

Related Services Issues Under the IDEA: Key Doctrines and New Areas of Concern

by

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1. Basics of the IDEA Related Services Requirement

Definition and Range of Services

Related services are defined as those services that “are required to assist a child with a disability to benefit from special education.” 34 C.F.R. §300.34(a). Thus, in special education there are two types of services: special education services and related services, which are those corrective and supportive services that are necessary for the child to benefit from the special education services.

The commentary to the Federal regulations include a listing of some related services, but make clear that the list is not exhaustive—if a certain related service is not listed, but is nevertheless necessary to enable a child to benefit from the IEP, it must be provided at no cost to the parent. The regulation lists the following related services:

1. **Audiology**, which includes identification of hearing loss, determination of range of loss, habilitative services (e.g. speech reading, auditory training), programs for hearing loss prevention, counseling, and determination of need for amplification.
2. **Counseling services**, provided by either social workers, psychologists, guidance counselors, or other qualified personnel;
3. **Early identification and assessment of disabilities in children**, which means implementation of formal plans for early disability assessment in children;
4. **Interpreting services**, including oral transliteration, cued language, sign language, and transcription services;
5. **Medical services** provided by licensed physician for evaluative and diagnostic purposes only;
6. **Occupational therapy** meant to improve, develop, or restore functions, or to improve independent functioning tasks, as well as to prevent further loss of function;

7. **Orientation and Mobility services** to assist visually-impaired students in achieving the capacity for safe movement across environments;
8. **Parent counseling and training**, if increasing parents' ability to manage their children or understand their disabilities is necessary for the children to benefit educationally from their IEPs;
9. **Physical therapy** provided by a qualified physical therapist;
10. **Psychological services**, including testing, interpretation of test results, interpreting and integrating information about child behavior and conditions relating to learning, psychological counseling, and consulting with staffpersons in planning IEPs;
11. **Recreation**, which includes assessment of leisure function, therapeutic recreation services, and leisure and recreation programs;
12. **Rehabilitation counseling services**, which means counseling that focuses on career development and integration into the workplace;
13. **School health services**, which means health services provided by qualified nurses or other staffpersons (e.g. catheterization, tracheostomy monitoring, monitoring of IV medication, etc);
14. **Social work services**, including counseling, working with community/home problems that affect the child at school, and mobilizing appropriate resources in the school and community (e.g. assisting with Medicaid paperwork, referrals to MHMR, etc);
15. **Speech-Language pathology**, including identification of children with speech/language impairments, appraisal of impairment, referral for medical or other professional attention, and counseling of parents, children, and teachers regarding speech/language impairments;
16. **Transportation**, including special buses with lifts.

The Legal Duty to Provide Related Services

The IDEA regulations state that the duty to provide a related service arises when a service is **“required to assist a child with a disability to benefit from special education.”** See 34 C.F.R. §300.24(a). Thus, even if a service would be beneficial or helpful to the child’s educational performance, the service is not required under IDEA unless it is *necessary* in order to assist the child in receiving educational benefit from their IEP.

Since educational benefit can be loosely defined as meaningful progress on appropriate IEP goals implemented in the least restrictive environment, the definition for related services could be restated as **those services necessary in order for a child to benefit from their special education services and make meaningful progress on IEP goals.**

2. Common Problematic Issues in Providing Related Services

Determining Appropriate Type and Level of Related Services

The determination of what level of related services are necessary, if any, must be based on evaluation data, usually including evaluations conducted by related services providers. Related services evaluations should include a report stating whether the student meets criteria for eligibility for the particular service and establishing whether the service is needed for the student to benefit from instruction. In addition, the evaluation must indicate the precise amount of services that will be required to enable the child to benefit from the IEP.

Related services evaluators may want to also consider the following questions in making their determinations:

1. Do I have a good understanding of the child's instructional objectives, so that I can determine what level of services will be required for the child to make progress on those objectives?
2. Why do I believe this service is required for the child to make progress on IEP objectives?
3. Can I support this finding with assessment data?
4. Are purely educational objectives the reasons for my determinations?
5. Have I taken into consideration private assessments provided by the parent with respect to the need for this service?
6. If the level of services is being decreased, can I substantiate this decision (other than with administrative reasons)?

Dealing with privately-obtained related services evaluations.

In providing related services appropriately, IEP teams must obtain and consider information that may be relevant to educational decision-making. With respect to various related services, including OT, PT, school health services, and nursing services, for example, parents may seek out the opinions and recommendations of the child's physician. But, is a physician's input accorded a greater weight than that of school-based evaluators when it comes time to make educational decisions?

Federal courts recognize no presumption in favor of students' treating physicians or private experts. See *Marshall Joint Dist. No. 2 v. Brian and Traci D.*, 54 IDELR 307 (7th Cir. 2010); *Christopher M. v. Corpus Christi Independent Sch. Dist.*, 17 IDELR 990 (5th Cir. 1991); *Cypress-Fairbanks Independent Sch. Dist. v. Michael F.*, 26 IDELR 303 (5th Cir. 1997). In *Christopher M.*, parents contested the school's decision to provide a severely disabled and medically-fragile child with a half-day program. Staff had noted that the student experienced extreme fatigue and distress with a full-day program, due to limited stamina. The parents and the child's private physicians testified that the student could withstand a full day program, and the parents argued that the opinions of their physicians were "presumptively valid." The Fifth Circuit rejected the argument, noting

that the opinions of school staff “were based on daily and continuing observation within the classroom environment. Christopher's physician, by contrast, saw him only infrequently and for short periods of time, nor did he regularly observe the actual effects of the educational program on Christopher.” A school does not err or violate IDEA in any way if it relies on its own therapists’ and teachers’ formal and informal assessment data and recommendations for level of services.

Note—Another reasserting this point involved a student with ADHD, whose doctors indicated in written OHI forms that he should qualify for special education services, while school staff uniformly testified otherwise. *Alvin Ind. Sch. Dist. v. A.D.*, 48 IDELR 240 (5th Cir. 2007). The court stated that the lower court properly determined that the testimony of A.D.'s teachers, who observed his educational progress first-hand, is more reliable than much of the testimony from A.D.'s physicians, who based their opinions on faulty information culled from isolated visits, select documents provided by A.D.'s mother, and statements from A.D.'s mother about what she believed was happening in school. In a footnote, the court added that “for example, Dr. Rasheed testified that she drafted her report under the mistaken impression that A.D. was failing all of his classes and without knowledge of A.D.'s successful performance on the statewide assessment. Moreover, A.D.'s physicians measured “need” according to whether or not A.D.'s potential could be maximized via special education services. However, as discussed above, a “free appropriate public education” does not require maximizing a student's potential.” *Id.*, at n. 9.

Schools’ duty is to consider privately-obtained evaluation data—34 C.F.R. §300.502. If parents’ assessment conflicts with District assessment, IEP team can choose to follow what it believes is the more reliable or educationally-relevant assessment.

What does “consider” mean?—OSEP has written that to consider an IEE means that it is reviewed by the IEP team, discussed, and, to the extent that it is not adopted, the team explains the basis for disagreement. *Letter to Anonymous*, 23 IDELR 563 (OSEP 1995). See also, *T.S. v. Bd. of Educ. of the Town of Ridgefield*, 20 IDELR 889 (2nd Cir. 1993)(“consider” means only to reflect on or think about with some degree of care). For an example of an IEP team’s failure to consider an IEE, see *Bd. of Educ. of the Nyack Union Free Sch. Dist.*, 42 IDELR 78 (SEA New York 2004)(IEP inappropriate in part due to failure to consider IEE—reimbursement for private placement granted).

What if an IEE is not educationally useful to the IEP team?— Some privately-obtained evaluations are conducted from a medical/clinical perspective (i.e. treatment, rehabilitation, return to full function) instead of an educational perspective. Public school related services evaluations, however, are generally focused from the perspective of IDEA requirements—whether and to what degree the child needs the service in order to assist them in benefiting from their educational program. The USDOE takes the position that it is appropriate for district IEE criteria to require that IEEs address the educational findings and decisions that the IEP team must make. “Sec. 300.304(b)(1) provides that an evaluation conducted by a public agency must use a variety of assessment tools and strategies to gather relevant functional, developmental, and academic information about the child, including information provided by the parent, that may assist in determining whether the child is a child with a disability under Sec.

300.8, and the content of the child's IEP, including information related to enabling the child to be involved in and progress in the general education curriculum (or for a preschool child to participate in appropriate activities). These requirements also apply to an IEE conducted by an independent evaluator, since these requirements will be a part of the agency's criteria." 71 Fed. Reg. 46,690. This point can be important when it comes time to consider an IEE provided by the parent. The USDOE emphasizes that the requirement to consider privately-obtained evaluations, "does not mean that the public agency is compelled to consider the parent-initiated evaluation at private expense in its decision regarding the provision of FAPE, if it does not meet agency criteria." Id. Thus, the USDOE takes the position that schools are required to consider IEEs only if they contain the educationally relevant information required under agency criteria for IEEs.

Tips for schools dealing with questionable private related services evaluations

- Ask the district's evaluator to comment on the parents' private assessment and help you with arguments to support the district's assessment.
- Does the evaluation report contain an indication that the evaluator's perspective is one of maximum benefit or maximum potential? If so, the evaluator's recommendations are likely to exceed the FAPE standard for services.
- Are the sources of data sparse? Few tests? Brief tests? No input sought from school staff? No input from persons other than parents? No effort to request previous evaluations?
- Is the evaluator properly qualified?
- Are the findings well-supported by data or fairly conclusory?
- Does the report go into purely educational decision-making not within the evaluator's expertise?
- Is the evaluator willing to answer some questions about the assessment?

IEP Issues

The IEP must set forth all the related services that the child needs in order to advance toward annual goals, be involved and progress in the general curriculum, and to be educated with other students. 34 C.F.R. §300.320(a)(4). The IEP constitutes a commitment to provide all the services listed.

Peer-Reviewed Research Basis for Services—The 2004 version of IDEA requires that the special education *and related services* provided to the child be "based on peer-reviewed research to the extent practicable." 20 U.S.C. §1414(d)(1)(a)(1)(IV).

What is "peer-reviewed research"?—USDOE states only that the term "generally refers to research that is reviewed by qualified and independent reviewers to ensure that the quality of the information meets

the standards of the field before the research is published.” 71 Fed. Reg. 46,664. This is, however, a highly generalized definition—nothing is included to help schools determine who is either “qualified” or “independent” within the context of research on educational methods. Presumably, also, it is up to the “field” to determine its own standards for quality of research information. What field, however? education, psychology, behavioral science, occupational therapy, etc...? Apparently, it is any and all of the various fields corresponding to the service being considered. The commentary adds that “there is no single definition of ‘peer-reviewed research’ because the review process varies depending on the type of information being reviewed. We believe it is beyond the scope of these regulations to include a specific definition of ‘peer-reviewed research’ and the various processes used for peer reviews.”

Procedural guidance to IEP Teams—The USDOE commentary to the final regulations adds that “we decline to require all IEP team meetings to include a focused discussion on research-based methods or require public agencies to provide prior written notice when an IEP team refuses to provide documentation of research-based methods, as we believe such requirements are unnecessary and would be overly burdensome.” *Id.* Thus, there is no requirement that IEP team meetings discuss the research bases of instructional methods and services. And, there is no requirement to provide prior written notice if the school refuses to provide documentation of any research basis for its special education and other services or methods. 71 Fed. Reg. 46,665.

What about competing research?—“States, school districts, and school personnel must, therefore, select and use methods that research has shown to be effective, to the extent that methods based on peer-reviewed research are available. This does not mean that the service with the greatest body of research is the service necessarily required for a child to receive FAPE.” 71 Fed. Reg. 46,665.

Lack of peer-reviewed research does not equal denial of FAPE—The commentary states “there is nothing in the Act to suggest that the failure of a public agency to provide services based on peer-reviewed research would automatically result in a denial of FAPE. The final decision about the special education and related services, and supplementary aids and services that are to be provided to a child must be made by the child’s IEP team based on the child’s individual needs.” 71 Fed. Reg. 46,665.

What is “to the extent practicable”?—The commentary to the regulations states that “the phrase ‘to the extent practicable,’ as used in this context, generally means that services and supports should be based on peer-reviewed research to the extent that it is possible, given the availability of peer-reviewed research.” 71 Fed. Reg. 46,665. Therefore, the requirement is tied to the availability of peer-reviewed research. The interesting implication of this statement is that a method’s lack of peer-reviewed research does not mean it is inappropriate or cannot confer a FAPE. This point is corroborated by the commentary above, which notes that a method’s failure to be supported by peer-reviewed research does not

mean it is denying the child a FAPE.

The IEP must indicate the precise amount of related services that the District will provide to the child. The regulations indicate that the IEP must specify the “**frequency, location, and duration**” of all related services in the IEP. 34 C.F.R. §300.320(a)(7). This also generally means that the IEP must clearly state whether a service will be provided on a direct basis or a consultative basis, or a combination of the two, in which case the IEP should state the amount of each type of service that will be provided.

State Education Agencies’ Position on Statement of Related Services—SEAs vary on their position regarding the degree of specificity required to set forth related services on IEP documents. Some states prefer for their schools to be very precise in stating the frequency and amounts of related services. Schools should make sure they understand and follow their respective state’s guidance on this issue.

Modality of services—The particular modality for providing a related service may need to be stated in the IEP for the parent and IEP team members to be clear on the specific commitment of school resources. For example, the provision of indirect OT services on a consultative basis in collaboration with the classroom teacher is quite different than one-to-one direct services to the child. Similarly, individual one-to-one counseling sessions are different than group counseling sessions. It is advisable for IEP teams to spell out in the IEP the exact modality in which the service will be provided, so the commitment of resources is clear to all. If a service will be provided in a combination of modalities, such as in a mix of consultative and direct services, the team may want to specify a certain amount and frequency for each modality of service.

The IEP should include goals and objectives for every related service provided, unless the related service is one that does not involve working on skills (i.e. transportation, school health services). OSEP has stated that goals for related services such as air conditioning or catheterization are not required to be included in an IEP if the service is necessary only to enable the student to attend school and is not intended to provide an educational benefit in itself. *Letter to Hayden, 22 IDELR 501* (OSEP 1994).

Note—A related service such as transportation also may fall into that category, depending on the purpose for which it is provided. Assuming it is provided solely to enable the student to attend school, then no goals are required. But if the mode of transportation is intended to provide some other benefit related to the student’s education, such as enabling the student to increase independence or have increased opportunities for socialization, then goals relating to independence or socialization must be included for the transportation service so progress can be monitored and measured. *Letter to Hayden* (cited above); *Letter to Smith, 23 IDELR 344* (OSEP 1995).

Methodology Issues—Sometimes, parents and schools have different ideas about the particular methodology for implementing a related service. Under established IDEA caselaw, starting with the Supreme Court’s opinion in the

Rowley case in 1982, school professionals have the discretion of choosing the educational methodologies to be used in providing special education and related services. But disputes about methodologies for implementation of related services can nevertheless arise. In the case of *Corpus Christi ISD v. Cole K.*, Civil Action No. C-03-112 (S.D.Tex. 2004), the parents of a child with physical impairments wanted the school to provide an aquatically-based form of OT provided by a private provider. The school proposed traditional land-based direct OT services, with additional consultative services to integrate appropriate fine-motor activities into the classroom setting to assist in work towards OT goals and objectives. The District agreed to try the private aquatic OT on a trial basis, along with the school's land-based OT service. Later, the school determined that the student was making progress with the traditional OT and the aquatic services were not capable of integration with classroom activities. Thus, the IEP team discontinued the aquatic OT, and the parents sued. The hearing officer ruled for the parents, finding that the since the district had agreed to the aquatic OT and then discontinued it, it had engaged in a net reduction in OT services by discontinuing the aquatic OT. The district appealed, and the federal court reversed and ruled for the district, finding that the dispute was really one of methodology—the parents preferred the use of an aquatic method for OT, while the district chose to provide land-based direct OT services in coordination with classroom activities. And, since the parents failed to show that the district's OT services were inappropriate or failed to assist the student in benefiting from his IEP, there was no reason to overturn the district's choice of OT methodology. Thus, the school was not required to continue funding the private aquatic OT services.

Note—Hearing officers and courts will generally respect a school's choice of related services methodology, as long as the student is making progress in the particular area, as evidence that the service is assisting the child in benefiting from his IEP. Although related services providers can choose to incorporate some of a parent's preferred methodology, if appropriate, the choice of methods is ultimately up to the providers.

3. More on the Medical/Educational Distinction

The Medical Services Exclusion and *Tatro*

The IDEA regulations state that related services may include “medical services” for diagnostic and evaluation purposes, as well as “school health services” provided by qualified school nurses or other qualified persons. 34 C.F.R. §300.34(b)(5) and (b)(13).

Medical services outside the diagnostic and evaluation realm, however, would not be the schools' responsibility. Thus, the Department of Education, in promulgating the Federal regulations, interpreted IDEA as requiring some measure of health services if the child requires such services within the range of IDEA's requirement to provide necessary related services. The legal scope of the range of services that might be required in this area was not clarified until 1984, when the Supreme Court issued its opinion in the case of *Irving Independent School District v. Tatro*, 104 S.Ct. 3371, 468 U.S. 883 (1984). And, the issue

continues to be debated in cases where the medical/educational distinction becomes more difficult.

The *Tatro* case

The *Tatro* case involved a child with spina bifida, orthopedic and speech impairments, and a neurogenic bladder. She required clean intermittent catheterization (CIC) every three to four hours to avoid injury to her kidneys and attend school. "The procedure is a simple one that can be performed in a few minutes by a layperson with less than an hour's training," stated the Court. After the school refused to provide the service by properly qualified personnel, the parents filed suit, which proceeded to the Supreme Court.

The Court held that the primary issue was whether CIC was a related service that schools must provide the child. To answer that question, two other questions must be answered first: **(1) whether CIC is a supportive service required to assist a disabled child to benefit from special education, and (2) whether CIC is excluded from this definition as a medical service serving purposes other than diagnosis or evaluation.**

With respect to the first question, the Court held that the child could not attend school without CIC services during the school day, and thus, could not benefit from her education. The Court cited other related services, such as transportation, that have no direct instructional purpose, but are nevertheless required in order for a child to access education by being physically present in the school.

With respect to the second question, the Court held that CIC was not an excluded medical service. First, the Court pointed out that the related services regulation included "school health services" provided by nurses and other qualified personnel as a legitimate related service. **Only medical services that *must* be provided by a physician would fall within the realm of the exclusion for medical services that are not for diagnostic or evaluation purposes.** See regulations cited above. State law, moreover, did not require that CIC be provided by a physician.

But, the Court also indicated that no matter how easily a service could be provided by the school, only those services necessary to aid a disabled child to benefit from education must be provided. "For example," the Court wrote, "if a particular medication or treatment may appropriately be administered to a handicapped child other than during the school day, a school is not required to provide nursing services to administer it." *Tatro*, at 104 S.Ct. 3378. Thus, if a service can be provided to the child at times other than the regular school day, the service cannot be a related service that the school is obligated to provide.

The Supreme Court's subsequent opinion in *Cedar Rapids Community Sch. Dist. v. Garrett F.*, 29 IDELR 966 (1999) upheld and reinforced the "bright-line" rule of *Tatro*. In that case, the Court ruled that the *Tatro* bright-line rule controlled all related services situations, even in extreme cases such as Garrett's, where a student needs a full-time personal nurse in order to attend school, due to complex and continuous minute-to-

minute nursing needs. Thus, the USDOE commentary accompanying the 2006 IDEA regulations states, citing *Cedar Rapids*, that “[t]he public agency also is responsible for providing services necessary to maintain the health and safety of a child while the child is in school, with breathing, nutrition, and other bodily functions (e.g., nursing services, suctioning a tracheotomy, urinary catheterization) if these services can be provided by someone who has been trained to provide the service and are not the type of services that can only be provided by a licensed physician.” 71 Fed. Reg. 46,571 (2006).

Educational/Medical Distinction and Amount of Services

Children with severe disabilities often need speech, occupational, and physical therapies in order for their conditions to be fully rehabilitated (i.e., to regain full function). When a child suffers a serious automobile accident, for example, there may be a need for a great deal of therapy for medical treatment purposes, in order to rehabilitate the child. Schools, however, need only provide those services that are necessary for educational purposes (i.e. in order to achieve progress on IEP instructional objectives). Schools do not treat or rehabilitate a child’s disabilities, but rather provide an appropriate education to disabled children *despite* their disabilities.

Thus, in many cases of severe disabilities, the amount of therapy services required for a child’s medical will exceed the amount required in order for the child to simply benefit educationally from his IEP. The key to “drawing the line” where the child’s educational needs for related services end and the medical needs begin is the school’s related services assessment, which must be based strictly on a judgment of what amount of services will be required in order for the child to make meaningful progress on his IEP goals and objectives.

Note—When interpreting or considering private assessments provided by the parents (usually seeking large amounts of therapy), keep in mind that private physicians and therapists are not evaluating a child’s need for therapy from an educational perspective, but rather a medical perspective. Thus, it is understandable when private physicians recommend (prescribe) what appear to be huge amounts of therapy. It is best to explain the distinction between the physicians’ perspective than the school therapists’ perspective rather than attempting to discredit the doctors’ recommendations. Those recommendations may in fact be correct, but only from a clinical/medical focus.

Services beyond those needed for FAPE may be only required “medically”—Conversely, services beyond those necessary to assist the child in receiving their education are not the responsibility of the school, even if medically required or recommended. Some of the related services listed in IDEA may also be necessary for the child’s medical treatment. One court, for example, has stated that “occupational therapy is always controversial because, despite its inclusion in IDEA as a ‘related service,’ it has elements of medical treatment as well. . .” *Metropolitan Nashville v. Guest*, 900 F.Supp. 905, 910 (M.D.Tenn. 1995). In that case, the district court found that the parents’ requests for higher level and quality of OT services “arguably cross the line between educational services and medical treatment,” and that the school was not required to “maximize” the student’s gains under IDEA. *Id.* But where is the line to be drawn in individual

cases? The legal scope of the range of services that might be required in this area was not clarified until 1984, when the Supreme Court issued its opinion in the case of *Irving Independent School District v. Tatro*, 104 S.Ct. 3371, 468 U.S. 883 (1984).

4. Common Areas of Legal Scrutiny Involving Related Services

- Dismissals from related services, or reductions in services, without formal re-evaluation
- Lack of individualization of determination of amount of needed related service
- Unmeasurable or vague annual goals (e.g., “student will improve in gross motor skills”)
- Failure to integrate related services with classroom activities and IEP goals and objectives
- Overreliance on consultative or indirect services
- Lack of progress measurement on consultative services
- Lack of specific schedule for consultative services
- Failure to make up sessions missed for staff-related reasons.

5. Nursing Services and Health Plans

Nursing Services

Schools choose the providers of nursing services at school—The parents of a student with multiple disabilities filed a legal action to force the school to hire a different nurse to attend to the student’s medical needs at school. *New Britain Bd. of Educ.*, 47 IDELR 86 (SEA Conn. 2006). The student uses a Constant Positive Airway Pressure machine to keep her lungs inflated, and also requires periodic suctioning of her tracheostomy tube. Although the student experienced three respiratory incidents under the school nurse’s watch, which greatly upset the parents, the nurse met required certification requirements and obtained additional training after the incidents. The hearing officer held that the nurse was adequately qualified to provide the needed services at school and on the bus. She ruled that schools are not required to provide a certain specific nurse unless the student’s IEP mandates a specific person. “This hearing officer cannot order the school district to replace a qualified nurse with another nurse.” See also, *Gellerman v. Calaveras Unified Sch. Dist.*, 37 IDELR 125 (9th Cir. 2002)(rejecting parental demand that school hire their homebased aide to assist the student during the school day instead of the school-chosen staffperson).

Note—While the dispute was pending, the parents obtained a homebound form from their doctor, and the child did not attend school for nearly a calendar year. They were unwilling to have the child return to school until the nurse was replaced. This fact scenario can be the unfortunate side-effect of disputes over the

nursing provider. But, here, the school acted appropriately—it arranged for a properly qualified nurse, and responded by sending the nurse to additional training after the respiratory incidents, which appeared to cause the student no long-term harm.

Dispute over amount of needed nursing services—In a Hawaii case, the dispute centered on the degree of nursing care required by a 5-year-old with a tracheostomy, gastrostomy tube, and reactive airway disease. *Department of Education, State of Hawaii*, 47 IDELR 148 (SEA Hawaii 2007). The school offered to place the child in a busy kindergarten classroom with limited adult supervision, and about 6 hours per week of skilled nursing services. The hearing officer held, however, that the student needed constant nursing care. In addition, because of the child’s susceptibility to infection, a regular classroom environment without close supervision would not be appropriate. At home, the child required constant nursing care, particularly to address respiratory issues, and classroom staff were not trained on addressing and meeting the child’s minute-to-minute medical needs. The school program therefore failed to meet the child’s medical needs and denied the student a FAPE.

Parent claims an aide is needed on the bus—In a Michigan case, the parents of a student with epilepsy requested that an aide be assigned to the school bus in case the student suffered from an epileptic seizure, which required immediate administration of a rectal injection. *Forest Area Comm. Schs.*, 47 IDELR 117 (SEA Mich. 2006). The hearing officer rejected the claim, finding that the bus driver was trained to both recognize the onset of a seizure, and administer the needed medication. Thus, an assigned aide was not needed in order to address the issue (although schools may decide that they would rather have a trained aide provide this service than a bus driver with a variety of other responsibilities).

Nursing Services During Transportation—In *Skelly v. Brookfield La Grange Park Sch. Dist.*, 968 F.Supp. 385 (N.D.Ill. 1997), the issue was whether the school was required to provide suctioning of a 4-year-old’s tracheostomy tube during bus transportation, or whether it was an excludable medical procedure. The court held that, as the school staff must conduct this procedure in class, it must also conduct in on the bus, since a doctor is not required to provide it. Ostensibly, the school argued that while the *Tatro/Cedar Rapids* bright-line rule applied in school, it did not have to apply in noneducational settings, such as transportation. The court, however, reasoned that without the service on the bus, the student could not be transported, and thus, could not benefit from his IEP.

Health Care Plans

When a child has medical needs that require either multiple interventions or planning for potential medical emergencies or crises, their IEP may need a structured health care plan developed in coordination with the student’s treating physician.

Disputes over implementation of plans—A Hawaii parent of a child with medical conditions claimed that the school failed to follow their child’s emergency action plan. *Department of Education, State of Hawaii*, 50 IDELR 179 (SEA Hawaii 2008). The hearing officer agreed, finding that the child underwent surgery that affected balance and coordination. Physical injuries, moreover, would risk damage to his surgical implant. Thus, his emergency plan called for one-to-one supervision, inservice training of staff,

and a plan for dealing with injuries, should they occur. The hearing officer found that neither the child's teacher nor educational assistant attended the training. At times, the student was observed unaccompanied on school grounds, and there were instances of failure to implement the plan with respect to dealing with injuries.

Practical guidance—The task of developing a consensus health plan to incorporate into the IEP is only the initial step. Staff must be informed of the plan, review the plan with care, ask for clarifications, and then, implement the plan. Disputes are likely if the plan is not implemented to the letter, particularly in a situation where it can lead to a medical crisis or injury. Thus, IEP teams should develop the plans with care, and avoid committing to excessive plans with unnecessary steps or services that may prove difficult to implement. If the child legitimately requires a complicated plan, the school should plan well in advance to collect the resources and staff that will be needed to implement the plan.

More strategies on health plans—Keep the provisions simple to promote clarity and consistent implementation. Avoid multiple plans, where the IEP team creates a plan, the school nurse has a "sub-plan," and instructional staff have another plan. Incorporate everyone's input into one plan that is developed by the IEP team. Then, as the plan is revised, clearly mark the effective date, and make sure staff return prior versions and implement only the current plan. As children mature, the plan may call for them to play a greater role in monitoring and attending to their conditions. This may call into play the need for goals and objectives designed to address self-care areas, with the help of nursing and instructional staff, and measure the child's progress in developing these competencies.