As a new speech-language pathologist (SLP) in ABC school district, you are excited to visit your assigned middle and elementary schools. While walking through the cafeteria at the middle school, you notice a staff member feeding a student with severe mental retardation and cerebral palsy. You become concerned when you notice that the student is slumping in his wheelchair; receiving a regular school lunch of hamburgers, potato chips, carrots, and milk; and coughing.

The next day on your visit to the early childhood special education classroom at the elementary school, you take note of four children who need assistance with eating during snack time. The teacher tries to feed these children while she attends to the behavior of their two classmates. You notice food and liquid spillage and occasional coughing. The special education teacher mentions that two of these children were frequently absent during the previous school year.

As SLPs, our scope of practice prepares us for addressing the needs of students with swallowing and feeding disorders in all settings, including public schools. However, are we as well prepared to speak with administrators and school staff about the legal and financial issues associated with serving these students?

This article will provide background information surrounding special education statutes and regulations; special education case law related to children with health care needs, including dysphagia;
and Medicaid funding for special education services. It will also offer recommendations for practice to assist school-based SLPs and school districts as they address the needs of children with dysphagia.

Logemann and O’Toole (2000) edited a clinical forum in Language, Speech, and Hearing Services in Schools, addressing the identification and management of dysphagia in public schools. This forum was a response to clinicians’ concerns and questions about their role and responsibility with respect to serving children with dysphagia in the schools. In O’Toole’s (2000) article on the legal and financial aspects of serving children with swallowing disorders in schools, he noted that dysphagia is not a disability category under the Individuals With Disabilities Education Act (IDEA, 1999) but suggested that the term “other health impaired” may apply to children with swallowing disorders, as dysphagia may cause the limited strength, vitality, and alertness that is characteristic of children with other health impairment. However, few state education agencies offer direction to SLPs and other school personnel on the provision of services to children with swallowing disorders in schools.

A search of state education agency Web sites reveals that few states have guidance documents that address dysphagia. The North Carolina Department of Public Instruction does address dysphagia in its guidelines (2003). This document states that speech-language pathology services do not include the treatment of swallowing problems unless the problem interferes with communication and has an adverse effect on the student’s education. Although this approach is understandable due to the nation’s focus on improving academic achievement of students with disabilities, it leaves district personnel with incomplete information for addressing the needs of children with swallowing and feeding disorders. In contrast, the Virginia Department of Education’s speech-language guidelines provide information regarding the creation of a districtwide dysphagia team, the recognition of symptoms, and the establishment of an individualized health care plan for students with dysphagia (Virginia Department of Education, 2005).

**Source of Legal Requirements**

A review of the focus of federal special education statues and regulations will assist in understanding why many state and local education agencies minimally address dysphagia services. The establishment of the rights of students with disabilities to a free and appropriate public education (FAPE) occurred with passage of the Education for All Handicapped Children Act in 1975. The parameters of special education law have evolved significantly in the past 3 decades, through reauthorization of the Act (currently titled IDEA 2004), federal regulations, state laws and regulations, and case law. Rather than merely ensuring access to education as it did for many children, further iterations of the federal statute and regulations, state-level statutes and regulations, and case law define the parameters of services to be provided to these children.

IDEA is a funding law that provides both the right to special education and the procedural protections to ensure these rights. States must comply with IDEA in order to receive federal special education funds (Klare, 1997). Additional policies related to special education may be created at the state level. Legislative bodies may pass laws, which may include implementing regulations. State educational agencies generally have the authority to develop state regulations and policies.

Special education case law arises out of disputes between parents and education agencies. IDEA provides for an administrative hearing at the state level (20 U.S.C. § 1415), often termed a “due process hearing.” After exhausting administrative remedies, the losing party in the due process hearing may appeal to either state or federal court. The final appeal would be to either the state or federal supreme court, depending on whether the appeal was in the state or federal court system. A state supreme court decision generally is viewed as establishing a precedent for that state (or a principle that a court adopts when deciding subsequent cases with similar facts or issues). Federal appellate courts cover a specific geographic region, termed a circuit. Decisions in these courts are binding on the lower courts in that circuit; conversely, lower court decisions are not binding on superior courts, although superior courts may use the legal reasoning of the lower courts. Although the state and federal courts are independent, and their decisions are not binding on one another, the decisions are often viewed as persuasive authority by judges. The decisions of the U.S. Supreme Court are binding on all courts (Klare, 1997).

**Federal Law**

The federal special education law was enacted “to assure that all children with disabilities have available to them...a free appropriate public education which emphasizes special education and related services designed to meet their unique needs” (20 U.S.C. 1401 (a) (9)). FAPE is based on the provision of special education and related services to eligible students, in conformance with the student’s individualized education program (IEP). A federal circuit court case in 1986 established that FAPE does not require best or optimal services; rather, the focus is on appropriate services (Mark A. v. Grant Wood Area Education Agency, 795 F. 2d 52 [8th Cir. 1986]). Special education focuses on instruction, as it provides “specially designed instruction” to students with disabilities that meets their unique needs (34 CFR §300.39) (a) (1)). Recent reauthorizations of the law have further raised the academic expectations for students with disabilities.

The focus on academics in special education makes it unlikely that children requiring dysphagia services receive those services as part of their “special education.” However, the statute provides that students with disabilities, who are found eligible for special education under IDEA, may receive related services and supplementary aids and services. Related services include “transportation and such developmental, corrective, and other supportive services … as may be required to assist a child with a disability to benefit from special education” (34 CFR § 300.34(a)). Specifically, related services include speech-language pathology, physical and occupational therapy, medical services, and school health services. Medical services are limited to those procedures that are for “diagnostic and evaluation purposes only” (34 CFR § 300.34(a)). The definition of medical services further clarifies that the services are those provided by “a licensed physician to determine a child’s medically related disability that results in the child’s need for special education and related services” (34 CFR § 300.34 (c) (5)).

IDEA 2004 added school nurse services to the definition of school health services, as follows: “School health services and school nurse services means health services that are designed to enable a child with a disability to receive FAPE as described in the child’s IEP. School nurse services are services provided by a qualified school nurse. School health services are services that may be

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provided by either a qualified school nurse or other qualified person” (34 CFR § 300.34 (c) (15)). IDEA also provides the right of children with disabilities to receive supplementary aids and services. This includes those “aids, services, and other supports that are provided in regular education classes or other education-related settings to enable children with disabilities to be educated with nondisabled children to the maximum extent possible” (34 CFR §300.42). Both related services and supplementary aids and services can include those services that a child with dysphagia may need. It is important to remember, however, that both related services and supplementary services are provided under IDEA only when the child is found eligible to receive special education services, that is, the child is receiving specially designed instruction to meet the unique needs of the child with a disability.

IDEA establishes categories of disabilities that describe children who are eligible to receive special education and related services. IDEA defines speech-language impairment as follows: “a communication disorder, such as stuttering, impaired articulation, a language impairment, or a voice impairment, that adversely affects a child’s educational performance” (IDEA, 34 CFR §300.8 (c) (11)). This definition was crafted in 1975 when dysphagia was not part of SLPs’ scope of practice. The Act has been reauthorized many times over the last 3 decades, yet dysphagia has not been included as part of the definition. However, in its review of comments on the regulations supporting IDEA in 2007, the U.S. Department of Education considered adding dysphagia. It declined to do so, citing “we believe that the definition is sufficiently broad to include services for other health impairments, such as dysphagia (Assistance to States, 2006). However, as most children with dysphagia have multiple disabilities, specialized health needs, and medically fragile conditions (American Speech-Language-Hearing Association [ASHA], 2000; Kurjan, 2000; Virginia Department of Health, 1999), it is unlikely that a child with dysphagia would be found eligible for special education solely under the category of speech-language impairment.

As O’Toole (2000) stated, the federal disability category that may be most appropriate to use with children with swallowing and feeding problems is “other health impairment.” IDEA defines other health impairment as

having limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that (i) is due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, arthritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, attention deficit disorder or attention deficit hyperactivity disorder, and diabetes; and (ii) adversely affects a child’s educational performance. (IDEA, 34 CFR §300.8 (c) (9))

Although the definition’s list of health conditions does not specifically include dysphagia, the definition is not a comprehensive list and allows for other health conditions that limit strength, vitality, or alertness. The category of “other health impairment” enables school districts to focus on the child’s health care needs that must be attended to in order for the child to stay in school. As seen in the later discussion of case law, these health needs go beyond instructional needs and often focus on attendance because children will not have an educational benefit if their health needs prevent attendance at school.

Children with dysphagia and other specialized health needs also receive protection under Section 504 of the Rehabilitation Act of 1973, frequently known as “Section 504” (29 U.S.C. §701 et seq.) This law provides that no otherwise qualified individual shall, solely by reasons of his or her disability, be excluded from participation in, be denied benefits of, or be subject to discrimination under any program receiving federal financial assistance. Any program receiving federal financial assistance, including public schools, is bound by the requirements of this statute (United States Department of Education [U. S. DOE], 2005). Section 504 defines a “person with a disability” as any person who “has a physical or mental impairment which substantially limits one or more of life’s major activities” (29 U.S.C. §706 (8) (B)). Dysphagia is certainly a physical impairment that limits one of life’s major activities—that of eating. As such, children with dysphagia are likely to be eligible for services under Section 504. However, Section 504 does not include funding for programs. As a result, school districts may be more likely to find children with disabilities, including students with swallowing and feeding disorders, to be eligible under IDEA than under Section 504. This practice, however, does not negate the value of Section 504 as a civil rights law that can protect persons with dysphagia from discrimination.

The Americans With Disabilities Act (ADA, 42 U.S.C. §1201) is another federal law that protects the rights of persons with disabilities (U.S. DOE, 1990). Established in 1990, this is a national mandate to address discrimination in all sectors, including education, employment, transportation, public accommodations, and telecommunications. School districts’ obligations under ADA and Section 504 are comparable, as ADA references Section 504 in the area of education (Klare, 1997).

Implications of Case Law

As is common in special education, case law, the decisions of the administrative and court hearings, frequently interprets or clarifies the statute or regulations. In a U.S. Supreme Court case, Irving Independent School District v. Tatro, 468 U.S. 883 (1984), (Tatro) adopted the “bright-line” rule to distinguish between services that only licensed physicians can administer and services that personnel other than licensed physicians can administer. This case, the first to address the question of whether health care services are excluded from medical services or supportive services under IDEA (then called the Education for All Handicapped Children Act of 1975), involved a child with spina bifida requiring a procedure called clean intermittent catheterization (CIC) during the school day. The Court used the Act’s definition of “related service” as “transportation and such developmental and other supportive service … as may be required to assist the handicapped child to benefit from special education” to hold that the child needed CIC to benefit from special education and that CIC was thereby a “supportive service.” Additionally, the Court used the U.S. DOE’s implementing regulations to hold that CIC was not a “medical service” required only for diagnosis or evaluation, but a “school health service,” which is defined in turn as a service “provided by a qualified school nurse or other qualified person.” In subsequent court decisions, the Tatro standard became the measure of whether a school health service is a related service or a medical service, which is excludable when it is not related to diagnostic services. The Tatro decision clarifies that children with health care needs, which can include dysphagia, may receive medical services as a related service in order to diagnose the condition and health services as a related service to meet their day-to-day service needs associated with swallowing and feeding.
The Garrett case changed the landscape for school districts. As a Supreme Court case, the findings of the Garrett case apply to school districts nationwide. This case established that any noneducational service may be a required service if it is critical to keeping the child in school during the day. This concept encompasses a large number of health services and includes services associated with swallowing and feeding. The impact of Garrett can be seen in a review of state due process hearings since that time. The presence of dysphagia and the provision of services to students with dysphagia have become factors in state-level hearings. Although hearing officer cases are least controlling in terms of legal decisions, their legal reasoning may be adopted when the facts and issues are similar.

In a New Mexico case in 2003, a state-level hearing officer addressed parents’ allegations that the school district failed to perform its obligations under the mediated agreement. One of the issues in the mediated agreement was the provision of a health plan for a 7-year-old student who was identified as a child with a disability under the category of multiple disabilities, including, among other conditions, dysphagia. In developing her conclusions, the hearing officer identified that “a service that enables a handicapped child to remain at school during the day is an important means of providing the child with the meaningful access to education that Congress envisioned” (New Mexico Department of Education, 103 LRP, 57798, SEA NM 2003). The hearing officer identified that in order to remain in school, the student needed “access to foods that comply with the mechanical soft diet prescribed, ... upright positioning during and after eating, thickening of all liquids...and careful monitoring for signs of reflux or aspiration” (New Mexico Department of Education, 103 LRP, 57798, SEA NM 2003). The hearing officer further concluded that provision of a “mechanical soft diet is a major factor in assuring adequate school health services,” and the absence of procedures in the health plan for providing a mechanical soft diet at lunch denied the child FAPE. The hearing officer also ordered that the school division must immediately modify the health plan to ensure proper administration of the student’s mechanical soft diet at lunch and must immediately provide “adequate staff training on the administration of the health plan sufficient to assure that student receives all the supportive services” (New Mexico Department of Education, 103 LRP, 57798, SEA NM 2003).

In a 2004 New Hampshire case, a state-level hearing officer concluded that the district denied the provision of FAPE to a student with multiple disabilities who also had swallowing problems. Of note to this article, however, is the student’s silent aspiration and consequent health problems. The district ignored the child’s safety in its failure to address the diet and feeding recommendations found in the medical records. Medical evidence included a swallow study that found that the student had a “severely weak pharyngeal swallow along with severe oral motor dysfunction” (Contoocook Valley School District, 41 IDELR 45, SEA NH 2004). The evidence was cited in the conclusion that inadequate feeding practices by the district “appear to have led to two hospital admissions for aspiration pneumonia” (Contoocook Valley School District, 41 IDELR 45, SEA NH 2004). The hearing officer concluded that the child was in danger of silent aspiration, and her feeding needs were beyond what could be offered in the school’s special education classroom. These and other IEP-related factors led the hearing officer to find that the IEP was “not reflective of the student’s needs and dangerously flawed” and that the “team meeting records compared to written submissions by the parent show that there has been resistance to incorporate parent’s observation-based advice and, more recently, medical professionals’ direction into a modified IEP.”

Collectively, the above cases suggest to school personnel that attention to a child’s swallowing and feeding needs is a health issue that, if not attended to, can result in a child’s absence from school, denying the child FAPE. A district’s culpability for denying FAPE increases if it does not provide for the child’s safe swallowing and feeding while at school.

Financial Issues

The costs of providing services to children with swallowing and feeding disorders are often viewed as additional expenses by school districts. Although there is no single source of funding for dysphagia, it is helpful to understand the funding sources that districts use to provide special education and related services.

The U.S. system of public education is built on funding at the local and state government levels. Federal funding is viewed as a supplement to that funding, designed to support certain initiatives of national importance or to rectify issues related to civil rights (Jones & Power-deFur, 1997). Although the portion of federal funding supporting special education has varied since passage of the Education for all Handicapped Children Act in 1975, it has remained a small portion of costs of special education. IDEA serves as the primary federal source of funding for special education.

Districts increasingly face financial challenges as they strive to ensure all students’ rights under special education. The per pupil expenditure for students with disabilities ranges from 1.6 to 3.1 times the per pupil expenditure for a regular education student (American Institutes for Research, 2003). As federal policymakers wrestled with the costs of providing special education and related services, they considered other sources of funding to support special education. In 1988, Congress authorized Medicaid as a source of funding to support educationally handicapped children with disabilities.
source of funding for certain services provided to children receiving special education. This action made it acceptable for schools to access Medicaid funds for any Medicaid-covered service provided by Medicaid-qualified school personnel to any Medicaid-eligible child (ASHA, 2004; Herz, 2006). IDEA specifies that, contrary to the Medicaid policy that Medicaid is the payer of last resort, the financial responsibility of Medicaid must precede the financial responsibility of the local and state education agencies (Herz, 2006). These provisions make Medicaid the primary source of funding available to districts to support their costs associated with serving children with swallowing and feeding disorders.

The Medicaid program for children requires the identification of children in need of health services and the provision of services to screen, diagnose, and treat such children. Most children requiring dysphagia services will be eligible for Medicaid due to their complex medical needs. Medicaid’s health services include speech-language pathology, audiology, occupational therapy, physical therapy, and nursing services (ASHA, 1991, 2004). Swallowing and feeding services may be reimbursable under Medicaid under both speech-language pathology and nursing services.

Medicaid is a federal–state program. States must adhere to all federal requirements, yet they have the authority to establish parameters of each state’s program. As a result, specific requirements regarding children’s eligibility for services, covered services, and eligible providers vary from state to state.

Relatively few districts access private insurance to support their costs. IDEA specifies that districts cannot require parents with private family coverage to use that coverage to pay for IEP services required at school (34 CFR § 300.142 (f)). In addition, given the experiences of health care providers regarding the administrative support needed to access private insurance and the morass of varying insurance requirements, it is not uncommon for districts to determine that the amount of funding they might receive from private insurance would not justify the increased administrative costs.

Best Practice

The review of special education, disability, and Medicaid requirements and information from case law corroborates best practice in the provision of services to children with swallowing and feeding disorders. School-based SLPs and school districts would be wise to implement the following practices to ensure compliance with legal requirements, to minimize liability, and to ensure that students’ needs are met.

- School districts should determine if their state’s education agency has regulations, policies, or guidance documents related to serving children with dysphagia and should secure such documents. District personnel should advocate for policies and guidelines education in states as needed.
- School districts should recognize dysphagia intervention service as a school health service, a service needed to support the child in safe eating and to prevent absences from school due to aspiration secondary to a swallowing disorder.
- SLPs should screen any child whose background suggests the presence of dysphagia (ASHA, 2000). The school nurse may identify the need for a screening following review of the medical information provided on the child’s enrollment in school. Diagnostic evaluations should be conducted for any student for whom the screening suggests the presence of dysphagia. The school nurse, principal, and other pertinent administrators and staff should be informed promptly of the need for an evaluation. The assessment should be conducted as part of the child’s evaluation for special education eligibility or as a medical service for children who are already eligible for special education services. The school SLP may conduct this assessment or refer to and collaborate with external SLPs.
- SLPs should work as members of a team when serving children with dysphagia. In addition to the SLP, the team should include the school nurse, a nutritionist, teacher(s), parent(s), occupational and physical therapist(s), and the principal or other administrator (ASHA, 2000). The school nurse frequently serves as the child’s school health case manager and the school’s liaison with the medical community (Lowman & Murphy, 1999; Virginia Department of Health, 1999).
- As dysphagia is a health issue, the child’s health needs should be addressed immediately. The child’s dysphagia requires direct and immediate intervention and should not wait for determination of special education eligibility. School health services should develop an individualized health care plan for children with health care needs as part of the standard of practice. District personnel should develop such a plan promptly whenever a child is identified who requires swallowing and feeding services while at school. The health care plan can be incorporated into the child’s IEP if the child later is found eligible for special education. The health care plan should include a description of the child’s medical history and current status, health care needs, medication, feeding and nutritional needs, transportation and restroom arrangements, and any specific procedures required to address the child’s health care needs (Lowman & Murphy, 1999; Virginia Department of Health, 1999). Specific procedures related to feeding and swallowing should identify the roles and responsibilities of the SLP, nurse, teacher(s), paraprofessional(s), and others working with the child.
- Districts should ensure that the IEP and any health care plan are adhered to for all children, including children with dysphagia. Each person working with the child on swallowing and feeding should have a current copy.
- Districts should ensure that the student’s IEP incorporates his or her health care plan (Lowman & Murphy, 1999). Swallowing and feeding goals may also be included directly on the IEP. As the health care plan will focus on medically related service needs, the IEP may address social and cultural aspects of swallowing and feeding. For example, goals associated with developing appropriate swallowing and feeding behavior and eliminating maladaptive eating behaviors may be more appropriate for the IEP than the health care plan.
- Districts should document training for all personnel who will be feeding the child. SLPs are instrumental personnel in planning and providing training that is individualized to the needs of each child with dysphagia. Districts should remember to include substitute teachers and paraprofessionals who work with the child.
• Districts should ensure that all staff involved in feeding the child document daily feeding activities on a log.

• Due to the schools’ responsibility for the safety and well-being of students during school hours on school property and during school-sponsored activities, schools should have written procedures and policies for managing first aid emergencies (Virginia Department of Health, 1999). SLPs should work with other school personnel in reviewing these emergency protocols to ensure that they appropriately address feeding and swallowing issues, especially actions to be taken in the event that a child aspirates. Sufficient school personnel qualified to perform cardiopulmonary resuscitation (CPR) should be available in all buildings. The district’s emergency protocols should include indicators for referral to outside medical providers.

• Team members should maintain communication with outside medical providers (e.g., SLPs, radiologists, and other physicians). The school SLP should assume responsibility for communication with the radiologist regarding the results of the modified barium swallow and with any other SLP who provides services to the child. Frequently, the child’s physician will issue an order associated with the child’s health care needs, including dysphagia. The school nurse typically is the team member who ensures that these standing orders (or general orders) are carried out. District personnel should be careful to follow all recommendations for diet or feeding that are provided by outside medical providers. The dysphagia teams and the district’s legal counsel should discuss liability issues associated with providing dysphagia services.

• SLPs serving children with dysphagia should pursue regular professional development in this area of practice (Power-deFur, 2000). Adherence to professional standards of practice is important to demonstrate that the SLP is exercising a reasonable standard of care in his or her duties to the student (O’Toole, 2000).

• Districts should check with their state Medicaid and education agencies regarding specific children’s eligibility for Medicaid in order to determine whether that state’s Medicaid state plan covers dysphagia services in schools.

• Districts interested in pursuing private insurance reimbursement for school-based health care or rehabilitation (speech-language pathology services, occupational or physical therapy) are advised to contact their state education agency for direction.

Case law has established that children needing dysphagia services are entitled to them to ensure their health, safety, and school attendance, thereby giving them access to FAPE. School districts would be wise to establish interdisciplinary teams to address the needs of children with disabilities. These teams should establish policies and procedures associated with serving children with swallowing and feeding problems, including development and implementation of individual health care plans and IEPs, training of school personnel, and development of emergency procedures. Districts can look to their state’s Medicaid policies and procedures to determine if school-based dysphagia services are billable to Medicaid. With the knowledge of these legal and financial issues, school-based SLPs are better able to educate school administrators and advocate for and address the needs of children with dysphagia in schools.

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CONCLUSION

Students with dysphagia are likely to have multiple disabilities and specialized health care needs and generally are not receiving only speech-language pathology services. Children with dysphagia have a right to receive the swallowing and feeding services they need in a public school setting, a right established under IDEA.

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1School nurses generally require a physician’s order to practice. As a result, most school districts will require a physician’s order for the dysphagia team to provide services. The requirement of a physician’s order for an SLP to provide services depends on the laws of each state.


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