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More Frequently Asked Questions About School-based OT and PT

Question: *I have a student who is 11 years old, in a self contained class. He has cerebral palsy, functions at a 2 month level on fine motor measures, 5 month level on gross motor measures, and 6 month level for feeding. These age equivalencies are no different when our current evaluation is compared to his evaluation 5 years ago. There is disagreement about the needed frequency of OT services. I want to collect data to show that the student will continue to progress towards his goals even with less frequent OT services. Any ideas on how to do this?*

Response: There are several things to think about in the situation you raise:

1. Basing service recommendations on chronological age versus test/ functional age-equivalent discrepancies, or comparison between age-equivalents over time, is a practice that lacks validity.

2. A critical component of effective decision-making for IEP services requires the team first know the child's needs in relation to the team's agreed-upon outcomes. Services and supports included in the IEP are those that address/satisfy these specific needs.

3. The IEP team's decisions need to be well informed, and even then, represent their best projection for a workable plan to help a specific student. Things may not proceed as anticipated and the team may need to change their plan.

Before you talk about whether this student needs school-based OT, and then, how much service is indicated, your team has to talk about what he will do in the future that he doesn't do now (behaviors). These goals are not predicated on developmental ages or test scores. So what are this boy's targeted outcomes in specific, jargon-free language that illustrates desired performance? For example, if it's something related to mealtime behaviors you need to define this. Is it scooping and ingesting food without help, eating within a targeted time period, eating additional types of food, interacting with peers at the table during lunch? Is it related to having friends and replying to social exchanges that others initiate? Is it related to pursuit of a constructive leisure activity?

For each outcome area you have to talk about what conditions, influences and contexts interfere with progress, as well as those that make it more likely that he will develop the targeted behaviors. Think of multiple options in order to amass opportunities for exposure, practice, mastery and generalization. Maybe there's specific equipment he needs,

maybe it's a new motor skill, perhaps the teaching staff needs some additional information or training. Maybe they need to stop doing something that is part of the current repertoire.

Once these variables are identified, the team has a list of program planning factors that are relevant to child-specific outcomes. Next, they determine what supports and services "fit" in order to limit the interfering variables and support the positive variables. Sometimes an OT's expertise is needed for this, either "in the trenches" or behind the scenes - and that's when we provide a related service.

These strategies are part of an effective evaluation process designed to plan a program for a student. All of this doesn't happen at the formal IEP meeting, and in fact, things don't work well if you wait till then. Yes, it takes time and effort to get together with parents and teachers to collect the information - but without this, we will continue to make service frequency decisions in ways that hold little more relevance than pulling numbers from a hat.

With all of this said, once the IEP is implemented, data collection is essential. Your team should collect measures of the boy's targeted behavior on days that he does receive OT as well as on interim days. Is there a trend over the short-term? Secondly, are there any observable changes between the data collected on "OT days" versus those without? Is there regression when he doesn't have OT, a big spike on days he does? What is his performance on Mondays, after he's had a two-day break from all school activities? This is one way to increase the evidence upon which you base your actions and recommendations - and it's focused specifically on the child and intervention approaches in question!

Question: *What about services to improve fine motor skills for students with very limited cognitive abilities? I've heard that when actual performance is similar to, or stronger than, intellectual capacity, therapy is not indicated.*

Response: Here are some resources on "cognitive referencing," an approach to service provision that predicts that children with motor delays that are commensurate with their cognitive abilities will not benefit from intervention to the extent that children with motor delays and higher cognitive abilities will benefit from intervention. The studies in these articles relate to speech, OT and PT services. They do not support IQ as a predictor of a child's response to treatment and question the model's use in service decisions as it may inappropriately exclude children from beneficial interventions.

1. Baker BJ., Cole KN., Harris SR. (1998). Cognitive referencing as a method of OT/PT triage for young children. Pediatric Physical Therapy, 10(1), 2-6.

2. Krassowski E. & Plante E. (1997). IQ variability in children with SLI: Implications for use of cognitive referencing in determining SLI. Journal of Communication Disorders, 30(1), 1-9.

3. Cole, KN., Mills, PE. (1997). Agreement of language intervention triage profiles. Topics in Early Childhood Special Education. 17(1), 119-30.

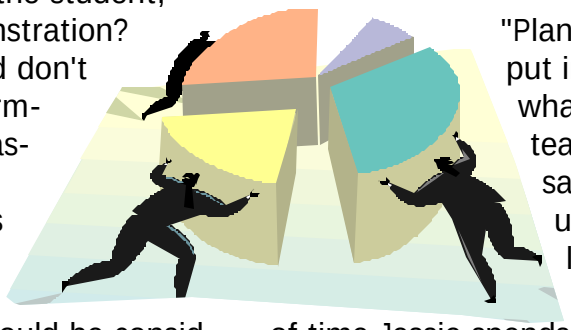
4. Cole, KN. et al. (1994). Agreement of assessment profiles used in cognitive referencing. Language, Speech & Hearing Services in the Schools. 25(1), 25-31.

5. Notari, AR. et al. (1992). Cognitive referencing: The (non)relationship between theory and application. Topics in Early Childhood Special Education. 11(4), 22-38.

6. Coggins, TE. & Sargent, L. (1992). Obtaining and using new knowledge: Determining the relationship between theory and application: A reaction and reply to Notari, Cole, and Mills. Topics in Early Childhood Special Education. 12(1), 44-53.

Question: *One school district suggested I use a guideline of a 25% measurable delay in fine motor, visual perceptual, or visual motor skills as justification for therapy within a student's IEP. Do others find this approach helpful?*

Response: Think about the "test score versus age" discrepancy approach. How do you make decisions when a child cannot be tested? What about the lack of validity/reliability in teacher or therapist-made checklists or lists of age-expected skills/performances? When a norm-referenced test is used, the resulting score tells you how the student's performance (at that point in time and under specified testing conditions) looked in relation to the reference group - which is usually children without disabilities. Children's performance is variable and unstable. What if the test day performance represents stellar behavior for the student, or an exceptionally poor demonstration? Many of the tests that are used don't measure relevant school performances/ functions and don't measure the impact of environment and other variables on a child's performance either.

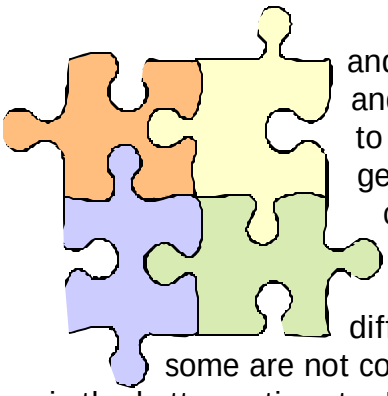


No one piece of information should be considered in isolation, nor should any approach that limits individualization be applied to decision-making. We don't have evidence that "degree of difference" is a good barometer for determining related services needs. This criterion provides no information about what needs to be done to support the student's achievement. *What needs to be done* is the heart and soul of IEP team deliberations. Evaluation reports that generate programming options for IEP team discussion are an essential feature of good school-based assessment approaches!

Question: *Sometimes team members hold very different views of the child and of the configuration of services in the IEP. What happens when teams have difficulty reaching consensus? Is the legal system the only remedy?*

Response: When there is difficulty with consensus regarding intervention options the team can try a period of "PLAN A" for a given time - along with good documentation related to student performance under these conditions - and then look for change in desired behaviors. For example, the team is presented with two options designed to increase Jessie's participation during written seatwork. One combines some tool/positioning/environment adaptations with the available curriculum resources; the alternative includes individual occupational therapy sessions for specific activities with Jessie on a routine basis, in addition to available curriculum resources. No one really knows the answer as to which approach will work for Jessie - we only have best guesses that are based on training, experience and beliefs.

"Plan A" - the first option - is put in place for 4 weeks (or whatever time period the team agrees) while work samples and other measures are collected and analyzed regularly (maybe you're looking for length of time Jessie spends at seatwork along with amount of written production, maybe it's legibility, maybe it's content, etc.). The team doesn't wait until the intervention period (4 weeks in this example) is complete. They look at the data regularly - are the targeted variables changing to reflect increased performance? If so, is the team satisfied with the rate



and types of changes, and what do they want to do next? If the targeted variables are changing to reflect deterioration, the team better do something different right away! If some are not convinced that PLAN A is the better option, try Plan B (the OT directing activities with Jessie) and collect the SAME information - what does it look like now?

When you first implement this type of systematic measurement approach, it takes some time to go through these steps. But this is time spent in activities that give tangible information to the team regarding Jessie's response to different intervention strategies. And, rather than a hearing officer's ruling, that's what they need in order to make an informed decision regarding the best plan for Jessie.

There will always be personal preferences that align some team members to particular approaches and even to providers. When this suggested type of data is incorporated into the process, it guides the team to what really seems to work for the child in relation to the desired outcome, and the unfounded opinions/biases become more difficult to sustain.

Question: *My supervisor has suggested that I move to a consultative model with some of my students, thus freeing up time to add more students to my caseload. How do I begin?*

Response: Therapy services that use consultation methodologies are often implemented based upon the assumption that they take less time. This is not necessarily true. Furthermore, the way that one provides a related service has to be based on the *child's needs.* Sometimes consultative approaches are the ideal intervention within a student's IEP, but in other situations they do not yield results.

Consider this example. Johnny has difficulty participating during circle time. This limitation may come from his visual distraction - or from hearing difficulties - or from his pressure sores - or from not understanding the English language (ESL) - or from inadequate seating support - or something else. If Johnny's pressure sores are the interfering variable the remedy is drastically different than if it's ESL or if it's not having appropriate seating support. Imagine how ineffective the service is when a lack of custom-fit supportive seating is the barrier and consultation is the mode of service delivery! If it's distraction, then perhaps consultation is the best option and direct service by an OT may be ineffective, or less effective in increasing Johnny's participation.

Evaluations that identify variables that are relevant to accomplishing the outcome enable the IEP team to identify the appropriate type and nature of services needed in the IEP. Knowing this information also helps the team determine how much service is needed. If lack of supportive seating is the barrier, perhaps it's best to provide PT (or maybe OT is the best option for this team) in a larger time block and at a greater intensity in the short-term at the start of the school year. The IEP might say *"PT for 3 hours within the first two weeks of school to locate and provide supportive seating for Johnny's use in circle."* When approached this way, the IEP is clear and supports the specific intervention that is needed for a targeted outcome. No one's guessing or is misinformed.

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