Guidelines and Tools for Educationally Necessary
Occupational and/or Physical Therapy

(Adapted from Riverside SELPA Policies and Procedures)

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Introduction

Each child has unique physical, sensory, neurological, emotional and mental functions, as well as challenges, which enhance or deter successful school performance. The following information is provided as a guideline to assist in looking at how to address children's needs for occupational therapy (OT) and/or physical therapy (PT). Individual professionals have different experiences as well as additional areas of training and expertise. Professionals are primarily responsible for development of a program to meet specific individualized family service plan (IFSP) or individualized education program (IEP) goals. However, activities need to be carried out across several environments. This requires a supportive, collaborative team approach.
The role of an occupational or physical therapist as a member of any team is to work collaboratively with other team members, to assist in identifying the student's priorities, strengths, and needs; to plan strategies and goals for educational performance; and to anticipate outcomes for the future. A therapist provides a unique professional expertise by explaining aspects of a medical disability and the relationship of that disability to the student's expected school performance.

Definitions and Occupational Therapists and Physical Therapists in Public Schools

In school-based practice, OTs and PTs support a child's ability to gain access to and make progress in the school curriculum. OTs are health professionals whose purpose in a public school setting is to support a child's engagement and participation in daily occupations, which include activities of daily living, education, prevocational work, play, rest, leisure, and social participation (American Occupational Therapy Association 2008).

PTs are health professionals whose purpose is to correct, facilitate, or adapt the child's functional performance in motor control and coordination, posture and balance, functional mobility, accessibility, and use of assistive devices (see http://www.apta.org). OTs and PTs have unique roles in the educational setting in working both on remediation (e.g., improving sensory and motor foundations of learning and behavior) and compensation (e.g., modifying the environment, tools, or task) to help a child succeed at school.

Differentiation between Adapted Physical Education, Occupational Therapy, and Physical Therapy

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The state and federal laws and regulations pertaining to individuals with exceptional needs incorporate a wide range of disabilities and a continuum of service options to meet the unique needs of each identified child. When a child exhibits deficits in motor skills, his or her educational needs may require the support of a person with specialized training in adapted physical education (APE), occupational therapy (OT), and/or physical therapy (PT).

Areas Addressed by APE: Basic concepts of movement, speed, force, pre-positions, rhythm, tempo, and object control; complex motor skills and sequences, such as aquatics, dance, games, sports, and leisure activities; physical and motor fitness, especially related to health and well-being.

Areas Addressed by PT: Bracing; pre-gait and gait training; muscle re-education, especially for lower extremities following trauma or surgery; prevention and management of orthopedic problems in trunk and lower extremities (i.e., range of motion, positioning, bracing, casting, splinting).

Areas Addressed by OT: Visual perception, integration and motor skills; fine motor skills and dexterity; self-help skills beyond foundational components; pre-vocational skills; communication systems (i.e., switch control, computers, and assistive technology tools).

Areas Addressed by APE / OT / PT: Developmental motor and locomotor patterns; movement exploration activities; balance; refining motor skills (especially gross motor); generalized strength and endurance; environmental adaptations; accommodations and adaptive techniques.

Areas Addressed by APE & OT: Body awareness; spatial relations, laterality, directionality; social group and interaction skills; play and leisure skills; social/emotional development; peer interactions; sportsmanship.

Areas Addressed by APE & PT: Functional gross motor skills training in relation to mobility and play; endurance and conditioning programs for physical fitness.

Areas Addressed by OT & PT: Assessment and treatment of muscle tone, range of motion, sensation, specific muscle strength and endurance, joint stability; use of prostheses, orthotics, splints, walkers, wheelchair and seating modifications; oral-motor and feeding sensory processing.

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Medical versus Educational Models

There are primarily four ways a child can receive occupational and/or physical therapy once a need has been identified.

- A hospital; served by medical model
- Outpatient clinic; served by medical model
- Home based services; served by medical model
- School based services; served by educational model only when occupational and/or physical therapy is required to meet educational needs

The factors determining need for intervention may be very different in these two models. This can sometimes be very confusing.

In The Medical Model

- Referral is initiated by the physician based on a particular diagnosis or observed delay in one or more areas of development.
- The parent is then referred to a hospital or clinic for an evaluation and/or treatment by the appropriate professional.
- Need for service is primarily based on testing and clinical observations. The assessment would take all settings into consideration.
- Children with mild, moderate and severe deficits may qualify for services.
- The parent is responsible for obtaining the needed services as well as payment for those services.
- Health insurance may frequently assist with payment, but not always.

In The Educational Model

- Occupational and physical therapy are provided by schools as a service only when it is related to educational needs.
- Related services are possible only when they are “required to assist a child with a disability to benefit from special education".
- The child is assessed for needs associated with his or her educational program. Need for service is primarily based on testing, classroom observations and input from the student’s IEP/IFSP team.
- The school district must establish whether the service is needed for the child to benefit from his or her education. In other words, it is deemed that the student’s educational program would be inappropriate without the service.
- A child who does not perform to what may be his/her full potential but does function adequately, would not qualify for school based OT or PT services.

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- Related services are provided only when they support an educational need. They are not provided when there is a transportation problem or other obstacle in getting medical model outpatient or home based OT and/or PT.

Educationally Versus Medically Necessary Therapy

Educationally necessary therapy is provided in the school to help the child access educational services and benefit from their educational program. In the school, educational goals hold a primary position, while occupational therapy goals are undertaken to support the educational goals. The school therapist delivers a wide range of services. These services cover individual therapy, as well as therapy within small groups, and consultation with school staff, and with the child's family. Thus, the school therapist is expected to share his/her knowledge and skills with others by demonstrating and monitoring activities that are educationally appropriate.

Medically necessary therapy is usually undertaken as an adjunct to medical treatment for acute and chronic conditions to ameliorate an underlying disability. The goal of medically necessary therapy is to improve global functioning through the use of a variety of modalities. Medically necessary therapy conducted in the school is not the same as therapy conducted in the clinic. Therapy differs in these two settings in terms of its intent, the role of the therapist, and the type of support available to the therapist. The significant ways in which clinical therapy and school therapy differ from one another are summarized below.

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Educationally Necessary Therapy	Medically Necessary Therapy
Educational goals are primary.	Therapy goals are primary.
Intervention is directed toward facilitating educational progress.	Intervention is directed toward alleviation of a specific medical problem.
Services are collaborative. Much time must be given to communicating with other service providers.	Services tend to be delivered individually in a clinic or hospital setting.
Focus is on functional skills and adaptations that promote the attainment of educational objectives.	Focus is based on developmental milestones and components of movement. The focus is on functional outcomes.
More responsibilities are delegated to parents and other educational professionals.	Few responsibilities are delegated except to parents.
The therapist works in the school setting.	Clients generally come to the clinics to see the therapist.

Adapted from: "The Role of the Physical Therapist and the Occupational Therapist in the School Setting," by Judith Hylton, Penny Reed, Sandra Hall, and Nancy Cicirello. TIES: Therapy in Educational Settings. A collaborative project conducted by Crippled Children's Division--University Affiliated Program, the Oregon Health Sciences University and the Oregon Department of Education, Regional Services for Childs with Orthopedic Impairment. Funded by the U.S. Department of Education.

Some children will receive services through both educational and medical models. For some children the frequency or intensity of OT and/or PT received at school through the educational model will not meet all of the child's OT or PT needs. There may be goals that are not addressed by school-based therapy that would require home or community based services from the medical model. In each setting, the child should be assessed individually to determine the best way to meet his or her needs.

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	Educational Model	Medical Model
Who Decides?	Educational team, including parents, student (if appropriate), educators, administrators and school based therapists determine the student's educational needs and what support is required by related services.	Medical team determines focus, frequency and duration of therapy. Insurance coverage may be a determining factor.
What?	Therapy focuses on adaptation and intervention to allow the student to participate, access their special education and school environment.	Therapy addresses medical conditions; works to get full potential realized.
Sample Activities	Cutting, drawing, writing, identifying shapes and sizes, sequencing.	Hair and teeth brushing, feeding, dressing, food preparation ambulation.
Where?	On school grounds, bus, halls, playground, classroom, lunchroom, …	In the clinic, hospital or home.
How?	The student's educational needs are met individually. Services may include direct one on one treatments, staff training, program development, collaboration with staff, integrated therapy, inclusive therapy (with peers) or by consultation for the student's daily program.	Direct one on one or small group treatment to accomplish set goals.
Eligibility	Educational need as determined by the IEP team.	Medical need as determined by medical professionals.
Cost	No cost to the student or family.	Fee for service payment by family, insurance or governmental assistance.
Documentation	Related to IEP with accessible, readable language guided by the setting and best practice.	Dictated by insurance requirements and guidelines of the setting. Emphasis on medical terminology.

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Educationally Necessary Therapy Services

Public schools are not required to provide a service to a child with a disability just because the child will benefit from the service or even if the child requires the service for other than educational reasons. A student might benefit from OT or PT if s/he is having significant difficulties in classroom performance as impacted by curriculum, educational environment, and abilities. Simply having needs in the areas of gross or fine motor skills does not mean that a child needs OT or PT. Special education teachers can assess and assist children who have special needs in fine or gross motor skills. Most special education children with needs in these areas can and should be served by their teachers. There are a few children whose needs are so significant and unique that the child's special education teacher cannot serve them. These children may need the services of an OT or PT.

A key factor the IEP/IFSP team must remember is that a related service such as OT or PT is warranted only if it is necessary for the child to benefit from their educational instruction. Therefore, if the IEP/IFSP team should determine if all other strategies, activities, or resources available have been exhausted and it has been determined that OT or PT is necessary for the child to benefit from his/her instructional program. OT and PT should not be viewed as a part of the curriculum but as a resource to allow the student to function within the school routine. The amount and intensity of services should increase or decrease according to the changes in educational demands and in a student's performance.

As a related service, OT and PT serve a supportive role in helping the student to participate in and benefit from special education. Educationally-related OT and PT services are provided within the context of the student's educational program, with service delivery occurring in the school environment where the need occurs. The goal of intervention is to assist the student to function in the school setting by adapting the environment, revising the functional tasks, and by promoting elements of sensorimotor development.

While physical therapists assist with muscle development, occupational therapists assist with the functional use of these muscles. In the educational setting, OT and PT services focus on "improvement of functioning" and not serving goals beyond the capacities of the individual. Services may include assessment, direct therapy, and several types of consultation. These intervention activities are not mutually exclusive and may occur at the same time.

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Determination of Educational Need for Therapy

According to the CA Ed Code and IDEA 2004, the IEP/IFSP team is addressing the question, “Is occupational therapy (OT) or physical therapy (PT) necessary for the child to benefit from his/her special educational instruction?” While “educationally necessary” is difficult to define precisely, determining the need for educationally necessary OT and/or PT may best be approached by the IEP team addressing a series of questions about the developmental issues involved in the student’s progress toward goals.

Indicators for Occupational Therapy Referral

- Poor hand use including illegible handwriting or poor pencil grasp. (OT is not appropriate if the child has not been taught correct handwriting or if the child uses a non-standardized pencil grasp yet writes legibly. If the student is unable to learn correct letter formation strategies despite repeated individual instruction and remedial programs like Handwriting without Tears, then an OT referral may be appropriate.)
- Extreme difficulty completing classroom activities requiring cutting, gluing, manipulating small objects without adaptive equipment, environmental modifications, or assistive technology.
- Deficits in adaptive self-help skills necessary in the educational setting, for example toileting, fastening clothing, feeding.
- Excessive difficulty learning new motor tasks.
- Modulation of sensory information in the areas of vestibular, proprioceptive, tactile, auditory, visual, olfactory and taste substantially impeding ability to access the educational plan.

Indicators for Physical Therapy Referral

- Difficulty navigating school grounds, including areas with uneven terrain, obstacles, congestion, etc.
- Difficulty climbing stairs, curbs, and bus steps with or without rails.
- Difficulty transitioning in and out of desks/chairs and to and from the floor independently.
- Difficulty keeping up with classmates while walking in line.
- Difficulty remaining stable in a seated position in order to do classroom work.
- Difficulty carrying books, backpack, lunch tray, and other school materials.
- Difficulty opening and closing school doors.
- Difficulty accessing playground equipment.

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- Difficulty accessing areas of the school using a wheelchair, walker, or other assistive device.
- Difficulty safe transport to and from school.

Response to Instruction and Intervention (RtI^2): In some areas, RTI^2 is being utilized prior to referral for assessment in the area of OT and PT. For more information on RtI^2, please refer to page 75 in the Guidelines for Occupational Therapy and Physical Therapy in California Public Schools, Second Edition (California Department of Education, 2010)

Referral for OT or PT Evaluation

A child with a suspected but not yet identified disability is initially referred to an Student Study Team (SST). Once identified, every year an IEP or IFSP team will be responsible for monitoring student progress and identifying any additional areas of needed assessment. As special education instruction frequently can overlap OT and PT activities in many skill areas, such teams need to thoroughly consider the level of professional expertise needed to assess in all areas of suspected disability and address educational goals. Going through this process helps to assure that general and special education resources have been explored before determining that OT and/or PT services are required for a student to benefit from their special education program. Public schools are not required to provide a related service to a student with disabilities simply because the student will benefit from the service. The IEP team must determine that a related service is warranted only if it is necessary for the student to benefit from the special education instruction. When the team has explored the strategies, activities and resources available within the instructional program, and has determined that the student is not likely to benefit from this program's opportunities without additional professional services from an OT or PT, then the case should be referred for a specialized evaluation.

Assessment Guidelines for School Based OT and PT

In conducting an evaluation, a school district must use a variety of tools and strategies to gather relevant information about the child's functional, developmental, and academic abilities, including information provided by the parent that will assist in determining whether the child has a disability and the extent to which the child is able to gain access to and make progress in the general education curriculum (20 USC § 1414(b)(2)(A); 34 CFR § 300.304(c)(6); EC § 56320).

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The use of standardized tests to determine special education eligibility and programming needs is being questioned by many professionals. Even tests with good reliability and validity measures often lack usefulness in developing specific student interventions. Occupational and physical therapists have frequently found that standardized assessment can incorrectly identify children. Performance on a standardized test can sometimes indicate below-average skills. However, the teacher may report that in the natural or educational setting, the child is functioning with minimal or no modifications and is not displaying any signs of stress. Rather than spending the time required for standardized assessments, it may be more effective for a therapist to use teacher interviews and to observe the child's performance within the classroom and school settings.

- Standardized scores are frequently used as the standard or comparison. Many other standards can be used within the natural environments, including local norms such as curriculum-based measurements, classroom and teacher expectations, criteria for the next environment, peer standards, and professional expectations or judgment.
- Curriculum-based measurement (CBM) is based on the academic performance of the students within their curriculum. CBM can be used to determine a student's strengths and weaknesses, as well as to provide information for the design of instructional programs. Written communication (handwriting) standards developed through CBM can also be used by occupational therapists to assess children for difficulties with handwriting.
- Classroom and teacher expectations vary. For instance, a practitioner may find the expectations different in each of the three first-grade classes in one school, but the performance within a given student's classroom sets the standard. The practitioner must be aware of that classroom and that teacher's expectations. To enhance the person-activity environment fit, the practitioner should observe the activity, the tools used, the time of day, the seating arrangement, the motivation and attention of the student, the teacher's expectations, and the performance of the student's peers.

The Ecological Model of Student Performance (EMSP) was developed as a philosophical framework for both OT and PT assessment of student functioning and service provision within the educational environment. The primary assumption within the EMSP is that the ecology of student performance (or the interaction between a student, the curriculum, and the environment) affects student performance and that performance cannot be understood out of context. Therefore one cannot do an evaluation of need

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for educationally based OT or PT in a clinic without first seeing the student in their classroom environment.

The evaluation process for OT and PT practitioners working in school and early intervention settings offers many unique opportunities. Because the therapist is able to observe the child functioning in his or her natural environment and to observe products of the child's performance (the child's written work, amount of lunch eaten, pulling self into standing position at the couch), reliance on criterion-referenced (standardized) tools has declined in favor of functional assessments. When therapists use functional assessment tools, the procedures depend on the questions asked or the decisions to be made. Therapists must immediately define the problem, collect baseline data related to the problem, determine the expected performance, and decide if a significant discrepancy exists.

By collecting information within the natural setting, rather than by pulling the child out to be tested, the occupational and/or physical therapist provides a more natural approach to evaluation, intervention, and programming needs. It is important to anticipate the needs of the child for future environments. Will there be a computer, stairs, narrow hallways, and different expectations? Sometimes the skills needed to be successful in the next environment must be addressed now. Many home-based early intervention personnel begin to prepare the toddler for preschool, while preschool teachers and related service personnel work to prepare the child for kindergarten. This approach also assists in program termination because it allows the therapist to compare the child's performance with the prevalent classroom or developmental standards (judgments by teacher, peer, district, or families) and to determine if ongoing services are necessary. For additional information on OT and PT assessments, please refer to page 82 in the Guidelines for Occupational Therapy and Physical Therapy in California Public Schools, Second Edition (California Department of Education, 2010)

Writing IEP Goals

An occupational or physical therapist should contribute to the IEP/IFSP process by cooperating with staff to establish educationally relevant annual goals, with short term objectives as needed. The goals included in the IEP/IFSP should be the consensus of the team and not represent only one profession. When the level of expertise of an occupational or physical therapist is required in order to work on a specific goal, the specialist should be listed as one of the person's responsible for implementing and monitoring progress on the goals.

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Since teachers are responsible for their students' overall development, and because OT and PT are considered a related service to help the student to succeed in the classroom, there should not be any "OT Only", "OT Specific", "PT Only", or "PT Specific" goals. The IEP team should be responsible for writing OT or PT goals just as they write academic, language and social/emotional goals. Goals should be written in ways that are measurable and quantifiable so that outcomes can be demonstrated. The method of documentation should be agreed upon, as well as persons responsible for data collection.

The purpose or objective of providing school based OT and PT is to have a child participate and function as independently as possible in the classroom and school setting. Once a child has been found to be eligible for special education, a listing of the student's needs which cannot be met by the regular education program must be made. This list becomes the basis for identifying the student's special education needs and specific goal areas. Needs in the areas of gross and/or fine motor, special physical adaptations or similar areas, which cannot be met by the regular or special education teacher, then raise the possibility of a therapist's involvement via consultation or direct service. The following chart delineates the relationship to education for each service provided within the functional skill areas.

Functional Area	Services Provided	Relationship to Education
Self-help	Mobility and transfer skills, feeding, toileting, adaptive equipment	To permit the child to manage personal needs in the classroom and school
Functional Mobility	Equilibrium and balance reactions, transfer skills	To permit the child freedom of movement within the educational setting
Environmental	Recommend modifications of school's or child's equipment	To help the child access the educational environment
Positioning	Positioning with wheelchairs and/or adaptive equipment & handling methods	To maintain the child in the best position for learning and functional use of hands
Neuromuscular & Musculoskeletal Systems	Activities which promote muscle endurance, strength, motor coordination and planning, and integration of developmental reflexes	To enable the child to participate maximally in school activities. To increase speed, accuracy, and strength in manipulative skills in pre-academic and academic tasks

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Sensory Processing	Activities which promote muscle tone and integration of tactile, visual, auditory, proprioceptive, and vestibular input	To process information that will enhance the child's ability to perform learning and motor tasks in school
Adaptive Equipment	Recommend and fabricate devices to facilitate fine motor and self-help tasks	Provide the child with alternative means to accomplish functional activities
Fine Motor/Visual Motor	Evaluate and improve functions such as reach, grasp, object manipulation, and dexterity	To facilitate the child's ability to manipulate classroom tools (such as writing implements, puzzles, and art materials)
Communication	In coordination with speech therapists & augmentative communication professionals, evaluate and recommend adaptive equipment, and communication devices necessary for functional communication	To enable the child to communicate in school, at home and in the community

Service Delivery Considerations

Neither state nor federal law sets aside distinct eligibility criteria for occupational therapy services. The Individuals with Disabilities Education Act (IDEA 2004) mandates that public schools offer occupational therapy (OT) and physical therapy (PT) services for children ages 3-21 that are needed for educationally-related difficulties. For a student to receive OT or PT services in the schools the student must be eligible for special education and OT or PT must be necessary to assist the child to benefit from special educational instruction.

Best practice dictates that occupational and physical therapists work collaboratively with special education team members to address the needs of individual children. Collaborative teaming entails an exchange of information, teaching techniques and therapeutic strategies among IEP/IFSP team members. Parents need to be part of this collaborative IEP/IFSP team process. Collaborative teaming enables therapy to be integrated into the child's educational program to address individual student needs through the school day and across all educational environments.

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Some of the issues to consider are:

- Is therapy likely to improve the student's ability to function in his or her educational environment?
- Is there a significant discrepancy in the student's fine motor, sensory motor, visual motor, or oral motor ability compared to his or her ability level in the areas of cognition, communication, social and or self-help skills?
- Are the instructional strategies and interventions designed at the appropriate level for the student, i.e. task analyzed into small enough steps with appropriate cues?
- Does the student need training in the use of environmental adaptations?
- Does the student need an assistive device in order to participate in an educational program?
- Who has the expertise to determine the need? Who has the expertise to train the student in the use of the device?
- Does the teacher know what activities, interventions, or procedures to provide to address the student's areas of assessed need? If not, who has the expertise to assist her/him?

No one service delivery method is exclusively better than another.

Consultation (Supplemental aides and services) means sharing of expert knowledge by one team member with another or other team members depending on the currently identified problem. Rather than being in an authoritarian position, consultation reflects the collegial nature of the team. This service is provided directly and indirectly to the student consisting of regular review of student progress, student observation, accommodations and modifications of core material, developing and modeling of instructional practices through communication between the general education teacher, the special education teacher, parent and/or related service provider.

Collaboration (Supplemental aides and services) is a service by which general education teachers, special education teachers, and/or related service providers work together to teach a student with and without disabilities in the classroom. All are responsible for direct instruction planning and delivery of instruction, student achievement, progress monitoring and discipline to support the student goals and objectives and access to curriculum.

Direct service delivery is the role in which occupational and physical therapists have most commonly been engaged. Teachers and parents may feel that only direct services are acceptable, although consultative services have proven equally effective for some

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students and have increased teachers' appreciation of therapy's contributions to education. Direct service or instruction is by a single special education provider designed to support, bridge, and strengthen student skills. It is an opportunity to provide specific skill instruction, re-teach, pre-teach, and scaffold instruction to support student goals and objectives and access to curriculum.

OT or PT services may be provided directly to students, as a consultative model, or as an integrated model incorporating both of these approaches. The service delivery models differ in who is the therapist's primary contact, the service delivery environment, the methods of intervention, and who the implementer of the activities as delineated below.

	Direct	Integrated/Collaborative	Consultative
Therapist's Primary Contact	Student	Student, teacher, parent	Teacher, parent, student
Service Delivery Environment	Distraction free environment (e.g., separate from regular learning environment); specialized equipment needed	Learning environment with support of others within that setting; may include a separate environment at times	Learning environment with support of others within that setting
Methods Of Intervention	Specific therapeutic techniques which cannot be safely delegated; emphasis on acquisition of new motor patterns	Educationally related functional activities; emphasis on practice of newly acquired motor skills in the daily routine	Educationally related activities; assistive technology; adaptive materials; emphasis on accommodations to learning environment
Implementer Of Activities	Physical Therapist (PT) or Physical Therapist Assistant (PTA)	PT or PTA; teacher, parent, other school personnel	Teacher, parent, other school personnel
Adapted From "Iowa Guidelines for Educationally Related Physical Therapy Services" by Kathy David (1996)			

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Research has shown that interventions that are set in natural environments and embedded in class routines that use functional life skills increase the efficacy of intervention, the achievement of IEP/IFSP goals, and the motivation to participate. This research has provided an impetus to move from isolated therapy provision to integrated therapy services. Along with this shift come changes in (a) the site of service delivery from the therapy room to the community site or school campus; (b) the focus of therapy outcomes, from improving postural and balance responses to improving sitting during dining; and (c) the personnel involved, from only the practitioner and child to several team members and the child.

By bringing the interventions into the classroom, lunchroom, gym, and home or community site, integrated services increase the opportunities for collaboration and skill building among team members, along with practice opportunities for the student or young child. Integrated and cooperative interventions in educational and therapy provide essential practice opportunities for students with severe disabilities and enhance the effectiveness of therapy.

Progress Monitoring and Termination of OT or PT Services

It is important that data be collected in order to reflect progress toward the functional outcome being worked on. This is necessary before any discussion of termination of services; whether for lack of progress or adequate progress toward goals. A student may be ready to be discharged from OT or PT services when s/he has evidenced one or more of the following:

- As reported by the teacher, the student is now able to function within average range as compared to the other children in the classroom.
- Deficits are not interfering with a child's ability to function adequately within the school environment.
- Therapy is no longer affecting change in a child's level of function.
- Child's needs are better served by an alternative program and/or service, as determined by IEP team
- Formal reassessment indicates the child no longer requires the previous level of service and the IEP/IFSP team concurs.
- The child has learned appropriate strategies to compensate for deficits.
- The student is meeting and/or exceeding all goals supported by the therapist and is performing successfully within the educational environment.
- Strategies can be effectively implemented by the current educational team and do not require the training and expertise of a specialized therapist.

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- Equipment and environmental modifications are in place and are effective.
- The child no longer shows potential for progress or performance remains unchanged despite multiple efforts by the therapist to remediate the concerns or to assist students in compensating.
- Therapy is contraindicated due to change in medical or physical status.

Discharging a child from intervention can be emotional for all parties. Children and practitioners become attached to each other, and practitioners can easily lose perspective on what goals have been reached and what goals are still to be met. Additionally, parents generally see intervention as important to the child's growth. Continued intervention frequently indicates to them that the child has potential for growth and change. Therefore, the decision to discontinue a child's services may not be well received. The occupational therapist must have an appropriate rationale for the change in service and be able to back up the decision with data, either through testing, observation, or both. Information from the teacher and other professionals working with the child should contribute to the decision to discontinue services.

Educationally Necessary Occupational Therapy

School based occupational therapy (OT) is designed to support the student's successful participation in the school curriculum and environment – not in treating the disability. The OT evaluation should follow the guidelines previously provided. When discussing possible services, OT should not be viewed as a separate curriculum, but as a support in accessing the existing curriculum.

In general, occupational therapists concentrate on postural background mechanisms, sensory impairments or motor impairments affecting function. For instance, support from an occupational therapist can include activities such as adapting the classroom environment, introducing adaptive equipment, using assistive technology, and participating as collaborative team members. There is, however, some overlap between the things teachers and therapists do in the course of helping children learn and become independent. The following chart shows some examples of who does what and how the roles/responsibilities complement one another.

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Areas of Need	What the Teacher Does	What the OT Does
Fine Motor Function	Teaches monitors and reinforces normal pencil grasp. Teaches and provides practice opportunities in form reproduction (lines, circles, squares etc.). Teaches letter reproduction, use of lines and spaces. Offers drill and practice opportunities in visual motor and visual perceptual activities. Offers opportunities and assistance to work with motor materials such as puzzles, peg boards, beads, and scissors. Monitors student progress.	Evaluates accommodations and assistive devices necessary for improved grip, grip strengthening activities, postural supports, fatigue minimization, kinesthetic cues. Provides activities which promote muscle endurance and motor planning. Monitors student progress.
Self-Help Skills	Encourages independent attitude. Teaches organizational systems for dealing with instructional materials. Teaches and monitors organizational systems for dealing with class work completion. Teaches dressing, toileting, self-feeding specific to individual developmental level, using known adaptations. Develops structure and processes necessary for independence in the cafeteria, restroom, and moving between classes. Defines necessary mobility and transfer skills, and minimizes obstacles in the classroom.	Assists with management of instructional materials by providing exercises to improve visual tracking, scanning, vestibular or tactile issues. Provides adaptations for dressing. Provides postural support/adaptations for toileting. Provides support for utensil usage in feeding, and helps resolve sensory based food resistance. Promotes independence in cafeteria and other school locations by developing adaptations and training the student and staff in their use.

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Behavior/ Attention	Addresses issues of oppositional behavior, immature social skills, different learning styles, decreased attention, impulsiveness and self - stimulatory behavior using behavioral/instructional strategies. These strategies include: posted schedules, transition supports, adapted curriculum, social skills training, self-monitoring programs, and systematic reinforcement of functionally equivalent replacement behaviors.	Addresses issues of increased or decreased arousal level based upon vestibular responsiveness, tactile irregularity, or kinesthetic sensation seeking. Addresses issues related to activity shift through work on vestibular/somatosensory regulation and modulation systems. Addresses self-stimulation behavior by assisting to design sensory activities that can be used in the classroom.
Keyboarding	Teaches keyboarding skills.	Provides adaptations, positioning assistance.

For example, in the area of visual attention wherein a child does not maintain eye contact on his work, interventions may focus on verbally cuing the child to keep looking at his paper, providing a physical prompt to position his head, decreasing external distractions to help the child focus on his work, and providing reinforcement when the child does look at what he is cutting. As another example, this time in the area of hand manipulation skills wherein the child does not position her scissors correctly in her hand, staff can assist the child in putting her right thumb through the upper handle of the scissor, with her pointer and middle finger through the bottom; reinforce that her fingers are flexed (bent) and not extended (straight) within the handles; provide physical assistance to curl the ring and pinky finger into the palm; provide hand over hand assistance to guide the child through rhythmic opening and closing of scissors; and saying “open-close” in correspondence to scissor movement. A third example applies to bilateral hand use, wherein the child does not stabilize or rotate his paper efficiently with his left hand while cutting with his right hand. Some strategies could include providing hand over hand assistance to help him stabilize the paper, providing verbal cues, and teaching the child to rotate his paper in a systematic way after finishing cutting a side.

Educationally Necessary Physical Therapy

Motor functioning assessment should not be considered the sole responsibility of the physical therapist and other professionals may also be involved in these assessments.

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The therapist is responsible for selecting appropriate assessment procedures that are designed to document developmental levels, physical status, and motor function as they affect educational performance. Developmental level assessments typically look at gross and fine motor skills, typically, but not always, with a standardized test. Neuromuscular-skeletal components may include any of the following: muscle tone, developmental reflexes, joint range of motion and joint mobility, static postural alignment, dynamic postural alignment, movement quality and movement patterns, strength and endurance, static and dynamic balance, motor learning and planning, general coordination, visual-motor integration, and oral-motor control.
The assessment will focus on the following area(s):

- Functional movement skills: Assesses the student's ability to move within and around the educationally related school, home, and/or community environment (i.e., rolling, crawling, assisted or independent walking, wheelchair mobility).
- Architectural accessibility: Assesses architectural barriers within the student's educational environment (including the home, school and/or community) that prevent the student from benefiting from the educational program (i.e., ramps, stairs, curbs, heavy doors, rough ground).
- Utilizing appropriate assistive devices: Assesses the student's need for and use of assistive devices (i.e., walkers, wheelchairs, prosthetic and orthotic devices). Transfers: Assesses the student's ability to perform educationally related transfers (i.e., to/from desk, chair, toilet, floor, bus, cafeteria bench, car).
- Independent sitting, standing, etc.: Assesses the student's ability to achieve and maintain these positions independently as required to benefit from his/her educational program.
- Assisted alternative positions: Assesses the student's need for alternative positions and/or alternative positioning devices within the educational environment (i.e., prone standers, side lyers, adapted tables and chairs).
- Transportation: Assesses the student's need for specialized and/or adaptive positioning during transportation.

California Children's Services (CCS) Medically Related Therapy Services

This section describes the referral to California Children's Services (CCS), assessment for medically related therapy services, Medical Therapy Program (MTP) definitions, and CCS IEP procedures.

Referral to California Children's Services: If a parent provides a medical doctor's prescription or recommendation for OT to school team members, any relevant input

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from a medical practitioner would be considered by an IEP team along with other health information. However, there is no educational requirement or authority to fill a physician's prescription for OT.

While the local education agency (LEA) provides OT or PT services to students based on educational need, there are other children who may exhibit a medical necessity for therapy. In such cases, the LEA may refer the case to CCS for determination of medical needs. A decision to refer to CCS depends on the information contained in the referral and the student's documented physical deficit.

If the student is referred to CCS by the LEA, the referral must be accompanied by:

- The student's medical diagnosis;
- Current medical records;
- Parental permission for exchange of information between agencies; and
- Application for the CCS program if the student is unknown to CCS.

If medical eligibility cannot be determined by medical records submitted, CCS shall:

- Notify the parent and LEA within 15 days of the receipt of the referral;
- Seek additional medical information; and
- If the additional medical information sought does not establish medical eligibility, and if the student's diagnosis is cerebral palsy, then the student shall be referred to a CCS panel physician for a neurological examination.

If CCS determines that the student is ineligible because the student's medical condition is not a MTP eligible condition, CCS shall notify the parent and LEA within five days of the determination of eligibility status for the MTP.

California Children's Services IEP Procedures

A "Related Service" is defined in the California Education Code as "…services that are necessary for the pupil to benefit educationally from his or her instructional program." The Education Code further states that California Children's Services (CCS) OT or PT, when defined as a "related service" by the IEP team, must include goals corresponding to that service written into the IEP. CCS therapists may share information and participate in a child's IEP when it is requested and notification of the IEP is provided. Documentation of CCS services should be clearly listed in the IEP. Use the Other Agency Services section of the Education Setting page to identify CCS as a provider. Services provided by CCS should be documented in the IEP team meeting comments. California Education Code requirements regarding notification to/from the IEP team:

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- When the student is a CCS client, CCS is required to notify the IEP team educational liaison in writing within 5 days of a decision to increase, decrease, change the intervention, or discontinue services. An addendum IEP must be held to make the changes to the IEP (telephone addendum procedures may be utilized).
- The District is required to notify CCS in writing 10 days prior to an IEP team meeting if the student is a CCS client. If the student receives CCS as a related service, the OT or PT provider is an IEP team member and must be excused by the parent if unable to attend.

Provision of Medically Necessary Services

CCS medical therapy services are available to all eligible children who require them and are available at no cost to the parents of those children. The frequency of CCS therapy services (monitoring or direct service) is based on physician prescription and is determined by the physician, parent, and therapy team. Services may increase or decrease based on the child's medical condition and progress towards therapy goals. If the parent or legal guardian is not in agreement with the frequency of prescribed occupational or physical therapy he/she may appeal this decision by contacting the CCS administrative office.

Medically based occupational and physical therapy levels of therapy service may include:

1. Weekly therapy for children who are changing rapidly or have acute needs (e.g. after surgery)
2. Frequent monitoring (up to two times per month)for children who need to be followed closely
3. Periodic monitoring 1 to 6 times a year for students who are stable, have met their goals, or who will continue to improve/maintain skills without therapeutic intervention

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