SOUTHEAST AREA COOPERATIVE

GUIDE

TO

OCCUPATIONAL THERAPY

PHYSICAL THERAPY

8.30.12

I. INTRODUCTION

This document provides general guidelines to promote consistency in the service delivery of occupational therapy and physical therapy in the public education agencies. The guidelines, based on federal and state regulations, and South Dakota licensure laws, are not meant to interpret law, nor are they meant to be mandates. They serve as recommendations for best practice for related services in the schools.

Occupational therapy (OT) and physical therapy (PT) are two of the related services that may be necessary to enable a child with a disability **to benefit from special education** under the IDEA. Therapists working in the school system should become familiar with the laws governing special education: federal IDEA law **(20 USC 1400 et seq.)** and the related regulations **(34 CFR, Parts 300 and 301);** (**South Dakota Administrative Rules 24:14:08:11; 24:14:08:12; 24:05:27:24;24:05:27:22 and South Dakota Codified Laws 13-37-1.1)**. Additionally, occupational therapists, certified occupational therapy assistants and physical therapists should become familiar with the rules and regulations of South Dakota Board of Medical and Osteopathic Examiners.

II. DEFINITIONS

It is important for all readers to have a common understanding of the terms used in this document.

Following are the definitions of terms used in this document.

SPECIAL EDUCATION

34 CFR 300.39 Special education means specially designed instruction at no cost to parents, to meet the unique needs of a child with a disability, including instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings; and instruction in physical education.

ARSD 24:05:13:01 (32) "Special education" - instruction specially designed to meet the unique needs of a student with disabilities at no cost to parents or guardians, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals, institutions, and other settings.

INDIVIDUALIZED EDUCATION PROGRAM

The individualized education program (IEP) means a written statement for a child with a disability that is developed, reviewed, and revised in a meeting in accordance with (**34 CFR 300.320–324)**. The IEP serves as a communication vehicle, commitment of resources, management tool, compliance monitoring document, evaluation device, and opportunity for resolving differences.

ARSD 24:05:13:01 (18) "Individual Educational Program" (IEP) a written statement for a specific child with a disability, in accordance with chapter **24:05:27,** based on a full and individual evaluation of the child and developed by an IEP team.

RELATED SERVICE

34 CFR 300.34 (a) According to IDEA, related service means transportation and such developmental, corrective, and other support services as are required to assist a child with a disability to benefit from special education. Related services may include speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation (including therapeutic recreation), early identification and assessment of

disabilities in children, counseling services (including rehabilitation counseling), orientation and mobility services, medical services for diagnostic or evaluation purposes, school health services and school nurse services, social work services in schools, and parent counseling and training.

ARSD 24:05:27:16; SCDL 13-37-1.1 Consistent with section **24:05:27:03 and 24:05:27:04**, the district shall provide related services at no cost to the parent. Related services include transportation; speech-language pathology; audiological services; interpreting services; psychological services; physical and occupational therapy; recreation, including therapeutic recreation; early identification and assessment of disabilities in children; counseling services; including rehabilitation counseling; orientation and mobility services; medical services for diagnostic or evaluation purposes; school nurse and school health services designed to enable a student with a disability to receive a free appropriate public education as described in the IEP of the student; social work services in schools; and parental counseling and training. Related services do not include a medical device that is surgically implanted, the optimization of that device's functioning (e.g. mapping), maintenance of that device, or the replacement of that device.

LEAST RESTRICTIVE ENVIRONMENT

34 CFR 300.114 The least restrictive environment (LRE) is another important provision of the law that affects the practice of occupational therapy and physical therapy in school settings. The least restrictive environment means that to the maximum extent appropriate, children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are non-disabled. It further means that special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

ARSD 24:05:28:01 Children in need of special education or special education and related services, to the maximum extent appropriate, shall be educated with children who are not disabled and shall be provided special programs and services to meet their individual needs which are coordinated with the regular educational program. Special classes, separate schooling, or other removal of children with disabilities from regular educational classroom may occur only when the nature or severity of the child's needs is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

Occupational and physical therapy services should be provided within the context of the child's educational program for the services to exemplify the spirit of least restrictive environment intended by IDEA. In order to integrate occupational therapy and physical therapy services effectively within the school setting, occupational therapists and physical therapists must understand special education and local school district programs and policies.

III. OCCUPATIONAL THERAPY AS A RELATED SERVICE

DEFINITIONS

Federal IDEA regulations define occupational therapy as services provided by a qualified occupational therapist. The definition includes improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation; improving ability to perform tasks for independent functioning if functions are impaired or lost; and preventing, through early intervention, initial or further impairment or loss of function **(CFR 300.34(c)(6)).**

ARSD 24:05:27:22 Occupational Therapy defined: Occupational therapy, as a related service, includes: *includes the development of fine motor coordination; sensory motor skills; sensory integration; visual motor skills; use of adaptive equipment; consultation and training in handling, positioning, and transferring students with physical impairments; and independence in activities of daily living. (Eligibility Guide)*

- Improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation
- Improving ability to perform tasks for independent functioning if functions are impaired or lost; and
- Preventing, through early intervention, initial or further impairment or loss of function

OCCUPATIONAL THERAPY SERVICES IN EDUCATION

In the public education system, the role of the occupational therapist ranges from direct service provider to provider of services such as consulting, program development, and training. By providing these services, occupational therapists are able to indirectly serve students while the students learn in more inclusive settings and thus comply with the least restrictive environment mandate. Additionally, the IDEA requirement that services be delivered within the general education curriculum as much as possible is met. Therefore, occupational therapists in schools often take on a greater role as consultants than when they work in non-educational settings. Occupational therapy services delivered to students, or on behalf of students, must be considered within the therapist's realm of work. Service delivery involves the therapist and the IEP team in a collaborative process of designing and implementing services in the most appropriate and least restrictive environment.

CRITERIA FOR OCCUPATIONAL THERAPY

(Eligibility Guide)

ARSD 24:05:27:23 A student may be identified as in need of occupational therapy as a related service if:

- The student has a disability and requires special education
- The student needs occupational therapy to benefit from special education; and
- The student demonstrates performance on a standardized assessment instrument that falls at least 1.5 standard deviations below the mean in one or more of the following areas: fine motor skills, sensory integration, and visual motor skills.

OCCUPATIONAL THERAPY PERFORMANCE AREAS

The expertise of the occupational therapist (OT) and occupational therapist assistant (COTA) lies in their knowledge of occupations (everyday life activities) and how engaging in occupations (everyday life activities at school) can be beneficial to students in their academic performance at school.

Therapy Practice Framework:

(Occupational Domain and Process, AOTA, 2002). OTs and COTAs often use the terms occupation and activity interchangeably to describe daily life pursuits. They are used interchangeably in this document as they pertain to school and educational performance. Within the school setting, the occupational therapist and occupational therapy assistant (under the supervision of an occupational therapist) look at student performance in the following areas of occupation:

1. **Activities of Daily Living**—activities that are oriented toward taking care of one's own body. They include personal hygiene and grooming, toilet hygiene, dressing (**as related to school performance**), eating, and feeding.

2. **Instrumental Activities of Daily Living**—activities that are oriented toward interacting with the environment and often involve complex routines. They include use of a communication device, meal/snack preparation and cleanup, safety procedures, and shopping (grocery and other).
3. **Education**—activities that are oriented toward being a student and participating in a learning environment. They include academic (e.g., assisting a student to be successful with learning and/or making adaptations for math, reading, writing) and non-academic areas (e.g., recess, lunchroom, hallway), along with participation in extracurricular and prevocational activities
4. **Play/Leisure**—any spontaneous or organized activity that provides enjoyment, entertainment, amusement, or diversion. This includes play exploration (e.g. exploration play, practice play, pretend play, constructive play, and symbolic play) and play participation (e.g., participating in play, maintaining a balance of play, and obtaining, using, and maintaining toys, equipment, and supplies appropriately).
5. **Work**—activities needed for engaging in employment or volunteer activities that, for students, may include learning to write out checks or complete job applications, as well as developing work habits.
6. **Social Participation**—individual and group interactions with peers and friends.

Occupational therapists and occupational therapy assistants also look at the many factors that influence the performance of students within the school environment, including:

1. **Performance Skills**—small units of performance

    a. **Motor skills** that include skills in moving and interacting with tasks, objects, and the environment (e.g., posture, mobility related to moving the body in space when interacting with tasks or objects, coordination, strength, and effort and energy).
    b. **Process skills** that include temporal organization to begin and end a task in logical sequence, organization of space and objects to find and use materials, and adaptation, which allows the student to notice cues in the environment and make adjustments as needed (e.g., finding a quiet area to read or write in the classroom when it gets noisy).
    c. **Interaction/communication skills** that include physicality (using the physical body when communicating, e.g., making physical contact with others, using eye gaze to communicate) and relations (maintaining appropriate relationships by collaborating, conforming to social norms, and learning to establish rapport with others).

2. **Performance Patterns**—behaviors developed over time

    a. **Habits**—specific, automatic behaviors that can either support or interfere with a student's performance in the school environment.
    b. **Routines**—established sequences of activities that provide a structure for daily life at school.
    c. **Roles**—set of behaviors that have some socially agreed upon function and for which there is an accepted code of norms.

3. **Context**—a variety of interrelated conditions within and surrounding the student that can influence performance within the school setting.
    a. **Cultural**—customs, beliefs, activity patterns, behavior standard, and expectations accepted by the society of which the student is a member.

b. **Physical**—accessibility to and performance within buildings and environment, objects, tools, devices, sensory qualities of environment.
c. **Social**—availability and expectations of significant others including parents, teachers, caregivers.
d. **Personal**—consideration of age, gender, socioeconomic status.
e. **Spiritual**—that which inspires and motivates the student.
f. **Temporal**—year in school, time of school year.
g. **Virtual**—environment in which communication occurs by means of airways or computers and absence of physical contact.

4. **Activity Demands**—aspects of an activity needed for the student to carry out the activity.
   a. Objects and their properties (pencils, scissors, crayons, utensils).
   b. Space demands (e.g., size, room arrangement, surface, lighting, temperature, noise).
   c. **Social demands** (e.g., rules of games, expectations of peers).
   d. **Sequence and timing for activities** (e.g., steps to making a sandwich for lunch).
   e. Required actions (usual skills required by student to carry out activity).
   f. Required body functions and body structures (e.g. use of two hands, crossing midline, joint mobility).

5. **Client Factors**—factors that reside within the student that may affect performance in areas of occupation at school.
   a. **Mental functions** including level of alertness and arousal, memory and perceptual abilities, orientation to person-place-time, energy and drive, body image, self-concept, self-esteem, regulation of emotions.
   b. **Sensory functions** including seeing and related functions (visual acuity, visual fields), hearing and vestibular sense, taste, smell, proprioception, touch and sensations related to temperature and pressure, pain.
   c. **Neuromusculoskeletal and movement-related functions** including range of motion, control of muscle tone, and integration of developmentally appropriate reflexes and reactions as the basis for more normal movement, muscle strength, endurance and postural control, gross coordination, motor planning, fine coordination and dexterity, oral motor control.
   d. **Body systems function** including cardiovascular, immunological, respiratory, digestive, metabolic, and endocrine.
   e. **Body structure categories** including the structure of the nervous system, structures related to movement.

The occupational therapist, as a member of the IEP team, participates in the development of and decision-making process relating to IEP goals (and, if appropriate, short-term objectives), frequency and duration of services, as well as monitoring of the IEP and progress toward IEP goals.

In the educational setting, the occupational therapist provides evaluation and therapy services based upon educational referrals, not physician referrals. Should the school receive a referral from a physician, the IEP team must consider the referral and base any subsequent recommendations on educational need. If a student has an identifiable occupational therapy need that does not affect the student's ability to learn and benefit from the educational experience, that therapy is not the responsibility of the public education agency.

IV. PHYSICAL THERAPY AS A RELATED SERVICE

DEFINITIONS

CFR 300.34 (c) (9) Federal IDEA regulations define physical therapy as services provided by a qualified physical therapist.

ARSD 24:05:27:24. Physical Therapy defined. Physical therapy, as a related service, includes gross motor development, mobility; use of adaptive equipment; and consultation and training in handling, positioning, and transferring students with physical impairments.

For purposes of defining physical therapy services provided in the schools, the IDEA definition and SD Rules, that of supporting educational goals, are used.

PHYSICAL THERAPY SERVICES IN EDUCATION

Within the educational model, physical therapists assist special education students with the development and practice of motor and postural control, safety and mobility in the educational environment, sensory processing, or other underlying performance components that significantly impact the student's educational experience. Physical therapists may also assist with equipment needs and communicate with community agencies on behalf of the student. A student may require either physical therapy as a related service to benefit from special education or physical therapy as an ancillary service to be maintained in the least restrictive environment.

Although certain disabling conditions cause motor dysfunction, the student may receive physical therapy through the school system only if the condition and movement problem interferes with the student's educational performance and ability to meet IEP goals. This interference must be identified and documented by the IEP/multidisciplinary evaluation team. Educational physical therapy services may include screening, assessment, program planning, intervention, communication, consultation, education, and documentation.

CRITERIA FOR PHYSICAL THERAPY

(Eligibility Guide)

ARSD 24:05:27:25 A student may be identified as in need of physical therapy as a related service if:

- The student has a disability and requires special education
- The student needs physical therapy to benefit from special education; and
- The student demonstrates a delay of at least 1.5 standard deviations below the mean on a standardized motor assessment instrument.

PHYSICAL THERAPY PERFORMANCE AREAS

The physical therapist uses educational expertise to support students in their:

1. Physical access to educational activities.
2. Movement requirements for daily living and self-care.

3. Prevocational physical requirements.
4. Access to school play and recreation activities and equipment.
5. Physical management components related to psycho-social development, functional communication, and transportation to and from school.

Specific student performance areas that may be addressed by physical therapy when it is required for a student to participate in school activities and remain in the least restrictive environment include:

1. **Neuromuscular and musculoskeletal systems**—range of motion, control of muscle tone, muscle strength, endurance, gross motor coordination, and motor planning.
2. **Sensory processing**—equilibrium and protective reactions, proprioceptive and kinesthetic input, and bilateral coordination.
3. **Functional communication**—classroom positioning, recommendations for adaptive devices or equipment.
4. **Environmental adaptations**—evaluations and recommendations for modifications of architectural barriers and children's equipment.
5. **Posture and positioning**—symmetry of positions, handling and transfer methods.
6. **Adaptive equipment**—skin care, recommendations for splints, bracing, and positioning devices.
7. **Functional mobility**—transfer skills, gait evaluation and recommendations, wheelchair mobility.
8. **Mobility and transfer skills**—adaptive equipment, wheelchair and equipment care, and use for self-help.
9. Physiological function—functional muscle strengthening, cardiorespiratory function and fitness, body mechanics, energy conservation techniques.
10. Prevocational and vocational skills—generally strengthening, sitting and standing tolerance, motor coordination, adaptive equipment.
11. Education/communication—information on disability and educational impact, staff training and development, liaison between medical and education staff (Martin, 1992).

As with the occupational therapist, the physical therapist participates in the development and decision-making process relating to IEP goals and services and the monitoring of progress toward IEP goals.

In the educational setting, the physical therapist provides evaluation and therapy services based upon educational referrals, not physician referrals. Should the school receive a referral from a physician, the referral must be considered by the IEP team and any subsequent recommendations based on educational need. If a student has an identifiable physical therapy need that does not affect the student's ability to learn and benefit from the educational experience, that therapy is not the responsibility of the public education agency (e.g., a child with a sports injury/cast continues to learn although he or she may be uncomfortable in the school environment).

V. SERVICES UNDER IDEA AND STATE STATUTES

PRESCHOOL TRANSITION

Transition from early intervention services to preschool programs is significant for many families. Changing from a system in which children may receive services in the context of the family and community to a school-base model in which related services (i.e., OT and/or PT) may be provided in groups in the classroom setting is often difficult to understand and accept. Transition requirements ensure that a team (teachers, early intervention providers, school district representatives, related service providers) works collaboratively with families to plan and provide for a smooth transition to the public school setting. Advance planning for a transition should begin as soon as appropriate (starting when the child is between 2.6–2.9 months of age). This advance planning often relieves much of the anxiety for the parents and helps to start the preschool experience on a positive note.

ARSD 24:14:08:11 Occupational therapy includes services to address the functional needs of a child related to adaptive development, adaptive behavior and play and sensory, motor and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school and community settings and include the following:

- Identification, assessment and intervention
- Adaptation of the environment and selections, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and
- Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability

ARSD 24:14:08:12 Physical Therapy includes services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation, including the following:

- Screening, evaluation and assessment of infants and toddlers to identify movement dysfunction
- Obtaining, interpreting, and integrating information for program planning to prevent, alleviate or compensate for movement dysfunction and related functional problems:, and
- Providing individual and group services or treatment to prevent, alleviate or compensate for movement dysfunction and related functional problems.

PRESCHOOL THROUGH AGE 21 SERVICES

Preschool through age 21 educational services from occupational and/or physical therapy are considered related services, and are required to assist a child with a disability to benefit from special education **(34 CFR 300.34(a)).** The least restrictive environment is addressed in the delivery of related services to preschool and school age children in special education. Often these services are provided within the context of the classroom or playground environment (in naturally occurring settings) with groups of children, rather than the one-to-one service model. Decisions relating to service delivery are always determined by the IEP team to best meet the educational needs of the individual child.

SECONDARY TRANSITION SERVICES

Secondary transition services, according to IDEA '04, are planned for special education students beginning at age 16, or earlier if so determined by the IEP team. "Transition services" means a coordinated set of activities for a student with a disability that is designed to be within a results-oriented process. The services should focus on improving the academic and functional achievement of the child to facilitate movement from school to post-school activities and may include post-secondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation. The activities should be based on the individual child's needs, taking into account the child's strengths, preferences, and interests and may include the areas of instruction, related services, community experiences, the development of employment and other post-school adult living objectives and if appropriate, acquisition of daily living skills and provision of a functional vocational evaluation **(34 CFR 300.43(a)).**

The occupational therapist and physical therapist may play a role as team members in transition planning for these students, and may find themselves part of the student's community experience, assisting in the acquisition of daily living skills and functional vocational evaluations, or they may need to assist in adaptations and access to employment and other post-school living opportunities.

INCLUSION SERVICES

The IEP team determines the least restrictive environment for placement of a child with preference given to placement with nondisabled peers, whenever appropriate. Inclusion is a term reflecting the current educational position that all children with disabilities should have the opportunity to learn from nondisabled peers and to be a part of the regular school environment. Services are provided during naturally occurring activities, giving relevance and support to a student's educational goal. Inclusion addresses the benefits of peer modeling from typical peers, especially for social, behavioral, and communication gains.

Within the school setting, inclusion is seen when a student with significant disabilities is placed in a general education classroom with support services to assist the student in meeting the IEP goals. In situations such as this, occupational and/or physical therapists can provide adaptive and compensatory strategies to increase the student's performance in mobility, access to curriculum/environments, activities of daily living, work, play, and leisure. The interventions they use include the use of activities designed to improve performance, as well as identify adaptive equipment, environmental modifications, and alternative methods necessary to support improved function. In working with students in inclusionary placements, occupational therapists and physical therapists with professional background and training in neurological conditions can become key members of the team. When collaborating with other educational professionals and parents, they assist with interventions and services to support the student in the general educational setting.

ASSISTIVE TECHNOLOGY SERVICES

Assistive technology (AT) may assist a student in special education in accessing a free appropriate public education (FAPE). Occupational therapists and physical therapists may play a major role in the schools in determining assistive technology needs for students. The term assistive technology device can mean any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability.

The term does not include a medical device that is surgically implanted, or the replacement of such device **(34 CFR 300.5)**. Assistive technology services mean any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. This term includes the evaluation of the needs of such a child, including a functional evaluation of the child in the child's natural environment; purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing AT devices **(34 CFR 300.6).** Assistive technology devices may include augmentative devices, environmental controls, computers, and modifications to buildings. However, the assistive technology does not always have to be expensive or elaborate. It can be as simple as adaptive eating utensils, inclined planes, adapted pencils, modified books and stories, or Velcro picture boards. Assistive technology services encompass technical assistance and training for children with disabilities and their families, as well as coordination of such services.

EDUCATIONAL MODEL

The educational model differs significantly from the medical model. **In the schools, the focus and purpose of occupational and physical therapy services is to enable the child to benefit from special education, i.e., to enable a child to reach academic and functional skills goals. The child's educational needs are specified in the IEP, placing the medical needs in the domain of parent responsibility for private providers. In the educational setting, the OT and/or PT provide evaluation and therapy services based upon educational referrals, not physician referrals**. Should the school receive a referral from a physician, the IEP team must consider the referral and base any subsequent recommendations on educational need. The occupational therapist, occupational therapy assistant, and physical therapist have distinct roles in providing services in the school setting.

The occupational therapist and physical therapist provide the following services within their respective area of expertise:

1. Screening and interpretation of screening results.
2. Evaluation and interpretation of evaluation results.
3. Program planning and implementation of intervention.
4. Documentation of services.
5. Clinical supervision of therapy assistants in conformance with statutory, regulatory, and professional rules.
6. Supervision and training of therapy aides who provide supportive services assigned by the occupational or physical therapist.

The occupational therapy assistant provides the following services:

1. Screening without interpretation of results.
2. Assistance with data collection and evaluation.
3. Implementation of intervention.
4. Documentation of services.
5. Communication with supervising occupational therapist with respect to professional needs and student performance.

DETERMINING THE NEED FOR OCCUPATIONAL OR PHYSICAL THERAPY

If the need for OT and/or PT services is suspected at the time of an initial or reevaluation, the appropriate therapist must participate in the evaluation process in order to ensure that the evaluation covers all areas related to the suspected disability. If the potential need for related services emerges during an interim period, the IEP team, including the appropriate therapist, must review all current information and decide what additional information, if any, is necessary to determine the need for and the scope of any related service. If no additional information is needed, the justification for the related service should be included in the IEP. If additional data that require parental consent are needed, the school should conduct a reevaluation. Once the additional information is available, the team must make a determination about the need for and scope of services.

The IEP team determines if OT or PT services are required in order for the child to benefit from special education**. It is often difficult for parents and others to understand that, while a child may indeed benefit from therapy, it may not be a required service within the context of special education.**

Examples of instances when therapy may not be indicated are:

1. Staff is aware of and understands implications of the student's medical and/or physical condition and is managing the student's environment appropriately without therapy.
2. Deficits do not interfere with the student's ability to function adequately within an educational setting.
3. Student has learned appropriate strategies to compensate for deficits.
4. Functional living skills are not goals of student's special educational program.
5. Modifications to the school environment have been made and are effective for the student.
6. Current level of achievement is consistent with other areas of development.
7. Assistive technology is available, in working order, and effective, and staff has been trained on the care and use.
8. Therapy is no longer effecting positive change in the student's level of function or rate of skill acquisition.
9. Needed strategies can be implemented effectively by current educational team, and continued occupational therapy and/or physical therapy intervention is not required.

10. Demands for written communication are within the capabilities of the student in the current placement.
11. Modifications to testing procedures or written communication formats have been made and are effective.
12. The student has adequate motor development to control and coordinate movements.
13. The student is demonstrating progress toward IEP goals and objectives or benchmarks without support of related services.

If therapy is deemed necessary, the therapist helps the team determine frequency, amount, and duration of the therapy, as well as the location for delivery of services (e.g., general education classroom, pull-out therapy room, special education classroom, playground, cafeteria) with emphasis on using naturally occurring environments. The therapist will also guide decisions on how therapy services will be delivered, e.g., individually or in groups, direct (hands-on) or indirect (consultation); how therapy may be reinforced by teachers, paraeducators, parents, and other staff; equipment management; and what training may be necessary to enable others (e.g., staff, parents, peers) to implement and support the therapy goals.

MAINTAINING DOCUMENTATION

Documentation is essential for good communication and accountability of the occupational therapist's and the physical therapist's actions. Documentation should conform to federal, state, and public education agency requirements. Educational relevance for all therapy services should be clearly documented. Documentation provides physical evidence for the service delivery to students. Documentation includes: assessment; present level of academic achievement and functional performance; annual goals; any benchmarks or short term objectives, if appropriate; and level of service, duration, and frequency. Generally, each local educational agency has procedures and forms that document the process from referral to placement for students identified as needing special education and related services. Documentation should include referral for occupational therapy and/or physical therapy; parental permission for any evaluation and prior written notice for initial and reevaluation (including procedural safeguards); evaluation report; determination of eligibility for special education services by the IEP team; the individualized education program (IEP); progress reports; IEP review/revision; documentation of classroom adaptations and modifications; and parent contact log. It is also wise to keep notes of any training provided to others in conformance with the IEP.

VI. INTERVENTION

COLLABORATIVE TEAMING

Occupational therapists and physical therapists must always strive to think in terms of collaborative teaming. In the public school system, this teamwork gets accomplished when the work of the group centers around planning for a student. Collaboration is most easily achieved when all members on the team are committed to teaching, learning, and working together across traditional disciplinary boundaries. The team should always include the parent, the child (if appropriate), and the student's teachers. Additional professionals on the team may include the psychologist, social worker, educational consultant, nurse, principal, and other related

providers (e.g., speech therapist). They often share information with each other through role release so the skills the student needs to learn and practice throughout the day/week/year are taught by the people who spend the most time with the student. Building a team takes time and requires a willingness to communicate and interact openly. Members respect the unique expertise of each individual on the team and value the sharing of information for the benefit of the student. Everyone on a team should have an equal voice, but not necessarily the same perspective.

As part of the team, the OT and PT share responsibility for identifying priorities, strengths and needs, planning strategies and goals for educational performance, and anticipating outcomes for the future. In order for this to happen, it is imperative that the related service providers become familiar with the general education curriculum and convey to teachers how services can assist the student to participate more fully. The determination about the need for related services should be a team decision, based on the needs of the student and the areas of expertise of the staff. Decisions are made by consensus. Plans formulated by the team are carried out until the team revises the plan. Realistically, because of varying opportunities for in-service training, background experience in teaming, and philosophical differences, not all members of a team are at the same level of sophistication, understanding, and commitment to a collaborative team model. Logistical problems relating to time and resources may also present barriers to collaboration. In spite of these realities, a team approach with a comprehensive plan for delivery of services is in the best interest of the student.

ADAPTATIONS, MODIFICATIONS, AND ACCOMMODATIONS

Through a collaborative process, team members identify a child's present level of educational performance and determine how a child's disability affects his or her involvement and progress in the general education curriculum. This process leads to the development of adaptations. Adaptations include accommodations and modifications and are based on an individual student's strengths and needs.

Accommodations are provisions made in how a student accesses and demonstrates learning. These do not substantially change the instructional level, the content, or the performance criteria. The changes are made in order to provide a student **equal access** to learning and **equal opportunity** to demonstrate what is known.

Modifications are substantial changes in what a student is expected to learn and to demonstrate. Changes may be made in the instructional level, the content, or the performance criteria. Such changes are made to provide a student with meaningful and productive learning experiences, environments, and assessments based on individual needs and abilities.

SERVICE DELIVERY

It is critical that the service delivery model chosen by the IEP team reflects the student's educational needs as outlined in the IEP. All services that an occupational therapist or physical therapist provides to a student or on behalf of a student must be indicated in the IEP and should be considered interventions. Therapists provide the following continuum of services to students:

Direct Services are hands-on services provided to the student when specialized therapy by a skilled service provider is determined to be the most appropriate model of service. These services can be delivered through individual, small group, and/or whole class activities. Individual contacts may require an isolated setting for a short period of time; however, the focus of any pull-out service is to return the student to the naturally occurring setting as soon as possible. Integrating therapy into the classroom routine provides opportunities for the student to learn functional motor, communication, and other skills as part of the natural routines in integrated school and community environments.

School-based therapists work in the natural environments of individual students. These may include the classroom, cafeteria, library, bathroom, playground, hallways, and/or other specialty areas on the school grounds and in the community. Direct services should include some level of indirect/consultative services with other team members to ensure that the therapist's specialized appraisal and suggested treatment are incorporated into daily activities and routines. The direct service option must be considered, discussed, and used when appropriate to meet the individual needs of the student. However, it is considered the most intrusive service option. The decision not to use this model cannot be made based upon personnel shortages or uncertainty regarding the availability of staff.

Indirect or Consultation Services are used in general training, observation of student performance, monitoring of performance data, and development of materials to adapt the curriculum. These types of indirect services are no less important to a student's success than hands-on service. Consultation service refers to the reciprocal exchange of information where the primary recipients of the service are other team members. It involves the exchange of ideas and skills between team members (including parents) that are related to the educational program for a specific student. It can include spending time on behalf of the student with student-related activities such as fabrication of materials, adaptation of classroom materials, and/or home/hospital/clinic visits with the student, as long as it is clearly documented in the IEP.

STAFF DEVELOPMENT AND TECHNICAL ASSISTANCE

At times, staff training and other supports are needed for personnel to fully implement the IEP and provide FAPE to the child. Educational staff must often implement strategies and interventions devised by the therapist that allow the student to practice the skills several times within natural environments and contexts. Techniques and strategies that are incorporated into a classroom program are not considered part of the therapy as delineated in the IEP, but are a part of the educational programming for the student. Parents/families and school staff may need specialized training to allow them to use certain equipment, materials, techniques, transfers, programs, etc. This is usually included in the IEP as "**Supports for School Personnel**."

1. Case/Colleague Collaboration: The result of this collaboration may include curriculum adaptations and classroom or environmental modifications, or it may generate a referral for an occupational therapy and/or physical therapy assessment.

2. Periodic Student Check: The therapist may follow up on a student who previously received related services or who is considered at high risk but is not currently receiving related service.

3. Equipment Consultation: Some students require periodic adjustments or repair of adapted equipment or supplies used in their educational setting. Therapists may be consulted on an as-need basis for students whose equipment needs repairs and who may not be receiving related services.

TERMINATION OF SERVICES

Prior to discontinuing services, the IEP team must have sufficient data to determine that services are no longer required. In some instances, the information may be obtained from informal sources such as classroom observations, therapy notes, work samples and parent interviews. In other circumstances, more formal assessment strategies may be necessary. In either case, documentation of the reasons for the decision should be documented in a reevaluation report or in the IEP. The IEP team reviews the evaluation results and makes the final determination.

Questions which may be used to determine whether a child continues to need occupational and/or physical therapy includes:

1. Has the student developed the performance components needed to progress toward the educational goals established in the IEP?
2. Have the environmental or curricular adaptations been established to allow for achievement of educational goals?
3. Are the student's needs being met by others at this time and no longer require the skilled services of a therapist?
4. Has the educational setting changed and is the student functional within this setting?
5. Has the student learned appropriate strategies to compensate for deficits?
6. Is therapy no longer effecting change in the student's level of function or rate of skill acquisition, or no longer required for the child to benefit from special education?

Prior written notice to parents must accompany the decision to discontinue services. The evaluation/reevaluation report or the present levels of academic achievement and functional performance should include information summarizing student's progress, current levels of functioning, and how that level of performance affects involvement and progress in the general education curriculum.

VII. ADDITIONAL CONSIDERATIONS

SCHEDULING

Team members need to be flexible when scheduling in order to meet a student's needs. Integrated programming can support student's success. Intervention may need to be provided in a variety of settings: academics, lunch, recess, and specials (art, PE, music, computers, etc).

Therapists may help the student accomplish goals more effectively by using a variable time rather than the traditional hands-on, 30 minutes per week. To accomplish the flexibility, it is often helpful to indicate the frequency as: minutes per week, minutes per month, or minutes per semester. It may be appropriate to specify

in the IEP more intense therapy services early in the school year, fading to less intense services as the year passes and routines are established across programs and activities of the school day. Whatever the frequency of the service, it is important that this is made clear to the entire team, including the parent, and the frequency is clearly documented in the IEP.

Block scheduling is a current trend in service delivery that provides a variable time schedule. Using this model, the therapist can vary types of intervention and the duration and intensity of services. In a variable time schedule, there can be flexibility from month to month, which would be reflected in the IEP. For example, on an IEP which calls for one hour of occupational therapy per month, one month may include: 20 minutes of hands-on intervention during handwriting in the classroom (week one); 10 minutes of intervention in the classroom and consultation with the teacher (week two); 15 minutes intervention during art (week three); 10 minutes intervention during PE and 5 minutes intervention during transitions in the hallway, going from the bus to the classroom. Month two may include: 30 minutes intervention in the classroom (week one) and 15 minutes intervention in art (week two) and another 15 minutes intervention in the classroom (week four). Block scheduling does not indicate a range of service time (e.g., 30–90 minutes per month) as ranges of time are not acceptable on the IEP.

VIII. SUMMARY

The occupational and physical therapies are vital additions to the educational setting. They can make a tremendous difference in the amount and speed of progress a student may make. However, they are also related services, meant to allow the student with a disability to benefit from their special education programs and services. Students may make sufficient progress and no longer require such services, even though they may still have disabilities.

Frequently Asked Questions

(Eligibility Guide)

1. What are the requirements under IDEA for finding a student eligible for related services?

First, the student must be evaluated and determined to be a student with a disability which adversely affects educational performance, and who, because of those disabilities, needs special education or special education and related services.
Second, the related service must support the provision of special education, including transportation and those developmental, corrective, and other supportive services determined by an IEP team to be required for an eligible child to benefit from special education.

2. What is meant by educationally relevant?

The term educationally relevant means that the service must be needed to enable the child to benefit from his or her educational program; the focus is educational relevance, not medical treatment. The goals and interventions address the child's present level of academic achievement and functional performance. As with all other related services, school-based OT and PT are provided only if a student needs it to benefit from special education.

3. Can OT and/or PT services be considered as special education in South Dakota?

No. If it is determined through an appropriate evaluation, under chapter §24:05:25, that a student has one of the disabilities identified in this chapter, but only needs a related service and does not need special education/instruction, the student is not a student with a disability under this article. Unless they are determined eligible under one of the disability categories, these services would not be provided.

4. What are the requirements under IDEA for finding a student eligible for OT and/or PT services?

There are two answers to this question:

1) To be eligible for OT or PT as a related service, the evaluation team must establish the existence of a disability and educational need.
2) Once the child is determined to be eligible for special education services, the IEP team will develop the student's special education program. The special education program will include fine motor or gross motor strengths and needs in the present levels of academic achievement and functional performance (PLAAFP) as well as the development of annual goals. The IEP team will identify which related services (if any) the child needs in order to benefit from the special education program. OT and PT may be added as a related service only if the student meets the 1.5sd criteria and if it is necessary for the student to benefit from the special education program being provided.

5. Can a student receive OT and/or PT as a related service if they meet the 1.5 standard deviation but do not meet the criteria as a student with a disability?

No. The student must first meet the criteria as a student with a disability which adversely affects educational performance under one of the thirteen 13 disability categories.

6. How are OT and/or PT services discontinued from a student's IEP?

The district shall follow the reevaluation procedures under ARSD 24:05:25:06 when determining whether the child continues to need special education and related services. The decision to discontinue therapy is made by the IEP team. This may occur when the student no longer is eligible for special education, when other members of the IEP team can provide necessary interventions, or when the child can perform school tasks without therapeutic intervention. Refer to the dismissal procedures in the appendix of the IEP Technical Assistance Guide. There may still be a need for medically-based service.

7. Should there be separate goals on the IEP that are dedicated to OT and/or PT?

No. Discipline-free IEP goals facilitate more of a collaborative effort from the IEP team. Since the student's special education program is developed from the present levels of performance, OT and/or PT services should support the accomplishment of the child's educational goals developed from the fine motor or gross motor strengths and needs.

8.How is eligibility for sensory integration service determined?

Once the child is determined to be eligible for special education services, the IEP team will develop the student's special education program. The IEP team will identify which related services (if any) the child needs in order to benefit from the special education program. OT (sensory integration) may be added as a related service only if the student meets the 1.5 sd criteria and is necessary to benefit from the special education program being provided.

9. Can a student who is eligible for special education services receive fine or gross motor instruction if they do not meet the 1.5 sd criteria for OT and/or PT as a related service?

Fine motor, gross motor or sensory integration services can be provided by general education or special education staff even if the student does not meet the criteria necessary to receive the services directly from an OT or PT.

10. When and how are "consultation services" documented in the IEP?

Consultation services can be documented in various sections of the IEP. In a situation where the student did not meet the 1.5sd criteria for OT or PT services but has fine or gross motor needs, the consultation may be necessary and documented under "supports for school personnel".
If the student meets the 1.5sd criteria for OT or PT services but the team determines the services will be provided by other staff with only consultation from the OT or PT the frequency and amount of time may be documented under the special education or related services to be provided.

11. Would one expect to see OT or PT consultation in the IEP if the student did not have any fine motor, gross motor, sensory motor etc. needs documented in the student PLAAFP?

No. However, this would not prohibit district staff from talking to other professionals about educational strategies if needed.

12. What "Sensory" evaluations may be used for determining eligibility for occupational therapy as a related service?

The "Sensory Processing Measure" and the "Sensory Profile" (both in eligibility guide) can be used for determining eligibility for OT as a related service if the student meets the 1.5 SD below the mean of 100. In these evaluations the category of "Difference" is equal to the 1.5 SD. The category of "Definite Difference" is equal to a 2 SD below the mean.