families may represent parent, caregivers, etc.* [4] *Schoolwide:* It means occurring or extending throughout a school [5] *At-risk students:* It refers as to students who are at risk of having developmental motor disabilities, motor skills disorders, physical disabilities/impairment, coordination disorders, motor dysfunctions, etc.

DISCUSSION

This study identified the core attributes and interventions that could be implemented as part of a collaborative tiered school-based PT service delivery model. Since service delivery models are still rare in rehabilitation [10], and even more so in the PT discipline [9], such a model could significantly advance the theory and practices in PT. Identifying core attributes and interventions and using expert consensus is among the first steps recommended in the development of new comprehensive service delivery models [20]. Consensus is often reported to be difficult to achieve [21], but in this case, despite the great diversity of participants' backgrounds and contexts, a clear and strong agreement was achieved on most of the initially generated core attributes and interventions.

Currently, the models used in PT practices have mainly been adopted from global health models (e.g., the model of disablement) [22] and the international classification of functioning [23]). The solid theoretical and consensus-based development of service delivery models could support the full scope of PT practice, moving beyond clinical practices entrenched in an impairment-oriented framework throughout the world [9]. A comprehensive service delivery model incorporating different approaches (e.g., biomedical model, biopsychosocial, and rehabilitation) is suggested for better outcomes [9]. In pediatric rehabilitation, considering the varied needs of children and adolescents (e.g., physical, mental, emotional, communicative, and relational) in the variety of contexts in which they much function every day (e.g., familial, social, and environmental) and the plethora of stakeholders (e.g., families, school personnel), a holistic model is essential [24]. The comprehensiveness of identified core attributes encompassing core principles of various models (e.g., learner-centred approach, strength-based model, UDL, response to intervention, multidisciplinary team approach) [11, 25, 26]. The fact that tiered interventions target various therapy outcomes (e.g. biomedical, functional, biopsychological, rehabilitation) show how PT interventions could be rooted in an integrated model of service and help portray the richness of PTs' scope of practice. Thus, further development of a holistic model based on the results of this study may provide the foundation for a comprehensive model that could inspire other context-specific PT practices beyond the school settings.

Collaboration, in this study, was perceived as an important core attribute of PTs' practice in school settings. Collaboration was connected to many activities, including early identification of students who need PT intervention, initial assessment, goal setting, preparing a management plan, the implementation of PT strategies, and the management of transition plan, which entailed very different types of interactions with multiple stakeholders. For example, collaboration could focus more on building school personnel and families' abilities to participate in early identification of children presenting developmental red flags or using coaching strategies with school personnel in the classroom or in the gymnasium. Collaboration could also include interactions grounded in teamwork and partnership, to work within an interdisciplinary team and/or engage with community partners to address the transition needs of a student. The potential of overlapping scope of practice with other professionals was also raised as an opportunity for collaborative goal setting and intervention management. For instance, children's skills and physical fitness could both be improved when PTs and physical education teachers work together [27-29]. Moreover, some core attributes identified in this study were consistent with those attributed to occupational therapists [8], while others for which agreement was reached could also be performed by other professionals (e.g., athletic trainers, physical education teachers) in some countries. These common practices may be an opportunity to adopt a transdisciplinary team approach where applicable.

In this study, interventions suggested were mainly indirect services (e.g., consultation, collaboration, and training), though several direct services were also suggested for Tier 1 (e.g., screening for the motor delay) or Tier 3 (e.g., individualized training) interventions. This seems to differ significatively from actual state of practice in most countries. For example, in the USA, the majority of time in school-based PT is spent in direct services (67%) [30]. The services are mostly provided independently of school activities with very little time invested working with students within the classroom context [30]. In our study, however, the integration of most of the identified interventions, both direct (e.g., individualized) and indirect (e.g., collaborative) were recommended to be performed within classroom or school setting in collaboration with school-related stakeholders. If indirect services require consultation and training, the participants also suggested telerehabilitation as an alternative to an in-person visit. School-based therapists who have recently employed telerehabilitation planned on sustaining the use of telehealth into future practice; furthermore, they found it beneficial to improve communication, team relationships, service access, consultation and carry-over of treatment interventions with team members and possibly family members [31]. Telerehabilitation as a delivery model was also suggested for counterbalancing staff shortages [31]. The concern about staff shortage was indeed a limited factor for our participants to generate new areas of interventions (e.g., interventions for obesity management) and render feasible a consistent PT presence in schools (e.g., weekly). Implementing telerehabilitation for PT service may provide a solution and offset service delivery shortages and service access issues.

The results of this study should be considered in the light of some limitations. We attempted to develop international

guiding principles for collaborative tiered school-based PT with global participation. Although we were able recruit participants from different parts of the world (e.g., North America, Asia, Oceania, Europe), it may not be representative of some specific contexts around the globe. On the other hand, our participants were diverse in terms of experience and their roles (e.g., clinician, researcher, manager) in school-based PT thus ensuring that diverse perspectives in the scope were captured. They might however represent perspectives of members familiar with the rehabilitation literature and might thus not represent the views of all clinical leaders. Moreover, some of the interventions they proposed were expressed as general statements (e.g., implementing interventions to address activity limitations) and were presented in the results under the Tier where it has been mentioned; yet, these statements might inform interventions for other Tier. This illustrate that our results, especially for the interventions, might be only a broad view of all the different interventions possible. This also remain us that the services should be designed to respond to students' needs, and students might receive at the same time services associated to Tier 1, Tier 2 and Tier 3. The main limitation of our study, however, relate to the fact that the core attributes and interventions proposed might not yet be supported by caseload models and policies, and might thus be challenging to implement in many countries. Yet, the intent of the study was to create a vision on which to build to improve PT services in schools.

CONCLUSION

This study identified the core attributes and tiered interventions of a potential collaborative tiered school-based PT service delivery model. The identified core attributes were shaped around goals of the practice, using interdisciplinary and multidisciplinary approaches through four pillars of collaboration (teamwork, partnership, knowledge translation and coaching), providing services that are aligned with the school curriculum, providing inclusive and accessible services, adopting schoolwide approach and UDL strategies, professional duties of PTs (e.g., documentation, professional development) and specific PT strategies (e.g., using learning centered approach, strength-based models). The tiered interventions were provided in three levels, and grouped according to their end goal, i.e., what they target. We believe that these elements can serve as building blocks for tailoring service delivery in school settings and recognizing the unique national policies and regulations that exist in different countries.

REFERENCES

[1] North, S. and D.G. Dooley, *School-Based Health Care.* Primary Care: Clinics in Office Practice, 2020. **47**(2): p. 231-240.

[2] Mccoy, S.W., et al., *School-based physical therapy services and student functional performance at school.* Developmental Medicine & Child Neurology, 2018. 60(11): p. 1140-1148.

[3] Education, U.S.D.o. *Individuals with Disabilities Education Act* 2004; Available from: https://sites.ed.gov/idea/.

[4] Effgen, S.K. and M.K. Kaminker, *Nationwide survey of school-based physical therapy practice.* Pediatr Phys Ther, 2014. 26(4): p. 394-403.

[5] SeekFreaks. *SEEKER'S CORNER:Response to Intervention, Multiple Tier Systems of Support & Physical Therapy.* 2015; Available from: https://www.seekfreaks.com/index.php/2015/10/29/rti-pt/.

[6] Millerat. *NC MTSS Implementation Guide.* 2019; Available from: https://www.livebinders.com/play/play?id=2052295.

[7] Dean, J., *Special needs in the secondary school: The whole school approach.* Vol. 15. 2018: Routledge.

[8] Missiuna, C.A., et al., *Partnering for change: an innovative school-based occupational therapy service delivery model for children with developmental coordination disorder.* Can J Occup Ther, 2012. **79**(1): p. 41-50.

[9] Bello, A., *Practice: A need for integration towards better patient care.* African Journal of Physiotherapy and Rehabilitation Sciences, 2012. **4**(1-2): p. 51-56.

[10] King, G.A., et al., *Bringing the Life Needs Model to life: implementing a service delivery model for pediatric rehabilitation.* Phys Occup Ther Pediatr, 2006. **26**(1-2): p. 43-70.

[11] Kennedy, J., et al., *A scoping review to explore how universal design for learning is described and implemented by rehabilitation health professionals in school settings.* Child Care Health Dev, 2018. **44**(5): p. 670-688.

[12] APTA. *The role of School-based Physical Therapy: Successful participation for All Students* 2012; Available from: https://pediatricapta.org/includes/fact-sheets/pdfs/12%20Role%20and%20Scope%20in%20Fitness%20Health%20Promo.pdf.

[13] Keeney, S., F. Hasson, and H. McKenna, *The Delphi technique in nursing and health research.* 2017.

[14] Jünger, S., et al., *Guidance on Conducting and REporting DElphi Studies (CREDES) in palliative care: Recommendations based on a methodological systematic review.* Palliat Med, 2017. **31**(8): p. 684-706.

[15] Chalmers, J. and M. Armour, *The Delphi Technique,* in *Handbook of Research Methods in Health Social Sciences,* P. Liamputtong, Editor. 2019, Springer Singapore: Singapore. p. 715-735.

[16] Sumsion, T., *The Delphi technique: an adaptive research tool.* British Journal of Occupational Therapy, 1998. **61**(4): p. 153-156.

[17] Elo, S., et al., *Qualitative content analysis: A focus on trustworthiness.* SAGE open, 2014. 4(1): p. 2158244014522633.

[18] Team, R.C. and *R: A language and environment for statistical computing.* R Foundation for Statistical Computing 2013; Available from: http://www.R-project.org/.

[19] VanderKaay, S., et al., *Tiered Approaches to Rehabilitation Services in Education Settings: Towards Developing an Explanatory Programme Theory.* International Journal of Disability, Development and

Education, 2021: p. 1-22.

[20] Indicators, A., *Monitoring the building blocks of health systems.* WHO Document Production Services, Geneva, Switzerland, 2010.

[21] Falzarano, M.P.O.T.R. and G.P.E.P.T. Zipp, *Seeking Consensus Through the Use of the Delphi Technique in Health Sciences Research.* Journal of Allied Health, 2013. 42(2): p. 99-105.

[22] Sullivan, K.J. and S.Y. Cen, *Model of disablement and recovery: knowledge translation in rehabilitation research and practice.* Physical therapy, 2011. 91(12): p. 1892-1904.

[23] Stucki, G., A. Cieza, and J. Melvin, *The International Classification of Functioning, Disability and Health (ICF): a unifying model for the conceptual description of the rehabilitation strategy.* J Rehabil Med, 2007. 39(4): p. 279-85.

[24] King, G., et al., *A life needs model of pediatric service delivery: services to support community participation and quality of life for children and youth with disabilities.* Phys Occup Ther Pediatr, 2002. 22(2): p. 53-77.

[25] Pivik, J., J. McComas, and M. Laflamme, *Barriers and facilitators to inclusive education.* Exceptional children, 2002. 69(1): p. 97-107.

[26] Pelham Jr, W.E., et al., *Implementation of a comprehensive schoolwide behavioral intervention: The ABC Program.* Journal of Attention Disorders, 2005. 9(1): p. 248-260.

[27] Cohn, S.L., *School-based practice: physical therapists collaborating with physical education teachers. Give it a try!* Phys Occup Ther Pediatr, 2007. 27(3): p. 4.

[28] Brink, Y., R.A. Maart, and Q.A. Louw, *School-based interventions to improve spinal health of children and adolescents: a systematic review.* Physiotherapy Theory and Practice, 2021: p. 1-24.

[29] Boll, M. and E. Boström-Lindberg, *Physiotherapists' understanding and approach to health promotion work in compulsory school: Perceiving and supporting coherence.* Physiotherapy Theory and Practice, 2010. 26(5): p. 318-326.

[30] Jeffries, L.M., et al., *Description of the Services, Activities, and Interventions Within School-Based Physical Therapist Practices Across the United States.* Phys Ther, 2019. 99(1): p. 98-108.

[31] Abbott-Gaffney, C. and K. Jacobs, *Telehealth in school-based practice: Perceived viability to bridge global OT practitioner shortages prior to COVID-19 global health emergency.* Work, 2020. 67(1): p. 29-35.

Appendix-1: Core attribute statements generated in Round 1 and percent agreement in Round 2 and 3

✓: An agreement was reached in the previous round

Core attributes suggested by the participants in Round 1 (N=24)	Round 2 N=23	Round 3 N=22
1) Supports educators in designing educational activities consistent with universal design approaches	96 %	✓
2) Supports educators in differentiating instruction	83 %	✓
3) Facilitates the educator's capacity to generalize successful strategies and implement accommodations a. Modified after Round 2 as "Facilitates the capacity of school personnel and families to generalize successful strategies and implement accommodations"	91 %	✓
4) Supports families in the implementation of successful strategies at home, at school, and in the community. (Keep as is)	100 %	✓
5) Uses a collaborative approach to communication and problem-solving, demonstrating respect for the expertise of the educator	100%	✓
6) Demonstrates an understanding of the school and classroom culture	100 %	✓
7) Explicitly communicates the rationale for utilizing trialed strategies to build the capacity of the educator a. Modified after Round 2 as "Explicitly communicates the rationale for utilizing trialed strategies to build the capacity of school personnel "	91 %	87 %
8) Models techniques to try when teaching a skill within the classroom	78 %	78%
9) Coaches the educator to support the implementation of strategies within the classroom	100 %	✓
10) Follows-up with educators regarding strategies previously trialed 11) Modified after Round 2 as "Follows-up with school personnel and families regarding strategies previously trialed"	96 % 66 %	91 % 55 %
12) Spends time at the school each week	91 %	✓
13) Modifies the environment in line with universal design principles to benefit all learners	83 %	✓
14) Uses regular curriculum activities (e.g. journaling, circle time, construction centre) for screening / dynamic assessment / differentiation / intervention	67 %	23 %
15) Uses Dynamic Performance Analysis as their primary assessment method	100 %	✓
16) Delivers intervention in context (e.g. classroom, playground, gym)	16)83%	16) 86 %
17) Builds the capacity of school team (e.g., educators, school support team) regarding 18) Modified after Round 2 as "Builds the capacity of school personnel and families regarding" 19) identification of children with atypical development that may be indicative of a health condition 20) the likelihood and consequence of primary and secondary health conditions 21) identification of the changes in the performance or function that require physiotherapy support or follow-up assessment 22) the expertise of physiotherapy professional 23) the importance of well-functioning motor skills and physical activity	17)91 % 18)88 % 19)91 % 20)91 %	17) 82 % 18) 91 % 19) 76 % 20)86 %
24) Focuses on participation, wellness and achievement, rather than deficit	100 %	✓
25) Provides services that are aligned with curriculum goals, and evidence-based teaching strategies	96 %	✓
26) Advocates for school access and inclusive practices	100 %	✓
27) Promotes participation in school routine, peer interactions and community involvement	100 %	✓
28) Promotes general health and healthy lifestyle for students, educators and families	96 %	✓
29) Provides culturally safe and sensitive practices for all children	96 %	✓
30) Acknowledges the specific needs of Indigenous Peoples / First Nations students when applicable	79 %	82 %
31) Is committed to continuous improvement of outcomes at the level of students and schoolwide	92 %	✓
32) Measures outcomes at the levels of the student, school and whole-of-service	79 %	69 %
33) Provides services which are flexible and responsive to a range of school contexts and settings	100 %	✓
34) Prepares students for transitions especially transition to post-secondary education, employment, and independent living	87 %	✓
35) Adopts a learner centre approach and facilitates a student's, family's, and teacher's active partnership and participation in the process	96 %	✓
36) Uses a strength-based model of problem solving	96 %	✓
37) Adopts a schoolwide approach for service delivery to serve all students	87 %	✓

38)	Is committed to interdisciplinary and multidisciplinary approaches to deliver high-quality services to schools and students	100 %	✓
39)	Collaborates with students, families school personnel and other service providers to identify common needs and goals and co-create interventions to reach the identified goals	100 %	✓
40)	Uses a cross-agency service delivery process including partnerships with the community	83 %	✓
41)	Collaborates with medical professionals (at primary, secondary and tertiary care services) regarding students' medical issues	96 %	✓
42)	Acts as a conduit between the health and education systems	79 %	91 %
43)	Is part of school team and has a role at departmental policy and in procedure planning	92 %	✓
44)	Introduces and implements scientific-based interventions	87 %	✓
45)	Screens the children at the certain intervals	62 %	73 %
46)	Introduce and implement initiatives, strategies and action plans regarding physical activity	79 %	78 %
47)	Documents all PT-related activities	87 %	✓
48)	Uses language that is accessible when communicating with families (e.g., based on primary language, jargon-free communication and appropriate reading levels)	96 %	✓
49)	Offers PT diagnostic assessments	87 %	✓
50)	Offers individual interventions in a therapy room	32 %	29 %
51)	Demonstrates an understanding of relevant law, policies (e.g., school health and wellbeing policies), ethical standard, and practice guidelines	92%	✓
52)	Is aware of community-level physical activity opportunities and recommends them to students	83 %	✓
53)	Demonstrates advocacy and leadership skills at the local, state, and national levels	79 %	78%
54)	Takes responsibility for continued learning through self-reflection and professional development	87 %	✓
55)	Is involved in professional activities to train and mentor new physiotherapists who are unfamiliar with school-based PT	83 %	✓
56)	Engages in professional activities and mentorship for own practice (Added after Round 2)	-	73 %

Tier 1 interventions generated in Round 1 and percent agreement in Round 2&3

✓: An agreement was reached in the previous round

Tier 1 interventions suggested by the participants in Round 1 (N=24)	Round 2 N=23	Round 3 N=21
1) Observing students in the classroom and physical education (PE) lesson to identify their needs	96 %	✓
Conduct screening in collaboration with school personnel and monitor the changes for 2) physical activity 3) physical well-being 4) general health status (e.g., body mass index) 5) strength 6) balance 7) motor function 8) scoliosis 9) back pain 10) postural dysfunction 11) developmental delay 12) developmental coordination disorders 13) sports injury screening 14) other condition that could impede physical activity in students	2) 96 % 3) 78 % 4) 62 % 5) 78 % 6) 83 % 7) 92 % 8) 70 % 9)70 % 10)83 % 11) 83% 12)78% 13) 53 % 14) 70%	2) ✓ 3)66 % 4)57 % 5)66% 6)✓ 7)✓ 8) 62% 9) 52% 10)✓ 11)✓ 12) 81% 13)22% 14)76%
15) Conducting a school environmental scan and a needs assessment to identify the needs of students at school	92%	✓
16) Providing developmental charts and/or checklists to educators to facilitate their ability to appropriately refer children for further screening or evaluation	74%	76%

Training of educators, teacher aids, and learning support team through professional developmental courses, seminars, etc. regarding 17) health and disability at each age 18) identification of at-risk students who benefit from PT interventions 19) type of school placement (e.g., special education placement, self-contained educational placement) 20) physical activity and its benefits on students' health status, academic achievement 21) health promotion, injury and disease prevention 22) manual handling 23) back care 24) public health approaches 25) transition needs (e.g., transition from class to class, elementary to secondary, school to work, school to community) (arose during Round 2 process)	17)74 % 18)87% 19)61 % 20) 87% 21)83 % 22)57% 23)70% 24)66 % 25)-	17)71 % 18)✓ 19)42 % 20)✓ 21)✓ 22)71% 23)76% 24) 76% 25)81%
26) Organizing seminars or workshops with transportation staff regarding safe transportation of students with disabilities (e.g., getting on and off buses, proper seating)	78 %	76%
27) Organizing seminars or workshops with school administrators and school personnel regarding how to improve or adapt existing school facilities (e.g., playground)	92%	✓
28) Providing leaflets regarding in-class developmental play ideas and how these assist developmental of physical fitness and strength.	70%	66%
29) Guidance for educators on proper fitting backpacks and appropriate weight	66%	62%
Supporting school personnel to implement a comprehensive schoolwide physical activity program and school-wide initiatives such as: 30) before or/and after school activities (e.g., an active way to school encouraging children to walk or bike) 31) recess and lunch activities 32) classroom-based physical activity (e.g., physically active lessons and active breaks during class time) 33) field day and clubs that include a physical activity component such as walking or gardening clubs 34) supporting school in creating a school environmental that encourages physical activity 35) supporting facility design processes to support access for all 36) schoolwide movement activities (e.g., Great Race) 37) gross motor skill and fitness activities in the mornings and afternoons 38) stress and mental health management (e.g., depression and anxiety management through exercise and breathing technique) 39) healthy workplace initiative for school personnel	30)66% 31)78% 32)87% 33)78% 34)87% 35)92% 36)92% 37)74% 38)61% 39)83%	30)66% 31)81% 32)✓ 33)62% 34)✓ 35)✓ 36)✓ 37)81% 38)57% 39)✓
40) Working with PE teachers and sports coaches regarding inclusive activities, schoolwide sporting events, access and safety	91%	✓
41) Coaching sport teams regarding the importance of preventative care in sport and physical activities (e.g., helmets for cycling)	53%	57%
42) Collaboratively planning best practices in manual handling, restrictive practices, preventive care	74%	76%
43) Collaborating with the school on the health education curriculum	83%	✓
44) Collaborating with the school leadership team to enact school policy and programmes (e.g., health and safety policy for manual handling)	83%	✓
Collaborating with educators on certain lessons (upon request) 45) to educate and support them 46) to use compensatory movement	45) 66% 46) 61%	45)90% 46)61%
Offering training to families through seminars or workshops 47) physical activity and its benefits on children's health status and academic achievement 48) proper fitting backpacks and appropriate weight 49) manual handling 50) the needs and worries that families and children bring up 51) back care 52) any topic regarding disability	47)87% 48)70% 49)61% 50)74% 51) 62% 52)74%	47) ✓ 48) 48 % 49)52 % 50)62 % 51)57 % 52)76 %
53) Guidance for families on proper fitting backpacks and appropriate weight	61%	57%
54) Collaborates with families to response to the needs of students and families.	83%	✓
Organize seminar, workshops, lectures with children regarding: 55) physical activity and its benefits, as well as the importance of a well-functioning motor skills 56) the needs and worries of families and children 57) healthy lifestyle 58) common health conditions for children that physiotherapists service in schools (e.g., Cerebral Palsy)	55)92% 56)78% 57)83% 58)83%	55)✓ 56)76% 57)✓ 58)✓
59) Identifying students' own worries regarding growth, development, functioning, sports, pain etc. and responding to them	78%	90%
60) Promoting students' participation in co-creating meaningful ways to promote health	92%	✓

	Round 2	Round 3
61) Promoting self-determination in all children, identifying strengths and needs related to their mobility, health-related fitness and healthy behaviors (sleep, nutrition, social-emotional strategies) (Arose during Round 2)	-	91%
62) Assisting students in accessing community organizations, resources, and activities	78%	81%
63) Group lessons on how to use a community gym for lifelong fitness opportunities	78%	71%
64) Coordinating promotional events in schools to raise awareness of disability and its impact on school access	74%	71%
65) Using pictograms about basic ergonomics for younger students	66%	57%
Handling out leaflets including information regarding 66) postural education and back pain 67) ergonomics (e.g., amount of sitting vs. standing for learning)	66)53% 67)53%	66)38% 67)38%
68) Displaying informative graphics on the boards in the school.	57%	52%
69) Communicating with local physicians about PT expertise and the role of the PT in schools	78%	76 %
70) Closely collaborating with school nurse and other personnel on access and safety, and to identify students' other needs	92%	✓
71) Building collaborative networks (e.g., local community organization) that can be partners in promoting students` health and functioning	92%	✓
72) Providing tele rehabilitation support (e.g., designing e-learning materials) to educators	87%	✓
73) Support research in school-based PT	82%	✓
74) Exposing students the roles of physiotherapists (as a potential career option)	70%	66%

Tier 2 interventions generated in Round 1 and percent agreement in Round 2&3

✓: An agreement was reached in the previous round

Tier 2 interventions generated in Round 1 (N=24)	Round 2	Round 3
1) Small group activities for screening and assessment	83%	✓
2) Evaluating students deemed at risk by educators, school personnel, families, and refer them to a physician if necessary	78%	85%
3) Workplace assessment and management plan for small groups of students undertaking work experience	74%	57%
4) Monitoring physical activity level using an exercise tracking form for all students	45%	29%
5) Monitoring students with continued impairment	74%	71%
6) Providing accessibility options for school excursion or camps	74%	85%
Group activities for students with high needs such as: 7) physical education circuit programmes 8) trike riding sessions 9) group hydrotherapy sessions	7)78% 8)66% 9)61%	7)76% 8)38% 9)38%
Group exercises or training with students who are: 10) not currently participating in school sport to prepare them to enter sports programs 11) using wheelchair (e.g., wheelchair mobility skills training) 12) with gross or fine motor delay or impairment 13) with obesity 14) presenting difficulties in performing two tasks at the same time who may be at risk of coordination disorders or attention deficit 15) having postural dysfunction (e.g., postural camp) 16) athletes or those who perform sport activities at high level (e.g., sport injuries prevention) 17) with cognitive impairment (e.g., gym sessions) 18) with decreased hand-eye coordination to address ball skills including catching, throwing, etc. 19) presenting difficulties in playground access and skills 20) undertaking work experience (e.g., skill development, education for adaptations) 21) with low levels of physical activity (e.g., physical activity camp)	10)66% 11)87% 12)96% 13)78% 14)78% 15)66% 16)40% 17)66% 18)74% 19)83% 20)66% 21)61%	10)43% 11)✓ 12)✓ 13)52% 14)71% 15)52% 16)28% 17)66% 18)52% 19)✓ 20)62% 21)47%

Teaching students some strategies and skills such as: 22) self-management skills 23) problem solving skills for environmental barriers 24) work-related skills 25) sport skills 26) travel training to use public transportation 27) motor skill development for reading 28) motor skill development for mathematics	22)74% 23)83% 24)74% 25)74% 26)57% 27)48% 28)48%	22)76% 23)✓ 24)76% 25)57% 26)62% 27)42% 28)42%
29) Psychomotor activities for students who could benefit from it (e.g., yoga, relaxation, therapeutic movement play)	74%	76%
30) Coaching at-risk students to develop a healthy lifestyle	70%	76%
31) Co-creating of activities with educators, students and families to enhance functional capacity of students	87%	✓
32) Educating PE teachers about motor learning principles to support PE lessons	87%	✓
33) Collaborating with educators on certain lessons (upon request) to educate and support them to use motor learning principles	87%	✓
34) Providing low-tech assistive technology (e.g., active sitting devices, devices for hand-writing) for small groups	74%	66%
35) Providing support for accessible and inclusive mealtimes or lunch breaks	83%	✓
36) Developing environments that promote motor learning in the context	87%	✓
37) Providing school personnel with orientation process (demonstration and guidance) regarding safe manual handling	70%	71%
38) Providing workshops on pacing and energy conservation strategies for educators, regarding students with chronic conditions or recuperating from an injury (e.g., concussion, spinal surgery)	78%	76%
39) Consulting with educators and school administration on modifications needed in classrooms, bathrooms, and playgrounds to meet the needs of their students	87%	✓
40) Consulting with transportation staff on bus modifications, for safe transportation on buses and ease of bus evacuation during an emergency	78%	66%
41) Collaborating with educators for movement breaks for specific student groups.	87%	✓
Serving as a coach or consultant 42) to support educators and classroom aides in supporting all students in/out of classroom 43) to support physical activity and playground activities 44) to ensure the proper delivery of PT based activities when PT is not onsite (e.g., by providing handouts) Modified as "consultant to ensure the proper delivery of PT based activities when PT is not on site (e.g., by providing handouts, training/demo, monitoring/checks, supports like photos of correct set up) after Round 2 " 45) for provision of orientation processes to schools with regards to safe manual handling.	42)79% 43)87% 44)89% 45)83%	42)76 % 43)✓ 44)76 % 45)✓
Providing training for physical education (PE) teachers on Modified after Round 2 as "Collaborate with physical education teachers to guide them regarding " 46) grading sport drills 47) adapting sport drills (e.g., dribbling drills) 48) ability development (e.g., ball throwing) 49) energy conversation strategies for youth 50) chronic conditions and recuperation from an injury (e.g., concussion)	46)44% 47)61% 48)57% 49)70% 50)70%	46)42% 47)62% 48)57% 49)62% 50)57%
Collaborating with PE teachers 51) to provide group exercises for students presenting with low level of physical fitness 52) to organize integrated group activities (e.g., as dance programs)	51)74% 52)61%	51)57% 52)62%
Organising seminars with families of students with motor difficulties regarding 53) management strategies for motor difficulties 54) participation in leisure and sport activities 55) usage and management of wheelchairs or ambulation equipment	53)96% 54)96% 55)92%	53)✓ 54)✓ 55)✓
56) Organizing seminars with families of students with obesity regarding management strategies for obesity and related complications	66%	57%
57) Providing families of students with special needs with some tips to increase activities at home, and use of transportation	87%	✓

58) Referring students with suspected of motor impairment to a physician Modified as "When motor deficits or medical concerns seen at school exceed the scope of their practice, physical therapists will refer them back to their medical provider"	92%	86%
59) Liaise with school-based occupational therapist to plan skill training Modified as "Liaise with other service providers (e.g., occupational therapists, speech therapist) and other school team members (e.g., special education teachers, learning support team) to plan skill training"	87%	95%
60) Workshops to other health professionals working within the school on specific conditions or physical interventions	70%	81%
61) Collaborating with school nurse to present seminar to school personnel on implications of chronic pain on participation in school	92%	✓
62) Developing relationship with clinics providing wheelchair and assistive devices for students throughout the district or region	87%	✓

Tier 3 interventions generated in Round 1 and percent agreement in Round 2&3

✓: An agreement was reached in the previous round

Tier 3 interventions generated in Round 1 (N=24)	Round 2	Round 3
1) Performing observational assessment of students during class-time, transitions, breaks, PE lessons, sport events, playground, and in the gym	100%	✓
2) Performing a full assessment of students with physical disabilities	91%	✓
3) Performing a Task Analysis (e.g., sitting posture)	96%	✓
4) Assessment for the need of specific equipment (e.g., walker, stander) at schools	96%	✓
5) Individualized assessment by using functional measures	96%	✓
6) Performing yearly assessment for students with motor impairment	66%	57%
7) Developing a management plan with families and school	87%	✓
8) Developing a transition plan with families (e.g., transition from primary school to secondary school) for students with motor impairments Modified as "Developing a transition plan with the family, student and school personnel (e.g., transition from primary school to secondary school) for students with motor impairments"	91%	90%
9) Performing collaborative assessment (e.g., PT and OT assessments together)	91%	✓
10) Performing environmental assessment to identify environmental barriers for students with physical challenges including school building, classrooms, bathrooms, playgrounds, transportation system and fire evacuation	91%	✓
11) Provision of all equipment (e.g., standing frames, walking frames, trikes, wheelchairs	91%	✓
12) Application for funding for equipment	70%	76%
13) Collaborating with orthotists, outpatient PTs/OTs and AT specialists to meet the needs of students	91%	✓
Collaborating with or coaching school personnel (e.g., educators, learning support team) to address the needs of students regarding 14) setting educationally relevant goals and collaboratively plan on how to promote students` learning and achievement 15) balance, coordination, and strength 16) accommodations and individualized strategies for a child with a disability 17) adaptive equipment and its use for a student to maximize functions of students 18) adapting activities in a gym or classroom to foster the participation of a child with a disability 19) mobility of the students in the schools (e.g., classroom, bathroom, playground) 20) postural support and positioning of students during school activities (e.g., positioning of a student with dysphagia at lunch or sitting ergonomics) 21) creating a maximal stimulating environment for students with motor impairment 22) physical activity program for students 23) learning new methods or ways to support a student in need 24) safe manual handling of a students at school (e.g., in and out of a chair, stander or walker) 25) equipment acquisition, modification, trails, adjustment and repair 26) fall prevention strategies 27) compensation strategies for students with motor impairment 28) orthotic support management 29) accommodations and individualized strategies for a student returning to school after an injury or surgery (return-to-school protocol)	14)100% 15)87% 16)100% 17)96% 18)100% 19)100% 20)91% 21)78% 22)87% 23)91% 24)91% 25)91% 26)87% 27)87% 28)87% 29)91%	14) ✓ 15) ✓ 16) ✓ 17) ✓ 18) ✓ 19) ✓ 20) ✓ 21)86% 22) ✓ 23) ✓ 24) ✓ 25) ✓ 26) ✓ 27) ✓ 28) ✓ 29) ✓
30) Collaborating with PE teacher on strategies to develop a skill with a specific student	91%	✓
31) Facilitating inclusion of students with disabilities in PE class and other activities in the school	96%	✓

Collaborating with or coaching families to address the needs of children regarding: 32) setting educationally relevant goals and collaboratively plan on how to promote students` learning and achievement 33) accommodations and individualized strategies for a student with a disability 34) orthotic support and an exercise program for students who need orthotic support such as cerebral palsy, pes planus, etc. 35) a maximal stimulating environment for students with motor impairment 36) compensation strategies for a student with motor impairment 37) understanding what can be done at home to help the student function better in school 38) learning new methods or ways to support the student in need 39) physical activity programs for students 40) assistive devices for students with motor impairment 41) accommodations and individualized strategies for a child returning to school after an injury/surgery (return-to activity/return-to-school protocol)	32)96% 33)91% 34)78% 35)66% 36)78% 37)87% 38)78% 39)78% 40)83% 41)87%	32) ✓ 33) ✓ 34)72% 35)76% 36)86% 37) ✓ 38)90% 39)95% 40) ✓ 41) ✓
42) Teaching students self-management strategies and problem-solving skills (e.g., accessing bus, playground, physical education curriculum, transition between classes)	96%	✓
43) Prescribing appropriate assistive devices or technology (e.g., postural support, dynamic orthotics, mobility devices)	91%	✓
44) Facilitating walking as appropriate Modified after Round 2 as "Facilitating the student`s mobility as appropriate"	78%	95%
45) Strengthening the child's agency- as being agents to overcome environmental barriers at school	91%	✓
46) Implementing appropriate activities of daily living (ADL) strategies into school routine to facilitate student access and participation of student with special needs in student activities	91%	✓
47) Supporting equipment acquisition, modification, adjustment and repair to enhance the functioning of a student in in school, home and community	87%	✓
48) Getting involved in the assessments, exercise interventions, and equipment acquisition for students with profound and multiple learning disabilities	87%	✓
49) Teaching children how to advocate their own needs (self-advocacy) at school	87%	✓
One-on-one training for students with various health condition (e.g., musculoskeletal, neurodevelopmental disorders) which may include 50) gross motor activity training of specific skills (e.g., sports skills, strength for sitting) 51) hands-on treatment in early stages of motor skill learning 52) manual facilitation for appropriate postural control 53) motor planning in the context of the child's environment 54) individualized exercise program 55) balance strategies to prevent or decrease falls 56) stairs training 57) gait or walking training 58) training for adaptive equipment or walking aids to use them safely 59) Strengthening programs 60) interventions to support motor, social, emotional, cognitive, and language function 61) interventions to address neuromuscular, musculoskeletal, sensory processing 62) interventions to address impairments, activity limitations impacting their participation at school or in the community 63) trialing, adapting mobility equipment and assistive devices, and monitoring them 64) performance-related physical fitness training (gross motor skills) 65) health-related physical fitness training (e.g., cardiorespiratory fitness, BMI) 66) scoliosis management 67) chronic pain management 68) intervention to facilitate seating and mobility in the classroom, school building and playground	50)87% 51)62% 52)57% 53)91% 54)78% 55)83% 56)78% 57)78% 58)83% 59)74% 60)66% 61)70% 62)96% 63)91% 64)83% 65)83% 66)66% 67)66% 68)92%	50) ✓ 51)81% 52)67% 53) ✓ 54)76% 55) ✓ 56)86% 57)81% 58) ✓ 59)81% 60)76% 61)70% 62) ✓ 63) ✓ 64) ✓ 65) ✓ 66)52% 67)62% 68) ✓
69) Collaborating with students to set educationally relevant goals and collaboratively plan on how to promote their learning and achievement.		81%