Occupational and Physical Therapy

Educationally Relevant vs. Medically Relevant Therapy

School-Based (Educationally Relevant) Services	*Medically/Clinical Services*
Governed by the IDEA (Individuals with Disabilities Education Act).	Governed by medical management, accreditation bodies, physicians.
Emphasis on skills impacting learning/education—where child is for the larger part of the day.	Emphasis on medical issues impacting functioning in all settings (home, school, community).
Focus to eliminate/decrease barriers to learning and to ensure participation in the educational environment through accommodations and modifications as opposed to attempting to change underlying causes.	Focus on increasing independence---addressing underlying weakness/causes.
IEP dictates what is addressed in therapy.	Insurance can dictate what can be addressed in treatment sessions and the number of visits.
Services provided based on education-related difficulties which impair the ability to function within the school environment.	Services provided based on referring diagnosis and physician request, evaluation, therapist's recommendations, and collaboration with parents/caregivers on needs/goals.
Physical impairments, sensory processing deficits, or attention deficits are not reasons, in themselves, to provide therapy.	Services may be provided to address physical impairments, sensory processing deficits, attention deficits, etc.
Available at no cost to all ESE students who require therapy services to benefit from their special education program (i.e., to meet IEP goals).	Payment is on fee-for-services basis; covered by private insurance, government assistance, or by the family (self-pay or co-pay).
Therapy available when school is in session.	Therapy available year-round.
Services to qualifying students ages 3 to 21.	Medically relevant therapy available to all with referral.
Process begins with a request for a consultation.	Requires physician referral.
Evaluation occurs in the educational environment in which performance occurs. Usually relies more on observations in the school setting than on standardized testing. Therapists may have access to and may utilize results of assessments completed by other professionals. Evaluation is only conducted to the extent that it is needed to determine barriers to educational success (based on IEP goals).	Evaluation occurs in clinical or home settings. Often relies on results of standardized testing as well as clinical observations. Therapists often do not have access to the results of evaluations completed by other professionals. Therapists may have more access to medical information than do school-based therapists.
Concerns such as improving range of motion, strengthening, or preventing contractures may impact the child's ability to meet the educational goals, but are part of treatment or classroom plan and are not designated as goals.	Goals may include preventive therapy—therapists to prevent or minimize problems in the future (e.g., contractures).
The team collaborates to determine emphasis of service, goals, frequency, and duration based on educationally relevant therapy needs. Team includes parents/caregivers, educational staff, and therapist.	Therapists, parents/caregivers, and possibly physicians collaborate to determine emphasis of treatment, goals, frequency, and duration based on medical needs. Team includes parents/caregivers, therapists, physicians.
Goals are educational in nature.	Goals are rehabilitative in nature.
Works directly with child in the classroom or other school setting, one-on-one or in a small group.	Works with child and parents/caregivers in clinical or home setting. Therapy usually conducted on-on-one.

School –Based (Educationally Relevant Services	***Medical/Clinical Services***
Regular contact with teachers and other IEP team members to coordinate the educational plan. Parent contact is usually at IEP meetings; other times to meet generally require prior arrangement. Meetings must be scheduled to update or change goals.	Regular contact with parents/caregivers to obtain history; their concerns, needs, and expected outcomes/goals; update and/or change goals.
Opportunity to provide instruction to teachers and child in the classroom. Parent contacted by pre-arrangement.	Opportunity to teach parents home program activities for carryover.
See functional impact, more realistic view of problems/difficulties in school setting. Provision of realistic accommodations for child as able to observe in the classroom.	See activities child is able to perform in a clinical setting. May not be able to observe in school environment.
Service delivery model is determined by the IEP committee and may include direct intervention, consultation, and adaptation of materials. Service scheduling may be dynamic based on needs.	Service delivery model is generally determined by a clinical team. Consists primarily of direct intervention with some consultation with patient and/or family. Service schedule is usually static (i.e., the same time each week).
IEP committee may determine that therapy services are not needed to support a student's educational program at a given time.	Discharge occurs when the patient meets all goals/objectives or when insurance funds are no longer available.