



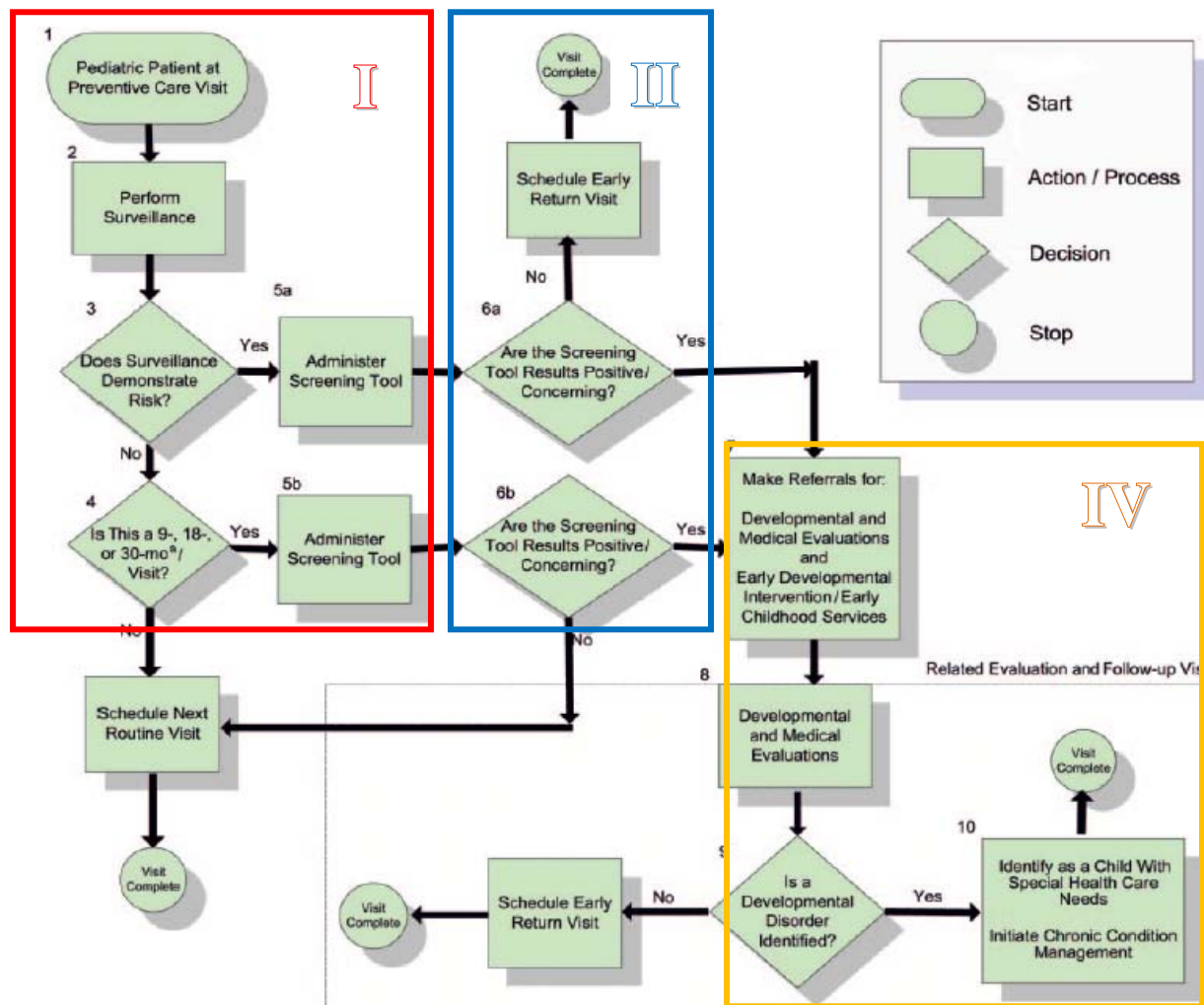
NCC Pediatrics Continuity Clinic Curriculum: Development I-IV Faculty Guide

Overall Goal:

Understand the proper use of developmental surveillance in the pediatric office, to include developmental screening, school readiness, & use of community resources.

Overall Objectives:

- Devo I: Typical Development
- Devo II: Atypical Development
- Devo III: Milestone Review & “Kids Game”
- **Devo IV: Developmental Interventions & Services**





NCC Pediatrics Continuity Clinic Curriculum: **Development IV: Interventions & Services** *Faculty Guide*

Pre-Meeting Preparation:

Please read the following enclosures:

- [“IEP: Summary, Process, and Practical Tips”](#) (click on link)
- “Provision of Educationally Related Services for Children and Adolescents with Chronic Diseases and Disabling Conditions” (AAP, 2007)
- Comparison of Disabilities Laws
- **BYOIEP = Bring Your Own IEP**, from one of your OWN patients. Be prepared to discuss how the IEP was created and what contributions you made or could have made to it. *Have there been any modifications since the original plan was drafted? How has the plan impacted the patient and/or the patient’s family?*

Conference Agenda

- Review Development IV Quiz: Residents—please attempt prior to meeting!
- Complete Development IV Cases
- **Resident/Preceptor Case Discussion:** Discuss resident IEP examples. *See prompting questions, above. Faculty—Consider having residents “pair share” their IEP packets first, prior to presenting to the full group.*

Extra-Credit:

- [“The Pediatrician’s Role in Development and Implementation of an Individual Education Plan \(IEP and/or an Individual Family Service Plan \(IFSP\)”](#) (AAP, 1999)
- [“The Receipt of Special Education Services Following Elementary School Grade Retention”](#)
- [Maryland State—Parent Guide to the IEP Process](#) → Give link to parents!
- [Farifax County—Parent Guide to the IEP Process](#) → Give link to parents!



Provision of Educationally Related Services for Children and Adolescents With Chronic Diseases and Disabling Conditions

Council on Children With Disabilities

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

ABSTRACT

Children and adolescents with chronic diseases and disabling conditions often need educationally related services. As medical home providers, physicians and other health care professionals can assist children, adolescents, and their families with the complex federal, state, and local laws, regulations, and systems associated with these services. Expanded roles for physicians and other health care professionals in individualized family service plan, individualized education plan, and Section 504 plan development and implementation are recommended. Recent updates to the Individuals With Disabilities Education Act will also affect these services. Funding for these services by private and nonprivate sources also continue to affect the availability of these educationally related services.

The complex range of federal, state, and local laws, regulations, and systems for special education and related services for children and adolescents in public schools is beyond the scope of this statement. Readers are referred to the American Academy of Pediatrics policy statement “The Pediatrician’s Role in Development and Implementation of an Individual Education Plan (IEP) and/or an Individual Family Service Plan (IFSP)” for additional background materials. The focus of this statement is the role that health care professionals have in determining and managing educationally related services in the school setting.

This policy statement is a revision of a previous statement, “Provision of Educationally Related Services for Children and Adolescents With Chronic Diseases and Disabling Conditions,” published in February 2000 by the Committee on Children With Disabilities (<http://aappolicy.aappublications.org/cgi/content/full/pediatrics;105/2/448>).

FEDERAL LAWS

Related services such as speech therapy, occupational therapy, physical therapy, and nursing care are provided to students in school because they are related to the student’s education. The term “related services” as currently defined in Part A of the Individuals With Disabilities Education Act (IDEA) includes the following¹:

... transportation and such developmental, corrective, and other supportive services (including speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, social work services, counseling services, including rehabilitation counseling, orientation and

www.pediatrics.org/cgi/doi/10.1542/peds.2007-0885

doi:10.1542/peds.2007-0885

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

Key Words

IEP, IDEA, Section 504, related services, special education, ICDH-2, physician’s role, children with chronic diseases and disabilities

Abbreviations

IDEA—Individuals With Disabilities Education Act

IEP—individualized education plan

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275). Copyright © 2007 by the American Academy of Pediatrics

mobility services, and medical services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a child with a disability to benefit from special education, and includes the early identification and assessment of disabling conditions in children.

The legal justification for the provision of related services without qualifying for special education placement can be found in Section 504 of the Rehabilitation Act of 1973.² This section prohibits discrimination that is based on disability within federal and federally assisted programs. Regulations promulgated by the US Department of Education have more broadly defined the persons covered by this act, as well as the services that are to be provided. According to Section 504, all children must be provided with an appropriate education that “could consist of education in regular classes, education in regular classes with the use of supplementary services, or special educational and related services.” Psychological testing and evaluation, counseling, physical and occupational therapy, medical services, speech pathology, audiology, and orientation mobility instruction are listed among the types of “developmental, corrective, and . . . support services” that may be provided to qualified persons. Thus, Section 504 states that children with chronic diseases and disabling conditions are entitled to appropriate modifications within their educational program to accommodate their special needs regardless of whether their classroom placement is considered regular education or special education. Some school systems have developed flexible, function-oriented “504 modification plans” for students. Unfortunately, some school systems still provide few services.³ Children with chronic medical conditions, who usually function well in the standard classroom, still need consideration for related services. Examples of such children are those with asthma and allergies, who often find themselves at odds with their schools and school districts because of issues related to classroom modifications (eg, no pets in the classroom, having hand-washing facilities), curriculum modifications (eg, alternatives to standard physical education on an as-needed basis rather than the usual exclusion or full participation), and access to medications.

On December 3, 2004, the IDEA (Pub L No. 108-446)⁴ was enacted. Most of the provisions of this law became effective July 31, 2005. The new law is likely to have a major impact on how students with disabilities are educated. Listed below are some of the key changes that occurred with the IDEA 2004.

- The long-established obligations for the individualized education plan (IEP) team to have short-term objectives for each child in his or her IEP will no longer be required as part of the annual goals.
- A child’s progress report toward meeting the annual goals must be reported to the IEP team as in the

previous IDEA legislation. With the new law, however, there is no longer a reference to “the extent to which the progress is sufficient to attain the goal by the end of the year.” The amendments clarify that the transition process for a student with a disability now begins at age 16. In the past, only transition planning, but not the actual transition process, would begin at age 16.

- A new section allows IEP team members to be excused from attendance if their area is not being discussed. When this section is applied with new provisions allowing alternate means of meeting participation (eg, conference calls), consolidation of reevaluation meetings and other IEP meetings, and a pilot program authorizing up to 15 states to use multiyear IEPs, the combined effect is a transformation of the traditional IEP meeting that had been a face-to-face meeting that required all participants to sit around a table at the school.
- The Secretary of Education is authorized to approve proposals from up to 15 states to allow local school districts to offer, with parental consent, a multiyear IEP not to exceed 3 years.
- The Secretary of Education is authorized to grant waivers of statutory and regulatory requirements, for a period not to exceed 4 years, to 15 states that propose to reduce excessive paperwork and noninstructional time burdens. The Secretary is prohibited from waiving requirements related to civil rights or the right of a child to a free appropriate public education.
- Parents of a child who is transitioning from part C (early childhood) to part B (school-age) services can request that an invitation to the initial IEP meeting be sent to representatives of the part C system to assist with a smooth transition of services. This provision does not require a part C representative to attend, but it does encourage collaboration.
- Services comparable to those described in the IEP that are in effect before a child’s transfer to a new school must be provided by the new school district. These services must continue until the previous IEP is adopted or a new IEP is developed, adopted, and implemented; regardless of whether the child is transferring in the same state or from another state, the child’s previous IEP will be valid. This new provision will help parents of transferring students know what they can expect from their new schools.
- The procedural safeguards notice, which explains the specific rights and responsibilities of the parent in the special education process, will be routinely distributed only once per year. However, a copy will be distributed after the initial referral, when a parent makes a request for an evaluation, when a due process complaint has been filed, or if a parent requests a copy.

- Parents now have 2 years in which to exercise their due process rights after they knew or should have known that an IDEA violation has occurred. Other due process changes can be found at www.pacer.org/idea/2004/summary.htm. The due process hearing is an impartial procedure used to resolve disagreements over issues related to special education services that arise between a parent and a school division. The right of the parents or the school division to request a due process hearing is guaranteed by federal and state laws that govern the education of children with disabilities.
- The right of a student with a disability to stay in his or her current educational placement pending an appeal is eliminated for alleged violations of the school code that may result in a removal from the student's current educational placement for more than 10 days. Before this update of the IDEA, the student with a disability would have been allowed to stay in his or her current educational placement pending an appeal regardless of how many days the violation would have removed him or her from the current placement.
- A child is entitled to receive programming and services necessary to enable him or her to receive a free appropriate public education consistent with section 612(a)(1) during the period in which he or she is in an interim alternative education setting.
- Before the IDEA 2004, the burden was on the school district to show that the behavior resulting in a disciplinary action was not a manifestation of the child's disability before being allowed to apply the same disciplinary procedures as it used for nondisabled children. Other changes in discipline can also be found at www.pacer.org/idea/2004/summary.htm.⁴

Medically Necessary Versus Educationally Needed

Health care professionals frequently view educationally related services as medically necessary or helpful for children and adolescents with chronic diseases and disabling conditions. Although this is appropriate in the health care setting, it is not the standard for services mandated to be provided by public education systems. The additional proviso that the service must be necessary for education or special education is a key component in the laws. Related services are those services indicated as necessary for the child to maximize his or her special education program (ie, IEP). In other words, without the related services, the child might not be able to maximize his or her special education program. This difference in perspective and interpretation by physicians and other health care professionals and parents often leads to misunderstandings, frustrations, conflicts, and problems in the development and implementation of related services within school programs for children with disabilities. To best serve children with disabilities and their families, physicians and other health care professionals need to be

familiar with these issues, their legal basis, and the special educational process and system. Maintaining this knowledge is a key function of the medical home provider for children with chronic diseases and disability conditions.⁵ Readers are referred to the American Academy of Pediatrics policy statement "The Pediatrician's Role in Development and Implementation of an Individual Education Plan (IEP) and/or an Individual Family Service Plan (IFSP)"⁶ for additional background materials.

In addition, functional classifications as suggested by the World Health Organization in its International Classification of Impairments, Disabilities, and Handicaps²⁷ offer many advantages to the current diagnostic systems used by the medical home provider for children with disabilities. In 2001, the World Health Organization approved the International Classification of Functioning, Disability, and Health as the international standard for conceptualizing, classifying, and coding function. It evaluates all children within the same structure and metric regardless of diagnosis. It highlights a child's unique strengths and needs for the purpose of directing interventions. This is particularly advantageous in the case of spectrum diagnoses such as autism and cerebral palsy in which a label alone is not sufficient to direct service interventions. A functional assessment of the child provides a more complete picture so that providers can better match resources and needs. Functional classification also looks at individuals within the context of their social and physical environment, taking into account the impact of human and technologic supports on an individual's "activities and participation." In addition, functional classification catalyzes interdisciplinary communication and collaboration by providing a common structure and language for discussion.

Challenges for Schools

Providing related services presents significant opportunities for the children served as well as challenges for the educational system. With greater numbers of children with chronic diseases and disabling conditions entering the school system and the increasing complexity of these conditions, many issues and problems have developed. The availability of services, designation of responsibility for their payment and provision, and conflicting legal imperatives, as well as other obstacles, result in vastly different services in various communities. The current trend of integration and inclusion of many children with a wide range of disabilities in "regular" classrooms and programs is making the provision of related services outside of traditional "special" educational settings a larger and more complex issue. Adequate classroom and school modifications (eg, ramps and accessible sinks and toilets) and support personnel (eg, instructional assistants, school nurses, and special education teachers) are needed in more classrooms and schools.

The difficulties in implementation of related services in schools are as varied and complicated as the disabilities of the children involved. These problems, among others, include:

- lack of clarity about which circumstances should result in a child's exclusion from school for medical reasons;
- uncertainty about the responsibility for, and administration of, complex nursing treatment or therapy in school⁸;
- inconsistencies in state and local guidelines and interpretations about which health care professionals should prescribe the type and amount of physical, occupational, and speech therapies;
- uncertainty about medical liability for therapies administered in school;
- conflicting opinions about the appropriateness of some therapies used for children;
- concern about the rising cost of special education services and whether all treatment required in IEPs is warranted; and
- the frequent lack of provision of related services for children who may not qualify for special education but who have chronic diseases and disabling conditions that impair their ability and readiness to attend or participate in school.⁹

School-System Responsibility

In March 1999, the US Supreme Court ruled that complex nursing service (ventilator care) is a related service.¹⁰ The difference between educationally related services and rehabilitation services is unclear. Court rulings have generally mandated that all therapies and equipment (eg, assistive devices) recommended in the IEP be reimbursed by the educational system.¹¹ However, this has not precluded the application of Medicaid or other public funding for payment of equipment or to support medical service provisions within the IEP for children with disabilities. Although private insurance carriers have generally declined reimbursement for therapies provided in the schools, in specific situations they may be responsible for payment of school-based services and frequently pay for community-based services. One example of private insurance carriers paying for these services would be during the summer when school is not in session. Even if insurance payment is an option, the parents may decide not to make claims against their insurance, because it would create a threat of financial loss, such as lowering the child's available lifetime medical benefits. Generally, school systems are not responsible for acute rehabilitation services.

In communities in which the school systems have borne the responsibility for implementing the IEP and funding most of the therapies, the educational authori-

ties are increasingly concerned about the responsibility for overseeing the provision of complex nursing care and other related services for children with disabilities who attend public school. School systems also are concerned about insurance companies and managed care systems shifting funding responsibilities for rehabilitation and medical diagnostic services from health care to the school system. Each state's mandate to the local school system may vary in the degree that any such services are paid by the school system. The variability of school systems to assume responsibilities has the potential to (1) increase conflicts with local physicians and other agencies responsible for health care provision, (2) contribute to the disjointed nature of health care for children, and (3) result in unnecessary treatment at increased cost,¹² which depletes educational resources for other children.

The special needs of students with complex health conditions that require modifications in the school environment are also commonly documented in an individual student health plan, also known as a student services plan, nursing care plan, or student medications plan. Although these plans are not mandated by law in every state, such plans typically provide information on a student's chronic health condition, instructions on the administration of medication, and emergency contact information. A combination of IEP and individual student health plan is often necessary to help manage a student's health condition in the school and classroom settings.

The Physician's Role

The physician's role mandated by the IDEA as a related service is defined to include only the diagnosis and evaluation of the disability. However, in the context of the medical home, the physician's role also includes the medical management, supervision, and program planning for the child. The IDEA does not mandate that these additional roles be paid for by the public school. Parents often need an advocate for the child who can be objective in assessing the child's special needs and determining realistic expectations. Input from the medical home professionals also assists with placing services in a developmental context in which changes in needs are to be expected over time. The important medical services extend beyond IDEA mandates. Currently, the funding for the physician and other health care professionals' time to complete this role is lacking in most health insurance programs and is not funded by most federal and state funds for education. However, physicians can bill for their consultative services and for other related services with some private insurance plans, Medicaid, and the State Children's Health Insurance Program.

CONCLUSIONS

A multidisciplinary assessment within the school system is required in the initial evaluation of children to deter-

mine their eligibility for services within the educational system. It is also necessary to maintain a comprehensive multidisciplinary approach in the provision of these services, which should be coordinated with the child's medical home professional. The inequalities in the interpretation and provision of services between and within states and school districts need to be corrected. The developmental, educational, functional, and medical needs of the child or adolescent should be determined first, and then the appropriate services to meet these needs should be provided in a timely manner. Issues of who provides the appropriate services and how payment is to be made must be resolved in the context of maintaining the child in the appropriate educational environment.

RECOMMENDATIONS

1. Physicians and other health care professionals should be well informed about the medical and educational needs of children and adolescents with chronic diseases and disabling conditions.
2. Educational opportunities should be developed and made available to physicians and other health care professionals at local, state, and national levels.
3. Physicians and other health care professionals should be aware of the issues and inconsistencies in the IDEA, parts B and C, and Section 504 of the Rehabilitation Act of 1973.
4. Pediatricians, including pediatric subspecialists, and other health care professionals should objectively appraise the special needs of children and adolescents, determine realistic expectations, and advocate for children and adolescents by assisting with establishing an appropriate balance between the recommendations made by the school team and the desires of the family.
5. The initial pediatric focus for services should be on the child or adolescent with a disability and on his or her specific needs, and these needs should not necessarily determine the child's placement. Once these specific needs have been defined, the role of the school system and the role of community providers should be determined. The specific class placement should not determine the provision of related services in school.
6. Care coordination for children and adolescents with chronic and disabling conditions should take place in the medical home, and the medical home must include the primary care physician, pediatric specialists, and other health and human services professionals regardless of the location of, or source of payment for, these services.
7. Physicians and other health care professionals should take a more active role in the development and implementation of individualized family service plans.
8. Physicians and other health care professionals should get involved at the systems level. Physicians, especially pediatricians, should seek representation on local advisory and interagency committees that oversee programs for school placement of children and adolescents with chronic diseases and disabling conditions.

COUNCIL ON CHILDREN WITH DISABILITIES EXECUTIVE COMMITTEE, 2006–2007

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Section on Developmental and Behavioral Pediatrics

Bonnie Strickland, PhD

Maternal and Child Health Bureau

STAFF

Stephanie Mucha Skipper, MPH

*Lead author

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- KidSource Online. Overview of ADA, IDEA, and Section 504. Available at: www.kidsource.com/kidsource/content3/ada.idea.html

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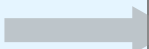
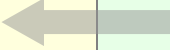
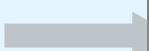
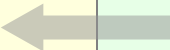

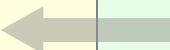
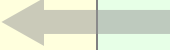
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ADVOCACY SUPPORT RESOURCES

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- Parent Advocacy Coalition for Educational Rights. Available at: www.pacer.org
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- Council for Exceptional Children. Available at: www.cec.sped.org
- Learning Disabilities Association of America. Available at: www.lidaamerica.org
- National Center for Learning Disabilities. Available at: www.nclld.org
- Office of Special Education and Rehabilitative Services. Available at: www.ed.gov/about/offices/list/osers/index.html?src=oc

**Comparison of the Individuals with Disabilities Education Act (IDEA '04), Section 504 of the Rehabilitation Act (Section 504),
The Americans with Disabilities Act (ADA), and The Elementary and Secondary Education Act
(also known as No Child Left Behind Act of 2001 – NCLB '01)**

	IDEA '04	Section 504	ADA	ESEA (NCLB '01)
Requirements in the Law	<ul style="list-style-type: none"> Ensures that all children with disabilities have available to them a free / appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment and independent living. 	<ul style="list-style-type: none"> Requires any agency, school or institution receiving federal financial assistance to provide persons with disabilities to the greatest extent possible, an opportunity to be fully integrated into the mainstream. 	<ul style="list-style-type: none"> Extends coverage of section 504 to employment, public and private educational institutions, transportation providers and telecommunications, regardless of presence of any federal funding. 	<ul style="list-style-type: none"> Targets improving the academic achievement of the disadvantaged, including students with disabilities.
Definitions in the law	<ul style="list-style-type: none"> Specific disability categories are defined in the law; covers children with educational disabilities that require special services from specially trained teachers. Not all children with disabilities are eligible. 	Defines persons with disabilities who: <ul style="list-style-type: none"> have a physical or mental impairment which limits one or more major life activities; have a record of such an impairment; or are regarded as having an impairment. 	<ul style="list-style-type: none"> Definition of disability essentially same as Section 504 and extends coverage to persons without disabilities who may be related to or associated with a person with a disability; Includes HIV status, contagious and non-contagious diseases. 	<ul style="list-style-type: none"> Same as under IDEA '04: Specific disability categories are defined in the law; covers children with educational disabilities that require special services from specially trained teachers. Not all children with disabilities are eligible.
Who is covered	<ul style="list-style-type: none"> Covers children with educational disabilities that require special education services ages 3-21 or until graduation. States have the flexibility to also serve infants and toddlers. 	<ul style="list-style-type: none"> Protects all persons with a disability from discrimination in educational setting based solely on disability. 	<ul style="list-style-type: none"> Protects all persons with a disability from discrimination in educational setting based solely on disability. 	<ul style="list-style-type: none"> Covers students with educational disabilities that require special education services ages 3-21 or until graduation. States have the flexibility to also serve infants and toddlers.
Services provided	<ul style="list-style-type: none"> Offers educational services that are remedial to children and available to all mainstream students (eg., PE, Art, field trips) 	<ul style="list-style-type: none"> Eliminates barriers that would prevent a student from full participation in programs or services offered to the general school population. 	<ul style="list-style-type: none"> Eliminates barriers that would prevent a student from full participation in programs/services offered to the general school population. 	<ul style="list-style-type: none"> Requires that schools provide students with a free and appropriate education with measurable outcomes. Students with disabilities must perform at the same standards as those set for non-disabled students.
Funding	<ul style="list-style-type: none"> Schools receive federal funding to provide remedial services for children in elementary and secondary schools. 	<ul style="list-style-type: none"> Requires that schools not discriminate based on student's disability and must provide appropriate accommodations, but schools receive no additional financial support to provide support services or auxiliary aids. 	<ul style="list-style-type: none"> Requires that schools not discriminate based on student's disability and must provide appropriate accommodations, but schools receive no additional financial support to provide support services or auxiliary aids. 	<ul style="list-style-type: none"> Funding is available to schools under Title I of the law. Schools which receive these funds must comply with NCLB and IDEA '04. Appropriate accommodations must be given to students during assessments, as well as in class.

	IDEA '04	Section 504	ADA	ESEA (NCLB '01)
Evaluation/ Documentation	<ul style="list-style-type: none"> • School district is responsible for identifying and evaluating children with disabilities. 	Same for elementary and secondary schools. 	<ul style="list-style-type: none"> • Students must self-identify as having a disability and must provide adequate documentation of disability. 	<ul style="list-style-type: none"> • School district is responsible for identifying and evaluating students with disabilities.
		Same for students in college 		
	<ul style="list-style-type: none"> • Evaluations are the responsibility of the school and are performed at no expense to child/parent. 	Same for elementary and secondary schools 	<ul style="list-style-type: none"> • Evaluations/documentations of disability are student's responsibility and expense. 	<ul style="list-style-type: none"> • Evaluations are the responsibility of the school and are performed at no expense to child/parent.
		Same for students in college 		
	<ul style="list-style-type: none"> • Parents must consent to evaluations and placement decisions. 	Same for elementary and secondary schools 	<ul style="list-style-type: none"> • Student has responsibility for advocacy, negotiating accommodations plan. 	<ul style="list-style-type: none"> • Districts must carry out performance evaluations, regardless of parental consent.
		Same for students in college 		
IFSP & IEP Accommodations	<ul style="list-style-type: none"> • Individualized Family Service Plan (IFSP) and Individualized Education Program (IEP) are developed with parents, teachers and other specialists. 	504 Plan developed with parents, teachers, school personnel involved (for elementary or secondary students).	<ul style="list-style-type: none"> • Accommodation plan developed with student and Disabilities Services Coordinator on campus. 	<ul style="list-style-type: none"> • Individualized Family Service Plan (IFSP) and Individualized Education Program (IEP) are developed with parents, teachers and other specialists involved.
		Same for college or postsecondary. 		
Classroom Placement	<ul style="list-style-type: none"> • Placement must be in the least restrictive environment (LRE). This may be special classrooms, resource, or regular classroom. (Elementary and Secondary children). 	<ul style="list-style-type: none"> • Placement is in regular classroom with support services to eliminate barriers to the educational experience (for elementary, secondary & college students). 	<ul style="list-style-type: none"> • All courses are mainstream with accommodations provided to students who qualify under ADA. 	<ul style="list-style-type: none"> • Placement must be in the least restrictive environment (LRE). This may be special classrooms, resource, or regular classroom. (Elementary and Secondary children).

Developed by the Postsecondary Education Consortium at the University of Tennessee, a member of PEPNet, through an agreement with the U.S. Department of Education, Special Education and Rehabilitative Services..

Development IV Quiz:

1. A “free appropriate public education” in the “least restrictive environment” is provided for by which Act? **IDEA**
2. What does Section 504 of the Rehabilitation Act of 1973 require school districts (as agencies that receive federal financial assistance) to provide? **Access for persons with disabilities**
3. An initial eligibility evaluation must be completed by the school district within how many days from the date the parent first consents to evaluation? **60**
4. The IDEA mandates re-evaluation of an IEP at least every **3** years.
5. Complaints alleging violations of IDEA or Section 504 may be filed with:
 - (a) Office for Civil Rights, U.S. Department of Education
 - (b) individual state Department of Education
 - (c) individual school district
 - (d) all of the above
 - (e) both (a) and (b)**
6. Match the federally-legislated written plan with the appropriate age group:

A. IEP (3)	1. Birth-3 years
B. IFSP (1)	2. 16 years and up
C. Transitional Services Outcome Plan (2)	3. 3 years-21 years

Development IV Cases:

Case 1:

Garrett, an 8 year old male, presents to your clinic for a skin rash. You diagnose him with scabies and order Permethrin cream. He tells you that he likes to play in the woods with his friends and that they found an old mattress there which they have been using as a fort. You suggest that it might not be such a good idea to play on the old mattress anymore. His mother sighs and tells you that she can't seem to keep him out of trouble. You notice your patient staring down at his feet while his mother gives you the laundry list of his recent issues: he is having trouble in school; he is moody at home; he has trouble paying attention at school and at home; he doesn't finish his homework. His father is currently deployed and his mother seems very stressed out. With tears in her eyes she finally concludes, “I just don't want him to struggle all the way through school like I did. I know I could have done better academically if someone would have helped me.” You find yourself somewhat surprised by this information since you found both your patient and his mother intelligent and articulate throughout the visit. Obviously there was a lot more going on here than you suspected.

What concerns do you have now about your patient’s social, emotional, and academic development?

Low Self-esteem, Anxiety, depression, ADHD, specific learning disability, perhaps in executive functioning

How could you evaluate the potential discrepancy between your patient’s poor academic performance and his obvious intelligence?

Psychoeducational testing

Knowing that he is also having some emotional disturbances, would you make any other referrals?

Child psychologist—same person could also do the psychoeducational testing and potentially create rapport to facilitate futures services like counseling or therapies

Is his maternal family history relevant? Does that increase your concern for academic problems?

Likely, yes...if mother has attention issues or a specific learning disability

Is ADHD a concern here? If so, how will you evaluate it?

Yes; Vanderbilts for home and school; family history; medication trial, if indicated; might consider Straterra for this patient with co-existing anxiety.

Note: ADHD will be discussed in greater detail in a separate module. Residents may refer to the [ADHD Toolkit](#) on the nccped website for copies of Vanderbilts, medication guide, and other physician, parent, and school resources.

How would you follow-up with this patient? How often?

At least monthly to maintain regular contact, continue work-up, partner with patient and parent to work through all the issues and sort out treatment options

After you finally manage to get his scabies under control, diagnose him with ADHD and start medications, and have psychoeducational testing done by a Pediatric psychologist, you follow-up with the patient and his mother to discuss how to best use the 30-page report you have received from the psychologist. Since the psychologist did recommend some classroom accommodations, you advise his mother to approach the school about creating an IEP for Garrett. She sighs, “The school has already refused to help me with any accommodations for him.”

What do you do now?

Advocate for patient; write letter to school; insist on IEP meeting; seek legal counsel, if necessary; educate parent about their rights under IDEA/ 504 and encourage parent to persist in demanding evaluation and accommodations from school district.

Case 2:

Abigail is a 5 year old healthy female who just finished her kindergarten year. Her mother brings her into clinic demanding to know if she has ADHD. She complains that Abigail did not do well at all in kindergarten and that her school has recommended that she repeat her kindergarten year next year. She insists that the whole family is super-smart so it must be that Abigail is not paying attention in school. When you ask about family history, it turns out that no one in the family has any attention problems. You note that Abigail seems immature for her age and that her language skills are not quite at the level that you would expect for a child starting first grade although she is quite attentive to your questions.

What, if any, screening would you do?

ASQ; family history of academic problems or specific learning disabilities

What other questions would you raise in taking the developmental history?

Birth history; development over first year of life; social issues during preschool; medical conditions; stressors at home; hearing tests; language skills development

How do you counsel the mother to respond to the school's request that the patient repeat kindergarten?

Consider benefits of repeating kindergarten but request eligibility evaluation from school in case accommodations should be offered to patient for speech therapy

For a popular-press review of recent studies arguing against delaying kindergarten, see New York Times (24 Sept 2011) article: [“Delay Kindergarten at Your Child's Peril”](#) and the related opinion pieces: [“Who's Ready for Kindergarten”](#).

Do you order psycho-educational testing? Do you recommend an evaluation from the school for IEP eligibility?

Yes; also consider speech evaluation; the take-home point here is that any child who is held back a grade should be fully evaluated for possible interventions or school accommodations; in this case, the patient may simply be too young to be successful in kindergarten so repeating the year may be a reasonable alternative; she should be evaluated, however, either by the school or by a child psychologist; since it is the school district recommending that she repeat kindergarten, it would make sense for the school to go ahead and do her formal eligibility evaluation for services

Development IV Board Review:

1. Results of a cognitive test given to a 7-year-old girl indicate functioning in the moderate intellectual disabilities range (intelligence quotient between 40 and 50). Her parents ask what the future holds for their child academically and vocationally.

Of the following, the MOST likely expectation is that the child

- A. can achieve a third- to sixth-grade reading level by adolescence
- B. can be employed in a competitive unskilled or semiskilled job
- C. can work in a sheltered workshop that provides close supervision**
- D. will only be able to learn to read simple signs such as stop and exit
- E. will require help with activities of daily living from caregivers when an adult

2. You are seeing a 3-year-old boy for a health supervision visit. He has a vocabulary of 50 words that he says clearly, and he is just beginning to combine words. He follows simple two-step commands. Past medical history reveals that he was born at term and had no perinatal problems. He has no history of recurrent ear infections and achieved gross motor milestones at appropriate ages. He resides in a bilingual household. According to the family history, his father also experienced delayed speech development. His older brother received speech therapy in elementary school, and his older sister had difficulty with reading comprehension but does well in math.

Of the following, the MOST likely cause of this boy's language delay is

- A. a bilingual household
- B. being third born
- C. genetic predisposition**
- D. hearing loss
- E. his sex

3. An 8-year-old boy has an above-average intelligence quotient, but he is struggling in school and consistently brings home failing grades. He is generally well behaved, but he gets angry with the poor grades. He enjoys being with his friends and is active in after-school activities.

Of the following, the MOST appropriate intervention is to

- A. have the parents set up a behavioral chart to encourage him to improve his grades
- B. reassure the parents that he is smart and schedule a follow-up appointment in 6 months
- C. refer him for psychoeducational evaluation**
- D. refer him to a psychiatrist
- E. tell the parents to punish him if he continues to fail

4. A mother is concerned that her 6-year-old boy has been struggling to learn his alphabet and numbers in kindergarten. He is in good health, and results of his vision and hearing screens are normal. His preschool teacher commented last year that he was a bit shy but enjoyed being with the other children.

Of the following, the MOST appropriate next step is to

- A. evaluate the boy for attention-deficit/hyperactivity disorder
- B. reassure the parents and schedule a 6-month follow-up appointment
- C. refer the boy for behavioral counseling
- D. refer the boy for psychoeducational evaluation**
- E. refer the boy for vision therapy

5. A 10-year-old boy has been receiving specialized educational services in school due to a learning disability. His parents encourage after-school or sports activities to promote positive self-esteem. They realize that academics are a challenge for him, and they express concerns about his future as an adult.

Of the following, the factor that has been shown to have the MOST positive effect on prognosis for such a child is

- A. early intervention therapy
- B. father's level of education
- C. having two or more siblings
- D. high intelligence quotient
- E. strong family support**

6. A 6-year-old girl is having difficulty in school and is unable to keep up with the first-grade classroom curriculum. She has problems sounding out words and doing basic math. Her parents seek your guidance in helping her.

Of the following, the MOST appropriate action is to

- A. begin trial of stimulant medication
- B. have the girl moved into a special education classroom
- C. have the parents hire a private tutor
- D. refer the girl for psychoeducational evaluation**
- E. suggest the girl repeat first grade