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Pediatric Therapy Service Delivery 101: What's the Difference and Why Does It Matter to Life Care Planners?

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Abstract

Children with disabilities often participate in therapy services to help remediate or accommodate their physical and functional limitations. To increase their clients' independence, therapists also recommend and assist clients with obtaining assistive technology. Allied health professionals, specifically speech, physical, and occupational therapists, psychologists, and audiologists, primarily work in two broad settings, medically-based or educationally-based. Similarities and differences, as well as benefits and disadvantages, exist between the two settings. Projected evaluations and projected therapeutic modalities are two common life care plan categories (Riddick-Grisham & Deming, 2011; Weed & Berens, 2018) which frequently contain recommendations for allied health services. Life care planners who possess a foundational understanding of these models will communicate more effectively with the team and will provide stronger recommendations and rationale in the related life care plan categories.

Pediatric Therapy Service Delivery 101

When a person experiences a chronic health condition or a catastrophic injury (Weed & Berens, 2018), therapy is often recommended to remediate physical dysfunction or accommodate the resulting limitations in activities and participation. Adults who require therapy obtain those services in hospital-based, outpatient, or home and community-based facilities. All of these settings are associated with and follow a medical model. Due to a progression of civil rights and educational laws aimed at protecting people with disabilities, children with disabilities may participate in therapy in an educational or medical setting or both. Each model shares some similarities and differences and embodies inherent strengths and weaknesses. By understanding the origin and purpose of the two primary pediatric therapy delivery models, life care planners will be better equipped to communicate with the child's team and develop life care plan recommendations.

Medically-Based Therapy Services

Allied health professionals are a "broad group of health professionals who use scientific principles and evidence-based practice for the diagnosis, evaluation and treatment of acute and chronic diseases; promote disease prevention and wellness for optimum health and apply administration and management skills to support health care systems in a variety of settings" (Association of Schools Advancing Health Professions, 2020). Several allied health professions developed, grew, or expanded in scope of practice following the World Wars (American Occupational Therapy Association, 2017; Campbell, n.d.; Duchan, 2002; History of the Professions, 2020). These professions are separate from medicine and nursing (Association of Schools Advancing Health Professions, 2020).

In the medically-based model, the term diagnosis may be defined as "the art or act of identifying disease from its signs and symptoms" (Merriam-Webster, n.d.). Psychologists (PhD or PsyD), psychiatrists (MD or DO), psychiatric and mental health nurse practitioners (MS or PhD), and counselors, in some states,

provide mental health diagnoses (National Alliance on Mental Illness, 2020; Licensed Professional Counselors Authority to Diagnose Postcard, 2020). Medical diagnoses are provided by physicians, nurse practitioners, and physician assistants. The primary diagnosis classifies the cause of disease, while the treatment diagnosis classifies the consequences that result from the primary diagnoses. Speech language pathologists diagnose communication and swallowing disorders, but those disorders are not considered differential diagnosis. Physical therapists provide physical therapy diagnoses and functional diagnoses of movement system impairments (Jiandani & Mhatre, 2018). Occupational and physical therapists, as well as speech language pathologists, also provide treatment diagnoses. Allied health professionals may suggest appropriate medical and primary diagnoses that pertain to the treatment diagnosis; however, the medical or mental health practitioner must decide if the suggestions are appropriate and accurate.

For a child to qualify for medically-based therapy, a physician usually provides an order to evaluate and treat the child. Physical therapists and audiologists are entry-point providers, so the family of a child may be able to go directly to the practitioner without a prescription. However, some insurance companies may still require a prescription from a medical provider for reimbursement purposes. Occupational therapists and speech language pathologists require a medical prescription to provide treatment and receive reimbursement from third party payers. Next, the allied health professional completes an evaluation to determine if therapy is medically-necessary for the child to properly develop his or her skills, particularly in the home and community environment. The therapist uses clinical reasoning as he or she reviews the parents' report, clinical observations, and standardized testing to develop functional and measurable treatment goals. Because therapists are able to rely on clinical reasoning, the therapist is able to consider the family's perception of the child's functional impairment and the impact the impairment has in the context of his or her specific family and community. Finally, the family must have a means of payment, which is typically insurance, Medicaid, or private payment. Insurance coverage varies widely regarding therapies. For example, some companies do not cover services for children with a primary diagnosis of developmental delay, while others do not cover services they consider more relevant to academic needs.

The frequency at which a child is seen for therapy is dependent on the family and child's availability, the therapist's availability, insurance coverage, and need. In a medically-based setting, a child is often seen 1-3 times/week, for 30-60 minute sessions. While some children are seen weekly for years, this setting offers opportunities for episodes of care in which a child is seen for a finite period of time to address specific functional deficits. Therapy intensives might be possible wherein a child is seen multiple times per week for several hours at a time to focus on acquisition of a specific skill (e.g. constraint induced movement therapy). Also, specialty clinics, such as spasticity and mobility, seating and positioning, and multidisciplinary feeding teams, are more common, allowing a child to be seen by multiple providers at once in an environment of collaboration to support the child's broader needs.

Allied health professionals are often responsible for recommending assistive technology to improve a child's independence and performance quality. When developing recommendations for assistive technology or equipment in a medically-based setting, for which the caregivers are seeking coverage through an insurance company, therapists must consider whether the technology is medically-necessary. This means the therapist should consider if the technology will be used primarily in the home and community and whether the technology is merely convenient or required for optimal function. Stramondo (as cited in Krasniansky, 2020) suggests that technology is assistive if the meaning the technology holds in our culture identifies the user as disabled. Certain devices or platforms are helpful to individuals with disabilities, but the use of technological conveniences by society at large blurs the line of determining whether it is

medically-necessary and "assistive." Therapists must consider whether the child requires the technology to function with increased independence and success.

The medical model of therapy delivery has many strengths. The equipment and "tools" are novel and enticing, which improves the child's motivation and desire to participate. Interaction with the child's family allows instruction regarding strategies to support development between sessions and insight regarding the lens through which the therapist approaches a skill or behavior. It also supports the child's understanding that the therapist may be the cause for the parents' new requests and expectations outside the clinic. Some family members choose not to be present in therapy sessions, in which case the treatment session may be viewed as a break from the stressors of caregiving. The clinic setting offers a clean slate for trial and exploration of activities and tasks that may have strong negative emotional connections with the child's typical environment. Finally, specialty programs, such as constraint induced movement, serial casting for spasticity and contractures, and pediatric incontinence, are more likely to be available.

On the negative side, concerns regarding payment, insurance coverage, and co-pays are common in the medically-based model. Therapists often have expectations to meet certain productivity requirements, which are calculated based on the percentage of billable time they produce in their day. This pressure places limits on the amount of time a therapist spends communicating with outside providers. Additionally, the clinic setting is unnatural to the child, limiting the degree to which the child is able to transfer and generalize the skills he or she gains in therapy. Therapists attempt to simulate home-like scenarios and discuss opportunities to embed therapeutic strategies into the child's daily routines, but it is not the same as actually being in the child's natural environment. Scheduling is often challenging for families because after school time slots are in high demand, forcing the family to choose between pulling their child from academics or therapy. Therapy becomes another activity for which they must find time and provide transportation.

Educationally-Based Therapy

Allied health professionals who work in educational settings are referred to as related services providers (U.S. Department of Education, n.d.-a) or specialized instructional support personnel (Every Student Succeeds Act-A Comprehensive Guide, n.d.). The most current term, specialized instructional support personnel (SISP), is derived from the Every Student Succeeds Act which was signed into law in 2015 and went into effect for the 2017-2018 school year. SISP's are defined as

> i) school counselors, school social workers, and school psychologists; and ii) other qualified professional personnel, such as school nurses, speech language pathologists, school librarians, OT, PT, etc. involved in providing assessment, diagnosis, counseling, educational, therapeutic, and other necessary services (including related services as that term is defined in section 602 of the Individual with Disabilities Education Act (20 U.S.C. 1401) as part of a comprehensive program to meet student needs. (Every Student Succeeds Act-A Comprehensive Guide, n.d.)

Several laws, both educational and civil rights, established the rights of students with disabilities leading to and expanding special education and related services. In 1965, Public Law (P.L.) 89-10, the Elementary and Secondary Education Act, provided a comprehensive plan for addressing inequality in schools, with a focus on supporting the needs of the underprivileged. This law led to the development of special education (Paul, n.d.). P.L. 93-112, the Rehabilitation Act of 1973, is a civil rights law that applies to private and public schools. It prohibited discrimination against individuals with disabilities and mandated equal access to educational activities. Section 504 of that law specifically addressed the right to

a Free and Appropriate Public Education (FAPE), related services, and transportation. In 1975, P.L. 94-142, the Education for All Handicapped Children Act, established the basis for federal funding of special education. It emphasized FAPE and due process (a formal way of resolving disputes between a family and a child's school), as well as mandated Individual Education Programs (IEPs) and service provision in the least restrictive environment (LRE). The Individuals with Disabilities Education Act (IDEA) (P.L. 101-476) and the Americans with Disabilities Act (ADA) (P.L. 101-336) were both passed in 1990. IDEA amended and renamed the Education for All Handicapped Children Act, emphasized transition services, defined assistive technology & services, and added autism and traumatic brain injury to the list of disability categories (England, 2011; The Advocacy Institute, n.d.). The ADA prohibited discrimination against individuals with disabilities in employment, public accommodations, public transportation and services, and telecommunications. The Amendments Act of 2008 changed the definition of disability to an impairment that substantially limits one or more major life activities, a record of impairment, or being regarded as having an impairment (England, 2011). Additionally, it placed more emphasis on the act of discrimination rather than proving a disability exists (Vierling, 2018).

In order for a child to qualify for special education and related services, the IEP team must determine whether he or she meets the criteria in the Prongs of Eligibility (Dahl, 2017). The number of prongs varies by state but all of the elements must be considered in the eligibility determination process. a.) The child must demonstrate eligibility for special education support based on a multi-disciplinary team assessment. This assessment must meet federal and state guidelines, which may differ. b.) The cause of the child's poor academic performance is not due to factors such as attendance, lack of appropriate instruction, or limited English language proficiency. c.) The child requires specialized instruction in order to access his or her educational curriculum, which is part of FAPE. For children ages 0-3 years, the document is called an Individualized Family Service Plan (IFSP). For children ages 3-21 years, the document is called an IEP. A child should qualify for special education before related service providers, or SISPs begin to assess the student's needs, because the child should have the opportunity to benefit from the special education programming before other services are added. Ideally, the therapist collaborates with special and general education staff to provide strategies that may be implemented before higher level interventions are explored.

An educational "diagnosis" is otherwise known as an educational determination, eligibility category, or educational classification. IDEA identifies 13 categories of eligibility: autism, deaf-blindness, deafness, emotional disturbance, hearing impairment, intellectual disability, multiple disabilities, orthopedic impairment, other health impairment, specific learning disability, speech or language impairment, traumatic brain injury, visual impairment including blindness (U.S. Department of Education, 2018). While states must follow IDEA, the state and the local education agency are able to determine who qualifies under each disability category. For example, the specific age of students who may qualify under "developmental delay" and the criteria and models used to determine the criteria for specific learning disability varies (Rosen, n.d.-a). A school psychologist may "diagnose" for the purposes of eligibility determination, based on the IDEA categories of disability, but the IEP team, consisting of a school psychologist, general and special education teachers, parent, administrator, and other related service providers as appropriate, makes the determination (Rosen, n.d.).

Allied health professionals in the educational model are referred to as a related service because they relate to the child's special education program based on the child's eligibility category. Occupational and physical therapists in this setting are always related service providers because there is no eligibility

category that specifically associates them to the IEP. For this reason, these therapists must support the special education program the team establishes. A speech language pathologist may be either a stand-alone service, when the child's IDEA eligibility category is speech or language impairment, or a related service if a different eligibility category is identified as the best descriptor of the child's needs.

As previously mentioned, although federal laws mandate certain aspects of special education and related services provision, the states and local education agencies have some autonomy to determine how a child qualifies and how the required services are implemented. Part C of IDEA, commonly referred to as early intervention or birth to three programs, and in certain circumstances, Part B of IDEA, mandate that qualifying infants and toddlers (0-3 years) receive appropriate special education and related services. Routines-based interventions and coaching models are gaining widespread popularity because they focus heavily on equipping caregivers to implement strategies throughout the child's daily routine, thus increasing the therapeutic impact. Therapists typically work with children in their homes or daycare, using the "equipment" that is naturally found in those settings (e.g., toys, household items, food that is available, etc.). For children ages 3-5 years, often referred to as preschool, Part B of IDEA mandates appropriate educationally-related services. These children are typically served in a special education preschool program where they encounter a mix of children who are typically developing and those who have delays or disabilities. By providing services in a rather natural environment, the programs meet the mandates of least restrictive environments, provide positive peer models and opportunities to develop social skills, and increase the likelihood of skill transfer and generalization. School-aged children, those in kindergarten through 21 years, are seen in the school setting. In many cases, the children receive individual, direct, pull-out therapy. However, push-in therapy, in which children are served in the classroom during their naturally occurring routines, is gaining momentum throughout the country. The move to service provision in the natural setting aligns with IDEA language related to least restrictive environments. Special education is moving toward inclusive programming; therefore, therapies are beginning to follow suit.

Related services, or those offered by SISP's, provide therapy either through direct or indirect/consultative service. For those who receive direct service, the duration and frequency of therapy is based on the needs of the child, the culture of the classroom, school, or district, the child's age, and the child's endurance. Children who require intervention in two different aspects of development within one discipline's purview will often be seen in two different sessions. Students in classrooms where teachers and administrators encourage inclusion and strongly embrace response to intervention (RtI) strategies may require less direct therapy. Finally, young children and those with certain disabilities have reduced endurance and attention spans and may benefit from shorter, but more frequent therapy sessions. Consultative or indirect services are those provided "to the child, or on behalf of the child, and [as]…program modifications for school personnel" (IDEA, 20 USC, Section 1414 (d)(1)(A) IV) as cited in AOTA, 2017).

Goals in the educational model should be educationally relevant, meaning that related services should support the needs identified in the IEP. Examples might include sensory processing interventions that support a child's behavioral skills; self-feeding, functional mobility or functional communication interventions to improve a child's adaptive skills; and visual motor interventions to allow a child to demonstrate knowledge via handwriting. Current skills, needs, goals, and objectives should be written in family friendly language. Children may experience success or challenge when presented with the same task in two different environments. For this reason, related services must consider the child's needs in the school environment and only provide intervention to support needs that are present in that context. For children who receive indirect or consultative services, a specific "therapy" goal may not be present, but

instead support an existing educational goal in the form of an accommodation or support.

According to the U. S. Department of Education (n.d.), "an assistive technology device is any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability," while assistive technology services are those that assist with the selection, acquisition, or use of the device. Low tech devices include but are not limited to picture exchange communication systems, specialized utensils, or adaptive writing paper. High tech examples include word processing devices and software, some standers, walkers, or wheelchairs, and augmentative and alternative communication systems.

For a school district to be responsible for the purchase, training, and maintenance of an assistive technology device, the device must be necessary for the child to access his or her education. In this case, the child may receive assistive technology as a reasonable accommodation under IDEA or as part of the school's responsibility to provide FAPE under section 504. Occasionally, schools allow assistive technology devices to go home, but only if the device is necessary for the child to progress toward the IEP goals (e.g. completing homework). The school district owns the device, so if the child withdraws from the school district, the child will be unable to bring the device to their new educational setting.

The educational model of therapy delivery possesses many strengths. Service provision occurs in the child's natural environment. Additionally, ample opportunities are available for therapists to collaborate with educational staff. These two attributes can improve the generalization and transfer of skills gained in therapy to other settings within the school. Because therapy occurs during the natural schedule and routine of the school day, families have fewer demands on their time in the evenings and weekends. Additionally, there is no cost to the family either in the form of copays or transportation to and from appointments. Finally, children are motivated by and learn from their fellow students, especially those that provide positive modeling of skills.

While there are strengths to the educational model, negative aspects are also present. Therapy provision is dependent on the school district's calendar. Therefore, the child does not receive therapy on holidays and during breaks. While a child may qualify for extended school year (ESY) services during the summer, he or she may not qualify for ESY related services. Communication with families is more difficult in this setting because there are few naturally occurring encounters. Because a child's team of therapists in the medical model and therapists in the educational model may see different behaviors, skills, opportunities, and challenges based on the context, therapist's recommendations and instructional methods may conflict, creating confusion for the child. School districts may have fewer resources than those available in the medical setting; and even if resources are available, the school district is only required to provide what is necessary for FAPE. With the move toward inclusive programming, children may receive less one to one and direct intervention. While IDEA is a federal mandate, there is room for individual states and districts to interpret and implement services, therefore variation exists. Finally, families and staff occasionally misunderstand the difference between related services and special education. While students continue to receive instruction until graduation or when they age out of services, therapy is not intended to last forever. Related services exist to support special education and must be required for the child to make progress toward their education. If another staff member can implement the necessary non-skilled strategies, then the principles of least restrictive environment and FAPE suggest related services are no longer required.

Implications for Life Care Planners

When life care planners or other forensic experts review records, it is helpful to understand the

terminology used in different settings. Because allied health professionals work in various settings, one might consider the services (related services, allied health provider, and specialized instruction support personnel), the purpose (e.g., medically-necessary versus necessary to access the educational program), and the terminology (e.g., diagnosis versus determination of eligibility) to be the same. However, the nuances have implications of which even knowledgeable families and health care providers may be unaware.

Allied health providers often need to explain or justify their role in the evaluee's care. They encounter several common biases which include a.) medically-based providers have greater skill and knowledge; b.) school-based providers try to cut corners to save the district money; c.) services provided in educational settings are inferior; and d.) medical providers may dictate services provided in educational settings. When conducting the evaluee's assessment, collaborating with other members of the health care team, or interviewing members of the treatment team, knowledge of service provision model differences saves time and supports rapport development.

Knowledge of the similarities and differences between the primary therapy delivery models may prompt targeted questions during collaboration with allied health professionals and during the evaluee's assessment, thus improving the expert's efficiency when speaking with other professionals. Understanding the purpose of each model facilitates better recommendations in terms of frequency, duration, and episodes of care. While collateral source rules will apply, the life care planner should consider what each therapy provision model is required to provide, especially when considering educationally-based services. Additionally, recommendations should be made in such a way as to ensure that necessary services or assistive technology devices are available should a child move to a state or district that follows different regulations or interpretation of IDEA regarding eligibility and service provision.

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