# Santa Clara County SELPAs
# I, II, III, IV, & VII

# Delivery Model
# For
# School Based
# Occupational Therapy
# Services

**2012**

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# PREFACE

## Introduction to Delivery Model

The purpose of developing a "Delivery Model for School Based Occupation Therapy Services" is to provide consistency in school based occupational therapy services within Santa Clara County SELPAs I, II, III, IV, & VII. The model is based on Federal legislation (Individuals with Disabilities Education Act (IDEA 2004), No Child Left Behind (NCLB), state of California legislation (California Education Code - Part 30 and the California Code of Regulations - Title 5), and the American Occupational Therapy Association (AOTA) domain and practice framework for best practices for occupational therapy services under IDEA.

Although occupational therapists (OT) have provided services to children in schools, many teachers, administrators, and parents may not clearly understand the OT's role. This document provides a guide which shows how an OT collaborates with educators, administrators, and parents to support the mission of education in the environment of the school. This document presents a school based delivery model for Occupational Therapy services that answers some basic questions about who OT's are, what their purpose is in school, and how they (working with educators and parents) can help children acquire the skills and knowledge they need to participate alongside other children in school.

Purpose of Document: The purpose of this document is to present a model (set of guidelines) for the delivery of OT services in the educational setting. The OT delivery guidelines are to assist and guide OT service providers, members of the educational team, and administrative staff in the design and implementation of school based OT services for individual students with educationally related difficulties, and implementation of a consistent delivery model among the school districts. These guidelines will help school districts within the county to guide program staff as they explore the concepts of collaborative/transdisciplinary team work and integrated therapy, or as they devise strategies for implementation, documentation, and review of student progress.

Scope of Document: The scope of this document is intended to address service delivery in the school setting and the related administrative support needed from the school district.

Basis for Occupational Therapy Services: The relationship between occupational therapy, the educational process, and the federal guidelines under which occupational therapy services are provided within the educational setting is as follows.

Under the Individuals with Disabilities Education Act (IDEA 2004) which mandates that occupational therapy services be offered by the public schools for children ages 3-21, OT services are provided only for educationally related difficulties, e.g., problems occurring in the educational setting secondary to educationally related difficulties. The American Occupational Therapy Association in its publication, *Occupational Therapy Services for Children and Youth under the Individuals with Disabilities Act,* notes that for a student to receive occupational therapy services the student must be eligible for special education and occupational therapy must be necessary to assist the child to benefit from special education. As a related service, occupational therapy serves a supportive role in helping the student to participate in and benefit from special education. School based occupational therapy assessments typically focus on the specific skills the child needs to succeed in the school environment, such as seated posture, grasp and control of classroom tools, self-regulation, etc. In many cases, school system occupational therapists will also focus on the development of sensori-motor foundation skills. In addition, the child's strengths are determined and utilized to encourage compensation for areas of difficulty. Educationally related OT services are provided within the context of the child's educational program, with service delivery occurring in the school environment where the need occurs. The goal of intervention is to assist the child to function in the school setting by adapting the environment, revising the functional tasks, and by promoting elements of sensori-motor development.

Educationally Relevant: Occupational therapy provided within the education setting must be educationally relevant and necessary for the student to benefit from his/her special education program. The IEP Team first must determine present level of performance and goals before identifying which special education services (e.g., small group instruction, behavior change program, occupational or physical therapy) are needed to achieve the goals on the student's IEP. The team must also decide if specially designed instruction will facilitate the attainment of IEP goals or if related services, such as occupational therapy, are also needed for the student to benefit from the specially designed instruction. Once the need for services has been determined to be educationally relevant, the IEP Team begins designing and scheduling the instructional components of the student's program.

Goals Goals do not represent any one profession; they represent the overall needs of the student so the student can access the general curriculum. Since OT services in the school setting are intended to help the student achieve educational goals these services

must support the educational goals of the IEP. The OT who provides services in an educational context is contributing to the student's overall ability to meet the goals of the IEP across educational settings.

## DELIVERY MODEL GUIDELINES

### Delivery of Educationally Related Occupational Therapy Services *to Students with an IEP*

Referral for an Occupational Therapy Evaluation: Anyone who has knowledge of the child can make a referral for an occupational therapy evaluation. This usually occurs when a child's suspected areas of need fall within the occupational therapist's areas of expertise. The OT then becomes one of the qualified assessors. A referral for an occupational therapy evaluation must come out of the IEP process and is generally based on educational observations which indicate concerns in the child's performance in areas related to occupational therapy which prevents the child form accessing the special educational environment.

Possible indicators for occupational therapy referral of a student include:

- Has difficulty in learning new motor tasks.
- Shows poor organization and sequencing of tasks.
- Demonstrates poor hand use and tool use.
- Has difficulty in accomplishing tasks without the use of adaptive equipment, environmental modifications, or assistive technology.
- Shows unusual or limited play patterns.
- Has deficits in adaptive self-help or feeding skills that are required in the educational setting.
- Shows difficulty with self-regulation for school engagement.
- Has notable overreaction or under-reaction to textures, touch, or movement that negatively interferes with functional task performance.

Occupational Therapy Evaluation Process: The assessment takes place after an assessment plan has been signed by the parent/guardian. The evaluation process is the sequence of steps necessary to conduct an occupational therapy assessment. The assessment is the methods (e.g. record review, parent/teacher interview, and student

observation) and measurements (i.e. specific tests) used to assess performance. Assessment tools do not have to include standardized assessments. Assessment tools can include observations, developmental checklists and response to intervention documents.

Occupational Therapy Assessment: The assessment should address the individual student's abilities and functioning within the educational environment. It should take into consideration areas of functional performance that are a problem, aspects of a student's performance components that are interfering, and areas of the environment that need to be addressed.

In preparing to conduct the assessment, the assessor should bear in mind the following questions:

- What are the educational concerns regarding the student's functioning in his/her special educational program?

- What is the student's current level of performance in the classroom?

- Within the curriculum, what is specifically expected of the student that he/she is not accomplishing?

The assessment should include multiple strategies and methods that will provide data that clearly identifies the child's educational needs relative to the ability to participate in and benefit from the general curriculum (What does the child need to do and what factors act as barriers to this). The therapists should select assessment tools and methods that are designed to answer the questions they seek to answer. All of this information enables the assessor to evaluate the student's performance comprehensively within the educational environment and provide informed recommendations to the IEP team. The assessment could include the following steps that may be used to gather information about the student's functional performance:

1. Gather relevant data from the student records.

2. Review information from the parent/guardian intake form and teacher checklist or questionnaire

3. Conduct interviews of the teacher, parents, and other personnel knowledgeable about the child for any additional needed information.

4. Observe the student within the educational environment and review work samples. The student cannot be evaluated accurately without observation of the student in the appropriate educational setting.

5. Identify any special supports or adaptations that have been tried and determine their effectiveness.

6. If appropriate, administer formal assessments, as determined by the occupational therapist, which may include non-standardized or standardized assessments. The link between standardized tests and student performance can be confirmed through observation of the student in the educational environment and interviews with the student, teacher, or parent.

Top Down Assessment Approach: In this approach, the assessor looks at functional difficulty and determines the cause rather than considering specific student factors out of context (skills the student can and cannot do), and presupposing a functional difficulty. This Top Down Assessment Approach begins with consideration of how the student participates across all settings. The assessment process is driven by contextual factors (the school environment), activity demands, and student needs (Dunn, Brown, & McGuigan, 1994; Muhlenhaupt, 2003). The assessor should consider all aspects of the school environment, including physical, temporal, social, and cultural considerations, and how context affects student performance (Muhlenhaupt, 2003; Swinth, 2003). The assessor should identify how the following factors interact to affect the student's educational performance:

- The student's abilities in performance skills, strengths and weaknesses, across all relevant school settings.

- The general curriculum or developmental demands and what is specifically expected of the student that he or she is not accomplishing.

Assessment Report Content: Once the assessment has been completed, information is synthesized for presentation to the IEP Team. The assessment report should be written in a manner that helps the IEP Team determine what is needed. The focus should be on the student's educational performance across all school environments. Because entry criteria do not exist for occupational therapy in the schools within the IDEA provisions, avoid suggestions that a student "qualifies" for therapy. Instead, make recommendations for a student's overall program, along with a discussion about how OT may help support the student's needs. On the basis of the student's program and placement, the IEP Team makes the final determination regarding the need for OT

services to support the student's program of special education. The written report must include, although is not limited to, the following:

- Background -- Reference relevant health and developmental history; state reason for the assessment; cite specific concerns, and include social or educational history.

- Methods of assessment and dates -- List methods used and dates (for example: review of records, teacher checklist, parent intake form, observations done, standardized and/or non-standardized testing used).

- Validity of findings -- Discuss child's behavior and indicate if testing appears to be an accurate reflection of his performance.

- Findings -- Report information resulting from variety of the tools used (e.g. observations, checklists, interviews and standardized/non-standardized testing), and discuss the educational relevance of the findings.

- Summary -- Summarize the significance of the assessment results as related to the student's educational performance and function in the classroom, including both strengths and areas of concern.

- Recommendations -- Identify supports and resources available to the child, provide appropriate suggestions for immediate educational implementation and a recommendation as to whether the student would benefit from occupational therapy to improve educational performance. Document how occupational therapy strategies and techniques may be able to support the student's educational needs. The IEP team is responsible for the final determination regarding the provision of special education and related services.

<u>Considerations in Determining the Need for Occupational Therapy:</u> The determination of whether or not a student requires school based occupational therapy services is not made solely by the OT, but is one made in collaboration with other members of the IEP Team, including the parents. Additionally, recommendations for educationally related occupational therapy services are not based only on a student's test results from specific assessment tools (Muhlenhaupt, 2000). This is an IEP Team decision based upon all the evaluation data collected by the team (not simply the occupational therapy data) about the child's ability to function within the educational setting. The IEP Team must decide if the discrepancies require the specialized techniques and strategies of an occupational therapist. Information provided by outside sources, such as physicians or non-school

based occupational therapists may be considered but does not dictate either the team decision or the type of interventions provided by the OT in the educational setting.

The IEP Team makes the final objective determination regarding the need for occupational therapy services to support the student's special education program based on the following:

- A review of information gathered from the assessment data.
- The student's skills and abilities.
- The occupational therapist's professional judgment.
- The student's goals and objectives to be achieved (the desired educational outcome).
- The type of educational setting (e.g. regular classroom with resource specialist assistance).

The IEP Team may consider the following questions when determining the need for occupational therapy:

- Does the student's current educational setting include efforts to address the identified issues?
- Has the student been benefiting from his or her educational program without the service?
- Could the student continue to benefit from his or her educational setting without the proposed service?
- Could the proposed service be addressed appropriately by the special education teacher, classroom teacher, or other core faculty or staff?
- Will the absence of this service interfere with the student's access to or participation in his or her educational program this year?
- Do the service recommendations of the IEP Team present any unnecessary overlap or contradictions with other proposed services?

- Can service provided in one context be adequately generalized to other settings without direct involvement of the specialist?

- Does the child have limitations that influence, interfere with, or prevent the child's progress toward academic and nonacademic goals?

- Do the effects of the child's disability influence, interfere with, or prevent the child's ability to function within the school environment?

- Will the effects of the disability interfere with, influence, or impede the child's educational progress, individual safety, or ability to function in the proposed school environment, particularly if the child is newly entering school or changing school environments?

- Does the occupational therapist's professional knowledge and expertise provide a needed component of the student's program that will achieve the desired educational outcome?

Implementing the Individualized Education Program (IEP): Once the IEP Team determines that occupational therapy services are needed, the team must decide which goals need occupational therapy support. It is important to remember that the goals are the student's and should be expressed in terms of the desired educational outcomes. The teacher and the OT work collaboratively on the student's goal. Separate goals for each provider or discipline are neither necessary nor always warranted.

The occupational therapist and the IEP Team determine who will receive the service, where the services will be delivered, what time, frequency and duration of service are needed to support the IEP.

Considerations in Determining Amount and Frequency of Therapy: The IEP must specify amount, frequency, duration, and location of services. According to federal law, the services must be clearly stated on the IEP so that everyone knows what will happen to support the student's participation in the general curriculum. When the IEP Team determines that a student requires the skills and expertise of an OT to achieve the student outcomes defined on the IEP, the OT works with the team to define the amount, duration, and frequency of services. Discussion about the nature of the service at the IEP Team meeting among members of the team, including the parents, help the team make well-informed decisions. The occupational therapist's perspective is unique in offering expertise in understanding the flow between the student and existing supports within the environment and identifying any missing components that require direct

intervention from the occupational therapist. The amount, duration, and frequency of services should be based on student need and any evidence that supports the proposed intervention plan. Occupational therapists need to consider that some students may benefit from a short period of intensive services or that a student may not require a full year of services.

The decision on the amount, duration, and frequency of services should take into account the following factors:

- Take into consideration the interrelationships among the various disciplines serving a particular student.
- Determine the student's potential to benefit from occupational therapy services
- Decide if this is a critical period of skill acquisition or regression related to development or disability.
- Consider who the client is -- the student, educational staff, and parents/caregivers.
- Determine if any part of the program can be performed by others in addition to the occupational therapist.
- Consider the amount of training that needs to be provided by the occupational therapist to others that are carrying out the program.
- Consider the degree the problem interferes with function in the educational setting.

Location of Services: In determining where services are provided, the IEP Team must consider the goal, the needs of the student, the program, and other variables such as context, materials, people, and routine. The IEP Team must indicate where each goal will be addressed.

- Example of *where* statement "in class learning situations with peers". This phrase applies to interventions that may be provided: in the classroom, on a field trip, in the cafeteria, in physical education class, or at recess.
- Example of *where* statement "in one-on-one sessions in an alternative setting". This phrase indicates that the student will work on a performance skill or performance pattern with the occupational therapist in a more specialized setting.

Whenever a specialized setting is called for, the goal is to help the student learn the performance skill or performance pattern, but then move the practice and refinement of that skill into the least restrictive environment (e.g., school routine or setting) as soon as possible.

Occupational Therapy Intervention Plan: The intervention plan is the occupational therapist's framework for implementing the occupational therapy service required by the child's IEP. The intervention plan is specific to occupational therapy and describes the methods, media, environment, and type of intervention that the therapist will use to assist the child to reach the educational goals in the IEP for which occupational therapy is a support service. It is not part of the child's IEP, but remains with the occupational therapist. The treatment plan is based on data gathered from the child's evaluation and may be changed as therapy progresses. Information from private evaluations may be considered but this does not dictate the type of intervention provided in the educational setting. It is the occupational therapist's responsibility to select the approach and theoretical perspectives from which to intervene. Schools are obligated to provide occupational therapy service, but not any specific treatment approach.

The intervention plan differs from the IEP in several ways, and the table below provides more detail about those differences:

## Comparison of the IEP and Intervention Plan

| **The IEP** | **The Intervention Plan** |
|---|---|
| must be developed in an IEP meeting by the team members | may be developed by the respective therapist alone or in collaboration with others |
| identifies the child's goals which may be addressed by one or more disciplines | identifies only the IEP goals that will be addressed by the occupational therapist |
| must not be changed without holding another IEP meeting or amendment. | may be changed by the therapist alone, except for components also found in the IEP |
| does not describe techniques, theory-based treatment, or therapy equipment needed to carry out the objectives | describes techniques, theory-based treatment, consultation strategies, and therapy equipment needed to carry out the objectives |
| becomes part of the child's confidential educational records | does not become part of the child's educational records, but remains with the therapist |

The occupational therapist may develop an intervention plan according to his or her individual style of preference. The OT may include these components in the intervention plan:

- Provide demographic data.

- Include present level of performance in priority areas.

- List measurable goals to be addressed by the related service.

- Show breakdown of objectives into components to be achieved in therapy.

- Describe intervention including methods, techniques, activities, and location of services.

- Provide documentation of progress, including explanation of method if appropriate.

The occupational therapy intervention plan should address the following topics:

- Long-term functional goals are goals written by the occupational therapist in educational terms that support the IEP educational goals. These goals address the functional limits that must change in order to achieve the anticipated outcome (for instance, identify the extent of the decrease of the functional limitation; state the rationale behind the decrease of the functional limitation; and relate the functional change that is to occur by the end of treatment).

- Short-term objectives are written by the occupational therapist in educational terms that directly relate to the long-term functional goals. These objectives address the skills that are to be demonstrated in order to achieve the anticipated outcome (for instance, identify how the skill will decrease the extent of the functional limitation, state the functional ability that will result from learning the skill, and predict the timeframe in which the change that will occur).

- Intervention procedures are activities, techniques, and modalities selected by the occupational therapist for use and how they relate to the goals. They describe the classroom program to be implemented in a school setting that would benefit the student and identify any special equipment that would be needed during the treatment sessions.

Integrated Service Delivery: The American Occupational Therapy Association endorses the use of the integrated collaborative services model. The integrated collaborative services model is based upon specially designed instruction and related services being

embedded in instruction across the student's daily routine and activities. The model emphasizes application of skills in natural learning environments and facilitates learning in the least restrictive environment. Research indicates that collaboration can significantly increase student opportunity for skills practice and positively affects overall skills functioning. (Dunn, 1990; Kemmis & Dunn, 1996)

Service Delivery Considerations: Service Delivery for educationally related occupational therapy services are meant to be inclusive, with service delivery occurring within the classroom setting and providing opportunities for practice and development of skills within the natural classroom environment. The type of service delivery is based on the child's needs within the educational setting and is consistent with the IEP. Service delivery should include awareness of constantly changing needs, resulting in flexible combinations of types of service delivery at various times, or one at a time. Service delivery should provide for role release (getting things done through others). The service delivery should address participation and access in the general curriculum focusing on dysfunction within the student rather than on the impairment. Services can range from modifications implemented by a classroom teacher or parents to extensive sensory motor interventions implemented by the occupational therapist and supported by the classroom teacher and other members.

Types of Service Delivery are Direct and Indirect. Occupational therapists use a variety of approaches and interventions to meet the unique needs of the students they are serving. The underlying considerations regarding service delivery should always be the student's improved functional performance and/or participation in the school environment or curriculum.

- Indirect service is a collaborative/consultation approach where the therapist works closely with teachers, parents, educational staff to facilitate implementation of intervention strategies across environments. In this approach it is imperative to observe, ask questions, listen to staff, and become familiar with routines, schedules, curriculum and classroom expectations. Examples of the collaborative/consultation approach include providing verbal or written suggestions to staff or parents, supplying adaptive equipment, adapting instructional materials, presenting in-services, modeling techniques to the staff for such issues as positioning, calming/alerting ideas, and writing strategies.

- Direct service is an approach where the occupational therapist works directly with the student. This approach may mean working with the student in small groups or with a whole class. Working with the student individually may mean that the occupational therapist uses a "push in" or "pull out" technique. "Push in"

involves entering the natural environment (school). "Pull out" is used to assist a student to work on a performance skill or performance pattern. "Pull out" one on one services to address performance skills and patterns should occur for short periods of time, or only as long as needed to assist the student's development so that activities can be practiced within natural contests and the least restrictive environment.

Levels of service delivery (progressing from the least intense to most intense) are as follows:

- Classroom and home suggestions are made with no further follow-up unless requested. For example a change in seating location or physical arrangement of the classroom may be needed in order to reduce environmental distractions. A home program may be designed to allow parents to carry over goals at home, such as hand strengthening activities to reduce hand fatigue when writing. Home programs should be simple and every effort made to fit them into the home routine using readily available supplies.

- Environmental strategies (positioning or materials, e.g. adaptations to furniture, using a pencil grip) are shared where occupational therapy provides training in use/upkeep and assists in monitoring progress. The classroom positioning and materials adaptations may be designed, selected and monitored by the therapist, but may also be implemented by others. If the student's positioning or materials that he uses to implement his IEP requires adaptation (such as a pencil grip, slanted surface, seat cushion) the therapist recommends adaptations, provides training in use and upkeep, and assists in the monitoring of progress as needed.

- Instructional activities (e.g. classroom motor or sensory activities developed and implemented by the occupational therapist and team members) are provided. If motor or sensory difficulties limit a student's ability to achieve his educational goals, an occupational therapist may collaborate with the instructional staff to embed therapeutic activities (motor and/or sensory) into the classroom to be regularly carried out by staff. The occupational therapist provides staff training to address and monitor therapy intervention plans as well as provide input in revising intervention plans throughout the school year as a part of the collaborative team process. The frequency level is determined by the IEP team. For example, pre-handwriting exercises can be taught to the student and be done prior to handwriting or keyboarding, either individually or with the class group. Specific sensory activities for calming and focusing can be developed and carried out regularly throughout the day.

- Individual therapy can be carried out by the occupational therapist at school. However, collaboration with staff occurs regularly so that the team plays a major role in daily implementation of appropriate supportive activities across daily routines and settings. Since initially the expertise of the therapist is required, the implementation strategies are carried out by the therapist until they can be performed safely by other collaborative team members.

Accountability through Record Keeping: Accountability in the provision of occupational therapy services is achieved through appropriate documentation. School occupational therapists should keep regular, ongoing documentation of each student's occupational therapy interventions. In addition to evaluation reports and intervention plans, record keeping for school based occupational therapy should also include other types of documentation. These records help the occupational therapist focus on educationally relevant intervention as well as provide helpful background and historical treatment information. Records help form a basis for the occupational therapist to determine representative amounts of therapy needed to accomplish similar outcomes with other children. A child's progress toward the IEP goals is documented at least as often or as frequently as children in general education receive progress notes (report cards). At a minimum, goals are reviewed annually in collaboration with the student's case manager.

The purpose of record keeping is as follows:

- Provide a written record to demonstrate intervention plan accountability.
- Record the student performance, progress monitoring data specific to OT supported goals and behavior.
- Provide a written record of the student needs.
- Provide information to make decisions about the need to modify the intervention plan.
- Generate data to assist in the decision making process related to amount, duration, location, type of intervention, and to help facilitate the generalization of skills across settings and individuals.
- Provide a written record to assist in the development of evidence based practice.

Types of documentation that are important for an occupational therapist to maintain are as follows:

- Prepare progress reports at appropriate intervals. See above
- Keep attendance records that document the amount and frequency of service the therapist provides to the student.
- Keep daily or monthly progress notes on student's progress relative to the intervention plan and the IEP goals.
- Maintain copies of home and classroom programs.
- Document contacts with parents
- Document consultations with physicians and other medical personnel
- Document contacts with teachers and education staff
- Write discharge reports.

Considerations in Determining Continued Need for Occupational Therapy Services: In reviewing the IEP for a student who has been receiving occupational therapy services, the following criteria may be used to discuss each area of need in deciding whether therapy should be continued as previous, changed to a different level of service, or discontinued. Therapy services continue only if the need remains or if new needs are identified that meet the initial criteria. If the IEP Team determines that therapy services need to continue in order to implement the IEP, then therapy services are continued at a level determined by the IEP Team. If no needs remain, no new areas of concern are identified, and if therapy services are not specified as necessary by the IEP Team, the IEP should propose that the student be dismissed from therapy. Consider recommending a change in service level or discontinuing or discontinuation of service when:

- The goals or outcomes requiring occupational therapy support have been met and no additional ones are appropriate.
- The rate of progress continues to be steady and commensurate with the student's overall level of progress in other areas despite a decrease in therapy services. The student is performing functionally in their educational environment.

- The student's needs are being met through accommodations or instructional activities by another educational provider.

- Each area of need has been addressed to the point that no other interventions are needed.

- The potential for further change in each identified area of need appears unlikely.

- The problem does not continue to be educationally relevant.

- There is a change in medical or physical status.

- No further adverse affect of issues addressed by occupational therapy are evident on educational performance.

## ADMINISTRATIVE GUIDELINES

### Caseload/Workload

There are no specific California guidelines that exist for establishing an exact caseload, although some states do have rules that define minimum and maximum caseload sizes. Each district should take into consideration a number of factors in determining an appropriate caseload. These would include, although are not limited to: identified administrative responsibilities of the therapist; for example keeping records, ordering equipment (Note: therapists use a variety of small and larger pieces of equipment in providing therapy services, such as therapy balls, scooter boards, T stools, slant boards, easels, a wide variety of hand tools, visual perceptual/visual motor materials, pencil grips, sensory related materials, etc.), attending meetings, scheduling, consulting, meeting with parents, in-service training, needs assessment; amount of travel between schools; the number of evaluations or screenings the therapist would be expected to do; and the specific service levels that are listed on students' IEP's, for example the number of students seen weekly, or twice monthly, or monthly or less. The occupational therapist needs sufficient time to do all of these work related responsibilities to insure quality services to students**.** Tools to be used to assist in determining appropriate workload are the Workload Management Form (WMF) appendix 11.1, written schedule, and maintenance of rosters by therapist which may include number of children served, frequency and duration, pending triennial and annual assessments.

### Training

District should provide professional development opportunities to occupational therapists. Occupational therapists in California are required to complete 24 professional development units every two years to maintain licensure.

## SOURCE DOCUMENTS

### Source Documents

AOTA Online Course Titled "Occupational Therapy in School-Based Practice: Contemporary Issues and Trends", Continuing Education from AOTA, May 2004, Authors: Yvonne Swinth, PhD, OTR/L, and Gloria Frolek Clark, MS, OTR/L, FAOTA.

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## APPENDIX A Definition of Terms

**Adaptive Equipment** are devices used for positioning or to assist with active movement that help to normalize tone and facilitate normal patterns of movement or response.

**Adaptive Response** is an appropriate or effective reaction in response to a stimulus or environmental demand.

**Arousal** is a state of the nervous system describing how alert one fells. One needs an optimal state of arousal to attend, concentrate, and engage with the physical world.

**Assessment** is a test or tests given to an individual by qualified professionals to determine current academic levels in such areas as math, reading, and spelling.

**Balance** is the stability of the body against gravity; equilibrium.

**Balance Reaction** is one of a set of automatic movement patterns that occurs in response to changes in the relationship of the body's center of gravity to the force of gravity that allows the individual to maintain balance.

**Base of Support** is the center of stability from which the individual moves (often derived from those body parts in contact with a solid surface such as the ground).

**Body Image** is the conscious awareness and perception of one's own body, including values and feelings about one's bodily function and appearance.

**Body Schema** is the unconscious awareness of one's own body both in terms of its individual parts and how they are related to make up the whole.

**CCS** California Children's Service.

**Central Nervous System** (CNS) is the brain and spinal cord, where incoming sensory impulses are received and from which outgoing motor impulses are sent. The CNS supervises and coordinates the activity of the entire nervous system.

**CFR** Code of Federal Regulations are rules and regulations of federal agencies as published in the *Federal Register*.

**Clinical Observations** are objective descriptions of the individual's behavior made by a trained professional and based on a comparison with typical behavior under similar circumstances.

**Co-contraction** is the balanced activation of muscle groups on both sides of a body part, providing stability for movements against gravity and for the maintenance of antigravity postures.

**Collaboration** is working jointly with another person or persons.

**Compensation** is the atypical posture or pattern of movement used instead of a normal posture or pattern to accomplish a functional goal.

**COTA** is a Certified Occupational Therapist Assistant. A person who has completed a program approved by the American Occupational Therapy Association, is certified by the American Occupational Therapy Certification Board, has an active license from the California Board of Occupational Therapy, and provides occupational therapy services under the supervision of a registered/licensed occupational therapist.

**Diagnostic Tests** are assessments and evaluations used to find specific strengths and weaknesses in a developmental learning skill or academic subject.

**Dissociation** is the ability to move different body parts of muscle groups separately from one another as appropriate.

**Dysfunction** is the impaired or abnormal functioning.

**Due Process Hearing** is the process for resolving disagreements between a local public agency and a parent regarding IEP and IFSP issues, including assessment, eligibility, placement, and services.

**Dysfunction** is the poor or impaired ability to perform or function in a particular way.

**Equilibrium** is the same as balance.

**Equilibrium Reaction** is one of a set of automatic patterns of body movement that enable the individual to adapt in response to change in the position of the body's center of gravity.

**Extension** is straightening; a movement that causes an increase in the angle between two adjoining bones.

**Extensors** are those muscles that, when contracted, produce extension.

**Evaluation** is the process of collecting and interpreting data in order to make a determination about the need for services. The evaluation includes planning for and documenting the process and results. It can be accomplished through a variety of methods, such as observation, record review, interview, or administering an assessment. As defined in the IDEA 97 Regulations: Procedures used to determine whether a child has a disability and the nature and extent of the special education and related services needed (34 CFR 300.500 (b) (2)).

**FAPE** Free Appropriate Public Education is special education and related services that are provided at public expense, under public supervision and direction, and without charge; meet State standards; include preschool, elementary, or secondary school; and, are provided in accordance with an appropriate IEP (34 CFR 300.13).

**Federal regulations** are rules generated by administrative agencies to help implement laws. These rules translate and interpret the broad and unspecific policies and procedures outlined in the law. The U.S. Department of Education generates regulations for IDEA.

**Fixing** is using abnormal bodily mechanisms (e.g., increased muscle tone, atypical posturing) to increase postural stability. Fixing increases stability but decreases mobility.

**Flexion** is bending; a movement that causes a decrease in the angle between two adjoining bones.

**Flexors** are those muscles that, when contracted, produce flexion.

**Goal** is the desired behavior to be brought about by the services. In Part B of IDEA, a goal is a statement of projected behavior change that will occur

over a one year period. Goals are to be clear, measurable, behavioral, functional, and appropriate to the student's needs.

**Graded Response** is a degree of response appropriate to the level of stimulus; a response from the midrange of possible responses rather than an extreme (all-or-nothing) response.

**High Tone** is the increased tone in the muscles above normal limits; hypertonia.

**Hypersensitive** is overly sensitive or overly responsive to stimuli.

**Hypertonia** is increased tension in the muscles that results in reduced mobility and limited range of motion.

**Hypotonia** is decreased tension in the muscles that results in lack of postural stability and excessive range of motion.

**IDEIA** Individuals with Disabilities Education Improvement Act is the federal educational law that delineates and governs special education services. It was reauthorized in December 2004.

**IEP** Individualized Education Program is a working document required by IDEIA, Part B, for the special education student from three through twenty-one years that documents the eligibility for services; level of present functioning of the student; appropriate goals, objectives, services, and service provider; and other specifics. When the IEP is signed as accepted by the parent or legal guardian, the IEP becomes the legal document for compliance with provisions for service. The IEP team refers to all the members, including the parents, who meet or provide services to the special education student as part of the free and appropriate educational program. The IEP meeting is where the IEP is discussed and formulated.

**Intervention Plan** guides the direction of occupational therapy services and defines the process for achieving the expected outcomes.

**Joint Approximation** (also called joint compression) is the use of pressure to bring the articulating surfaces closer together.

**Kinesthetic System** is the sensory system that responds to (sends information to the brain about) the movement of individual body parts.

**LEA** Local Education Agency. The school district or county office of education.

**Localization** is the ability to identify the source of a stimulus.

**Low Tone** is the reduced tone in the muscles below normal limits; hypotonia.

**LRE** Least Restrictive Environment is the concept of providing education in the most natural environment, with typically developing peers, as appropriate to meet the student's needs. LRE as used in Part B of IDEA ensures that children with disabilities are educated with typically developing children to the maximum extent appropriate. It also ensures that that students with disabilities are removed from general education only when the nature or severity of their disabilities, even with supplementary aids and services, prevents satisfactory achievement in general classes (34 C.F.R. §300.550).

**Mainstreaming** and **inclusion** are terms frequently used when referring to general education opportunities for children with special education needs. Mainstreaming refers to the educational team's recommendation for a special education program as the student's primary placement and includes opportunities in the general education setting. Inclusion refers to a program that is primarily general education, with special education resources and supports provided as needed.

**Midline** is an imaginary line running down the center of the body from head to toe.

**Motor Planning and Sequencing** is the capacity to sequence actions, behaviors, words, images, and thoughts to produce a coherent and understandable outcome.

**Muscle Tone** is the amount of tension in the muscles.

**Natural environments** refers to those settings that are "natural or normal" for the student's peers who do not have disabilities.

**Objective** An objective is the projected behavior that would indicate progress toward an annual goal. Objectives should represent specific, measurable,

intermediate steps. A statement of the objectives describes the child's performance, the conditions under which he performance is to occur, and the criteria for the acceptable level of performance.

**Occupational Therapy** is defined in the Code of Federal Regulations (C.F.R.) as a related service in IDEA, Part B, and as an early intervention service in IDEA, Part H.

**Postural Stability** is the ability to maintain posture against gravity using normal patterns of movement.

**Postural Tone** is the degree of tension in the muscles.

**Posture** is the position from which an individual starts a movement.

**Perception** is the process by which the brain organizes, integrates, and makes sense of incoming stimuli and sensations.

**Prone** is lying on the stomach.

**Proprioceptive System** is the sensory system that responds to (sends information to the brain about) sensations from the joints, muscles, and tendons.

**Related Services** A federally defined service in IDEA that may be provided to a special education student to benefit from his or her special education program. Occupational therapy is federally defined related service. Related services are developmental, corrective and other supportive services as are required to assist a child with a disability to benefit from special education; includes services such as transportation, physical therapy, occupational therapy, audiology, etc.

**Responsiveness** is the individual's ability to change behavior when environmental stimuli change.

**Rotation** is movement around the long axis of the body part.

**RSP** Resource Specialist Program.

**SDC** Special Day Class.

**Self-regulation** is the ability to maintain and change the level of arousal appropriate to the situation; to match energy and behavior to the demands of the situation.

**SELPA** Special Education Local Plan Area is an educational region that provides special educational services to children within a defined geographic area. A SELPA may include more than one local educational agency.

**Sensation** is the awareness of a stimulus.

**Sensorimotor** relates to both senses and movement and the combination of the input of sensations and the output of motor activity. Motor activity reflects what is happening to the sensory organs such as visual, auditory, tactile and kinesthetic sensations.

**Sensory Integration** is the ability to organize the input from multiple senses for use in adaptive responses.

**Sensory Integration Dysfunction** is an irregularity in central nervous system function that makes it difficult to process, organize, and/or use sensory input effectively.

**Sensory Modulation** is the ability to manage sensation in a graded and adaptive manner.

**Sensory Processing** is the ability to register, decode, comprehend, and differentiate sensory input, sensory sequences, and sensory patterns.

**Sensory Receptors** are nerve cells that receive information to be sent to the central nervous system.

**Social Play** is the social interactions that include how the child relates to his or her parents, therapists, teachers, and peers as well as the ability to engage in developmentally appropriate play activities.

**Spatial Relations** is relating to information about the position of objects in space and their relationship to other objects in space.

**Supine** is lying on the back.

**Symmetrical** is the same on both sides of the body.

**Tactile** is having to do with touch.

**Tactile Defensiveness** is a sensory integrative dysfunction in which the individual is excessively sensitive to touch sensations and responds with negative emotional and/or physical reactions to touch sensations.

**Treatment Plan** is the same as an Intervention Plan.

**Tactile System** is the sensory system that responds to touch sensations.

**Vestibular System** is the sensory system (whose receptors are located in the semicircular canals of the inner ears) that responds to the position of the head in space and in relation to gravity, and to changes in direction and speed of movement.

**Visual Motor Coordination** is the ability to coordinate vision with the movements of the body or parts of the body.

**Visual Perception** is the identification, organization and interpretation of stimuli received by the individual through vision/eyesight.

**Weight Bearing** is supporting some or all of the body's weight.

**Source Documents**

California Department of Education, Sacramento. (1996). *Guidelines for Occupational and Physical Therapy in California Public Schools.* Sacramento, California.

Coling, M. (1991). *Developing Integrated Programs: A Transdisciplinary Approach for Early Intervention.* Tucson, Arizona.

Wisconsin Department of Public Instruction. (1996). *Occupational Therapy and Physical Therapy. A Resource and Planning Guide.* Madison, Wisconsin

# APPENDIX B Job Description -- Occupational Therapist

## JOB TITLE

Occupational Therapist

## SCOPE OF RESPONSIBILITIES

Reports ultimately to the School District Special Education Director or designated individual. Provides students with occupational therapy assessments and services that are necessary for the student to benefit from special education, including adapting the environment, modifying the functional tasks, and, if needed, addressing elements of sensori-motor performance. Assists educators in identifying students who may benefit from occupational therapy intervention and provides services in accordance with a student's Individualized Education Program (IEP). Participates as a member of the educational team, and assists in program development to incorporate occupational therapy strategies into the classroom to benefit all students. Consults with regular education and special education staff and parents regarding implementing occupational therapy interventions for an individual student into the educational setting. Provides inservice training to District staff.

## EDUCATION

Must be a graduate of an accredited college or university with a Bachelors or Masters degree in Occupational Therapy.

## LICENSURE

Must be licensed by the California Board of Occupational Therapy to practice as an Occupational Therapist in California, and maintain a current license.

## LENGTH OF WORK YEAR

Services are required for the regular school year and extended school year.

## EXPERIENCE

Minimum of 1 year experience providing occupational therapy services in a pediatric setting, preferably school based. Any other related training and/or experience which demonstrates that the applicant is likely to possess the required skills, knowledge and abilities may be considered.

**DUTIES AND RESPONSIBILITIES**

1. Assists in the development of the school district's occupational therapy assessment policy and development of written procedures to be followed related to making a request for assessment.

2. When requested, participates in the initial screening of a student, and in the special education referral process.

3. Conducts an occupational therapy assessment that evaluates a student within the educational (natural environment) setting to assess the student's performance in activities that are curriculum oriented and applicable to functioning in a classroom and in daily life routines necessary at school.

4. Includes in the occupational therapy assessment an observation of the student in the educational setting, a review of student records, an interview of appropriate educational staff, and standardized/non-standardized test procedures in areas of suspected disability

5. Completes the assessment and provides a written report within California mandated timeline.

6. Reports assessment findings to the IEP Team and helps the IEP team identify the student's abilities, as well as educational, developmental, and functional needs.

7. Assists the IEP Team in developing educationally related goals/objectives and/or student outcomes to be included in the IEP.

8. Develops an occupational therapy intervention plan that supports the student's goals and objectives and/or student outcomes as written by the IEP team.

9. Implements the intervention plan which may include: assisting teachers in adapting or modifying the student's classroom environment, materials, and curricula; providing strategies and activities for classroom, group, or home; providing pullout services when inclusive strategies are insufficient to meet the student's needs.

10. Monitors student goals and documents student progress, maintains records as required in the special education process identified in federal, state, and school district regulations and procedures.

11. Consults with general and/or special educational personnel and shares occupational therapy activities and strategies which can be incorporated into the educational setting.

12. Provides inservice training to the educational staff, organizes workshops for parents and makes presentations to administrators.

13. Participates in the assessment of school facilities and educational activities and makes recommendations to ensure accessibility and reasonable accommodations to school environments for individuals with disabilities as mandated by federal and state laws.

14. Performs other duties as assigned by the District Special Education Director, which might include coordinating student services or exchanging information between the local school district, CCS, regional centers, or other agencies.

**PHYSICAL DEMANDS**

The work requires the use of hands for simple grasping, pushing and pulling, and fine hand manipulations. The work at times requires bending, kneeling, squatting, or crawling on the floor and the ability to lift, carry, push, or pull equipment or objects less than 40 pounds. Must be able to lift and position students weighting 40 pounds or less in wheelchairs, or on/off other equipment. On occasion, therapist may be required to physically restrain a student. The therapist may need to assist in the cleaning and personal hygienic needs of a student. The work requires driving automobiles, and exposure to dust, fumes and gases.

**SPECIAL REQUIREMENTS**

Involves travel to various school sites/locations, requires the use of a personal automobile, and a valid California Class C Driver's license.

# APPENDIX C Job Description – Certified Occupational Therapy Assistant

## JOB TITLE

Occupational Therapy Assistant

## SCOPE OF RESPONSIBILITIES

Reports to the School Occupational Therapist. The occupational therapist has the ultimate responsibility for service delivery. Included in this responsibility is the supervision of the activities performed by the Certified Occupational Therapy Assistant (COTA).

The certified COTA provides students with therapy services, under the supervision of a licensed therapist that are necessary for the student to benefit from special education, including adapting the environment, modifying the functional tasks, and, if needed, addressing elements of sensorimotor performance.

## EDUCATION

Must have a High School Diploma or GED. Must be a graduate of an occupational therapy assistant program accredited by the American Occupational Therapy Association.

## POSITION QUALIFICATIONS

Must have a current certification from the National Board for Certification in Occupational Therapy.

## CERTIFICATION

Must be certified by the California Board of Occupational Therapy to practice as an Certified Occupational Therapy Assistant, and maintain a current certification.

## LENGTH OF WORK YEAR

Services are required for the regular school year and extended school year.

**EXPERIENCE**

Minimum of 1 year experience providing occupational therapy services in a pediatric setting, preferably school based. Any other related training and/or experience which demonstrates that the applicant is likely to possess the required skills, knowledge and abilities may be considered.

**DUTIES AND RESPONSIBILITIES**

1. Administers treatment and implements programs as designed by the therapist.

2. Interacts with parents and school personnel, and contributes information in meetings, conferences, or informal interactions.

3. Assists the therapist in communicating with parents concerning home programs, equipment , and other therapy-related matters.

4. Documents student progress and maintains appropriate data/records pertaining to therapy services

5. Track student's record to determine when reviews are scheduled.

6. Recommends individual equipment needs and modifications to the therapist and assists in adapting, fabricating, and maintaining equipment.

7. Participates in providing inservice programs to school district personnel.

8. Performs other duties as assigned by the therapist.

**PHYSICAL DEMANDS**

The work requires the use of hands for simple grasping, pushing and pulling, and fine hand manipulations. The work at times requires bending, kneeling, squatting, or crawling on the floor and the ability to lift, carry, push, or pull equipment or objects less than 40 pounds. Must be able to lift and position students weighting 40 pounds or less in wheelchairs, or on/off other equipment. On occasion, therapist may be required to physically restrain a student. The assistant may need to assist in the cleaning and

personal hygienic needs of a student. The work requires driving automobiles, and exposure to dust, fumes and gases.

**SPECIAL REQUIREMENTS**

Involves travel to various school sites/locations, requires the use of a personal automobile, and a valid California Class C Driver's license.

# APPENDIX D Educationally Related IEP Goals

The Individualized Education Program (IEP) goals must contain a statement of measurable annual goals, including benchmarks or short-term objectives, if the student is taking CAPA, related to meeting the child's educational needs. Prominent members of the American Occupational Therapy Association (AOTA), the professional OT association, have expressed their position that separate occupational therapy goals should not be included in the IEP.

The role of occupational therapy is as a support service to the educational goals, and separate OT goals are not written for inclusion in the IEP. Rather occupational therapy is listed as a responsible party under the goals which the therapy service will support, just as teacher, RSP, or speech and language therapist may be indicated. While the occupational therapist should have his/her own intervention plan for addressing the IEP goals, this is not included in the IEP, much as a teacher's lesson plan is not included in the IEP. The occupational therapist should collaborate with the IEP team to develop appropriate educational goals and should also provide input into review of these goals at appropriate intervals.

An AOTA online continuing education course offered in May, 2004, discussed the development of outcomes and goals for the IEP. The AOTA online course was entitled "Occupational Therapy in School-Based Practice: Contemporary Issues and Trends". The authors of the following educational material were Yvonne Swinth, PhD, OTR/L, and Gloria Frolek Clark, MS, OTR, FOTA.

The information from this course remains consistent with information which the AOTA has been providing school based occupational therapy practitioners since the revision of IDEA in 1997.

> As explained by AOTA the IEP team members collaborate in developing educationally based and measurable goals for the IEP. Outcomes and goals are established before determining the need for instructional staff, related services, and supports to achieve the outcomes and goals. Too often teams decide on services before fully discussing the needs of the child, which may result in an overlap in services, a gap in services, or a lack of progress toward stated outcomes or goals (Giangreco, 1995, 1996, 2001b; Giangreco, Edelman, Luiselli, & MacFarland, 1996). Teams need to revisit this "old" way of thinking and adjust their communications and processes to determine the child's needs first, and then discuss services.

For the IEP, goals are written to reflect how the student's educational progress will be documented and measured.

It is important to remember that in educational settings, goals should reflect not what the therapist will do for the child, but rather how the team will measure child progress.

The IDEA contains specific requirements for the IEP. None of the regulations are prescriptive regarding specific teaching or therapy interventions (e.g., the IDEA does not require therapists to state that sensory integration therapy will be the intervention used). Nor do these regulations outline exactly what any given program should look like.

The IEP for each child with a disability must include -- A statement of measurable annual goals, including benchmarks or short-term objectives, for students taking CAPA related to: meeting the child's educational needs that result from the child's disability to enable the child to be involved in and progress in the general curriculum (i.e., the same curriculum as for typically developing children), or for preschool children, as appropriate, to participate in appropriate activities; and meeting each of the child's other educational needs that result form the child's disability.

Finally, developing a child's program and plan must be a collaborative process. The team must recognize the unique skills and expertise of each professional and where those skills and expertise may overlap. The process must be centered on the needs of the child rather than on a specific therapeutic intervention or therapy methodology.

When writing goals, the team should not have "occupational therapy" or "speech" goals; the goals are child or student goals, and they should reflect the needs of the child or student. Related services and supports may be provided under any goal, as appropriate.

The following narrative expresses the viewpoint of some prominent members of the AOTA regarding AOTA's interpretation of Individuals with Disabilities Education Act (IDEA) Amendments (1997), in writing IEP "student" educational goals. Source references have been included in the endnotes.

Occupational therapy is one of a number of related services available for children with disabilities under the IDEA. An Individualized Education Program (IEP) is written that documents an educational program that will help the student progress in the general curriculum. The IEP guides the delivery of special education and related services.

The IEP must include certain information about the educational program designed to meet the child's needs.[3] Annual goals are written that the child can reasonably accomplish in a year. Goals may be academic, address social or behavioral needs, relate to physical needs, or address other educational needs.

A child's IEP goals are "student" goals and not occupational therapy goals.[4] The teacher, occupational therapist and other related service providers are all responsible for these goals. The IEP is a process and document that leads to and describes an individualized program of special education services and strategies that a student requires in order to achieve the IEP team-generated goals.[5] The IEP does not belong to the service providers, and IDEA never intended that each discipline create their own portion or own versions of the IEP. There should be one set of student-focused goals in the IEP, and the IEP should not include separate occupational therapy goals. The team members are responsible to identify the services that are needed to help the student accomplish this set of annual goals. Special education and related service providers contribute different areas of expertise and strategies toward the specific IEP objectives related to annual goals -- for example

> "Susan will produce legible written/drawn responses for 80% of items on weekly math and language arts worksheets."

The Occupational Therapist (OT) supporting this outcome devises adapted tools and systems that Susan needs in order to produce lasting and understandable responses to the worksheet items, while the resource room teacher addresses the academic concepts that are required for Susan's participation.

In summary, an IEP goal should result in an educational outcome (e.g. completing written assignments, being able to get dressed for PE, or being able to participate in school activities).[6] The IEP goal addressed by an OT should be linked back to the general curriculum. The OT, as the service provider, is responsible for developing an occupational therapy treatment plan, using evaluation data, information from the rest of the team, and his/her professional judgment. The occupational therapy treatment plan is comparable to the teacher's lesson plan and is not included in the IEP.

Information was extracted from the following References:

1. Individuals With Disabilities Education Act Amendments. (1997). Public Law 105-17, 20 U.S.C. §1400 et seq.

2. Individuals With Disabilities Education Act Amendments. (1999, March 12). Public Law 105-17, Final regulations, 34 CFR, Parts 300, 303, Federal Register, Vol. 64, No. 48.

3. A Guide to the Individualized Education Program. (2000, July). This guide developed by the U.S. Department of Education, with the assistance of the National Information Center for Children and Youth with Disabilities (NICHCY). Editorial Publications Center, U.S. Department of Education.

4. Clark, G. and Jackson, L. (1998, May 8). Web-based Workshop: "Occupational Therapy Services Under the Individuals With Disabilities Education Act (IDEA)". Sponsored by American Occupational Therapy Association (AOTA).

   Leslie L. Jackson, MEd, OT/L, is the Pediatric Program Manager in the Practice Department of AOTA. In this role she represents pediatric practitioners to multiple audiences within the association and external groups. Leslie and AOTA's Government Relations Department were actively involved in the reauthorization of IDEA, with a particular emphasis on ensuring the appropriate utilization of occupational therapy services and practitioners.

5. Muhlenhaupt, M. (2002). Frequently Asked Questions about School-based OT and PT Practices. Web site: www.kidsot.com.

   Mary Muhlenhaupt, OTR/L, FAOTA, has been an occupational therapist for twenty-six years. With expertise in occupational therapy as a "related service," she advocates for education programs for children with special needs that are built upon cooperative practices between families and school personnel. Mary serves on the staff of AOTA as Education/Research Liaison, School System Special Interest Section (2000-Present). She was Chairperson, School System Special Interest Section (1997-2000), and a member of the AOTA Executive Board (1994-1997).

6. Jackson, L. (2002, October 18). "IEP Objectives", E-mail response on "Sensory Integration SIS Listserv" from <ljackson@aota.org>

## APPENDIX E General Comparison of Medically Related and Educationally Related Occupational Therapy Services

**General Comparison of Medically Related and Educationally Related Occupational Therapy Services:** Medically related occupational therapy is usually one to one and occurs outside the classroom with intervention normally focusing on the underlying causes of the problem. Educationally related occupational therapy services are meant to be inclusive, with service delivery often occurring within the classroom setting and providing opportunities for practice and development of skills within the natural classroom environment. This type of service delivery is based on the child's need within the educational setting and is consistent with the IEP.

**Comparison of Medically Related and Educationally Related Occupational Therapy Services**

| Medically Related | Educationally Related |
|---|---|
| Treatment goals are top priority. | IEP goals are top priority. |
| Intervention is discipline based | Intervention more collaborative based. |
| Assumes an underlying cause with diagnosis based on symptomatology. | Acknowledge underlying cause. Focus in on what behavior or function needs to be accomplished. |
| Evaluation to reveal underlying problem. | Evaluation to determine what functional problem needs resolution (i.e., student's unique education needs). |
| Dysfunction is within the student. | Dysfunction is a mismatch between student's abilities and what is being demanded or asked by the educational environment. |
| Intervention focuses on "curing" the cause and tends to be long term because underlying causes are often never able to be fully cured. | Intervention focuses on function and is typically more short term. |
| Intervention is usually one to one and occurs in a setting outside of the classroom. | Intervention is **usually** group oriented and can be in the classroom or other school settings. |
| Intervention location is clinic based. | Intervention location is least restrictive environment. |
| Provider uses medical terms that are not generally understood by parents and teachers. | Provider typically uses everyday language that are more readily understood by parents and teachers. |
| Delegation of intervention to others is infrequent. | Delegation of techniques to non OT's through consultation. |

**APPENDIX F Assessment of Occupational Therapy Needs & Report**

# Assessment of Occupational Therapy Needs

The purpose of assessment is first to assess in all areas of suspected disabilities and then to determine the student's needs and provide a rationale for addressing those needs as they relate to special education or related services. The occupational therapist delineates components that support or hinder student performance and contribute to the overall educational plan for a student. A student's progress is assessed continually by the service provider and annually or more frequently if requested by the IEP Team. Both the initial and triennial assessments are comprehensive measures of student performance. The annual and triennial assessment will address changes in function over time or in response to intervention (California Education Code Section 56380-56381).

An occupational assessment addresses both individual student abilities and functioning within the educational environment. Within the *Ecological Model of Student Performance*, information is gathered from three factors: student abilities, curriculum, and environment. The interaction of these factors is what constitutes student performance. The goal of the assessment is to identify the components that affect a student's performance. Generally, occupational therapy assessments involve the following components: review of records; interviews of the teacher, parents, and other personnel knowledgeable about the child; and observation of the student within the educational environment. In addition and as appropriate, formal assessments, including standardized assessments and any relevant clinical observations, may be used to gather additional information about the student's functional levels.

Student performance cannot be evaluated accurately without observation of the student in the appropriate educational setting. Common standardized tests that assess student abilities do not evaluate student performances. The link between standardized tests and student performance can be confirmed through observation of the student in the educational environment and interviews with the student, teacher, or parent.

All of this information enables the assessor to evaluate the student's performance comprehensively within the educational environment and provide informed recommendations to the IEP team. The *Ecological Model of Student Performance* Table presents pertinent questions related to each factor. The questions may be used to select assessment tools and organize relevant information. Selection of assessment tools will

depend on a variety of factors: the purpose of the assessment; the child's personal characteristics; the philosophical orientation of the educational program (e.g. functional, developmental, or academic); and the overall team approach used within a particular setting (e.g. multidisciplinary, interdisciplinary, or transdisciplinary).

## Ecological Model of Student Performance: Assessment Questions

| Factor | Student abilities | Curriculum | Educational environment |
|---|---|---|---|
| **Record review / Checklist** | What is the medical diagnosis? What is the eligibility for special education? Establish a profile of strengths and areas of concern. (Assess in these areas.) | What are the IEP goals? What goals are related to occupational therapy areas of expertise? | What is the program placement and classroom setting? Who are the educational personnel addressing educational areas of concern or IEP goals? |
| **Parent / Teacher** | Does the student have the ability to participate in the ongoing structure/routine of the class? What does the teacher/parent see as the child's strengths and weaknesses? What are the parent's concerns regarding their child's functioning in his/her educational program? | What type of curriculum is being used? In which areas of the instructional program is the student having the greatest difficulty? (Assess in those instructional areas.) What are the teacher's expectations for the students in his/her classroom? What are the methods of behavior management? | In which setting is the child having the greatest difficulty? (Assess in these settings.) How does the student interact and work with peers in the classroom? What other staff might contribute information about his student's performance in areas of concern? Is the student using any special adaptations of special equipment? What is the student's daily school schedule? |

# Ecological Model of Student Performance: Assessment Questions

| | | | |
|---|---|---|---|
| **Student observation** | To what extent is the student able to participate in the environment? Focus observation on occupational therapy areas of expertise relevant to the educational program. | Do the curriculum demands match or accommodate the student's abilities? Is the student sufficiently challenged within his/her educational environment? | Is the physical environment (student's desk, educational technology, lighting, acoustics, instructional materials, and classroom/campus design) suitable or does it present an obstacle to the student? Do the organization, structure, and routine meet the student's needs? Is the child able to follow the social rules and interact with classroom members? |
| **Standardized / Non-standardized assessment** | Targeting areas of concern, focus assessment on occupational therapy areas of expertise to discern additional relevant factors and underlying skills that impact student performance. | | |
| **Summary** | What does the assessment information reveal about the student's abilities? What is the student's potential for improvement, maintenance, or regression? Would therapeutic interventions likely result in improved functional changes in the classroom? | Within the curriculum, what is specifically expected of the student that he/she is not accomplishing? Is the student inefficient/slow? Are there modifications that could enable the student to participate more successfully? | Would modifications or classroom adaptations alone suffice as an intervention? What environmental accommodations would assist the student in functioning? Would changes in structure, routine, or the social environment assist the child in participating in the educational program? Are there other educational personnel who can address the student's areas of need? |

# Report of the Assessment

Once the assessment has been completed, information is synthesized for presentation to the IEP Team. For each of these areas -- student abilities, curriculum, and environment -- the therapist lists the strengths, areas of concern, and suggestions for educational planning.

California Education Code Section 56327 requires that after an assessment has been made, a report must be written and must include but not be limited to all of the following as appropriate to the discipline:

(a). Whether the pupil may need special education and related services

(b) The basis for making the determination

(c) The relevant behavior noted during observation of the pupil in an appropriate setting

(d) The relationship of that behavior noted during observation of the pupil in an appropriate setting

(e) The educationally relevant health and development, and medical finding, if any

(f) For pupils with learning disabilities, whether there is a discrepancy between achievement and ability that it cannot be corrected without special education and related services

(g) A determination concerning the effects of environmental, cultural, or economic where appropriate

(h) The need for specialized services, materials, and equipment for students with low incidence disabilities consistent with guidelines pursuant to Section 56136

Key elements of the occupational therapy report are the following:

1. *Background*: May include relevant health and developmental history, reason for the assessment, parent concerns, social or educational history.

2. *Methods of assessment and dates*: List methods used and dates (e.g. review of records, observation, interview, checklist, non-standardized or standardized testing procedures or both).
3. *Validity of findings*: Discuss child's behavior and whether testing appeared to be an accurate reflection of performance.

4. *Findings*: Report information gathered through observation, interview, or checklist and standardized test scores, together with an interpretation of the educational relevance of these findings.

5. *Summary*: Summarize the significance of the assessment results as related to the student's educational performance and program, including the student's strengths, areas of concern, and the level of performance of function needed for the student to benefit from the educational program.

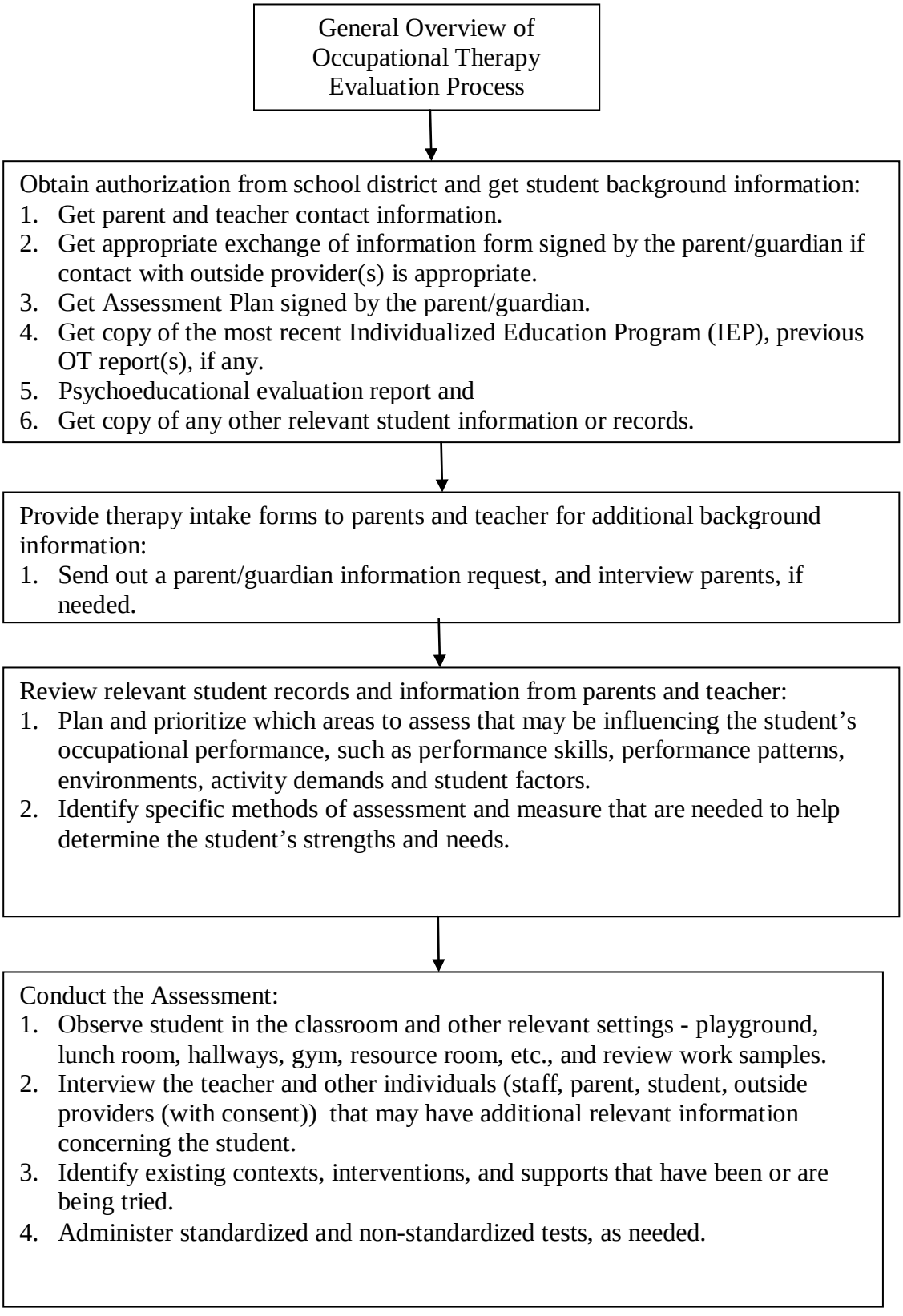
6. *Recommendations*: A statement as to whether the student will benefit from occupational therapy to improve educational performance should be included. The IEP Team is responsible for the final decisions regarding the provision of special education and related services.

**Source Document**

California Department of Education, Sacramento. (1996). Guidelines *for Occupational and Physical Therapy in California Public Schools.* Sacramento, California.

**APPENDIX G Flowchart – General Overview of Occupational Therapy Evaluation Process**

- **This flowchart is merely a guideline for the assessment process. All assessment should comply with the requirements of the Individuals with Disabilities Education Act (IDEA) and the California Education Code.**



Review all compiled information and analyze test results to identify performance skills, performance patterns, environments, activity demands and client factors that affect the student's ability to function in the educational setting:

1. Review educational background information.
2. Review student observation notes.
3. Review teacher and other individual(s) interview notes.
4. Review parent information/interview form.
5. Review teacher classroom questionnaire/checklist.
6. Analyze student standardized/nonstandardized test results.

Prepare a written occupational therapy evaluation report and send to school district. The report should include:

1. Referral and relevant health and developmental history.
2. The purpose of Evaluation.
3. The results of assessment activities, including interviews, observation and testing (i.e., the bases of any of the determinations made in the report).
4. Summarize student's strengths and needs related to student's occupational performance and academic and social functioning across appropriate school environments.
5. If appropriate, document how occupational therapy strategies and techniques may be able to support the student needs.
6. Provide recommendations for IEP team to consider with regard to the student's occupational need and its relationship to the student's total educational

Attend and present the occupational therapy evaluation results at the IEP team meeting:

1. Present the occupational therapy evaluation report.
2. Explain the suggested recommendations and answer any questions.
3. Propose goals to the IEP team for any identified areas of occupational therapy need.
4. Collaborate with team members regarding the final determination for the provision of occupational therapy services.

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