

PHILOSOPHY OF SERVICE

How do you interpret medical services vs. educational services?

- *Really shouldn't be any difference...the focus should be on functional skills/occupational roles. Insurance companies are pushing this. Clinics/hospitals are not "natural" settings but tend to be more appropriate places for certain resources/modalities and using a "rehabilitative" focus. Supports/services we provide in school settings are more easily designed to help the child function in their role as student.*

Do you perceive a therapist's role as adapting for deficits so that the students can learn, or to "fix" the deficits which takes time from the learning?

- *Consider the impairment vs. disablement models. What is really "fixable", will the child really "catch up?" Can an accommodation/adjustment/adaptation allow the child greater participation/independence in their role as a student?*

Is there an age when we no longer provide direct therapy only indirect therapy?

(i.e. no direct therapy after age 7)

- *No, service is based on educational needs...we expect needs to change over time, and between settings. Look at what Direct service is and what change/rate of change is occurring. Is a therapist doing something that no one else is doing, if so, why and how much of a difference is it making to the child's ability to perform classroom activities/school tasks?*

ASSESSMENT

What are your thoughts on standardized testing?

- *Very few formal tests are actually standardized on the population of kids we work with. Most standardized tests tell us what we already know...the kid is different than normal. OTs and PTs don't need to do standardized testing... we may choose to administer some testing to demonstrate how different they are, and perhaps baseline skills at a particular point of time (if anticipating retesting to show change/growth rate) but remember most disabled kids don't usually follow "typical/normal" development...repeated testing generally tends to illustrate "life-long" impairments/abnormalities.*

Should therapists be involved with initial assessments?

- *When assessing to determine initial eligibility for special ed services for the 0-3 year old population, OTs and PTs are commonly involved given their motor and developmental expertise (areas that most obviously/most frequently reflect problems and where concerns lie at this early age. I suggest that a conservative stance be taken for older aged students who are undergoing initial assessment, unless the student has a medical diagnosis that would typically present educational needs that are likely to be met by therapists (i.e. MD = PI eligibility). Our role as "Related Service" providers, implies that we would not become involved in initial assessments for older aged students, since eligibility and their response to initial intervention provided by other special educators has not yet been established. When it has been determined that needs persist beyond the skills and supports provided by other service providers, then it becomes clearer that additional assessment and potential service from an OT/PT may be needed.*

If we have an 8th grade student who is tripping on steps and in the hallway and a referral is made, what standardized assessment options are there?

- *Standardized assessment is required only to determine special education categorical eligibility. It is not required to determine educational needs that may warrant therapy service. It would be sufficient for the therapist to review files, talk to a parent/doctor or school staff, do an observation of the student moving in the hallway (perhaps tally the number of times in a day and the situations/locations where the student trips), and conduct a student interview/structured movement interaction to determine what's going on and why.*

If we note this 8th grade student has a lack of flexibility in the ankles how do we measure it? Do we list a test for this on the assessment?

- *You can usually tell by looking and asking the student to perform the movement...you might also want to ask the student if you may move their ankles. You are assessing using observation, student interview and structured movement interactions. If the ankles seem tight, you might want to talk to the parent and physician if needed to find out if they have information about this and what possible things they have done about it.*

If this 8th grade student needs his balance checked what assessment do we list on the assessment determination?

- *If balance is a concern for this student, it seems logical to think that DAPE would be involved in conducting a motor skills test...your "collaboration" in the evaluation process should probably include a review of the DAPE findings (could you plan to observe the DAPE teacher administering their skills test?) and probably an observation of a regular PE class. Your assessment plan would reflect these assessment techniques.*

COMMUNICATION/ DOCUMENTATION

How do you “gel” your information gathered on a child into the IEP?

- *Try to use collaboration throughout the entire process. Interpret information functionally...ask “how does this impact the child’s ability to perform a school task/activity?” Avoid using therapy jargon. Focus on what you can do to help others know what to do, but don’t expect them to become therapy replacements.*

Should therapy goals be imbedded or can separate goals be attached to the IEP?

- *There should never be separate "therapy" goals...there are only educational goals...the therapist may collaborate with others in identifying educational goals (e.g. Asking a special education teacher if she/he is planning to write a goal on written language, and if so, would she/he like to plan a handwriting objective with you?). Sometimes people think therapists are responsible for completing sections of the IEP related to Motor performance...this is an incorrect assumption since our service can also relate to functional and academic areas of performance, and most transition performance areas. Be cautious when considering goals that are "developmental" in nature. Some students may never reach age appropriate levels of visual/fine motor skill development due to their cognitive impairments. Goals/objectives should also be realistic to the child's potential ability and referenced so as not to exceed that what might be reasonably expected of typical peers (i.e. what are teachers expecting from most of the students in the class/are curriculum expectations unrealistic for this age?).*

What is the current form for writing goals and objectives on an IEP? Do we need to include a present level of function? Function in 1 year? Who will observe the performance? How often we should see it over how many days? Environment performance occurs in?

- *Yes, but don't you just hate it?*

What type of information should we include in the adaptations section?

- *You can be liberal in using this section. Describe service and other relevant information. Most problems arise when people aren't provided enough information to understand what you are doing. Avoid saying "as needed".*

I would also like some ideas, explanations, etc. with dealing with those difficult case managers that are going to question why I am going from seeing a student Direct 2X/week to Indirect monthly...I've told them that I was going to do a "burst" of treatment for a few months, then back off - the student has a hand strengthening program set up prior to doing fine motor and does adequate handwriting for me, but not for them...I've been told "she needs OT"

- *Some times our conversations with our team members are challenging, especially if they like us, we are taking care of something that they then don't have to worry about, or if they anticipate that parents will become upset with change. We must always be mindful of reinforcing the notion of defining "what does the student need to be able to do?" Occasionally we can promote change in some children, but most often the children we work with have greater success if we can change/ adapt aspects of their environment. Perhaps when they say "she needs OT" they are really saying, "handwriting is still a problem in the classroom" and that means some other strategy or understanding/ expectation needs to happen in the classroom. It may no longer be an issue of fine motor/strength, but more of an issue of attention/ organization/work habits/ability to understand content demands of written assignment, etc. All of those aspects should be carefully addressed through a collaborative effort by the entire team.*

SERVICE OPTIONS

Is there a difference between indirect therapy and consultation or are the terms synonymous?

• Indirect service is much broader than just consultation. It can also include things like research, securing/preparing materials and equipment, supervision of therapy assistants, teamings, going with parents to clinic/medical appointments, documentation, etc. Most people do not give themselves enough credit for their indirect service. This is a concept not easily understood by others who have typically fashioned their support services around the "pull out" model, and then only credit themselves for that amount time when developing an IEP (e.g. an SLD teacher only noting their 45 minutes per day of direct instructional support).

What is your perception of direct, indirect and adaptations in regards to services?

- *All are special education terms used to categorize forms of service. Neither is more important than the other, nor are they exclusive of each other. View them as baskets which hold the array and continuum of service you do. Indirect service tends to be a bigger basket that is shared more with others. Direct service tends to be a smaller basket that we are less inclined to share, and others don't want to peek into or sample. The accommodations section of an IEP is a great place (more space) to offer more description/details of service.*

Give some examples of what Indirect "looks" like vs. what Direct "looks" like - I know that we've talked about Direct and Indirect can both be "hands on" manipulation of the student, but I'm still confused as to when to call it Direct or Indirect.

- *Some times both services can look the same. It has to do more with the "intent" of your involvement. If you are doing Direct, the student is present and interacting with you, and what you are doing is an intensive/intricate thing that requires a more complicated set up with continual adjustments in presentation/guidance/feedback, and the student's response to those adjustments is not yet predictable/consistent/reliable. Direct service usually involves greater frequency (at least weekly) to accommodate rather fast or irregular changes in performance. That type of interaction shouldn't be occurring indefinitely or for extended periods of time...if it is, then it probably suggests that the thing you are trying to do doesn't have the efficacy you had hoped, or it is too complex to produce reliable/sustainable responses. Indirect service could look the same in that the student is present and interacting with you, but the frequency of your scheduled sessions would be decreasing. The intent of your interaction would be ascertaining that the child's functional status is stable or that skill use/growth is occurring as you anticipate. You may also be probing the effectiveness of an intervention you've designed that is being incorporated during the child's day or being implemented by others.*

What is the service called on the IEP
when a child has a para and you are
training the para to do something with
the child present...
is that direct or indirect?

- *I would consider it Indirect service involving a face to face student interaction.*

What is the service called on the IEP when a student doesn't have a one to one para, and we either pull for OT or work with the student directly in the classroom...is that direct or indirect?

- *It depends...what are you doing with the child and why? If this happens monthly, to monitor the student's progress/response to a classroom strategy used by the teacher, or supplemental support strategies recommended for home use, then it could be considered Indirect. If Direct pullout or in-class service has been happening on a weekly basis for longer than 3 months, the child is making predictable response to the interventions used and/or it is clear that an accommodation/adaptation/compensatory strategy would support the child, it would be appropriate to consider moving to indirect service, looking at resources and ways that the therapist would support others in using those strategies/interventions daily and throughout the day as natural contexts/opportunities arise.*

Do you consider home visits (B-3) direct or indirect?

- *Hopefully the intent of your home visit is to check with the parent/caregiver regarding the questions/problems they may have had since the last time you visited, to assess their competency and compliance in using an intervention strategy or support you previously provided them, and to determine any changes in the child's responses since your last visit. It is probably a combination of both Indirect and Direct, both of equivalent duration or most of the session considered Indirect (although the entire time the child was probably present and being interacted with).*

If indirect service from an OT and/or a PT is chosen when information, materials and techniques/strategies of support can be shared with or taught to others who work with the child/student on a routine basis (manual p. 63), and we only have visits where we are working with a parent (all home visits), Para, or teacher (all school visits) do we ever do direct therapy?

- We should never do only Direct therapy. If Direct therapy is warranted, then it is likely that we are doing an equivalent if not greater amount of Indirect therapy.*

If we do direct therapy on home visits (the parent is always there and we are working with the child and parent) and we are there one hour, is there a suggested standard time split for direct/indirect? (i.e. 45 mins. direct, 15 mins. Indirect)

- *Although there is no requirement for a "standard time split," it is likely that both types of services are happening simultaneously. Designating more time to the Direct category may give others the assumption that it must somehow be more important/valuable than the indirect service. Be very careful as you may be laying a foundation of expectation for parents that can cause problems later on.*

If we do a burst of direct therapy when a child is in school is there an accepted standard for length of time for the burst of direct therapy?

- *There is no accepted standard...it is your best guesstimate of how long you think you need to refine your intervention technique, and determine the effectiveness of it based on the child's response/rate of change. I suggest it is reasonable to determine this within an 8 week to 3 month time frame. This may best be planned/timed to align with an upcoming progress review.*

What is the difference between a burst of direct therapy and just doing indirect therapy when you are working with a student plus their Para or teacher particularly when a student transitions from one building to another?

- *Remember that a "burst" of therapy can occur for either Direct or Indirect service (i.e. weekly vs. monthly/quarterly). It is used to help describe "episodic" care that implies changes in service to align with changes in needs. Use the start/duration dates on the service page to define this.*