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The Provision of School Health Services to Students with Disabilities: The Intersection of Health Care Policy, Education and the Law in the Post-Garret F. Era

Leslie Seid Margolis

THE PROVISION OF SCHOOL HEALTH SERVICES TO STUDENTS WITH DISABILITIES: THE INTERSECTION OF HEALTH CARE POLICY, EDUCATION AND THE LAW IN THE POST-*GARRET F.* ERA

LESLIE SEID MARGOLIS, J.D.*

I. INTRODUCTION

This article traces the development of the law and policies governing school health services for students with disabilities who receive special education through the public school systems. Beginning with a brief overview of relevant provisions of federal law regarding special education, this article continues with a discussion of the case law through which the parameters of school health services have been defined, culminating with the United States Supreme Court's 1999 decision in *Cedar Rapids Community School District v. Garret F.*[1] An analysis of the policy and implementation issues raised by the Supreme Court's decision, including the barriers standing in the way of consistent access on the part of students with complex health needs to the health services mandated by federal law follows. This article concludes with several ideas about how practitioners and policymakers might begin to dismantle those barriers.

II. OVERVIEW OF FEDERAL LAW

The Individuals with Disabilities Education Act (IDEA) is the primary statute governing the provision of special education to students with disabilities.[2] Originally enacted in 1975[3] and reauthorized and amended several times,[4] most recently in 1997,[5] the IDEA mandates a free appropriate public education in the least restrictive environment

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* Managing Attorney, Maryland Disability Law Center; J.D. Stanford University; A.B. Princeton University. The author would like to thank Alyssa Fieo, Janice Johnson Hunter, Denny Stein, and Linda Kennedy, all colleagues at the Maryland Disability Law Center, Russell L. Margolis, M.D., and Diane Smith, National Association of Protection and Advocacy Systems, for their willingness to read earlier drafts of this Article and for their valuable input.

1. 526 U.S. 66 (1999).

2. 20 U.S.C. §§ 1400-1490 (1994 & Supp. V 1999).

3. Education for All Handicapped Children Act of 1975, Pub. L. No. 94-142, 89 Stat. 773 (1975).

4. *E.g.*, Education of the Handicapped Act Amendments of 1986, Pub. L. No. 99-457, 100 Stat. 1145 (1986); Education of the Handicapped Act Amendments of 1990, Pub. L. No. 101-476, 104 Stat. 1103 (1990) (changing the name of the statute to the Individuals

to eligible students.[6] Such education is to consist of special education instruction and related services.[7] Related services are those services that are necessary in order for the student to benefit from his or her special education.[8] Although the regulatory definition of "related services" lists a number of specific services, including school health services, the list is not exhaustive.[9]

Students are eligible for special education under the IDEA if they have any one of a number of disabilities that are specifically listed in the statute.[10] These disabilities include autism, traumatic brain injury, blindness or visual impairment, deafness or other hearing impairment, mental retardation, specific learning disability, other health impairment, orthopedic impairment, emotional disturbance, speech/language impairment, deafblindness, multiple disabilities, and in some states, developmental delay up to age nine.[11] For a student to be eligible for special education under the IDEA, the disability must adversely affect his or her educational performance.[12]

The heart of the IDEA is its requirement that every eligible student have an individualized education program (IEP).[13] The IEP must include, among other items, measurable annual goals and short term objectives or benchmarks, the specific special education and related services to be provided, and any supplementary aids or services or programmatic support and modifications that are necessary to en-

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with Disabilities Education Act); Individuals with Disabilities Education Act Amendments of 1991, Pub. L. No. 102-119, 105 Stat. 587 (1991).

5. Individuals with Disabilities Education Act Amendments of 1997, Pub. L. No. 105-17, 111 Stat. 37 (1997).

6. 20 U.S.C. § 1412(a)(1)(A), (a)(5)(A) (Supp. V 1999).

7. *Id.* § 1401(8).

8. *Id.* § 1401(22).

9. Related services are defined in the implementing regulations as "transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training." 34 C.F.R. § 300.24(a) (2001). "As used in this part, the term *include* means that the items named are not all of the possible items that are covered, whether like or unlike the ones named." 34 C.F.R. § 300.14 (emphasis added).

10. 34 C.F.R. § 300.7(a)(1); *see* 20 U.S.C. § 1412(a)(1)(A) (Supp. V 1999).

11. 34 C.F.R. § 300.7(a)(1), (b).

12. *See id.* § 300.7(c)(3), (c)(4)(i), (c)(6), (c)(9)(ii), (c)(11), (c)(13).

13. 20 U.S.C. § 1414(d)(2)(A) (Supp. V 1999).

able the student to meet the goals of the IEP and to participate in the general curriculum.[14]

A number of procedural safeguards are set forth in the IDEA and its implementing regulations[15] governing everything from who must attend IEP meetings,[16] to the content of parent notices about any decisions to be made regarding a student's special education program.[17] Additionally, the IDEA requires states to have a framework for complaint resolution and a system for mediation and impartial due process hearings.[18]

As might be expected, the question of what constitutes an "appropriate" education has sparked a tremendous conflict. The United States Supreme Court entered the fray in 1982 with its decision in *Board of Education of the Hendrick Hudson Central School District v. Rowley*.[19] The Court stated that the IDEA provided a "basic floor of opportunity" designed to open the schoolhouse doors to students with disabilities, but guaranteed no particular level of services once the students got in the doors.[20] The *Rowley* Court held that an appropriate education is one in which the IEP is reasonably calculated to enable the child to make educational progress, such as advancing from grade to grade.[21] While this standard has generally been interpreted by other courts and by states and local school districts to require only a minimal level of service, courts have also recognized that the progress required by the IDEA must be more than "trivial"[22] and, in fact, the educational benefits provided must be "meaningful."[23] When examined in conjunction with the purposes of the reauthorized IDEA, it is clear that what is "appropriate" for students with disabilities has changed over time as expectations for students with disabilities have increased, and as statutes such as the Americans with Disabilities Act[24] have been enacted.[25] To appreciate how much the landscape has

14. 34 C.F.R. § 300.347.

15. *See, e.g.*, 20 U.S.C. §§ 1414-1415 (Supp. V 1999); 34 C.F.R. §§ 300.660-2, 300.507-11.

16. *See* 20 U.S.C. § 1414(d)(1)(B) (Supp. V 1999).

17. *See id.* §§ 1414(b)(1), 1415(c).

18. *Id.* § 1415(d)(2), (e), (f); *see also* 34 C.F.R. §§ 300.662, 300.507-11.

19. 458 U.S. 176 (1982).

20. *Id.* at 192.

21. *Id.* at 203.

22. Hall v. Vance County Bd. of Educ., 774 F.2d 629, 636 (4th Cir. 1985).

23. Polk v. Central Susquehanna Intermediate Unit 16, 853 F.2d 171, 184 (3rd Cir. 1988); *see also* Reusch v. Fountain, 872 F. Supp. 1421, 1425-26 (D. Md. 1994).

24. 42 U.S.C. §§ 12101-12213 (Supp. V 1999).

25. For example, the 1997 amendments clarified that one of the purposes of the IDEA is "to ensure that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet

changed, particularly for students with complex health needs, it is instructive to examine the history of school health services for students with disabilities.

III. SCHOOL HEALTH SERVICES UNDER THE IDEA

While "school health services" are not mentioned in the statute, the IDEA's implementing regulations define school health services as "services provided by a qualified school nurse or other qualified person."[26] Courts had occasion to examine this provision as early as 1981 when the Third Circuit determined that clean intermittent catheterization was a necessary related service for a student with spina bifida who needed the service in order to attend school.[27] The Ninth Circuit also addressed the issue of school health services and found that nursing services consisting of intermittent tracheostomy care were required as part of an appropriate education for a child with respiratory problems.[28]

The Supreme Court entered the special education arena again, this time examining the requirement that school districts are to provide related services, particularly school health services, as part of a free appropriate education. In *Irving Independent School District v. Tatro*,[29] the Supreme Court held that the Education of All Handicapped Children Act,[30] the IDEA's predecessor, required the provision of clean intermittent catheterization to a young child with spina bifida.[31] The Court analyzed the provisions of the statute regarding special education and related services as well as the definitions of "school health services" and "medical services,"[32] and set forth a three part test for

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their unique needs and *prepare them for employment and independent living.*" Individuals with Disabilities Education Act Amendments of 1997, Pub. L. No. 105-17, 111 Stat. 37 §601(d)(1)(A) (1997) (emphasis added). This was the first acknowledgement by Congress that there was a reason for special education beyond simply education as an end in and of itself. *See also* Ellen Callegary, *The IDEA's Promise Unfulfilled: A Second Look at Special Education and Related Services for Children with Mental Health Needs after* Garrett F., 5 J. HEALTH CARE L. & POL'Y (forthcoming Spring 2002).

26. 34 C.F.R. § 300.24(b)(12) (2001).

27. Tokarcik v. Forest Hills Sch. Dist., 665 F.2d 433 (3d Cir. 1981).

28. Dep't. of Educ. v. Katherine D., 727 F.2d 809, 813 (9th Cir. 1984).

29. Irving Indep. Sch. Dist. v. Tatro, 468 U.S. 883 (1984).

30. Education for All Handicapped Children Act of 1975, Pub. L. No. 94-142, 89 Stat. 773 (1975) (codified as amended at 20 U.S.C. §§ 1400-1490 (Supp. V 1999)).

31. *Tatro*, 468 U.S. at 894-95.

32. Medical services are defined as "services 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." DOE Assistance to States for the Education of Children with Disabilities, 34 C.F.R. § 300.24(b)(4) (2001).

determining if a health service is a related service under the IDEA.[33] First, in order to be entitled to health services, the student must have a disability and be in need of special education.[34] Second, the services must be necessary for the student to benefit from special education.[35] If, for instance, the service could be provided to the student at a time of the day other than during school hours, then the school system is not required to provide the service.[36] Finally, the health service must be such that it can be provided by a nurse or other qualified person.[37] If services must be provided by a physician, then they are not considered "related services."[38] The Court found the regulations promulgated by the United States Department of Education defining school health services as services that can be provided by a school nurse or other qualified person to be a "reasonable" interpretation of the statute.[39]

Although the three part test set forth by the *Tatro* court seemed clear and incontrovertible, a number of lower courts undercut the decision in a subsequent series of cases involving children with significant disabilities and complex health care needs.[40] The first case to back away from the *Tatro* holding was *Detsel v. Board of Education of Auburn Enlarged City School District*, a New York case concerning a child with severe physical disabilities who was oxygen-dependent and used a ventilator.[41] The court held that because the child needed constant nursing care by at least a licensed practical nurse, and because her needs could not be met by a regular school nurse who had to attend to other children, the services required were not school health services but, rather, medical services that did not need to be provided by the school district.[42]

Extending the *Detsel* decision, the District Court for the Western District of Pennsylvania determined in *Bevin H. v. Wright*[43] that the

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33. *Tatro*, 468 U.S. at 894.

34. *See id.*

35. *See id.*

36. *See id.*

37. *See id.*; *see also* 34 C.F.R. §300.24(a), (b)(4), (b)(12).

38. *See Tatro*, 468 U.S. at 894.

39. *See id.* at 892.

40. *See infra* notes 41-58 and accompanying text; *see also* Letter to Anonymous, 25 IDELR 531 (Nov. 13, 1996); Letter to Anderson, 24 IDELR 180 (Feb. 22, 1996); Letter to Johnson, 20 IDELR 174 (Apr. 20, 1993); Letter to Greer, 19 IDELR 348 (July 14, 1992); Letter to Del Polito EHLR 211:392 (June 24, 1986).

41. Detsel v. Bd. of Educ. of Auburn City Sch. Dist., 820 F.2d 587 (2d Cir. 1987) (per curiam), *abrogated by* Cedar Rapids Cmty. Sch. Dis. v. Garret F., 526 U.S. 66 (1999).

42. *See Detsel*, 820 F.2d at 588.

43. Bevin H. v. Wright, 666 F. Supp. 71 (W.D. Pa. 1987).

constant nursing attention required by the child was like private duty nursing in nature and was "so varied, intensive and costly" that it was "more in the nature of medical services" and, therefore, was not properly considered to be an IDEA-mandated related service.[44] The court found that to put the "burden" of the services required by Bevin on the school system would be inconsistent with the "spirit of the Act and the regulations."[45] Even more ominously, the decision implied that a non-classroom setting might be more appropriate for the child.[46]

Although *Macomb County Intermediate School District v. Joshua S.*[47] relied on *Tatro* to hold that a Michigan school district must provide transportation and nursing services to a student who required positioning in his wheelchair and suctioning of his tracheostomy tube while traveling,[48] the balancing of interests and consideration by courts of factors such as cost, burden, reasonableness, and the nature, scope, and complexity of the service continued almost unabated. For example, in *Clovis Unified School District v. California Office of Administrative Hearings*,[49] the Ninth Circuit examined whether the psychiatric hospitalization of an emotionally disturbed student was an IDEA-covered, educationally related service or an excluded medical service and emphatically concluded that it was a medical service.[50] The court read into the *Tatro* holding a requirement that courts should look at the nature of the requested service and the burden that provision of the service would place on the district.[51] Explicitly addressing the *Tatro* physician/non-physician bright line test, the court stated: "If a licensed physician may provide related services without their becoming instantly 'medical,' we believe that by the same token a program clearly aimed at curing an illness – whether mental or physical – does not become instantly 'related' when it can be implemented by persons other than licensed physicians."[52]

The *Tatro* decision clearly was intended to open the doors of public schools to students with health needs and enable them to attend

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44. *Id.* at 75-76.

45. *Id.* at 75.

46. *See id.* "[W]e recognize that the Act is not restricted in application to classroom settings but envisions the need for specialized programs. Such an alternative may be appropriate for Bevin but the issue is not before us." *Id.*

47. Macomb County Intermediate Sch. Dist. v. Joshua S., 715 F. Supp. 824 (E.D. Mich. 1989).

48. *Joshua S.*, 715 F. Supp at 825, 827.

49. Clovis Unified School District v. Cal. Office of Admin. Hearings, 903 F.2d 635 (9th Cir. 1990) (per curiam).

50. *See Clovis*, 903 F.2d at 645-47.

51. *See id.* at 642.

52. *Id.* at 643.

and remain at school safely for the duration of the school day. However, those school doors were slammed in the face of Shannon M., a child with multiple disabilities, when the District Court for the Central District of Utah concluded in *Granite School District v. Shannon M.*,[53] that constant nursing, which included tracheostomy care, was an excluded medical service.[54] Carrying forward the implication of the *Bevin H.* decision, the court found that the school district satisfied the requirements of the IDEA by providing Shannon with nothing more than home instruction.[55]

Samantha Neely, a seven year old child with several disabilities who required intervention when she stopped breathing on occasion, fared no better.[56] The Court of Appeals for the Sixth Circuit, overturning a favorable Tennessee lower court decision,[57] held that constant nursing care was not a related service based on the cost and burden to the school system, as well as the school system's potential liability, since the child could die if she did not receive constant monitoring and intervention when warranted.[58] Similarly, relying on the cost and burden to the school district for providing constant nursing care, the District Court for New Jersey denied such services under the IDEA to Carissa Fulginiti, a child with multiple disabilities.[59]

It was with these cases as a backdrop that *Cedar Rapids Community School District v. Garret F.*[60] began its journey through the court system. The journey was remarkable because at every step from the administrative hearing to the United States Supreme Court, Garret F. prevailed, unlike almost every other student with severe disabilities who preceded him in the battle to obtain one-to-one health services as part of an education program.

IV. THE CASE OF *CEDAR RAPIDS COMMUNITY SCHOOL DISTRICT V. GARRET F.*

Garret F. is, in the words of the United States Supreme Court, a "friendly, creative, and intelligent young man."[61] At the age of four,

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53. Granite Sch. Dist. v. Shannon M., 787 F. Supp. 1020 (D. Utah 1992).

54. *See Shannon M.*, 787 F. Supp. at 1030 (D. Utah 1992).

55. *See id.* at 1028-29.

56. *See* Neely v. Rutherford County Sch., 68 F.3d 965 (6th Cir. 1995).

57. Neely v. Rutherford County Sch., 851 F. Supp. 888 (M.D.Tenn. 1994), *overruled by* Neely v. Rutherford County Sch., 68 F.3d 965 (6th Cir. 1995).

58. *See Neely*, 68 F.3d at 972-73.

59. Fulginiti v. Roxbury Township Pub. Schs., 921 F. Supp. 1320, 1325-26 (D. N.J. 1996), *aff'd without published opinion*, 116 F.3d 468 (3d Cir. 1997).

60. Cedar Rapids Cmty. Sch. Dist. v. Garret F., 526 U.S. 66 (1999).

61. *Garret F.*, 526 U.S. at 69.

he was seriously injured in a motorcycle accident with his father, and his spinal column was severed, leaving him paralyzed from the neck down and dependent on a ventilator to breathe.[62] In December, 1994, an administrative law judge issued a hearing decision in which he found that the one-to-one nursing services required by Garret in order to attend school were related services within the scope of the IDEA.[63] Although the hearing officer relied on the *Tatro* case, he analyzed the situation under the criteria set forth in the *Detsel, Bevin H., Shannon M.*, and *Neely* cases.[64] He recognized that the care required by Garret could be provided, and in the past had been provided, by trained laypersons.[65] He also noted that the increased cost of providing a nurse was not unreasonable.[66]

The Cedar Rapids School District appealed the hearing officer's decision. In a very short decision, the United States District Court found in favor of Garret, holding that although the parties disputed the seriousness of Garret's health needs, they agreed that his needs could be met by a person other than a doctor.[67] The court applied the *Tatro* physician/non-physician ruling as a bright line test.[68] The Eighth Circuit Court of Appeals similarly relied upon the *Tatro* bright line test and affirmed the decision.[69] In the meantime, although the Iowa Board of Nursing changed its regulations to permit delegation of the type of care required by Garret to a licensed practical nurse (LPN),[70] Cedar Rapids continued to take the position that Garret's care required a registered nurse and that the services he needed fell outside of the IDEA's bounds.[71] Cedar Rapids sought, and was granted, certiorari by the United States Supreme Court.[72]

Finally, in March 1999, in a stunning vindication for students with complex health needs, the United States Supreme Court handed

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62. *See id.*
63. Cedar Rapids Cmty. Sch. Dist., No. SE-98, 22 IDELR 278 (Dec. 16, 1994).
64. *See id.* at 284-90.
65. *See id.* at 287.
66. *See id.*
67. Cedar Rapids Cmty. Sch. Dist. v. Garret F., Case No. C95-5-EJM (N.D. Iowa 1996).
68. *Id.*
69. Cedar Rapids Cmty. Sch. Dist. v. Garret F., 106 F.3d 822, 825 (8th Cir. 1997).
70. *See* Cedar Rapids Cmty. Sch. Dist. v. Garret F., 526 U.S. 66, 77 n. 9.
71. *Id.* at 84.
72. Cedar Rapids Cmty. Sch. Dist. v. Garret F., 523 U.S. 1117 (1998). Special education attorneys and others with an interest in school health service issues waited anxiously to see if the United States Supreme Court would stand by the *Tatro* decision or back away from it. In the meantime, the Seventh Circuit weighed in on the issue and affirmed an Illinois federal district court ruling requiring the administration of continuous nursing services to a child with multiple disabilities. Morton Cmty. Unit Sch. Dist. v. J.M., 152 F.3d 583 (7th Cir. 1998).

down a ruling completely affirming the bright line physician/non-physician test set out in the *Tatro* decision.[73] The Court stated:

> Whatever its imperfections, a rule that limits the medical services exemption to physician services is unquestionably a reasonable and generally workable interpretation of the statute. Absent an elaboration of the statutory terms plainly more convincing than that which we reviewed in *Tatro*, there is no good reason to depart from settled law.[74]

The Court addressed the cost concerns raised by the Cedar Rapids Community School District and noted: "Defining 'related services' in a manner that accommodates the cost concerns Congress may have had . . . is altogether different from using cost itself as the definition."[75] Referring to its decision in *Rowley*, that States are not required to "maximize the potential [of students with disabilities] commensurate with the opportunities provided to other children"[76] and recognizing that "potential financial burdens. . .may be relevant to arriving at a sensible construction of the IDEA,"[77] the Court nevertheless declared that "Congress intended 'to open the door of public education' to all qualified children and 'require[d] participating States to educated handicapped children with nonhandicapped children whenever possible'."[78]

Finally, the Court summed up its position in a clear statement that stands as a ringing endorsement of the rights of children with complex health needs to attend school, and not simply to be educated:

> This case is about whether meaningful access to the public schools will be assured . . . [i]t is undisputed that the services at issue must be provided if Garret is to remain in school. Under the statute, our precedent, and the purposes of the IDEA, the District must fund such 'related services' in order to help guarantee that students like Garret are integrated into the public schools.[79]

As would be expected, the decision triggered strong reactions on the part of families, school district administrators, nurses, and others with a stake in the provision of health services to students in the

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73. *Garret F.*, 526 U.S. 66 (1999).
74. *Id.* at 76.
75. *Id.* at 77 (citation omitted) (emphasis omitted).
76. *Id.* at 77-78.
77. *Id.* at 78.
78. *Id.*
79. *Id.* at 79.

school setting.[80] These reactions ranged from relief and a sense of vindication to anxiety and concerns about the cost of nursing services.[81] While the decision provided a concrete legal victory to students with disabilities and did, to some extent, address the cost concerns of school district administrators, it did not examine the policy implications of requiring nursing services as an element of an appropriate education for some students with disabilities. It is important to identify these policy issues raised by the decision and to examine the barriers that make full implementation of the decision elusive.

V. POLICY AND IMPLEMENTATION ISSUES RAISED BY THE *GARRET F.* DECISION

A. *The Physician/Non-Physician Bright Line Test: Do Any Services Meet the Definition of an Excluded Medical Service in the Post-*Garret F. *Era?*

Over time, nurse practitioners, nurses, and unlicensed lay people have begun to perform more and more medical services.[82] Therefore, it is difficult to identify services which only a physician can provide that would fall outside of the parameters of the IDEA. Concurrent with this broadening of who may provide particular health services has come the increased survival rate of children with severe disabilities and children with complex health needs who need school placements.[83] Thus, school districts have found themselves responsible for providing or arranging for a host of services ranging from tube feeding and administration of oxygen to administration of insulin and intravenous treatments.[84] It is undisputed that school districts must

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80. *See* Debra Viadero, *'Medically Fragile' Students Pose Dilemma for School Officials,* EDUCATION WEEK, Mar. 11, 1987 at 1, 14.

81. *See id.*

82. *See* Donna Lehr, *Providing Education to Students with Complex Health Care Needs,* FOCUS ON EXCEPTIONAL CHILDREN, March 1990, at 5. "Even though they often do not feel adequately prepared to implement some of the procedures students require, school nurses, teachers, or aides may be responsible for implementing the procedures." *Id. See also,* Donna H. Lehr & Mary Jo Noonan, *Issues in the Education of Students with Complex Health Care Needs, in* PERSONS WITH PROFOUND DISABILITIES: ISSUES AND PRACTICES 139, 150-3 (Fredda Brown & Donna H. Lehr eds., 1989). "Improved technology has also enabled family members and teachers to conduct various medical procedures in less controlled settings, resulting in the transfer of the sophisticated care that was traditionally provided by physicians and nurses to families." *Id.* at 140.

83. *See* Lehr & Noonan, *supra* note 82, at 140; *see also,* Viadero, *supra* note 80, at 14.

84. Interview with Vicki Taliaferro and Donna Mazyck, Health Service Specialists, Maryland State Department of Education (June 5, 2001) (The information provided by this interview is based on surveys on file with the Maryland State Department of Education). *See also,* Lehr & Noonan, *supra* note 82 at 145-7; Dick Sobsey & Ann W. Cox, *Integrating*

provide these services under the *Garret F.* ruling, but does the case settle the issue of what constitutes an excluded "medical service"? Are there tasks other than prescribing medication and performing surgery that only a physician can perform? Is there, in fact, a bright line between physician and non-physician services, or is the bright line illusory since a nurse or a trained lay person can provide almost every health service? While the other requirements of *Tatro* must still be met, that is, the service must be supportive of the student's education and can not feasibly be provided outside of school,[85] it must be recognized that the physician/non-physician standard is a very broad one indeed.

B. *How Can Schools Provide an Increasing Array of Health Services to Students While Keeping the Focus on Education?*

The great benefit of the *Garret F.* decision is, in fact, its broadness. Students with severe cognitive or physical disabilities such as Bevin H. and Samantha Neely are covered by the decision, as are students without cognitive impairments such as Garret F.[86] The strength of the *Garret F.* decision is that it reaffirms the rights of students with disabilities, no matter how severe, to attend school.[87] However, as those students who may have previously been educated at home, in hospitals, or in segregated settings enter the public school system or regular classes, it is important to recognize that the training and support of school staff and the provision of adequate resources are critical to the effective provision of health services to these students.

School districts face the challenge of ensuring that these health services are incorporated into the flow of the regular school day while focusing on the child's education, rather than on his or her health needs.[88] The principles of the IDEA regarding participation in the general curriculum, least restrictive environment, and independence

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Health Care and Educational Programs, in EDUCATING CHILDREN WITH MULTIPLE DISABILITIES, A TRANSDISCIPLINARY APPROACH, 227-40 (Fred P. Orelove & Dick Sobsey eds., 3d ed. 1996).

85. Irving Indep. Sch. Dist. v. Tatro, 468 U.S. 883, 894 (1984).

86. *See* Neely v. Rutherford County Sch., 68 F.3d 965, 967 (6th Cir. 1995) (child suffering from Congenital Central Hypoventilation Syndrome, an extremely rare condition that requires a tracheostomy to assist in breathing); Bevin H. v. Wright, 666 F. Supp. 71, 72 (W.D. Pa. 1987) (legally blind child with tracheostomy and gastrostomy tube having several disabilities include Robinow syndrome, severe broncho-pulmonary dysplasia, profound mental retardation, spastic quadriplegia, seizure disorder, and hydrocephalus); Cedar Rapids Cmty. Sch. Dist. v. Garret F. ex rel Charlene F., 526 U.S. 66, 69 (1999) (child was ventilator-dependent but able to attend regular classes).

87. *Garret F.*, 526 U.S. 66 (1999).

88. *See* Donna Lehr, *Providing Education to Students with Complex Health Care Needs*, FOCUS ON EXCEPTIONAL CHILDREN, Mar. 1990, at 5-6.

should guide the school district's approach to health services so that the classroom does not feel like a hospital room with the student with disabilities at the center of attention.

Integrating health services into the regular school routine takes work and resources. It is easier to line up all tube-fed students in the hallway of a school for disabled children and administer their feedings at one time[89] than it is to obtain sufficient staff to individualize feedings, thereby permitting students to socialize in the cafeteria with fellow students. It is even more difficult to serve each of those students in his or her neighborhood school. However, the practice of lining up students and feeding them in the hallway runs counter to the IDEA's mandate that services be individualized and that related services *support* the student's education.[90] Individualizing feedings and permitting students the maximum amount of time possible in the regular school setting is consistent with the IDEA and should be the norm.

Those who provide health services to students in the school setting must ensure that the student is safe and has his or her health needs met.[91] In addition, these health care service providers may need to receive training and administrative support to ensure that the students' educational and social needs are also met.[92] Likewise, those who are primarily responsible for educating the student need to understand the student's health needs and be flexible enough to include equipment, technology, and possibly other staff in their classrooms. As the distinction between school health and medical services has blurred because non-physicians provide so much treatment, teachers have had to open their classroom doors to oxygen canisters and other equipment, and sometimes to private duty nurses as well.[93] Teachers need training and support in order to feel comfortable with what otherwise might be considered intrusions into their classrooms.[94]

In order for schools to provide the necessary health services, numerous practical issues must be addressed. Where will equipment such as extra oxygen be stored? Where in the classroom does the nurse or assistant sit? Does the nurse or assistant have any functions other than monitoring and providing services to the student? How

89. Based on a case on file with the author at the Maryland Disability Law Center.

90. *See* 20 U.S.C. § 1412 (Supp. V 1999).

91. *See* Lehr, *supra* note 88, at 6.

92. *See id* at 8.

93. *See* Lehr & Noonan, *supra* note 82, at 155.

94. *See* Judith S. Palfrey et al., *Project School Care: Integrating Children Assisted by Medical Technology into Educational Settings*, 62 JOURNAL OF SCHOOL HEALTH 50, at 54 (Feb. 1992).

can the nurse or assistant perform his or her functions without impeding the student's ability to make friends in the classroom?

Additionally, very basic questions arise that need to be answered. Will an oxygen canister pose any danger to a group of students clustered in their preschool classroom's housekeeping area?[95] What kind of information should be provided to school staff and to students? If accessible transportation is required for field trips, will non-disabled students be able to ride on the bus with the student with disabilities so that he or she is not socially isolated?

The challenge of the *Garret F.* decision is in its day-to-day application. While the decision confirmed a school district's obligation to provide health services to students with disabilities, it is not at all clear that sufficient training, technical assistance, financial resources, and personnel resources have been provided at the state and district levels to enable school staff to comfortably fulfill their legal obligation.

C. *In Maryland and Nationally, A Shortage of Nurses Has Reached A Crisis Level*

The number of students with complex health needs who require one-to-one nursing services is quite small.[96] For example, last year in Maryland, approximately 120 students required one-to-one nursing services out of a total school population of 850,000 students.[97] Seventy-five of those students were oxygen-dependent.[98] However, the number of students who require health services because of chronic conditions such as asthma, allergies, and diabetes is large.[99] The Maryland State Department of Education does not yet collect data regarding the number of students with chronic conditions, but school nurses report that the most common condition they address is asthma.[100]

Unfortunately, while the number of students requiring health services in schools has increased, the number of nurses has decreased,

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95. Based on a case on file with the author at the Maryland Disability Law Center.

96. Interview with Vicki Taliaferro and Donna Mazyck, Health Service Specialists, Maryland State Department of Education (June 5, 2001) (the information provided by this interview is based on surveys on file with the Maryland State Department of Education).

97. *Id.*

98. *Id.*

99. American Federation of Teachers, *Federation of Nurses and Health Professionals, School Nurses Health Index Page,* http://www.aft.org/fnhp/schoolnurses/index.html (visited Sept. 14, 2001) (on file with the Journal of Health Care Law & Policy).

100. Interview with Vicki Taliaferro and Donna Mazyck, Health Service Specialists, Maryland State Department of Education (June 5, 2001); Telephone Interview with Donna Mazyck (July 20, 2001) (the information provided by these interviews is based on surveys on file with the Maryland State Department of Education).

resulting in a nursing shortage in schools, communities, and hospitals. A survey published last year found that "the average ratio of children to nurses is almost twice the National Association of School Nurses' recommendation of one nurse for every 750 children."[101] Last year, the president of the Federation of Nurses and Health Professionals/ American Federation of Teachers announced, "The shortage of nurses in the United States is reaching the level of a health care emergency."[102] The realization of a nursing shortage has entered the public consciousness as a result of frequent popular and trade newspapers, magazines, and journal articles reporting on the issue.[103] The state of Maryland, in fact, has established a five year Commission on Nursing Shortage to address the problem;[104] fortunately, school nurses are represented on the Commission.[105]

For students with complex health needs, the nursing shortage makes the promise of the *Garret F.* decision more difficult to attain. For students who need one-to-one nursing services as a related service in school, merely finding a nurse to provide those services may pose a significant challenge. In Maryland, only half of the 24 jurisdictions hire their own school nurses, the other half arrange for nurses through the local health department.[106] These nurses are often con-

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101. Ann Marie McCarthy et al., *Medication Administration Practices of School Nurses*, 70 J. SCH. HEALTH 371, 372 (2000).

102. American Federation of Teachers Publications, *Nurse Shortage is a Health Care Emergency*, http://www.aft.org/publications/healthwire/jul-aug00/nurseshort.html (July/August 2000).

103. *See, e.g.*, JP Bender, *Pay Raises, Interns Used to Battle Nurse Shortage*, The South Florida Business Journal, (Feb. 9, 2001), http://southflorida.bcentral.com/southflorida/stories/2001/02/12/focus1.html; Stacy Burling, *Major Nurse Shortage Feared in Years Ahead*, The Philadelphia Inquirer, (Oct. 10, 2000), http://inq.philly.com/content/inquirer/2000/10/10front_page/10NURSE.htm; Laura Cohn, *No Way Out of the Nurse Shortage*, Businessweek Online, (Feb. 26, 2001), http://www.businessweek.com:/2001/01_09; Maria Guzzo, *Nurse Shortage Inspires New Firm, Makes School Intensify Recruiting*, Pittsburgh Business Times, (May 12, 2000), http://Pittsburgh.bcentral.com/Pittsburgh/stories/2000/05/15/focus3.html; Judy Maire, RN, MN, *School Nurse Shortage Creates Fears About Student Health*, Washington Academy of Family Physicians (Spring Journal, 2001), http://www.wafp.net/school_nurse_shortage.asp; *Health and Science: Nurse Shortage Plagues U.S. Schools*, The Nando Times (2001) http://archive.nandotimes.com/health.sci; *Study Finds Nurse Shortage Looms in California, Nationwide*, U.S. Department of Health & Human Services Press Release, (Dec. 8, 1999), http://www.hrsa.dhhs.gov/Newsroom/releases/CaliforniaNursingStudy.htm; *Survey: Nurse Shortage Will Be Worse Than Current Estimates*, AFT Press Release, (Apr. 19, 2001) http://aft.org/press/2001/041901.htm (all materials on file with the Journal of Health Care Law & Policy).

104. MD. CODE ANN., [HEALTH OCC.] § 8-7B-01 (2000).

105. *Id.* § 8-7B-01(b)(9).

106. Interview with Vicki Taliaferro and Donna Mazyck, Health Service Specialists, Maryland State Department of Education (June 5, 2001) (the information provided in this interview is from surveys on file with the Maryland State Department of Education).

tractual with no benefits.[107] It is, therefore, difficult to attract nurses to work in the school setting. It is not unusual for a student with special health care needs to miss days, and sometimes weeks, of school while school system officials try to locate a nurse to assign to the student.[108] Even if a student comes to school with a private duty nurse funded through Medicaid or the family's insurance, the school system must ensure that a back-up nurse is in place if the student's nurse is ill or otherwise unavailable. It is extremely difficult to find substitute nurses on short notice. If a substitute nurse cannot be obtained, the student must miss school unless a parent or other adult who is able to care for the student is willing to come to school to provide the services. As a result, the relationship between families and school staff may deteriorate, since it is the families who end up shouldering the responsibility that rightfully belongs to the school system. Unfortunately, school systems feeling pressed by their inability to meet the IDEA mandates sometimes try to shift responsibility for provision of nurses and provision of services from the school system to the families themselves. Families are then forced to seek legal assistance to secure implementation of the services guaranteed to their children by law.[109]

One of the reasons why school systems have great difficulty obtaining nurses to provide one-to-one services may be that schools usually pay less than private nursing agencies. In addition, not all nursing agencies are willing to contract with school systems to provide nurses for the school setting. An effective solution, and one which has been incorporated into several individualized education plans in Maryland, is to require the school system to supplement the pay so that nursing agencies and private duty nurses do not end up in a financially disadvantageous position for providing services in schools.[110]

In addition to the nurse shortage, many school nurses, even if they are registered nurses, do not have recent experience providing some of the health services needed by students with complex health needs such as suctioning or tracheostomy care. In Maryland, although nurses must obtain much of their professional development on their own time, a good deal of professional development is available, and nurses can be sent for specialized training to perform particu-

107. *Id.*

108. Based on a case on file with the author at the Maryland Disability Law Center.

109. Issue raised in cases handled by the Maryland Disability Law Center and on file with the author.

110. *Id.*

lar procedures for students.[111] Additionally, medical facilities are often able to send nurses out to work with school nurses and families.[112] Further, once nurses are trained, they are often able to train other nurses following a train-the-trainers model.[113]

In light of the shortage of nurses and the critical need for trained personnel to meet the health needs of students in school, it is not at all unreasonable to ask who must, who may, and who might be able to provide these services. Perhaps nowhere else do health practices and the law intersect as much as in the delegation of nursing functions.

D. Nurse Practice Acts, the IDEA, and Delegation of Nursing Functions in the School Setting

The provision of nursing services is governed by state nurse practice acts.[114] Although the requirements of these statutes vary from state to state, generally they regulate nursing practices and describe what nurses can and cannot do and, sometimes, what and to whom nurses may delegate.[115] Delegation is the transfer to a "competent individual" the "authority to perform a selected nursing task in a selected situation."[116] Nurses are permitted to delegate certain tasks to licensed practical nurses (LPN) and, sometimes to unlicensed assistive personnel (UAP).[117] When tasks are delegated, the delegating nurse retains responsibility for supervision and accountability for the outcome of the delegated task.[118]

Because legal guidance regarding delegation of nursing duties in the school setting may not exist or may conflict with other laws or regulations, a number of professional organizations have tackled the issue by developing position statements or guidelines and standards. For example, in 1995, the National Council of State Boards of Nursing issued *Delegation Concepts and Decision-Making Process*, a position paper outlining the factors that must be taken into account when making

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111. Interview with Vicki Taliaferro and Donna Mazyck (June 5, 2001) (the information provided in this interview is from surveys on file with the Maryland State Department of Education).

112. *Id.*

113. *Id.*

114. *See, e.g.*, MD. CODE ANN., [HEALTH OCC.] §§ 8-101-802 (2000).

115. *See, e.g., id.* § 8-101(e), (f).

116. NADINE C. SCHWAB & MARY H.G. GELFMAN, LEGAL ISSUES IN SCHOOL HEALTH SERVICES 108 (2001).

117. *Id.*

118. *See id.*

delegation determinations in any setting.[119] The National Association of School Nurses has issued a position statement and an issue paper, among other documents.[120] The American Nursing Association has weighed in on the issue as well.[121]

According to the National Council of State Boards of Nursing, the nursing process (consisting of appropriate assessment, planning, implementation, and evaluation) and the decision to delegate must be consistent with the patient's needs and circumstances.[122] Further, the qualifications of the person to whom the task is to be delegated, the legal authority regarding delegation in the nurse's jurisdiction, and the nurse's personal competence in the area of nursing relevant to the delegable task must also be considered.[123] In 1997, the Council published a delegation decision-making tree to assist nurses in making delegation decisions.[124] The tree includes such questions as: "Does the ability of the care-giver match the care needs of the client?" "Can the task be performed without requiring nursing judgment?" "Are the results of the task reasonably predictable?" "Can the task be performed without repeated nursing assessments?"[125]

Specifically addressing the role of the school nurse, the National Association of School Nurses Issue Brief states that, "[p]rimary consideration in the delegation of care is the health, safety and welfare of the school-age child"[126] and notes that a delegation decision must include an "assessment of the health care needs of the individual student, the health care needs of the school population, the nature,

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119. National Council of State Boards of Nursing, Position Paper, *Delegation: Concepts and Decision-Making Process*, http://www.ncsbn.org/public/resources/ncsbn_Delegation.htm (1995) (on file with the Journal of Health Care Law & Policy).

120. National Association of School Nurses, Issue Brief, *School Health Nursing Services Role in Health Care: Delegation of Care*, http://www.nasn.org/briefs/delegation.htm (1995); National Association of School Nurses, Position Statement, *Delegation* http://www.nasn.org/positions/delegation.htm (revised Sept. 1995) (on file with the Journal of Health Care Law & Policy).

121. *See* American Nursing Association, *Registered Nurse Utilization of Unlicensed Assistive Personnel*, http://www.nursingworld.org/readroom/position/uap/uapuse.htm (effective Dec. 11, 1992) (on file with the Journal of Health Care Law & Policy).

122. National Council of State Boards of Nursing, Position Paper, *Delegation Concepts and Decision-Making Process*, http://www.ncsbn.org/public/resources/ncsbn_Delegation.htm (1995) (on file with the Journal of Health Care Law & Policy).

123. *Id.*

124. National Council of State Boards of Nursing, *Delegation Decision-Making Tree*, http://www.ncsbn.org/public/res/uap/delegationtree.pdf (1997) (on file with the Journal of Health Care Law & Policy).

125. *Id.*

126. National Association of School Nurses, Issue Brief, *School Health Nursing Services Role in Health Care: Delegation of Care*, http://www.nasn.org/briefs/delegation.htm (1995) (on file with the Journal of Health Care Law & Policy).

frequency and complexity of the specific task, physician orders, availability of adequate supervision, and the education, training, and skills of the UAPs."[127] The Association's position statement recommends that the school nurse be involved in the development of school district policy and procedure related to delegation of care and that school districts establish maximum allowable student-to-nurse ratios that take students' health needs into consideration.[128]

In 1992, the American Federation of Teachers published *The Medically Fragile Child in the School Setting: A Resource Guide for the Educational Team,* a handbook designed to address the roles, responsibilities, and needs of various school personnel serving students with health needs.[129] The document includes a matrix of health services with guidance as to what can be delegated, in what circumstances, and to whom.[130] While the matrix represents an attempt to navigate the complexities of providing health care in the school setting, its delineation of specific tasks that can be delegated runs counter to the position of the National Council of State Boards of Nursing. The Council states that because delegation should be consistent with the nursing process, which includes assessment, "a list of tasks that can be routinely and uniformly delegated for all patients in all situations" is precluded.[131] Precisely because it simplifies the delegation process, the matrix makes assumptions about the skill required to perform certain tasks. For instance, the matrix considers certified teaching personnel to be qualified to provide oral feeding but not gastrostomy tube feeding to students.[132] However, a student who has a swallowing disorder but eats orally might be much more difficult to feed than a student with a gastrostomy tube, and considerably more nursing judgment might be required regarding what the oral eater may safely eat or

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127. *Id.*

128. *See* National Association of School Nurses, Position Statement, *Delegation,* http://www.nasn.org/positions/delegation.htm (revised Sept. 1995) (on file with the Journal of Health Care Law & Policy).

129. AD HOC COMMITTEE ON HEALTH CARE RESPONSIBILITIES IN SPECIAL EDUCATION, AMERICAN FEDERATION OF TEACHERS, THE MEDICALLY FRAGILE CHILD IN THE SCHOOL SETTING: A RESOURCE GUIDE FOR THE EDUCATIONAL TEAM (1992).

130. *See id.*, Appendix A at 10. This matrix was originally published in 1990 by a joint task force of the American Federation of Teachers, the Council for Exceptional Children, the National Association of School Nurses, and the National Education Association. *See* THE JOINT TASK FORCE FOR THE MANAGEMENT OF CHILDREN WITH SPECIAL HEALTH NEEDS, GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING (1990).

131. National Council of State Boards of Nursing, Position Paper, *Delegation Concepts and Decision-Making Process,* http://www.ncsbn.org/public/resources/ncsbn_Delegation.htm (1995) (on file with the Journal of Health Care Law & Policy).

132. AMERICAN FEDERATION OF TEACHERS, *supra* note 129, Appendix A at 10.

drink than might be required to feed the student with the gastrostomy tube.

The short supply of school nurses, the increased number of students requiring health services in school, school administrators' concerns about cost control, and nurses' concerns about the safety of students and their own liability have converged to make delegation one of the most difficult issues to address in the school setting. On the one hand, increased delegation to UAPs would address the lack of sufficient nursing personnel and would expand the number of people available to provide health services at a lower cost to the school district. On the other hand, school nurses may be reluctant to delegate functions because they do not want to assume liability for the actions of another person, particularly if the nurse divides his or her time between several schools. As one nursing administrator at the Maryland State Department of Education noted: "Delegation means that someone is still responsible. . . . Supervision is different when a nurse is covering several schools."[133]

Another issue that complicates delegation is that while anyone may easily perform a task such as medication administration, the decision whether to administer medication may not be easy to make. As another Department of Education official remarked: "You can't delegate judgment."[134] Maryland enacted a statute in 1998 defining a certified medicine aide as a "certified nursing assistant who has completed a 60 hour, state-approved course in medication administration,"[135] and a certified nursing assistant as a person "who routinely performs nursing tasks delegated by a registered nurse or a licensed practical nurse."[136] The statute also defines a medication assistant as a person who "has completed a 16 hour course in medication administration approved by the [state Board of Nursing]"[137] and who has registered with the Board.[138] The Maryland State Department of Education is currently working with the Maryland Board of Nursing to develop a school nursing curriculum.[139]

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133. Interview with Vicki Taliaferro, June 5, 2001 (the information provided in this interview is from surveys located in the Maryland State Department of Education).

134. Interview with Donna Maczyk, June 5, 2001 (the information provided in this interview is from surveys located in the Maryland State Department of Education).

135. MD. CODE ANN., [HEALTH OCC.] § 8-6A-01(e) (2000).

136. *Id.* § 8-6A-01(f)(1).

137. *Id.* § 8-6A-01(h).

138. *See id.* § 8-6A-03. It is important to note that the practice of nursing is state regulated and states vary on their regulations regarding delegation of nursing tasks.

139. Interview with Vicki Taliaferro and Donna Maczyk, June 5, 2001 (the information provided in this interview is from surveys on file with the Maryland State Department of Education).

Ultimately, the decision about which tasks may be delegated and which may not requires honest and thorough consideration of a student's needs, free of budgetary concerns, political considerations, "turf" protection, and administrative convenience. Recognizing that the "[g]uiding principle is the safety of the child,"[140] state boards of education and boards of nursing should look at all health-related tasks currently provided in the school and, setting aside preconceptions based on tradition, should develop a list of tasks that presumptively may be delegated to a licensed practical nurse or UAP, those that can never be delegated, and those that presumptively may not be delegated but might be able to be delegated in specified circumstances. Whether a particular task is or is not delegated would then become an individualized decision within this framework. Such an approach would be entirely consistent with the IDEA's requirement that special education services be individualized to meet the "unique needs" of the child.[141]

E. The Intersection of Health Care, Education, and the Law

One of the byproducts of the infusion of health services into the education setting is the involvement of non-education agencies in the education process. For example, private duty nursing agency staff may participate in meetings regarding a student's individualized education plan. Medicaid may be able to pay for nursing or other services required by a student during school hours. Service coordinators from a state's developmental disabilities administration may play a role in obtaining services for a student. Recognizing the important role that non-education agencies can play in the provision of education, Congress mandated in the 1997 reauthorization of the IDEA that states enter into interagency agreements or some other form of interagency coordination to ensure that any other agencies with a responsibility to provide or pay for special education or related services do so.[142] In fact, the IDEA specifically makes education agencies the payers of last resort for such services.[143] Thus, with the caveats that a student's right to out-of-school services cannot be diminished in any way and that families cannot incur any type of financial loss or decrease in insurance coverage, the cost of many of the health-related, behavioral, or therapeutic services provided to students with disabilities can be finan-

140. Interview with Vicki Taliaferro, June 5, 2001 (the information provided in this interview is from surveys on file with the Maryland State Department of Education).

141. 20 U.S.C. § 1401(25) (Supp. V 1999).

142. *See id.* § 1412(a)(12).

143. *See id.* § 1412(a)(12)(A)(i).

cially covered by agencies other than the school system or state department of education.[144]

For students with complex health needs, including those with mental health needs as well as those traditionally viewed as "medically fragile," this requirement of the IDEA is potentially of great importance. If viewed as more than simply a payment provision, the requirement offers the as yet largely untapped potential to link services provided inside and outside school and to bring students, families and all service providers together. Meaningful interagency coordination could involve supplementing school staff with service providers from other agencies, routinely including representatives of non-education agencies at education meetings when families are receiving services from other agencies at their home, or ensuring the consistency of services provided at home and in school. Although the school system retains the ultimate responsibility of ensuring the provision of special education and related services, including health services, to students with disabilities, the responsibilities of other public agencies should not be ignored. Because the IDEA is an entitlement statute, it is much easier to pursue all services through the education system. However, the interagency coordination and payment requirement of the IDEA offers fertile ground for advocates and school districts to join forces in order to define the obligations of other public agencies and make them fulfill those obligations.

VI. THOUGHTS FOR THE FUTURE

The policy ramifications of the *Garret F.* decision are significant and the legal system, the education system, or the health system alone cannot easily resolve the issues discussed in this paper. Even if the systems work together, determining how to integrate health services, sometimes complex ones, into the education system and how to pay for those services presents a challenge. That said, the following thoughts are offered to begin a policy discussion about these issues.

First, it seems essential that all teachers and other school-based service providers and administrators receive information and training regarding their legal obligations to students with health needs, the health services required by any of the students in their schools and how health services can be provided in a way that supports, rather than interferes with, a student's program. Training should be interdisciplinary and should include lawyers or others who are knowledgeable about the IDEA and other disability laws, health care

144. *Id.*

professionals, and educators. Also, training should be user-friendly and practical.

Follow-up training should be provided regarding the specific health needs and plans for particular students in the school. For example, while all the school staff might receive a general training about seizure disorders, the classroom staff and related service providers for a particular student at the school might then receive more detailed follow-up training about the types of seizures that student has, who will administer emergency medication if necessary, and any other steps needed to be taken in the event that a seizure occurs. However, the training effort can be taken a step further by looking specifically at how to provide health services in a way that supports the student's education. If the student's seizures are due to a chronic disorder and he or she is likely to experience seizures at school, his or her classmates might benefit from training or information about seizures. Additionally, the staff training might include the need to arrange a place for the student to sleep if necessary after a seizure, with the goal of re-including the student into the life and activities of the classroom as soon as he or she is able to participate again. This is a more appropriate and far preferable educational alternative than the approach commonly taken, which is to contact the parent and ask him or her to take the student home. For a student with a chronic seizure condition who recovers well from seizures, the latter approach places an emphasis on the seizure disorder and may cause the student to lose a good deal of educational time.

The goal then is to provide interdisciplinary general training to all staff and more specific, tailored training about the needs of a particular student to the staff who will be serving that child or interacting with him or her. It may be as important for cafeteria staff to understand distress signs in an oxygen-dependent student as for the student's teacher. The more particularized training could also answer the kinds of questions raised earlier in this paper regarding a one-to-one nurse's role, communication, equipment, etc. To the extent they wish to be included, parents should play a role in training school staff.

The second policy issue discussed in this paper, the current nurse shortage, is a problem that cannot easily be addressed. Perhaps in addition to efforts that are currently underway to recruit nurses and to encourage high school students to choose nursing as a career, incentive programs similar to those instituted for teachers could be developed or expanded. For example, salary bonuses or home purchase credits, or a student loan forgiveness program could be created for nurses who choose to work in schools. Further, every effort should be

made to increase the pay of and reimbursement rates for nurses who work in schools so that they more closely match the rates obtainable by private-sector nurses and nursing agencies.

Third, given the shortage of nurses, a review of the issue of delegation of nursing functions is warranted. Professional nursing organizations should undertake a comprehensive review of health services and divide these services into the categories of absolutely not delegable, presumptively delegable and presumptively non-delegable, based on the skill and judgment level required to perform the service. Using the system of presumptions described above, decisions could then be made about specific health services for a particular person based on that person's needs.

While this, perhaps, does not seem too different from current nurse practice acts which often list non-delegable functions and functions that may be delegated at the nurse's discretion, the proposed system would permit more individualization and flexibility by creating a new category of presumptively non-delegable tasks and permitting delegation of these tasks in certain circumstances, while not permitting delegation of presumptively delegable tasks in other situations. For example, gastrostomy tube feeding might be a presumptively delegable task, but given a particular student's needs, it might not be delegated. Tracheostomy care might be presumptively non-delegable, but might be delegable to an unlicensed staff person at the school because of that person's exceptional level of interest, skill and willingness to receive training and supervision.

Along with a review of nursing functions, which might lead to revision of states' nurse practice acts, consideration should be given to certifying instructional assistants or certified nursing assistants to perform particular functions for specific children. The decision as to whether a function is delegated or not might then also turn in part on the availability and qualifications of the person to whom delegation would be made, though the ultimate decision would still have to be based on the student's needs and the obligation to perform necessary functions in a manner that keeps the student safe and as healthy as possible. In addressing delegation issues, staffing plans should be developed that would take into account the need for supervision and whether such supervision could be done indirectly or would have to be done on-site. Further, as concern about liability cannot help but be a factor in whether a nurse chooses to delegate a function or not, it is important to think about whether or not it is possible to structure the supervision of the provision of delegated health services in such a way that the delegating nurse retains supervisory responsibility but not

liability. While such a system may not be feasible or realistic, it seems worth some consideration as a means of addressing an often unspoken but real barrier to the delegation of nursing functions.

Finally, the coordination of education services across agencies and the development of a coherent, sensible means of funding these services is essential if students with complex disabilities and health needs are to be served effectively. Implementation of the IDEA's interagency coordination and funding mandate would be a strong first step towards the creation of a cross-agency service system that could truly meet the needs of these students both in and out of school. Such a system should be based on flexible funding and flexible assignment of responsibilities across the education, home, and community environments. In order to work, the agencies would need to operate with a joint budget in such a way that funding could flow freely across agencies and service environments.

It is important to distinguish the proposed system of interagency coordination from the system currently in place in Maryland. Maryland has an Office of Children, Youth, and Families within which is lodged a statutorily-created system of local coordinating councils, comprised of representatives from all the local public agencies that serve children.[145] The task of the councils is to make placement decisions for children who need restrictive placements or other intensive services and to identify a lead agency and funding sources for the placement.[146] A state coordinating council is comprised of state-level counterparts to the local coordinating council members.[147] In theory, the system should result in the blurring of agency boundaries as the agencies work together to serve children. In practice, the lack of a funding pool that belongs to all of the agencies, as opposed to funding belonging to each separate agency, has seriously hindered the effectiveness of the system, which has often functioned as little more than yet another bureaucratic hurdle for families to jump over in their efforts to obtain services for their children.

Another problem facing Maryland's current system is, of course, the lack of sufficient funding to serve children appropriately. For example, the state's share of special education funding has not increased in more than ten years, with the predictable result that local school systems bear a disproportionate share of the responsibility of funding special education services. However, although it is clear that

145. MD. ANN. CODE art. 49D § 1 (1991).
146. *Id.* § 16.
147. *Id.* § 15.

resources are inadequate, it is also clear that agencies often duplicate services and could be using the resources they have much more wisely.

Creation of a coordinated system of services for children would recognize that the question raised by the cases culminating in *Garret F.* (i.e., whether a health service is medical or educational) is really a broader question of where the boundary lies between the medical system and the educational system. Is behavior management medical or educational, or is it viewed as one or the other simply on the basis of where the service is provided and who pays for it? At what point does physical therapy or any other therapeutic service stop being educational and start being medical? The current organization of agencies and systems mandates that these questions be answered. However, true interagency coordination would make these questions and their answers irrelevant because it would reflect the fact that there are no clear boundaries. While bureaucratic, budgetary, and practical realities may make a unified service system all but impossible, it behooves policymakers and practitioners in all disciplines to think creatively about alternative ways to structure the delivery of health, education, and other services to children.

VII. CONCLUSION

Some of the recommendations made in this article may be controversial. However, they are offered as a means of stimulating interdisciplinary discussion among disability lawyers and advocates, health care providers, educators, and policymakers about practical ways in which the issues raised by this paper can be resolved, and they should be considered in that spirit. These issues are not hypothetical; they are faced by the Maryland Disability Law Center's clients, by other families, by teachers and school administrators, and by health care providers in Maryland and every other state on a daily basis. It is beyond time for practitioners and policymakers to set aside professional boundaries and work together to ensure that administrative, political, budgetary, and practical barriers do not continue to complicate or, even worse, to prevent, the provision of health and education services to students with disabilities.