Occupational Therapy Guidelines

BERRIEN RESA
Today's Purpose - Tomorrow's Promise.

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Contents

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School-Based Occupational Therapy

General Information

Educational environments, theories and thoughts have changed over the years. More often, students with learning challenges are educated in local schools, in general education classrooms, with typically developing peers. Students' needs demand a continuum of programming options, including local schools, regional programs or center based programs. Occupational Therapy (OT) within the context of educational settings can be provided within a variety of service models. When determining school placement and related services, consideration of “free appropriate public education" in the least restrictive environment is mandated. 34 CFR §§300.121 and 300.13

School occupational therapists are key contributors within the education team. They support a student’s ability to participate in desired daily school activities or “occupations.” They help children to fulfill their role as students by supporting their academic achievement and promoting positive behaviors necessary for learning. School occupational therapists support academic and non-academic outcomes, including social skills, math, reading and writing (i.e., literacy), behavior management, recess, participation in sports, self-help skills, prevocational/ vocational participation, transportation, and more. Because of their expertise in activity and environmental analysis, practitioners are particularly skilled in facilitating student access to curricular and extracurricular activities. They focus on the student’s strengths, and can design and implement programming to improve inclusion and accessibility, such as Universal Design for Learning. Additionally, they play a critical role in educating parents, educators, administrators and other staff members. They offer services along a continuum of prevention, promotion, and interventions and serve individual students, groups of students, whole classrooms, and whole school initiatives. They collaborate within the education team to support student success. In this way, occupational therapy practitioners can contribute within both general and special education. (AOTA, 2016.).

Occupational therapy practitioners have specific knowledge and expertise to increase participation in school routines throughout the day. Interventions include:

1. Conducting activity and environmental analysis and making recommendations to improve the fit for greater access, progress, and participation
2. Reducing barriers that limit student participation within the school environment
3. Providing assistive technology to support student success
4. Supporting the needs of students with significant challenges, such as by helping to determine methods for alternate educational assessment and learning
5. Helping to identify long-term goals for appropriate post-school outcomes
6. Helping to plan relevant instructional activities for ongoing implementation in the classroom
7. Preparing students for successfully transitioning into appropriate post–high school employment, independent liv-ing, and/or further education

Federal IDEA defines occupational therapy as services provided by a qualified occupational therapist; and includes: (A) Improving, developing, or restoring functions impaired or lost through illness, injury or deprivation; (B) Improving ability to perform tasks for independent functioning if functions are impaired or lost; and (C) Preventing, through early intervention, initial or further impairment or loss of function. (IDEA, 2002). The American Occupational Therapy Association (AOTA, 2016), defines occupational therapy as the therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of enhancing or enabling participation in roles, habits, and routines in home, school, workplace, community, and other settings.

The practice of occupational therapy does not include any of the following:

i. The practice of medicine or osteopathic medicine and surgery or medical diagnosis or treatment.
ii. The practice of physical therapy.
iii. The practice of optometry.

Educational Requirements for Occupational Therapists Employed By Berrien RESA:

a. Successful completion of an entry-level Master's degree occupational therapy program at an accredited institution. (All occupational therapists who were initially certified prior to January 2007 will be "grandfathered" in.)
b. Successful completion of the national occupational therapist registration examination.
c. Current registration with National Board for Certification in Occupational Therapy (NBCOT).
d. Current licensure with the State of Michigan Licensure board. Occupational therapists are licensed by the state of Michigan under 1978 PA 368, MCL 333.

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OT services in the educational setting differ from those in rehabilitation and other medical settings in both scope and intent. In the school setting, OT is part of a broad program based on students' achievement and functional performance congruent with the educational curricula. The provision of therapy and outcome is based on the impact the disability has on educational performance rather than on the disability itself. OT services in the schools are intended to support the educational process. A student may manifest a disability that does not significantly interfere with educational performance and then school-based OT would not be warranted. Occasionally, a student may require medically based therapy services outside the scope of the IEP goals, and the family can pursue community resources to meet medical-rehabilitation needs.

Collaboration

There is a growing body of evidence that supports collaboration as an effective service delivery model. (Hanft & Shepherd, 2008; Orentlicher, HandleyMore, Ehrenberg, Frenkel, & Markowitz, 2014)
Therapy services in an educational setting are most effective when delivered according to a collaborative model, using a collaborative team approach in the design and implementation of student goals and objectives. School-based collaboration is an interactive team process that focuses student, family, education and related services partners on enhancing the academic achievement and functional performance of all students in school. A collaborative model implies that OT programming is an integral part of the student's daily life, and therefore is carried out not only by the therapists, but also by various members of the educational team, in naturally occurring settings. Therapists have responsibilities not only for design and implementation of programming, but also for teaching, monitoring and updating other staff and parents in specific programming for individual students. While other team members complete, prompt, and reinforce activities under the development and support of the OT, these team members are not considered therapists or as doing "therapy".

The collaborative approach is defined as the transference of knowledge across discipline boundaries in order to facilitate the provision of consistent programming for individual students.
Components of the collaborative approach include:

1. Discipline specific evaluation related to the student's functional abilities in educational environments.
2. Student IEP goals and objectives developed collaboratively by the team, with shared responsibilities for implementation.
3. OT goals and services integrated rather than isolated from a student's total educational program.
4. Therapeutic intervention provided in a variety of sites for a given student, such as a classroom, gym, cafeteria or job site.
5. Use of naturally occurring situations to maximize a student's opportunity for learning and/or improving their skills.
6. OT involvement in both the design and implementation components of the student's educational program.

The use of a collaborative model does not imply a reduction in staff or decreased time involved with service, nor does it imply that services are interchangeable. The OT needs to commit to involvement that is flexible in nature, and includes sharing expertise with others in order for the student to make progress.

The OT, as a member of the student's educational team, can provide input to support others in facilitating the student's progress toward educational goals. Legislation and mandates such as Every Student Succeeds Act (ESSA) and the Individuals with Disabilities Education Act (IDEA) encourage collaborative teamwork.

A collaborative approach to service delivery is the most effective. The collaborative approach encompasses both direct and consultative services. This takes advantage of naturally occurring situations and provides consistent ongoing support. However, there are circumstances when other models are needed for other students.

Service Delivery

Given the complexities of service delivery, administrators need to work together with therapists to ensure the delivery of appropriate services. Transforming caseload into workload requires thinking not only about caseload "numbers" but also about what is the most effective "work" that occupational therapy professionals can perform. The question for therapists and administrators is not "Are you doing things right?" but rather "Are you doing the right things?" Recognizing and defining what appropriate work is in school-based practice are important tasks for occupational therapy practitioners and their supervisors.

The following are components for successful implementation of the collaborative service delivery model:

1. Jointly consider integrated IEP goals that are flexible, collaborative and not discipline-specific.
2. A "combination" of direct and consultative services can be identified on the IEP.
3. Staff who are accessible to other team members for ongoing and crisis intervention as well as formal and informal team meetings.
4. Provide flexibility in scheduling to permit the therapist to work with students in naturally occurring situations as well as with non-routine events. Time is also needed to allow for collaborative planning.
5. Both caseload (number of students seen by OT as part of the IEP) and workload (all work activities OT performs to benefit students directly and indirectly) must be considered in determining reasonable student number and responsibilities of the OT.
6. Sufficient space to carry out activities. While most activities should be carried out within the context of the daily classroom routine and in appropriate environments, a few others have space requirements outside of the classroom.
7. Knowledgeable team members who are willing to share skills and work together with trust, honesty and flexibility.
8. Support of administration, therapists and teaching staff to build team relationships and support the successful implementation of the service delivery model.
9. Accommodate travel time in the daily schedule to allow the therapist to travel between school buildings throughout the county.

Absence of components listed above can compromise the effectiveness of this approach and may require alternative approaches. The collaborative service delivery model is complex and requires a commitment of all involved. Extensive and ongoing training is a necessary process in which administrative support is essential.

Determination of the appropriate ratio for an individual therapist must take into consideration the following:

- The severity of each eligible child's needs
- The level and frequency of services necessary for the children to attain IEP goals/objectives
- Time required for planning services
- Time required for evaluations and report writing, including student observations
- Time required for planning and formulating IEP requirements
- Time required for professional/staff development
- Time required for follow-up and consultation
- Travel time required for the number of districts and buildings served

Direct Service

The OT works directly with the student on goals and objectives individually, in small groups, or in classroom groups. The OT is primarily responsible for documentation (reporting out) of progress on the goal. This implies increased responsibility for follow through related to the goals and objectives. The student is seen directly by the OT in a frequency and location determined by the IEP team. OT service includes ongoing discussion with the teacher regarding student progress.

Consultation

The OT supports the teacher/staff in addressing the student's goals and objectives and is not in direct contact with the student. The OT documents consultation topics and dates. In a consultative model, the OT helps to create solutions and seeks to educate staff so that in the future they can generalize to other students or situations.

What Is the Difference Between Workload and Caseload?

"The concept of workload encompasses all of the work activities you perform that benefit students directly and indirectly. Caseload refers only to the number of children seen by occupational therapy as part of the Individual Education Program (IEP). A traditional caseload "counting" approach does not fully appreciate the complexity of the occupational therapy role in current best-practice scenarios. Pullout services built around a clinical model of predictable, routine "appointments" have limited support in the educational literature and do not necessarily promote the generalization of skills to the classroom or other appropriate settings. A simple caseload also does not recognize the potential occupational therapy contribution to the Individuals with Disabilities Education Act of 2004's (IDEA's) participation focus or its mandate that services support access to and progress in the general education curriculum or natural environment" (American Occupational Therapy Association, 2006).

Top 10 Caseload Responsibilities

1. Provide direct and indirect therapy/service to students with IEPs using a continuum of service delivery options.
2. Evaluate students for initial and ongoing special education eligibility, functional performance in the school environment, specific disabilities and ongoing assessment / data collection to determine effectiveness of interventions.
3. Complete mandated paperwork such as report writing based on evaluation results, collect, record, and report student progress data, complete daily service logs, complete mileage reports, collect and report information to a 3rd party billing agency (Medicaid service logs and Random Moments).
4. Attend and participate in or coordinate Multidisciplinary Team conferences, Individualized Educational Program, Evaluation Review Plan meetings, Parent-Teacher meetings.
5. Train/Coach/Monitor other adults working with students (paraprofessionals, aides, teachers, etc.) on specific procedures such as sensory diets, assistive technology, activities of daily living, or fine-motor activities to integrate therapy into the whole school environment of the student.
6. Observe classrooms and design/recommend adaptations to the environment, curriculum, and delivery of instruction to assure progress in the least restrictive environment.
7. Research/order/prepare/adapt/provide equipment or materials to meet the needs of the student in all school settings (classroom, lunchroom, hallway, bathroom, playground, bus, gym, etc).
8. Communicate and collaborate with other agencies, therapists and physicians regarding student.
9. Plan for student transitions to different buildings, programs, work or college.
10. Collaborate with parents to access resources or provide home activities to support the student's progress.

Top 10 Workload Responsibilities

1. Screen students to determine appropriate instructional strategies, provide follow-up consultation and documentation.
2. Monitor students for maintenance of skills in the areas of sensory processing / use of sensory strategies, visual-motor skills, use of assistive technology, functional skills, etc. Maintain ongoing documentation.
3. Provide Multi-tiered System of Support (MTSS) at all three tiers and maintain ongoing documentation.
4. Provide support to special education classrooms as needed.
5. Participation and collaboration in teams at the building, district, and county level, and act as liaisons and advocates with community agencies.
6. Provide training to students, staff, and families; trainings may include assistive technology, sensory theory and intervention, developmental stages, handwriting, ADL training, pre-vocational and vocational, etc.
7. Evaluate and provide supports to maximize success and access in the school environment (e.g., seating/positioning, lighting, low-tech solutions, etc.).
8. Identify sensory needs in students; develop, train and monitor sensory programming (e.g., Alert Program, sensory diets, movement programs).
9. Assist with the identification, and recommendation of materials, technology and equipment for school or district-wide use.
10. Participate in professional development, professional association activities and maintain professional certification/licensure.

In addition to the IEP contact hours, the provider workload should also include time for:

- IEP meetings
- Student problem-solving team meetings and screenings
- Evaluations and observations
- Documentation, report writing, including Medicaid claim submission
- Program consultation
- Communication & consultation with staff/parents/outside agencies
- Travel between sites (varies based on number of sites served and distance between sites)
- Equipment acquisition, maintenance and training
- Intervention planning and scheduling
- Professional development
- Staff meetings, site-based committee meetings, and site-based duties, as assigned
- Lunch

OT Workload Calculation Formula:

Many states, including Ohio, North Carolina, Wisconsin, Washington, California, Louisiana, and the American Occupational Therapy Association provide guidelines and recommendations for appropriate workload formulas for Occupational Therapists to support effective and compliant provision of services. While the number of children serviced by each therapist will vary according to 1) the level of service rendered, 2) the distance traveled between schools, and 3) other additional responsibilities, the following provides a generalized framework from which an appropriate caseload can be derived.

Based on a 38.75-hour workweek:

- 46% - providing intervention as called for by student's IEPs (17.75 hours/week)

- 31.5% - Other services - including completing initial evaluations/reevaluations, attending IEP meetings, staff training/development, collaboration/consultation and all documentation (12.25 hours/week)
- 16% - travel related to provision of itinerant services (6.25 hours/week)
- 6.5% - lunch (2.5 hours/week)

Multi-Tiered System of Supports

Multi-tiered System of Supports (MTSS) or Response to Intervention (RtI) uses a multi-tier model of early intervening and service delivery to support student success. “RtI and early intervening services (EIS) have been used as frameworks for high quality instruction and data-based decision making in both general and special education, thus integrating services across educational levels” (Clark & Polichino, 2010). Through participation in MTSS, occupational therapists participate in team-based problem solving for students in occupational performance activities related to participation in their educational program.

The MTSS model includes Tier 1, Universal Prevention; Tier 2, Targeted Intervention, and Tier 3, Intensive intervention.

Tier 1 (Universal Prevention)– OT may provide classroom consultation regarding environmental accommodations, such as seating and positioning adjustments, adjusting sensory input, movement programs, co-teaching to demonstrate motor/sensory strategies, suggesting a variety of paper/writing utensils; etc.

Tier 2 (Targeted Intervention) - OT may work closely with teacher/staff to develop classroom interventions for a particular student to be successful in their educational program. Examples may include a pencil grip, slant board, ball chair, adapted scissors, etc.

Tier 3 (Intensive Intervention) - OT may work with staff and student on intensive and individualized interventions, individualized handwriting program, developing/monitoring an individualized sensory diet, use of visual supports, etc.

Occupational Therapy Response to Intervention

Use of School materials: Continuum of Supports

Tier 3

Intensive Intervention: Use of School Materials Examples

- Provide direct intervention to student(s) in the classroom during typical classroom tasks (during cutting, computer use, manipulation of small items during math or art)
- Provide individual or small group instruction (in or out of the classroom) regarding fine motor skills or use of school materials
- Provide individual intervention programs and materials for teacher/paraprofessional, provide ongoing monitoring and support
- Provide and instruct regarding the use of assistive technology

Tier 2

Targeted Intervention: Use of School Materials Examples

- Provide information/materials regarding the use of fine motor tools for daily use
- Provide information/materials regarding proper use of pencil grip
- Provide information/materials regarding “Mid-tech” accommodation (slant board, technology, adapted scissors)

Tier 1

Universal Prevention: Use of School Materials Examples

- Provide information/materials regarding proper seating (hips, knees and feet at 90 degrees, desk height just above elbow)
- Provide information/materials regarding proper keyboarding skills
- Provide information/materials regarding proper pencil grasp
- Provide information/materials regarding proper letter/number formation for teaching handwriting
- Provide information/materials to classrooms (i.e., fine motor activities, sensory break ideas, scissor skills)
- Provide information/materials regarding fine motor activities, such as manipulating small items to develop finger prehension
- Provide information regarding the benefits of upper extremity weight bearing activities (animal walks, push-ups, wheelbarrow walking)
- Assist teachers with planning center time activities to incorporate developmental motor activities
- Provide training regarding facilitation of developmental motor levels
- Provide suggestions for low-tech devices or adaptations (pencil grips, weighted items, adapted scissors, line/paragraph strips, alternative paper)

Written Work

Tier 3

Intensive Intervention: Written Work Examples

- Provide direct intervention to student in the classroom during handwriting or writing assignment
- Provide individual or small group instruction (in or out of the classroom) for fine and visual motor skills, letter and number formation, line use, and visual spatial organization
- Provide instruction for use of Assistive Technology required by specific student

Tier 2

Targeted Intervention: Written Work Examples

- Provide instruction to classroom staff on specific intervention for fine motor, visual motor, letter and number formation, line use, visual spatial organization
- Provide instruction for use of Mid-tech accommodations (graphic organizers, specific writing tools or paper, colored overlays or reader strip)

Tier 1

Universal Prevention: Written Work Examples

- Provide information/materials for development of finger coordination for handwriting: small beads, Legos pegs, coins, push pins, tearing activities, unifix cubes, small blocks, etc.
- Provide information/materials for pre-writing visual motor activities that encourage pencil/crayon/marker control, like tracing, mazes, dot-to-dot, and coloring
- Provide information/materials for hand and finger strengthening using resistive materials: playdough, squeeze balls, clothespins, paper punch, tearing paper, tweezers, rolling paper into tiny balls, and squeezing sponges
- Provide information/activities to help develop isolated movement of individual fingers, such as finger plays, computer, “finger exercises”
- Provide information/instruction for warm-up prior to handwriting , do 1-2 minutes of large muscle warm-ups, and 1-2 minutes of hand and finger exercises
- Provide information and instruction pertaining to proper pencil grasp, develop cues to remind students how to correctly hold their pencil
- Provide information and instruction regarding pencil grips
- Provide information and instruction regarding proper paper positions (right corner higher for right handed, left corner higher for lefties)
- Provide information/instruction/activities pertaining to use of non-dominant helping hand to stabilize the paper
- Provide information/instruction regarding proper seating (feet flat on floor, hips/knees/ankles at 90 degree angles, desk height 1-2 inches higher than elbow)
- Provide information regarding the use of multi-sensory strategies to teach proper letter formation (sand trays, raised letters to trace, verbal cues, gel bags, shaving cream, skywriting, “writing” on carpet, building letters out of wood pieces)
- Provide information/instruction regarding proper letter formation (top to bottom and left to right)
- Encourage quality in writing, not quantity, 5-10 minutes (the last letters written are the ones that may be stored in the motor memory)
- Provide information/instruction regarding opportunities for working on vertical surfaces: chalk or whiteboard, paper taped to wall, easels
- Provide information regarding the variety of paper that is available (line width options, graph, colored, or unlined)

Behavior/Self-Regulation

Tier 3

Intensive Intervention: Behavior/Self-Regulation Examples

- Provide a sensory program which may include: proprioceptive, auditory, visual, vestibular, and tactile input designed to facilitate modulation of sensory input
- Monitor and adjust the sensory program as needed

Tier 2

Targeted Intervention: Behavior/Self-Regulation Examples

- Provide information/materials regarding alternative seating options (seat cushion, standing table, ball chair, rocking chair, T-stool, prone on floor, bean bag)
- Provide information/materials regarding weighted and pressure tools (lap weight, weighted vest, neoprene waist wrap, backpacks or heavy coats deep pressure input to shoulders)
- Provide information regarding preferential seating (front of room to minimize distractions, back of room to allow for extra movement, low stimulation "view")
- Provide information/materials regarding noise reduction "tools" (earplugs, headphones, hat)
- Provide information/materials regarding specific movement program
- Provide information/materials regarding frequent and scheduled quiet breaks, (such as running errands out of the classroom)
- Provide information/materials regarding individualized sensory activities to help keep the student calm and organized
- Provide information regarding accommodations for potentially overstimulating situations (transitions, lunchroom, cafeteria, specials, assemblies, recess)

Tier 1

Universal Prevention: Behavior/Self-Regulation Examples

- Provide information/materials regarding organized physical environment (*minimize "clutter")*
- Provide information/materials regarding quiet spaces for individual work centers
- Provide information/materials regarding frequent movement opportunities within the classroom
- Provide information/materials regarding limiting visual stimulation (keep white boards clean, do not hang things from ceiling, cover shelves with fabric, use calm colors like blue and green)
- Provide information regarding use of natural lighting, limit fluorescent lighting
- Provide information/materials regarding frequent structured movement breaks that incorporate head movement and muscle resistance (group movement breaks should include deep breathing, stretching and slow rhythmical movement patterns for maximal calming effect)
- Provide information/materials regarding use of a visual schedule, give advance notice of changes/transitions
- Provide information/materials regarding use of water bottles/straws, gum in the classroom
- Provide information/materials regarding use of hand tools or fidgets
- Provide information/materials regarding the creation of a designated "personal space" area
- Provide information regarding the adverse effects of removal of recess as a punishment; provide plenty of playground / recess opportunities
- Provide information regarding the positive effects of classical music or white noise

Personal Management/Self-Care

Tier 3

Intensive Intervention: Personal Management/Self-Care Examples

- Provide direct intervention to student during the classroom routine for managing clothing, toileting, personal hygiene, or eating/management of food, organizational skills, or managing environment.
- Provide individual or small group instruction (in or outside of the classroom) for specific skill training for managing clothing, toileting, personal hygiene, or eating/management of food, organizational skills, or managing environment.
- Provide specific adaptations for managing clothing/shoes, toileting, personal hygiene, or eating/management of food, organizational skills, or managing environment.
- Provide and instruct in the use of assistive technology (adaptations for clothing, toileting, hygiene, eating, organization, and management of the physical environment.)

Tier 2

Targeted Intervention: Personal Management/Self-Care Examples

- Provide recommendations for clothing management (fastening, donning/doffing winter clothing, or shoes/boots)
- Provide recommendations for feeding or adapted equipment (weighted utensils, scoop dishes, terry cloth wristbands, managing containers, oral motor skills)
- Provide recommendations for accessibility to bathrooms and appropriate hygiene supplies, (post visual guides/pictures for appropriate routines for personal hygiene such as hand washing or toileting)
- Provide recommendations for environmental accommodations (leave class a few minutes early to avoid crowded hallways, use elevator instead of stairs, use peer buddy for assistance with doors or books, tape off personal space)
- Provide recommendations for organizational strategies (colored coded folders for notebook, planners, use of note taking outline or notes from teacher or student buddy, homework checklists or timelines, highlighter)

Tier 1

Universal Prevention: Personal Management/Self-Care Examples

- Provide recommendations for oral motor exercises and foods to help develop oral sensory motor skills (crunchy, chewy, salty, sour, and sweet)
- Provide recommendations for eating/feeding (opening containers, managing lunchroom, using utensils)
- Provide recommendations for clothing management (dressing/undressing techniques, opens/closes fasteners, manages outerwear, ties shoes)
- Provide recommendations for toileting (accessibility, physical environment, manages clothing, manages toilet paper)
- Provide recommendations for visual guides/pictures for sequencing (hand washing, toileting, dressing, eating)
- Provide recommendations for hygiene (one-handed hand washing or wiping technique)
- Provide recommendations for organizing materials (desk, locker, backpack)
- Provide information regarding management of school physical environments (playground equipment and outdoor environment, doors, stairs, hallways)

Evaluation

OTs can function as part of a multidisciplinary evaluation team for students suspected of being in need of special education. Evaluative input by the occupational therapist can include clarifying the reason for referral, observations in various school environments, interviews, testing, progress monitoring, and record review. Determination of therapy services is the decision of the Individualized Educational Planning Team (IEPT). Consideration of the following questions may assist the IEPT in determination of therapy provisions:

1. What are the student's educational needs for which the occupational therapist can provide unique skills and perspective?
2. How do the needs of the student impact educational performance?
3. How will OT services improve performance that will contribute to the achievement of the student's educational goals aligned with curricula?
4. What can the OT provide that is different from other team members?

The purpose of a school-based occupational therapy evaluation is to contribute to the IEP Team's body of knowledge about the student in the areas described in the Referral section. The data helps the team understand and prioritize the student's educational strengths and needs and, if needed, build a relevant, manageable IEP. The occupational therapy evaluation data helps the IEP Team answer questions like:

- What supports this student's performance?
- What limits this student's performance?
- What does this child need to access the classroom and campus?
- Does this student have a disability?
- Does the disability adversely affect academic and/or functional performance? If so, how?
- Does the student require specially designed instruction?
- What does the child need to access, participate and make progress in the general education curriculum?

The school-based occupational therapy evaluation is not intended to answer the question: "Does this student need occupational therapy as a related service?" If the need for occupational therapy is based solely on a therapist's evaluation (whether school- or community-based), important information from other sources may be missed or misinterpreted. Evaluations can include, but are not limited to, observations, interviews, behavior checklists, structured interactions, play assessments, adaptive and developmental scales, criterion and norm-referenced instruments, clinical judgment, and other techniques and procedures as deemed appropriate by the evaluator.

Parents must understand what the occupational therapist will be assessing with their student and provide consent prior to an initial OT evaluation. If the parent provides current occupational therapy evaluation data from a community based setting, the IEP Team should consider the educationally relevant aspects as part of the data used for eligibility determination and IEP development. Upon completion of the evaluation, the school-based occupational therapist provides a written report to the IEP Team according to policy timelines. IEP Teams are strongly encouraged to include occupational therapists as early as possible in the evaluation process in order to ensure access to quality, comprehensive data. Likewise, the IEP Team should include the occupational therapist in all meetings where occupational therapy data are discussed.

If a student is found eligible for special education in one of the areas of eligibility, then the student "qualifies" for all related services needed to implement the IEP. It belongs to the IEP Team to determine which related services are needed --after the development of goals and identification of supplemental aids, services, accommodations, and modifications.

Guidelines for Determination of Occupational Therapy Service

Qualification Process

- Student must be eligible for Special Education services
- The need for services is determined by student performance, standardized assessments, therapist observations, teacher input, IEP team, and service specific rubrics
- Rubric guides us in making frequency recommendations to the IEP team

Occupational Therapy Frequency Rubric

Complete the rubric below based on staff/parent input, your evaluation, as well as your interpretation of data. Using your professional judgment, consider the following: potential for change in the student's occupational performance, previous interventions, underlying limitations in occupational performance components (e.g., postural, perception, coordination, processing), factors such, environmental, emotional, lack of experience, additional paraprofessional or adult support, reduced school day, homebound or medical factors, etc. The total score provides a range for service frequency. More specific timeframes will be indicated on the individual's IEP, as determined by the therapist's own clinical judgment and IEP team input.

Area Evaluated	1 point	2 points	3 points
Standardized Scores *Develop Percentile Ranks 26-40%=1, 5-25%=2, <5%=3			
Classroom function % of school tasks child needs 1:1 assistance *Develop Percentages 25-50%=1, 51-75%=2, 76-100%=3			
Teacher Knowledge Base in Area of Delay Independent=1, Prior Experience=2, New Experience=3			
Classroom Setting Self-contained=1, Resource=2, General Education=3			
Student Need to provide exposure=1, Need to reteach=2, Need to provide adaptations=3			
Responsiveness to OT Intervention 4-5 years=1, 2-3 years=2, 0-1 years=3			

Total: __

Frequency Recommendations based on total score:

- **6-10:** 0-60 minutes per month
- **11-14**: 60-120 minutes per month
- **15-18:** 120-240 minutes per month

The following questions may help guide decision-making on the extent, type, and duration of occupational therapy services:

- What is the least restrictive means of providing support in the student's education program?
- What evidence exists to support the focus and frequency of the occupational therapy intervention program?
- What impact will the intervention have on social participation with peers?
- How much/often will the occupational therapy provider contribute to environmental changes that improve the student's ability to function in the present educational setting?
- How well has the student responded to previous or other types of intervention?
- How much do this student's deficits interfere with his or her ability to profit from the educational process in the present setting?

Discontinuing OT Services

According to the Occupational Therapy Code of Ethics (AOTA, 2015), a collaborative decision regarding discontinuing services should be made when the goals of the services have been met or when ongoing services do not continue to produce measurable changes. In schools, decisions about the need for occupational therapy should be based on the results of the child's initial evaluation or reevaluation; his or her academic and/or functional needs, progress data, and the goals or outcomes identified by the individualized education program (IEP) team. It is appropriate to discontinue occupational therapy services when the services are no longer relevant to the child's educational program (i.e., the service does not relate to the program and priorities identified by the team) or when they are no longer necessary (i.e., the absence of the service would not inhibit the child's ability to participate and make progress in the team identified program) (Giangreco, 2001).

Clearly defining the outcomes for occupational therapy at the initial evaluation and having annual discussions with the teams about how therapy services will evolve as the child ages as well as when it may be appropriate to consider adding or discontinuing services, can help teams determine the ongoing need for services. It is important to recognize that adding services, such as occupational therapy, onto a child's general education program creates an environment that is more restrictive than when the child participates in the general education program without additional services. Thus, continuing to provide services when they are no longer needed may interfere with the child's ability to receive a free appropriate public education in the least restrictive environment

Evidence-Based Practice

Evidence–based practice (EBP) refers to the integration of clinical expertise with the best available external evidence from systematic research. It also takes into consideration the students' preferences and goals. EBP is mandated by IDEA and Elementary and Secondary Education Act, and must be a critical component in determining delivery of school-based OT services.

EBP refers to the use of research and scientific studies as a base for determining the best practices in the field of occupational therapy. EBP uses various methods (e.g. carefully summarizing research, putting out accessible research summaries, educating professionals in how to understand and apply research findings) to encourage professionals and other decision-makers to pay more attention to evidence that can inform their decision making. Where EBP is applied, it encourages professionals to use the best evidence possible, i.e., the most appropriate information available.

Evidence-based practice is a philosophical approach that is in opposition to rules of thumb, folklore, and tradition, or "the way it's always been done".

EBP is a process for making informed clinical decisions.

EBP is about USING research - not doing it. Examples include Critically Appraised Topic (CAT).

EBP involves clinical reasoning to integrate:

- clinical experience
- students/families' preferences
- highest quality evidence available (both quantitative and qualitative)

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