

# Individuals with Disabilities Education Act (IDEA) Reauthorization

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*Recommendations of the  
American Speech-Language-  
Hearing Association*



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The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 191,500 members and affiliates who are audiologists; speech-language pathologists (SLPs); speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

ASHA has identified 10 specific areas of the current law that we recommend be modified to enhance and modernize the Individuals with Disabilities Education Act (IDEA). For additional information, please contact Ingrida Lusic, ASHA's director of federal and political advocacy, at [ilusic@asha.org](mailto:ilusic@asha.org) or Neil Snyder, ASHA's director of federal advocacy, at [nsnyder@asha.org](mailto:nsnyder@asha.org).

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## Audiologists and Speech-Language Pathologists in School Settings

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Audiologists who work in school settings are uniquely qualified to understand the impact of hearing loss on classroom learning and have the knowledge and skills to recommend specific strategies and technology to meet the individual communication, academic, and psychosocial needs of students with hearing loss. They perform the following important functions:

- Manage audiologic equipment, oversee the proper fit and functioning of hearing aids and other hearing assistive technology, and perform comprehensive and educationally relevant evaluation
- Provide important insights into the implications of hearing loss on communication access and learning

Even though audiology services are available under the Individuals with Disabilities Education Act (IDEA, 1990 (American Speech-Language-Hearing Association, 1994, August), there remains a shortage of audiologist positions in the schools.





Speech-language pathologists (SLPs) are uniquely qualified to provide services to families and their children who are at risk for developing, or who already demonstrate, delays or disabilities in language, including play and symbolic behaviors as well as communication, language, speech, literacy, and/or feeding and swallowing behaviors. In addition, SLPs perform cognitive evaluations related to head trauma that an individual received as a result of playing sports or being involved in a motor vehicle accident. In providing these services, the SLP participates in the following primary functions:

- Prevention
- Screen, evaluation, and assessment
- Plan, implement, and monitor intervention
- Engage in interprofessional education/interprofessional collaborative practice (IPE/IPP) and interprofessional education (IPE) with educational team members, including families and other professionals
- Service coordination
- Transition planning
- Advocacy
- Awareness and advancement of the knowledge base in communication sciences and disorders

## Executive Summary

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It is important to remember that, with the passage of the Every Student Succeeds Act (ESSA, 2016), which reauthorized the Elementary and Secondary Education Act (ESEA) of 1965—this major federal K–12 law—students with disabilities are, first and foremost, general education students, and state and local authorities must meet their needs. Whether students receive accommodations/modifications under Section 504 of the Rehabilitation Act of 1973 (U.S. Government Printing Office, 2017), Multi-Tiered Systems of Support (MTSS) under ESSA, or special education and related services under the Individuals with Disabilities Education Act (IDEA, 1990), all students are entitled to a free appropriate education (FAPE) from the public school system.

Audiologists and speech-language pathologists (SLPs) increasingly face ethical challenges and dilemmas due to budget constraints, ongoing guidance from the U.S. Department of Education (ED), and lack of clarity related to provisions in disability and education laws. IDEA reauthorization should modernize and clarify policies to ensure that audiologists and SLPs—who are recognized as specialized instructional support personnel (SISP)—are not placed in these difficult, ethically challenging situations.

IDEA reauthorization should ensure parity with ESSA, including the ways in which it relates to funding stream access. Static federal appropriations of funding for IDEA have forced states and school districts to seek alternative funding streams to support the education and services of students with disabilities. Congress needs to keep its promise to provide up to 40% of IDEA funding by restoring and then increasing funding for special education. Full funding is essential to ensuring appropriate service delivery options and allowing students the ability to receive a full range of services from qualified professionals in order to access the general education curriculum. Maintaining the authority of the individualized education program (IEP) and the individualized family service plan (IFSP) teams, enabling children access to the general curriculum, appropriate caseload/workload sizes, and excessive paperwork rank high on the list of concerns voiced by audiologists and SLPs in school settings according to surveys of ASHA members.

More than half of ASHA's members work in a school setting<sup>1</sup> as part of the educational team. They provide important and valuable services to help all students, including students with disabilities, access the general curriculum and are instrumental in designing learning systems for students. ASHA's members support students, families, and staff from early education through graduation in both general and special education. The issues below have been identified as critically important to student outcomes and the professions of audiology and speech-language pathology in school settings during the upcoming IDEA reauthorization.

## Key Terms

**Free and Appropriate Public Education (FAPE)**—an educational program that is individualized to a specific child, that is designed to meet that child’s unique needs, that provides access to the general curriculum, that meets the grade-level standards established by the state, and from which the child receives educational benefit.

**Individualized Education Program (IEP)**—a written document that is developed for each public school child who is eligible for special education. The IEP is created through a team effort and is reviewed at least once a year.

**Individual Family Service Plan (IFSP)**—a plan for special services for young children with developmental delays. An IFSP applies only to children from birth to 3 years of age. Once a child turns 3, an IEP is put into place (see term above).

**Telepractice**—the application of telecommunications technology to the delivery of audiology and speech-language pathology professional services at a distance by linking clinician to client/patient or clinician to clinician for assessment, intervention, and/or consultation.

## IEPs and Teams

SLPs are concerned that their role in the IEP process is being bypassed by other professionals who are acting as sole decision makers when determining the services and supports for students with particular disabilities—and, as a result, bypassing the IEP process as stipulated in the law. One example of this is the applied behavior analysis (ABA) therapists, who act as a sole decision maker when determining the services and supports for students with autism spectrum disorder (ASD). Allowing one individual professional to assess and make decisions about treatment usurps the IEP team’s authority and integrity. In response to reports that a growing number of children with ASD may not be receiving speech and language services, ED issued guidance (in the form of a “Dear Colleague” letter)<sup>2</sup> to school systems nationwide recognizing the importance of speech-language pathology services and the necessary role of an SLP in both evaluation and treatment of children with ASD. In its guidance, ED states that some IDEA programs may be including ABA therapists exclusively without including, or considering input from, SLPs and other professionals who provide a spectrum of therapies or who use a variety of strategies that may be appropriate for children with ASD. ED clarified that ABA therapy is just one methodology used to address the needs of children with ASD and reminded states and local programs to ensure that decisions regarding services are based on the unique needs of each child. Relevant guidance from the Centers for Medicare & Medicaid Services affirms the need for an evaluation and treatment plan that is based on input from multiple providers—not just on input and services from ABA therapists.<sup>3, 4</sup>



## Personnel Qualifications

The 2004 IDEA reauthorization and 2006 regulations removed the 1999 regulatory provision that required state education personnel standards to meet the highest requirement for a profession or discipline in that state. At the same time, the statute and the regulations removed the option that state requirements could be waived on an emergency, temporary, or provisional basis.

IDEA needs to be strengthened by bringing back the “highest qualified provider in a state” language for related services personnel and by adding provisions that help school districts improve their recruitment and retention of qualified personnel.

## Paperwork

The challenge of paperwork and administrative compliance continues to be a perennial top issue for ASHA’s school-based audiologists and SLPs. States and school districts are committed to complying with their legal obligations but receive little leadership or guidance from ED, states, or local governments on how to streamline the administrative requirements of IDEA. The burden of interpreting and complying with federal, state, and local mandates often rests with clinicians, thereby expanding their duties during and beyond the regular school day. Although federal efforts to eliminate unnecessary or redundant paperwork have been attempted, many states work in a reactionary framework and continue to add paperwork that is designed to prevent due process claims; but, in reality, this additional documentation creates enormous amounts of work and time lost with students. As a result, delivering direct services to children with disabilities is in constant competition with the demand to complete time-consuming administrative paperwork. This requirement often places the professional in situations where recommended services are constrained and quality of services are compromised, causing an ethical challenge/dilemma for audiologists and SLPs.

## Funding

Static federal appropriations of funding for IDEA has forced states and school districts to seek alternative funding streams to support the education and services of students with disabilities. Congress needs to keep its promise to provide up to 40% of IDEA funding by restoring and then increasing funding for special education (e.g., IDEA grants and programs). The primary alternative funding stream to IDEA is now Medicaid. The unintended consequence of additional Medicaid billing is an increase in recordkeeping for billing purposes at the expense of frequency and intensity of services.

Permissive and mandated use of IDEA funds (up to 15%) for struggling learners in general education also erodes the financial support for special education students. IDEA and ESSA should share funding responsibility for those struggling learners who receive comprehensive early intervening services (CEIS), and ED should provide additional guidance to states and local districts about how to ensure that MTSS services are appropriately provided and funded. Inadequate federal funding causes a strain on state and local school budgets, which generally rely on property taxes to fund education services.

The demand for services for children with disabilities will always be there, and the need to fund these services will remain. However, federal, state, and local budgets for special education are barely able to support services at the basic levels required to comply with the law. This results in larger class sizes and special education caseloads, reduced individualized instruction and therapy, diminished frequency and intensity of services, and reduced academic achievement among students with disabilities.

## Caseload/Workload

Traditionally, the workload of a school-based audiologist or SLP has been conceptualized as being almost exclusively synonymous with caseload; but the reality is that caseload is only one part of the picture. When a student is added to a caseload for direct services, significant amounts of time within the school day, week, or month must be allocated for additional important and required workload activities. The total volume of workload activities required and performed by school-based audiologists and SLPs should be taken into account when establishing caseloads. ASHA does not recommend a maximum caseload number, but does urge districts to support a workload analysis approach to setting caseloads, which would ensure that students receive the individualized services that they need to support their educational programs in accordance with IDEA. It is only when audiologists and SLPs have the opportunity to work with an appropriate number of students, on the basis of a workload analysis, that a FAPE can be provided.

## Service Delivery Models

Reauthorization of IDEA should encourage flexibility in states and local school districts to explore and provide alternative service delivery models, more flexible scheduling, and interventions as part of the MTSS. Not only are state and school districts required to provide FAPE to children who have been identified with disabilities, but also, now—under ESSA requirements—states and school districts must provide supports to struggling learners. IDEA (2004) allows local education agencies (LEAs) to use up to 15% of its IDEA Part B funds for supportive services to help K-12 students who are not yet identified with disabilities, but who require additional academic and

behavioral supports to succeed in the general education environment. The law encourages LEAs to focus their efforts on students in kindergarten through grade 3. The allowable use of funds should not be confused with either Part C Early Intervention Programs (ages birth through 2 years) or Section 619 Preschool Grants (ages 3–5 years), both of which also focus on children with disabilities.

## **Implications for Children Who Are Deaf or Hard of Hearing (D/HH)**

It is estimated that about 131 of every 1,000 school-age children<sup>5</sup> have some degree of hearing loss that can potentially affect communication, learning, psychosocial development, and academic achievement. Audiologists and SLPs play a critical role by recommending and implementing strategies and technologies to meet the individual needs of children who are D/HH. Children can be born with permanent hearing loss or can acquire it after birth. Much of their learning is auditory based, and students are typically educated in noisy classroom environments. This makes identifying and managing hearing loss in school-age children critically important. Federally supported state early hearing detection and intervention (EHDI) programs, along with advances in hearing aid and cochlear implant technology, have served to increase the number of students who are D/HH who are participating in general education (with and without IEPs or formal 504 plans).

## **Effective Communication**

In 2014, the U.S. Departments of Justice and Education issued joint guidance<sup>6</sup> on the provision of effective communication for students with disabilities under IDEA and under the Americans with Disabilities Act (ADA, 1990 as amended). This guidance outlines the responsibility of public schools to ensure that their communication with students who have hearing, vision, or speech/language disabilities is as effective as their communication with all other students. Public schools must apply both the IDEA analysis and Title II of ADA—effective communication analysis—when determining how to meet the communication needs of a student with a hearing, vision, or speech/language disabilities. These additional services are to be provided without any extra funding to states or local school districts. Funding for services for students is limited, and states need adequate funding to meet the expanding need for services for students with and without an IEP. Encouraging additional supports and services for students without a comprehensive assessment and service determination from the IEP team may result in added pressure to find students who are eligible for IDEA while usurping the authority of the IEP team. This could require individuals to provide services for which they were not trained or services that lack support from evidenced-based research.

## IDEA Advisory Commission

Because IDEA is permanently authorized, there must be a mechanism in place to allow feedback to ED on the implementation of the law. Therefore, ASHA recommends establishing the IDEA Advisory Commission during the next IDEA reauthorization with broad authority to receive public feedback, conduct studies, and provide advice and guidance to ED on the implementation of IDEA. Although IDEA guarantees that parents and practitioners have direct input on the education of a child with a disability, there are no formal avenues for input or feedback to the federal government on the law's implementation. Congress has established advisory committees and commissions for other departments and agencies on the implementation of other laws; therefore, Congress should do the same for parents and practitioners who wish to provide input on IDEA. The proposed IDEA Advisory Commission should comprise the full range of professionals who provide services to students with special needs, including SISP.

## Part C

IDEA Part C offers early intervention services to infants and toddlers with disabilities (birth–age 2 years) and their families—one of the earliest opportunities to identify a disability and intervene with a young child to improve long-term outcomes. Effective early intervention programs can reduce later identification, educational failure, and referral for special education services, which can significantly reduce the potential for more costly services. If identified, many speech, language, and hearing–related disabilities could be addressed early in a child's life. Transition between Part C early intervention services and Part B services under IDEA can often result in a delay or disruption in services and result in a loss of follow-up for children and families who are transitioning between programs. Access to qualified providers who have expertise in each area of disability should be identified to participate in the IFSP and intervention process.

## Overarching Principles of IDEA Reauthorization

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The Individuals with Disabilities Education Improvement Act (IDEA, 2004) is essential in ensuring that children with disabilities receive a free appropriate public education (FAPE) that includes all supports and services needed to access the general education curriculum. Audiologists and speech-language pathologists (SLPs) play an integral role in ensuring that children are identified as having a disability and that these children receive appropriate services under IDEA. The law has been in place for many years, despite the failure of Congress to fully fund the program. School districts have met the minimum requirements of the law, but maximizing student achievement will require full funding. Congress needs to modernize the law by allowing states and local education agencies to have greater flexibility in providing supports and services and reducing administrative burdens on providers while still maintaining due process for parents.

The American Speech-Language-Hearing Association (ASHA) is committed to working with Congress to reauthorize IDEA. ASHA is the national professional, scientific, and credentialing association for 191,500 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. More than 50% of ASHA's members provide school-based services.<sup>7</sup>

ASHA has several recommendations to enhance IDEA. In the recommendations below, we highlight five principles that affect the overall reauthorization—principles that we believe will strengthen the law.



## Key Principles for IDEA Reauthorization

**A**

**Students with disabilities are, first and foremost, general education students.**

Whether students receive special education and related services under IDEA, accommodations/modifications under Section 504 of the Rehabilitation Act of 1973, or Multi-Tiered Systems of Support (MTSS) under the Every Student Succeeds Act (ESSA, 2016), all students are entitled to receive FAPE from the public school system.

**B**

**Congress must meet its obligation to fully fund IDEA.** It is imperative that Congress keep its promise to provide up to 40% of IDEA funding by restoring and increasing funding for special education (e.g., IDEA grants and programs) in order to meet the increasing needs and complexities of students with disabilities.

**C**

**IDEA reauthorization must address the overwhelming paperwork and administrative burden on providers, both of which reduce valuable services to students.** Duplicative Medicaid documentation, high caseloads, and mandated documentation at the federal, state, and local levels are the top generators of paperwork for school-based professionals. The paperwork and administrative burden on school-based providers of services continue to be serious challenges and play a key role in the recruitment and retention of audiologists and SLPs.

**D**

**To ensure that FAPE is provided, all appropriate and qualified providers—audiologists and SLPs—must afford students under IDEA Part B a complete assessment and treatment.** FAPE must be provided to all students, and only an individual determination made on a case-by-case basis can ensure that the full complement of appropriate providers and services is available.

**E**

**IDEA reauthorization should ensure parity with ESSA.** This should include the ways in which IDEA and ESSA relate to access of funding streams and the terminology in the use of specialized instructional support personnel (SISP). States and LEAs should be encouraged to utilize funding flexibility when providing MTSS services for struggling learners in general education. Promoting funding flexibility will allow districts to allocate funding, which ensures the availability of the full range of services for both struggling learners in ESSA and students with disabilities who are identified under IDEA.

## Issues, Recommendations, and Rationale

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### Issue: IEPs and Teams

SLPs are concerned that their role in the IEP process is being bypassed by other professionals who are acting as sole decision makers when determining the services and supports for students with particular disabilities—and, as a result, bypassing the IEP process as stipulated in the law. This can lead to individuals practicing outside their scope of practice and children not receiving services from the most qualified provider with the most appropriate training and expertise. In one example, the IEP process is being compromised because the full evaluation and complement of appropriate service providers is not being used to assess and treat children with autism spectrum disorder (ASD), and other providers, such as music therapists and early interventionists, claim that they (and they alone) can evaluate and treat communication disorders.

One of the cornerstones of IDEA is the decision-making authority of the Individualized Family Service Plan (IFSP) under IDEA Part C, and the IEP under IDEA Part B. Allowing individual service providers to assess and make decisions about treatment usurps the IEP team's authority and integrity. Although ASHA believes that each team member has expertise to offer when determining the appropriate supports and services for children with disabilities, each professional has explicit education and training to support students in that professional's own area of expertise.

The increasing number of regulations, guidance, lawsuits, and mandates have eroded the professional judgment and authority of IEP teams—and this limits their flexibility to design an appropriate education program customized for each individual student with a disability. This may result in inappropriate IEPs that potentially may limit student growth and stifle professional authority and innovation. In addition, it may not provide FAPE as mandated by IDEA. FAPE is an individual determination made on a case-by-case basis, which ensures that the full complement of appropriate providers and services is available to each student with a disability. It does not restrict access to services provided by audiologists, SLPs, and other SISP. In addition, students with disabilities have direct access to the highest qualified providers that a state licenses for a profession or service in schools.

ASHA is aware of other professions who claim that they can provide services to individuals who have communication and swallowing disorders. Music therapists, developmental therapists, and applied behavior analysis (ABA) therapists, among others, include in their scope of practice language that references their ability to treat and sometimes assess communication disorders.

One illustrative example was brought to ASHA's attention by a member who works in a school in Michigan. An applied behavioral analysis (ABA) therapist working with her district indicated to the child find team that she could do the required assessments to determine whether or not the child has a disability and was eligible for special education services, including speech and language services. The SLP was contacted by the IEP team (although she was not a part of the assessment or IEP team) and was asked to develop communication goals for the ABA therapist to implement. In this case, the SLP was not involved in the assessment process to determine if the child had a communication disorder and was not part of the IEP team that determined goals and appropriate services. The ABA therapist was not an SLP and was not trained to assess or deliver speech/language services.

School-based SLPs are concerned that ABA therapists are acting as sole decision makers when determining the services and supports for students with ASD. Allowing individual therapists to assess and make decisions about treatment usurps the IEP team's authority and integrity. In response to reports that a growing number of children with ASD may not be receiving speech and language services, the U.S. Department of Education (ED) issued guidance (Musgrove, 2015) to school systems nationwide; this guidance recognizes the importance of speech-language pathology services and the necessary role of an SLP in both evaluation and treatment of children with ASD. In its guidance, ED states that some IDEA programs may be including ABA therapists exclusively without including or considering input from SLPs and other professionals who provide different forms of therapy that may be appropriate for children with ASD. In the guidance documents, ED clarifies that ABA therapy is just one methodology used to address the needs of children with ASD and reminded states and LEAs to ensure that decisions regarding services are based on the unique needs of each child. Relevant guidance from the Centers for Medicare & Medicaid Services was previously issued on this topic as well.



## Recommendations: IEPs and Teams

ASHA makes the following recommendations related to the issue of IEPs and teams.

### *Recommendation #1*

Congress should amend IDEA to strengthen the IEP team’s autonomy and professional authority while maintaining accountability for student outcomes by ensuring that children with disabilities receive a comprehensive evaluation with the full complement of appropriate service providers being used to assess and treat these children.

**Rationale:** IDEA requires parents and professionals to be equal members in the decision-making process and bring different, but important, perspectives to the team. We are concerned that the recent Department of Justice and Education Department’s joint guidance on Effective Communication gives “primary consideration” to the aid or service requested by the person with the disability. Although students and family members have an important role to play on the IEP team, unilateral decision-making by any team member diminishes the important role and contributions of professionals with specific expertise on the team. This holds true in any education team decision-making process. This document has the potential to compromise the standards and procedures inherent in IDEA.

### *Recommendation #2*

Congress should protect students and parents from unqualified providers and providers who provide services outside of their education and training (scope of practice) by restoring highest qualified provider (HQP) requirements for all school-based personnel.

**Rationale:** It is critical for the state education agencies (SEAs) to recognize the appropriate qualifications for SISP—particularly audiologists and SLPs—so that parents consider the child’s best interests when meeting that child’s educational goals. Ensuring that providers have received adequate professional preparation to meet the needs of today’s student population will ensure that students with disabilities receive the appropriate quality and quantity of services, which is consistent with the intent of Congress. The establishment of separate standards for school-based audiologists and SLPs that are less rigorous than the standards for all other settings within the state, (i.e., state licensure in the vast majority of states)

would create a two-tiered system in which children served in the schools would receive services that are inferior to those received in all other settings in the state (e.g., hospitals, private clinics)—settings for which a higher standard is mandated.

### *Recommendation #3*

Empower ED to recognize and allow the use of a hybrid IEP process that would allow parents and children with mild and mild-to-moderate disabilities to opt-in to a less rigorous IEP process while maintaining civil and due-process rights. Allowable activities could include (a) less frequent team meetings with parents and (b) enhanced use of technology for IEP team meetings. Require outcome measures and a liberal opt-out process for parents who are interested in returning to a more rigorous structure or for those times when changes are proposed to the IEP. Consider a study to identify parental satisfaction, student progress, and greater efficiency. [See Caseload/Workload subsection]

***Rationale:*** There is a need to streamline the IEP process, where possible. For many children with mild and mild-to-moderate disabilities, the mandated frequency of IEP meetings provides no benefit to the parents or the providers, especially as children reach middle and high school. Previously, some states experimented with a slimmed-down, voluntary IEP, but were not permitted to continue by ED because this experimental framework was not specifically authorized in IDEA.

### *Recommendation #4*

Add “under the direction of” language to IDEA—similar to that found in Medicaid—to strengthen the supervision of less qualified practitioners and to bring the two laws into alignment.

***Rationale:*** Medicaid regulations for reimbursement of speech-language services, which are provided in school settings, are specific in regard to the qualifications of the SLP providing those services; however, the regulations offer no specific direction regarding reimbursement for services provided by personnel who do not meet those standards. Personnel who do not meet the qualification standards may provide services “under the direction of” a qualified SLP. In

the absence of specific federal guidance on the requirements for “under the direction of” services, states have developed their own specific criteria, resulting in great differences nationwide regarding the qualifications of personnel who are providing services for Medicaid billing in the schools and creating the potential for several untenable legal, ethical, and workload situations for SLPs. Adding parallel “under the direction of” language to IDEA would reduce audits, improve the quality of services to children, and reduce ethical challenges.

### *Recommendation #5*

Add a Parents’ Right to Know provision—similar to that found in ESEA/ESSA—requiring the professional qualification disclosure at IEP team meetings.

**Rationale:** Parents should know the education levels and professional certification/licensure requirements of those who provide services to their child under IDEA. Children should receive services from only those individuals who are qualified to provide those services. In the past, school districts have had problems finding qualified providers and have received emergency waivers to hire or allow less qualified individuals to provide services. These individuals may be teachers with one weekend of training or high school graduates. Unfortunately, these less qualified providers remain in the school system for years, rather than serving as a temporary means for addressing staffing needs. IDEA reauthorization should require schools to document their attempts to first hire qualified providers and, if unsuccessful, only then to hire less qualified individuals—and only on a *limited and temporary* basis. Less qualified and unqualified personnel should not be permanently employed in the schools. In federal law, this Parents’ Right to Know provision will place SISIP on par with similar provisions for other school-based educators. Speech-language pathology assistants (SLPAs) who are academically and clinically trained and who are appropriately supervised can provide quality services—just like physical therapy assistants and occupational therapy assistants with appropriate supervision—and may be employed by school districts as qualified providers of services to children under IDEA.



## Issue: Personnel Qualifications

IDEA needs to be strengthened by bringing back the “highest qualified provider in a state” language for related services personnel and by adding provisions that help school districts improve their recruitment and retention of qualified personnel.

The 2004 IDEA reauthorization and 2006 regulations removed the 1999 regulatory provision that required state education personnel standards to meet the highest requirement for a profession or discipline in that state. At the same time, the statute and the regulations removed the option that state requirements could be waived on an emergency, temporary, or provisional basis.

ASHA-certified and state-licensed audiologists and SLPs are uniquely qualified to deliver services to children who have communication problems that affect their success in classroom activities, social interaction, literacy, and learning. In addition, *universal state licensure* (also referred to as *comprehensive licensure*) ensures the protection of individuals of all ages who need the services of audiologists and SLPs by allowing one licensing body in each state to maintain jurisdiction over the practice of the professions. Currently, 29 states require one license to practice audiology (this includes states that do not license audiologists to work in schools; therefore, a state license would be required), and 18 states require one license to practice speech-language pathology. The remaining states require a separate license or certification to work as a speech-language pathologist in the schools. For audiologists, in the majority of the remaining states, a separate license/certification is required to practice in a school setting. Universal state licensure also:

- deters the hiring or substitution of other workers who do not have the necessary, accurate, and/or appropriate education, qualifications, and training;
- provides *job portability*, which would allow those who are qualified for full licensure to work in all settings;
- enhances recruitment of other professionals;
- deters unethical behavior from professionals and employers, such as under/overutilization, fraud, and misrepresentation;
- provides a venue for consumers to seek censure for individuals who have committed malpractice or other unethical behavior; and
- provides the necessary authority to intervene in cases of provider misconduct.

Unqualified or underqualified related service providers often have little or no clinical experience and may use out-of-date practices. Their lack of clinical practice experience and limited education often results in children being on special education rolls longer—costing local districts more money. Finally, having school districts provide special education services with unqualified or underqualified personnel is misleading and disingenuous to children with disabilities and their parents.

The final 2006 regulations allow the use of paraprofessionals and assistants, but they require that these paraprofessionals and assistants be appropriately trained and supervised. ED noted in its *Analysis of Comments and Changes* (2006) that the act should not be construed to permit or encourage the use of paraprofessionals as a replacement for teachers or providers of related service. ED further emphasized that these personnel are not directly responsible for the provision of special education and related services to children with disabilities; rather, they provide services only under the supervision of special education and related services personnel.

The danger in these changes is that LEAs may be tempted to turn to SEAs to lower personnel standards when faced with difficulties finding qualified personnel to fill vacancies. This could have grave consequences for the students receiving related services.

The use of unqualified providers could lead to misidentification of students in need of special services and could significantly impede the progress that students make in mastering specific skills and strategies as well as their application of those skills and strategies toward academic achievement and functional performance. This short-term solution not only fails to meet the student's needs in an efficient and effective manner, but also can exacerbate personnel shortages by inflating caseloads.

There is also a risk that some LEAs will turn to the use of paraprofessionals and assistants to help alleviate personnel shortages, inappropriately giving these individuals responsibilities beyond their training and scope of practice.

Finally, just as general and special education classroom teachers need SISP support, SISP need appropriate and accessible professional development opportunities to improve their knowledge, skills, and abilities.

## Recommendations: Personnel Qualifications

ASHA makes the following recommendations related to the issue of personnel qualifications.

### *Recommendation #1*

Reinsert the “highest qualified provider in a state” language back into IDEA.

**Rationale:** States retain the authority to establish personnel qualifications for all professions (e.g., doctors, lawyers, nurses, teachers) that practice within the state. Exempting school districts from meeting personnel qualifications that exist in every other setting in that state condones a two-tier system of services: a lower level in a school building and a higher one outside of the school building. By reinserting the “highest qualified provider” language into IDEA, it would ensure that students with disabilities are receiving services from qualified providers. Further, parents would have the comfort of knowing that their children are receiving services from a provider who meets the state-established standard for that profession.

### *Recommendation #2*

Prioritize IDEA Part D Personnel Preparation Grants to target states that still allow bachelor’s degree–level providers and help those providers obtain a master’s degree.

**Rationale:** In some states, such as Maryland, some universities offer special school provider programs where school districts will pay for a provider’s graduate degree if the provider commits to a certain number of years of service in the district. Similar incentive programs could be established through IDEA Part D grants.





## Issue: Paperwork

The challenge of paperwork and administrative burdens continues to be a perennial top issue for ASHA's school-based audiologists and SLPs. ASHA surveys and a U.S. General Accountability Office (GAO) investigation indicate that up to 35% of a practitioner's time is spent on paperwork and administrative compliance instead of working with children.

States and school districts are committed to complying with their legal obligations, but they receive little leadership or guidance from ED, states, and local governments on how to streamline the administrative requirements of IDEA. The burden of interpreting and complying with federal mandates often rests with clinicians; thereby, expanding their duties during and beyond the regular school day. As a result, delivering direct services to children with disabilities is constantly in conflict with completing time-consuming administrative paperwork. Additional burdensome state and district guidelines, paperwork, and processes also help marginalize student services and achievement.

All levels of government (federal, state, and local) contribute to the total burden shouldered by the individual clinicians. For example, federal statute and regulations from ESSA, IDEA, and Medicaid, as well as several other smaller programs generate paperwork and process burdens. State laws also contribute to additional administrative reporting burdens. Local school districts further exacerbate the problem of paperwork in anticipation of and/or from compliance with litigation and court consent decrees and with local/district-level paperwork to follow their specific processes and procedures.

A recent GAO report (2016) found that school-based practitioners "spend between 2 to 3 hours per day on administrative tasks, or roughly 20 to 35 percent of their time," which is consistent with past research on the issue. Parents, taxpayers, elected officials, school administrators, and ASHA members should be very concerned about the diversion of time and resources taken away from direct services to children in order to complete onerous and often duplicative administrative tasks. It is estimated that of the \$11.5 billion that the federal government spends on special education each year, up to \$2.3 to \$3.4 billion of those funds are spent on completing administrative tasks and not on direct services to children. It is estimated that federal, state, and local governments annually spend \$14.5 to \$25.2 billion on administrative tasks related to the provision of special education services for children. These are critical funds that could have been spent on caseload reduction, recruitment and retention programs, or technological upgrades that would directly reduce the paperwork burden.

A growing and concerning trend implemented by local school districts is the practice of keeping separate—but complete—IDEA and Medicaid records on every child in IDEA, even if the child is not currently Medicaid eligible. This doubles the paperwork burden on school-based providers, including ASHA's members, which reduces their ability to provide the appropriate individualization, frequency, and intensity of services to which children with disabilities are entitled. Further, this double bookkeeping decreases professional morale and increases attrition out of school settings.

Other nongovernmental factors contribute to the burden as well. Inconsistent documentation systems, formats, and technologies within and between school districts and states increase the paperwork burden, especially for transient or displaced students. High caseloads of students (65 students or more, compared to a typical general education class size of 30 students) also contribute. Finally, programs aimed at early intervention and reducing special education identification have additional paperwork.

## Recommendations: Paperwork

ASHA makes the following recommendations related to the issue of paperwork.

### *Recommendation #1*

Revise and improve the state paperwork reduction pilot program offered within IDEA, and provide incentives for states to participate in such efforts. Make mandatory the inclusion of SISP on committees and programs for these efforts. Sole participation by special school districts (SSDs) in paperwork reduction initiatives does not always resolve all barriers and identify all solutions.

**Rationale:** A new or revised pilot program should have (a) an adequate funding stream; (b) more options available for innovation and collaboration with staff; (c) use of technological or remote service delivery options such as telepractice; and (d) efforts to increase paperwork consistency across districts and states, with the goal of increasing services and decreasing the quantity of time spent on paperwork.

### Recommendation #2

Harmonize Family Educational Rights and Privacy Act (FERPA, 1974) and Health Insurance Portability and Accountability Act (HIPAA, 1996) requirements for IDEA and school-based Medicaid services to improve efficiency and reduce redundancy of reporting data.

**Rationale:** Both FERPA and HIPAA require different personally identifiable data requirements from schools that have students with disabilities who are Medicaid eligible. This can result in reporting similar information, but doing so in different manners depending on the law. By harmonizing FERPA and HIPAA within an IDEA reauthorization, states, school districts, and providers can still protect student data privacy while improving the implementation of services.

### Recommendation #3

Encourage states and school districts to explore/provide alternative service delivery models to increase the efficiency and effectiveness of services for students.

### Recommendation #4

Allow states and LEAs to provide flexibility in their IEP reporting (e.g., contact hours per month) that would encourage the exploration of alternative service delivery models.

**Rationale for Recommendations #3 and #4:** Encouraging flexibility would allow schools to determine the best method for providing “appropriate” services for each child with a disability. Effective alternative service delivery scheduling and intensity models are currently being used and include the following:

- Adhering to the 3–1 model, where services are provided during a 3-week period, and the fourth week is spent on indirect services such as paperwork, collaboration, IEP meetings, professional development, and training. Students who are being served in a 3–1 model have similar outcomes to those in traditional service delivery models. SLPs who have used this approach have reported increased job satisfaction.
- Providing short intensive therapy to teach a speech or language skill.

- Effective service delivery approaches such as *telepractice*—the application of telecommunications technology to the delivery of audiology and speech-language pathology professional services at a distance by linking clinician to client/patient or clinician to clinician for assessment, intervention, and/or consultation.

#### *Recommendation #5*

Reduce the federal paperwork requirements by either (a) amending IDEA to decrease the frequency in the collection and reporting of data or (b) aligning the frequency and paperwork for which data are collected and reported for both IDEA and Medicaid.

**Rationale:** Encouraging states to eliminate redundant or extra paperwork will provide more time to focus on appropriate services for students and for planning, collaboration, and interprofessional practice.

#### *Recommendation #6*

Improve “Payor of Last Resort” provisions (Section 640) to require not only the “consistency between the agreements or mechanism under Part B”, but also the collection and reporting of data between and/or among other public insurance programs, such as Medicaid, to reduce redundancy, increase efficiency, and improve the delivery of services.

### *Recommendation #7*

Mandate the coordination and collaboration between ED and the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services to improve efficiency and the delivery of services.

***Rationale for Recommendations #6 and #7:*** Medicaid, a public health insurance program, requires separate and different documentation from IDEA, an education program. Creating a unified reporting system for both Medicaid and IDEA would free up SISIP to provide more services to children with disabilities. Additionally, growth in Medicaid-managed care has caused a substantial amount of additional work because of the limited funding allocation allowed and the need to demonstrate and re-demonstrate a continued need for service in order to get Medicaid funds. School-based audiologists and SLPs need to provide continued treatment regardless of whether Medicaid is covering the services, and additional requirements often interrupt/influence the ability to provide continued service.



## Issue: Funding

Static federal appropriations of funding for IDEA have forced states and school districts to seek alternative funding streams to support the education and services for students with disabilities. Congress needs to keep its promise to provide up to 40% of IDEA funding by restoring and then increasing funding for special education (e.g., IDEA grants and programs). The primary alternative funding stream for IDEA is now Medicaid. Unfortunately, Medicaid billing doubles the administrative burden, resulting in less frequent and less intense services to the student.

Permissive and mandated use of IDEA funds (up to 15%) for struggling learners in general education also erodes the financial support for special education students. IDEA and ESSA should share funding responsibility for struggling learners who receive comprehensive early intervening services (CEIS), and ED should provide additional guidance to states and local districts about how to ensure that MTSS services are appropriately provided and funded. As a general education initiative, CEIS may also be funded through ESSA funds.

## Recommendations: Funding

ASHA makes the following recommendations related to the issue of funding.

### *Recommendation #1*

Authorize discretionary funding levels to increase the federal share of educating children with disabilities to 40% in 10 years.

**Rationale:** The federal funding commitment to children with disabilities remains unmet. Congress can demonstrate to its constituents where its funding priorities are by restoring—and then increasing—funding for special education (e.g., IDEA grants and programs). The IDEA Full Funding Act (2016), introduced in the 114th Congress, proposed to gradually increase IDEA funding from its current annual appropriation of \$11.6 billion to \$35.6 billion by fiscal year 2025.

Local, state, and federal budgets for special education barely meet the basic requirements in order to comply with the law, and the educational and service requirements for the academic success of children with disabilities never go away. The demand for special education services—and the lack of funding made available to provide these services—results in larger class sizes and larger special education caseloads, restricted individualized instruction and therapy, diminished frequency and intensity of services, and reduced academic achievement among students with disabilities.

### *Recommendation #2*

Lock in current discretionary funding, and index future Part B funding to a separate indicator.

**Rationale:** Congress could convert the current discretionary funding for IDEA to mandatory spending. This would release billions of dollars in discretionary funding, which could be used for future increases to IDEA funding. Future discretionary funding increases could be calibrated to an economic indicator—such as the average per-pupil expenditure, school lunch enrollment, and the student population.

### *Recommendation #3*

Authorize and enhance research-driven accountability (RDA) to incentivize states for providing appropriate services and interventions.

**Rationale:** Congress should authorize ED to provide incentives to states for increasing the frequency and intensity of services. These incentives could include funding bonuses. RDA shifts ED's accountability efforts from a primary emphasis on compliance to a framework that focuses on improved results for students with disabilities. This effort not only enhances services provided to students, but also offers continued assistance to states by ensuring compliance with the IDEA's requirements. RDA will emphasize child outcomes—such as performance on assessments, graduation rates, and early childhood outcomes.



#### *Recommendation #4*

Improve “Payor of Last Resort” provisions (Section 640) to require not only the “consistency between the agreements or mechanism under Part B”, but also the collection and reporting of data between and/or among other public insurance programs, such as Medicaid, to reduce redundancy, increase efficiency, and improve the delivery of services.

***Rationale:*** Medicaid, a public health insurance program, requires separate and different documentation from IDEA, an education program. Creating a unified reporting system for both Medicaid and IDEA would free up resources for children with disabilities.



## Issue: Caseload/Workload

*Caseload* refers to the number of students with IEPs, IFSPs, and 504 plans served by school-based audiologists and SLPs as well as other professionals through direct and/or indirect service delivery options. In some school districts, caseloads may also include students who receive intervention and other services, within general education, designed to help prevent future difficulties with speech, language learning, and literacy (e.g., MTSS). Caseloads can also be quantified in terms of the number of intervention sessions in a given timeframe.

*Workload* refers to all activities required and performed by school-based audiologists and SLPs as well as other professionals. Workload includes the time for face-to-face direct services to students as well as the time spent performing other activities that are necessary to support students' education programs. Implementation of a workload approach is a best practice for school-based hearing and speech-language services, and it ensures compliance with IDEA and other mandates.

Traditionally, a school-based SLP's workload has been conceptualized as being almost exclusively synonymous with caseload, but the reality is that caseload is only one part of the picture. When a student is added to a caseload for direct services, significant amounts of time within the school day, week, or month must be allocated for additional important and required workload activities. The total number of workload activities required and performed by school-based audiologists and SLPs should be taken into account when establishing caseloads. ASHA does not recommend a maximum caseload number but does recommend taking a workload analysis approach to determine appropriate caseloads in order to ensure that students receive the individualized services that they need to support their educational programs in accordance with IDEA.

School-based SLPs often have high caseloads. Extremely high caseloads often lead to less opportunity for planning and collaboration with other professionals, high levels of paperwork, greater attrition of practitioners, and difficulty in recruiting and retaining qualified SLPs to work in schools. It may also contribute to an SLP's inability to provide FAPE. Respondents to ASHA's *2016 Schools Survey* indicated that paperwork and caseloads were top concerns of audiologists and SLPs who work in schools, and 54% of respondents reported that there were more job openings than job seekers in their facility.

## Recommendations: Caseload/Workload

ASHA makes the following recommendation related to the issue of caseload/workload.

### *Recommendation*

Authorize a study to look at provider caseload, workload, working environments, access to technology, and professional development among school-based audiologists and SLPs.

**Rationale:** The retention rates of special educators are bad—in major part due to challenging working conditions, including high caseloads/workloads. ASHA members report that the driving forces causing them to leave the school setting are paperwork and high caseloads, which impede them from providing the quality of services required by the ASHA Code of Ethics.<sup>8</sup>

Although various factors have contributed to personnel leaving the schools, there has been little research on best practices for recruitment and retention of SISP. In addition, there are no defined strategies for states and LEAs to implement in order to improve provider caseload, workload, and working conditions.

## Issue: Service Delivery Models

Reauthorization of IDEA should encourage flexibility in the states and school districts to explore and provide alternative service delivery models and more flexible scheduling. Not only are states and LEAs required to provide FAPE to children who are identified with disabilities, but, under ESSA requirements, they must also provide supports to struggling learners. When IDEA was last reauthorized in 2004, it allowed LEAs to use up to 15% of its IDEA Part B funds for supportive services to help K-12 students who are not yet identified with disabilities, but who require additional academic and behavioral supports in order to succeed in a general education environment.

In spite of research to support other service delivery models, many school districts continue to rely upon a 40-year-old model of service delivery, which prescribes two sessions per week, at 20–30 minutes per session, for children with speech and language impairments. This may not be what is best for the child, and it is certainly not the best service delivery model for most students throughout the school year. Districts should be led to encourage school-based audiologists and SLPs to use a more dynamic approach for service delivery by varying the amount, location, and frequency of service based on the changing needs of the student, the changing demands of the classroom, the student's response to treatment, and other factors. Nontraditional service delivery models could increase the provision of services (e.g., applying intensive, short bursts of therapy to teach a skill; providing different amounts of therapy throughout the month; engaging in telepractice). This would allow schools to better determine the best method of providing “appropriate” services for children with disabilities and for struggling learners.

The concept of *interprofessional practice* (IPP) occurs when multiple service providers from different professional backgrounds provide comprehensive educational services by working with individuals and their families, caregivers, and communities to deliver the highest quality of services. IPP holds great promise by engaging all team members in assessing, planning, service delivering, data collecting, training, and evaluating the quality and effectiveness of supports and services. Time, opportunity, and administrative support should be encouraged for teams to work together on an ongoing basis to ensure outcomes that are more positive for students. For example, IEP teams do not necessarily work together before a meeting to determine eligibility or to ascertain that ongoing collaborations (after a child is granted services) are systematic and serve the best needs of the child.

There is some evidence that integrating services into the general education classroom has a positive impact on staff and students and should be encouraged within the context of IDEA.

IDEA reauthorization should clearly define that the schools must use all available funding streams to assist struggling learners and children with disabilities in order to access the general education curriculum. Further, in the absence of adequate funding, the schools may use alternative service delivery models to serve these populations.

## Recommendations: Service Delivery Models

ASHA makes the following recommendations related to the issue of service delivery models.

### *Recommendation #1*

Allow and encourage states and districts to implement a workload staffing model that would allow for more innovative service delivery models.

**Rationale:** IDEA should encourage local flexibility in the delivery of services by balancing a practitioner's total workload (students + non-direct services), utilizing 3-1 models (where services are provided during a 3-week period, and the fourth week is spent on indirect services such as paperwork, collaboration, IEP meetings, professional development, and training), and/or implementing the use of telepractice or other service delivery models. Large caseloads limit practitioners' opportunities for planning, attending meetings, collaborating, engaging in professional development, and completing required paperwork. Large caseloads erode practitioners' morale and professional growth, which drives them away from the school setting to other settings. Most school districts look at practitioner caseloads to maintain compliance with IDEA mandates. However, high caseloads actually make it difficult for audiologists and SLPs to provide FAPE and inhibit positive outcomes for students. Compliance with the law does not always result in student growth and academic success.

ED, with regard to IDEA, has not provided enough guidance to states to encourage newer practice models at the state and local levels. Therefore, states and school districts are reluctant to implement innovative practice models under the IDEA law. Adding these options to IDEA would clearly indicate congressional support and spur ED to action by innovating new alternative service delivery models.

### *Recommendation #2*

Establish IDEA demonstration sites as competitive grants in order to collect data on different service delivery models.

**Rationale:** There is little to no support of evaluating promising new service delivery models, affirming their efficacy, and replicating them nationwide. A well-funded, time-limited demonstration program with an evaluation component would help identify promising service delivery models.

### *Recommendation #3*

CEIS language in IDEA should be strengthened to ensure that regular education funds under ESSA are the primary source of support for struggling learners.

**Rationale:** CEIS is authorized for students in general education and not for students with disabilities; however, the funding for these services comes at the expense of funding and services authorized through IDEA. Although ESSA “allows” the “coordination” of Title I and IDEA funding, among other programs, it does not require the use of regular education dollars for these regular education services.

### *Recommendation #4*

Strengthen existing CEIS language to encourage broader use of this program in states and districts.

**Rationale:** ED has indicated that very few school districts opt to leverage the promise of CEIS, and children continue to fail academically before providing interventions. IDEA should encourage states and local school districts to use the flexibility of funding in both ESSA and IDEA in support of CEIS.

### Recommendation #5

ESSA references Multi-Tiered Systems of Support (MTSS) as a means of providing CEIS yet provides no specific funding or guidance on its implementation. Therefore, include references in the new IDEA to MTSS and expand the language to support districts' efforts with properly implementing a successful program.

### Recommendation #6

Substitute the terms *related services* and *related service providers*, found in IDEA 2004, with *specialized instructional support services* and *specialized instructional support personnel* (SISP), respectively.

**Rationale for Recommendations #5 and #6:** These recommendations would make terminology consistent and uniform with the terms used in ESSA.

### Recommendation #7

Include “SISP” in the professional development activities that are allowed under CEIS in IDEA.

**Rationale:** SISP are critical team members who screen for and address academic and behavioral shortfalls/deficiencies in students. SISP need training to better provide CEIS supports and services, and they need to be given opportunities to provide professional development to teachers and other educational professionals in their specific area of expertise.

### Recommendation #8

Encourage the use of telepractice, as appropriate, to reduce barriers and offer an alternative service delivery model, particularly in districts with personnel shortages. Telepractice services must be equal to in-person services in terms of quality and intensity. Require compliance with FERPA and HIPAA guidelines, and ensure that parents retain the authority to opt-in for these services. Work with Medicaid to remove barriers for telepractice and to streamline policies and paperwork. Some additional barriers are as follows:



- Limits on education and training for practitioners to appropriately provide alternative service delivery models.
- Limits on the education and knowledge of administrators regarding alternative service delivery models.
- In some states, Medicaid reimbursement policies require the same service delivery on new codes, each of which is to be approved separately, versus different service delivery on already established codes, all of which can be approved together.
- Portability of license issues.

### *Recommendation #9*

States/LEAs that provide services via telepractice must ensure FAPE to children with disabilities; each school district must implement the evaluation, eligibility, IEP, and the least restrictive environment requirements under IDEA.

### *Recommendation #10*

Each state must have policies and procedures in place to ensure that children with disabilities who receive telepractice are included in all general state- and district-wide assessment programs, including assessments with appropriate accommodations and alternate assessments, where necessary, and as indicated in their respective IEPs.

Some barriers to expanding telepractice include the following:

- Lack of appropriate education and training courses available for providers
- Lack of resources to educate administrators on implementation
- Limits to the portability of license

***Rationale for Recommendations #8, #9, and #10:*** The educational rights and protections that are afforded to children with disabilities and their parents, under IDEA, must not be diminished or compromised when children with disabilities receive services through telepractice.



## Issue: Implications for Children Who Are Deaf or Hard of Hearing (D/HH)

It is estimated that about 131 of every 1,000 school-age children have some degree of hearing loss that can potentially affect communication, learning and literacy, psychosocial development, and academic achievement (ASHA, 2002). Children can be born with or acquire permanent hearing loss after birth. Additionally, hearing losses that are mild, unilateral, fluctuating, or temporary (e.g., due to chronic middle ear conditions) may go undetected but have major educational consequences. Much of learning is auditory based, and students are typically educated in noisy classroom environments. This makes identifying and managing hearing loss in school-age children critically important.

However, many schools do not employ or effectively use educational audiologists. ASHA members continue to see children go through the special education testing process with no information on their hearing status because they cannot participate in a typical pure-tone hearing screening. Further, districts can put undue financial and logistical burdens on the families to get this evaluation done outside the school setting (i.e., in the community). In many cases, if an educational audiologist comes in, the child can be quickly screened or evaluated at school.

Federally supported state early hearing detection and intervention (EHDI) programs, along with advances in hearing aid and cochlear implant technology, have served to increase the number of students who are D/HH that are participating in general education (with and without IEPs or formal 504 plans).

## Recommendations: Implications for Children Who Are D/HH

ASHA makes the following recommendations related to the issue of implications for children who are D/HH.

### *Recommendation #1*

Separate the term “audiology” from the term “speech-language pathology” in Parts A and C.

1. In Part A, Section 602, Definitions, separate “speech-language pathology and audiology services” by changing this phrase to “audiology services, speech-language pathology services.”

2. In Part C, Section 632, Definitions, separate “speech language pathology and audiology” in both paragraphs “E” and “F”—place them on separate lines as follows:

“(iii) audiology services;”

“(iv) speech-language pathology services;”

**Rationale:** Current IDEA statutory language lists audiology and speech-language pathology together, as a single term. Audiology and speech-language pathology are two very different professions. Listing the professions together in federal legislation implies a similar scope of practice and training, which is not the case. Being listed together also leads to confusion and a misunderstanding at the local level by implying that either audiologists or SLPs can provide the same services to children with communication disorders. While collaboration between audiologists and SLPs is critical to quality outcomes for students who are D/HH, as professionals, they each contribute unique knowledge and skills and have separate professional credentials. For example, SLPs should be able to troubleshoot and monitor the function of auditory assistive devices, but they should not be recommending or fitting hearing technology. Listing audiologists and SLPs separately would clarify and highlight the important and very different nature of educational audiology services. Further, this would provide more consistency between Parts B & C.

Educational audiologists are uniquely qualified to understand the impact of hearing loss on classroom learning, and they possess the knowledge and skills to recommend specific strategies and technology to meet the individual communication, academic, and psychosocial needs of students with hearing loss. More than one in 10 school-aged children have some degree of hearing loss that can potentially affect communication, learning, psychosocial development, and academic achievement. Because classrooms are auditory learning environments—in which most learning takes place through listening to teachers or instructors who provide verbal instruction—it is imperative that children can hear what the teacher is saying.

Educational audiologists perform the following tasks:

1. Provide comprehensive, educationally relevant hearing evaluations and make recommendations to enhance communication access and learning.
2. Provide training about hearing, hearing loss, and other auditory disorders for school personnel, students, and parents to facilitate a better understanding of the impact of auditory impairments on language, learning, literacy, and social development.
3. Evaluate and make recommendations for the use of (a) hearing aids and cochlear implants and (b) personal, classroom, and other hearing assistive technology.
4. Ensure the proper fit and functioning of hearing aids, cochlear implants, bone-anchored devices, and hearing assistive technology that individuals use to access auditory information.
5. Interpret audiological assessment results to school personnel.
6. Collaborate with school staff, parents, teachers, support personnel, and relevant community agencies and professionals to ensure delivery of appropriate services.
7. Measure classroom noise, evaluate acoustics, and make recommendations for improving the classroom listening environment.
8. Assist in program placement decisions and make specific recommendations to address listening and communication needs.
9. Coordinate hearing screening programs for preschool and school-aged students, ensuring that professional standards are followed and that screening personnel are appropriately trained.
10. Facilitate programs for speechreading, listening, auditory training, communication strategies, and use and care of amplification devices, including hearing aids, cochlear implants, and hearing assistive technology.
11. Administer relevant assessments to measure central auditory processing function and to make appropriate educational recommendations.
12. Collaborate with students, teachers, and parents to facilitate a greater understanding of the impact of noise exposure and hearing loss prevention.

### Recommendation #2

In Parts A and C, separate “cued speech and sign language services” from “speech-language and audiology services.” Cued speech and sign language services should be listed in a separate section rather than being included as part of audiology and speech-language pathology services.

**Rationale:** The provision of sign language and cued speech is the purview of multiple professionals, not just audiologists and SLPs, but also teachers of students who are hard of hearing. Listing “cued speech and sign language services” as its own separate section is an effective way of clearly showing that a host of professionals—not just audiologists and SLPs—play an important role in the provision of cued speech and sign language services.

### Recommendation #3

Clarify coverage of hearing aids and assistive technology devices.

**Rationale:** The language in IDEA is clear on prohibiting the use of funds to cover implantation of cochlear implants; however, it is not clear on the use of funds to cover hearing aids and assistive technology devices. ASHA supports access to hearing aids for children, but additional discussions need to occur regarding the potential payer(s) of these important devices. The law should stress the important role of audiologists in the fitting and management of assistive technology.

### Recommendation #4

In Part A, Section 605(b), add a reference to International Building Code A117.1, Classroom Acoustics Standard.

**Rationale:** Since IDEA was last reauthorized 13 years ago, the American National Standards Institute (ANSI) has revised its classroom acoustics standard. In 2017, that standard was adopted by the International Code Council (ICC) as part of the International Building Code (IBC) A117.1 accessibility standards.

A low-reverberant learning environment promotes improved academic performance for all students, but especially for those with hearing loss and auditory processing disorders. Further, a quiet and low-reverberant classroom reduces teacher vocal strain and absenteeism.

Finally, the technology, engineering, design, and building materials already exist that would allow new school construction to easily meet these standards with minimal extra costs. Any costs could be outweighed by academic gains and lower special education costs.

### *Recommendation #5*

ASHA opposes the inclusion of the Alice Cogswell and Anne Sullivan Macy Act (2017) into IDEA. Although well intended, the legislation establishes a new precedent of placing visual and hearing disabilities ahead of others identified in IDEA by adding specific disability-related mandates and requiring additional resources to accommodate only visual and hearing disabilities (vs. all disabilities). Also, not only is the bill redundant of current IDEA mandates, but the bill fails to recognize the full scope of services and personnel available to children and students who are hard of hearing, deaf, and/or deaf-blind.

***Rationale:*** The legislation amends IDEA to require a state to identify, evaluate, and provide special education and related services to children who have visual or hearing disabilities (or both) and who also are—or may be—classified as deaf-blind. A state must ensure that it has enough qualified personnel to serve children who have such disabilities and that a full continuum of alternative placements is available to meet the needs of children with disabilities for special education and related services. In addition, the legislation stipulates that a state's closure of a special school that serves children who are deaf or blind shall count as a reduction of its financial support for special education and related services. This connects a state's maintenance of effort to the support of state-run special needs schools and could influence its compliance with IDEA.

In this legislation, the IEP for each child with either (or both) visual or hearing impairment must include specified components and must provide the child with instruction that meets the child's unique learning needs. Similarly, the IFSP for an infant or toddler with a hearing disability must include specified components. In mandating how to meet the needs of students, the Alice Cogswell and Anne Sullivan Macy Act references only two forms of communication—American Sign Language and spoken English—but fails to reference other modalities, such as cued speech.

ASHA supports appropriate accommodations for students with hearing disabilities; however, the Association believes that the current mandates in IDEA already address the needs of these individuals.



## Issue: Effective Communication

In 2014, the U.S. Departments of Justice (DOJ) and Education issued joint guidance<sup>9</sup> on the provision of effective communication for students with disabilities under IDEA and the Americans with Disabilities Act (ADA; 1990), which outlines the responsibility of public schools to ensure that communication with students who have hearing, vision, or speech disabilities is as effective as communication with all other students. Public schools must apply both the IDEA analysis and the Title II (of ADA) effective communication analysis when determining how to meet the communication needs of an IDEA eligible student who has a hearing, vision, or speech disability. The guidance includes frequently asked questions (November, 2014), a “Dear Colleague” letter (November, 2014), and a fact sheet titled *Meeting the Communication Needs of Students with Hearing, Vision, or Speech Disabilities* (November, 2014).

This joint guidance is the result of a federal court case in a Western district, which highlighted that the Title II effective communication requirement differs from the requirements in IDEA. In some instances, in order to comply with Title II, a school may have to provide the student with auxiliary aids or services that are not required under IDEA. In other instances, the communication services provided under IDEA will meet the requirements of both laws for an individual student. The court case and the joint guidance mandate the provisions of communication supports that are not necessarily the result of evidence-based, data-driven decision making. The guidance also creates ambiguity for states and districts when determining which law takes precedence in schools—ADA or IDEA.

Further, these additional services are to be provided without any additional funding to states or local school districts. Funding for services for students is limited, and states require adequate funding to meet the expanding need for services for students with and without an IEP. Encouraging additional supports and services for students without team agreement may result in added pressure to find students eligible for IDEA because it is the primary funding source for those supports and services. Further, pressure to accommodate parent/student requests for supports could result in inappropriate identification and the inclusion of services in an IEP.

Encouraging additional supports and services for students without a comprehensive assessment and service determination from the IEP team may result in added pressure to find students who are eligible for IDEA while usurping the authority of the IEP team. It may also require providers to offer services (a) for which they are not trained or (b) that are not evidence-based and that, ultimately, lead to more costly services that may not be evidence-based or cost effective.

IDEA reauthorization needs to clarify which law, rule, or guidance takes precedence in school settings and which funding streams are available to provide the resources necessary to accommodate and integrate students with disabilities into our nation's classrooms.

## Recommendations: Effective Communication

ASHA makes the following recommendation related to the issue of joint guidance on effective communication from DOJ and ED.

### *Recommendation*

Clarify that IDEA supersedes the ADA in terms of special accommodations for children with disabilities.

**Rationale:** The joint guidance on effective communication from DOJ and ED does not clearly define which law takes precedence. As a result, the guidance causes confusion in the school system and has the potential to require audiologists and SLPs to provide treatment that they do not believe to be appropriate—thereby placing them in an ethical dilemma. The current guidance and its lack of clarity regarding which statute applies first has the unintended consequences of compromising the decisions of the IEP team when determining the most appropriate services that are necessary for the success of the child and potentially could deny a FAPE. The joint guidance requires that entities give “primary consideration” to the communication requests of individuals with disabilities—the expertise of the IEP team is not given equal consideration, as it should be. Although students and family members have an important role to play, recommending unilateral decision-making by one individual diminishes the important role and contributions of professionals with specific expertise who are members of a cross-disciplinary team that is ultimately responsible for these important decisions. As a result, this potentially impacts the implementation of the IEP team's decision regarding what a FAPE is for each child.

## **Issue: IDEA Advisory Commission**

Although IDEA guarantees that parents and practitioners have direct input on the education of a child with a disability, there are no formal avenues for input or feedback to the federal government on the law's implementation. Therefore, Congress should establish an IDEA Advisory Commission for this purpose. The proposed IDEA Advisory Commission should compose the full range of professionals who provide services to students with special needs, including SISP.

Congress has established advisory committees and commissions for other federal departments and agencies on the implementation of other laws and should do the same for parents and practitioners who wish to provide input on IDEA. Congress no longer supports, or funds, opportunities for practitioners or the public to share new treatment approaches, staffing models, technological innovations, or opportunities for interprofessional learning. Further, ED affords few, if any, opportunities for the public to comment and provide feedback on the general implementation of IDEA. Feedback is critical to be able to continue to meet the needs of children with disabilities—even 13 years after the last reauthorization of the law.

## **Recommendations: IDEA Advisory Commission**

ASHA makes the following recommendation related to the issue of the proposed IDEA Advisory Commission.

### *Recommendation*

Establish the IDEA Advisory Commission during the next IDEA reauthorization, with broad authority to receive public feedback, conduct studies, and provide advice and guidance to ED on the implementation of IDEA. The Commission should comprise a mix of congressionally appointed members who represent a broad sample of the special education community, including parents, advocates, self-advocating individuals with special needs, special education directors and regional complaint due-process individuals, administrators, principals, teachers, SISP, parents, students, and others, as appropriate.

**Rationale:** Congress has established commissions and committees for other federal programs, including the Medicare Payment Advisory Commission (MedPac) and the Interagency Autism Coordinating Committee (IACC).

MedPac is an independent congressional agency that was established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise Congress on issues affecting the Medicare program. The Commission's statutory mandate is quite broad. In addition to advising Congress on payments to private health plans, participating in Medicare, and advising providers on Medicare's traditional fee-for-service program, MedPac is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

The IACC is another an example of a federal advisory committee that coordinates all efforts within the U.S. Department of Health and Human Services (HHS) concerning ASD. Through its inclusion of both federal and public members, the IACC helps ensure that a wide range of ideas and perspectives are represented and discussed in a public forum.

The new IDEA Advisory Commission could be modeled on either of these two groups.

## Issue: Part C

IDEA Part C offers early intervention services to infants and toddlers with disabilities (birth–age 2 years) and their families. Part C offers one of the earliest opportunities to identify a disability and intervene with a young child in order to improve their long-term outcomes. Effective early intervention programs can reduce later identification and referral for special education services. If identified early in a child’s life, many language, speech, and hearing-related disabilities can be addressed effectively and can ensure the highest quality long-term outcomes for that child.

The transition between Part C early intervention services and Part B services under IDEA can often result in a delay in services and loss of follow-up for children and families who are moving between programs. Access to qualified providers who have expertise in each area of disability should be provided so that the child and their family may participate in the IFSP and intervention process. For children who are deaf or hard of hearing, the qualified providers identified in the IFSP include audiologists, who have the appropriate knowledge and skills to assess and treat hearing loss in the infant/toddler population.

## Specific Recommendations: Part C

ASHA makes the following specific recommendations related to the issue of Part C (early intervention services).

### *Specific Recommendation #1*

Separate the term “audiology” from “speech-language pathology” in Parts A and C.

1. In Part A, Section 602, Definitions, separate “speech-language pathology and audiology services” from “audiology services, speech-language pathology services”.
1. In Part C, Section 632, Definitions, separate “speech language pathology and audiology” in both paragraphs “E” and “F”—place them on separate lines, as follows:
  - “(iii) audiology services;”
  - “(iv) speech-language pathology services;”

**Rationale:** Current language lists “audiology and speech-language pathology” together, as a single term; however, audiology and speech-language pathology are two very different professions. Listing the professions together in federal legislation implies a similar scope of practice and training, which is not the case. Being listed together leads to confusion and a misunderstanding at the local level, which implies that either audiologists or SLPs can provide the same services to children with communication disorders. Although collaboration between audiologists and SLPs is critical to quality outcomes for students who are D/HH, as professionals, they each contribute unique knowledge and skills. For example, SLPs should be troubleshooting and monitoring the function of assistive devices, but they should not be recommending or fitting hearing technology. Listing “audiology” and “speech-language pathology” separately would clarify and highlight the important and very different nature of audiology and speech-language pathology services.

#### *Specific Recommendation #2A*

Separate “cued speech and sign language services” from “speech-language and audiology services” as currently listed.

**OR**

#### *Specific Recommendation #2B*

Include a new separate line for communication modality (i.e., cued speech, sign language, and auditory-oral).

**Rationale for Recommendations #2A and #2B:** The provision of sign language and cued speech is the purview of multiple professionals, including not only audiologists and SLPs, but also teachers of students who are D/HH. Therefore, it is recommended that these services be listed in a separate section rather than being included as part of “speech-language pathology and audiology services.”

### *Specific Recommendation #3*

Add “feeding and swallowing” to the list of developmental needs under Early Intervention Services.

**Rationale:** Speech-language pathology services include the provision of services for infants/toddlers with feeding and swallowing disorders (i.e., dysphagia). Therefore, the list of speech-language pathology services should be comprehensive and should include this critical service.

## **General Recommendations: Part C**

ASHA makes the following general recommendations related to the issue of Part C (early intervention services).

### *General Recommendation #1*

Convert the term “Limited English Proficiency” (LEP) to “English Learners” (EL).

**Rationale:** This change in terminology would make the language of the reauthorized IDEA conform to the current language of ESSA law.

### *General Recommendation #2*

In Section 636, Individualized Family Service Plan (IFSP), amend Items A and B as follows:

1. In Item A, affirm that the IFSP is the decision-making authority and that, during this process, the full evaluation and complement of appropriate service providers is used to assess and treat children with disabilities.
2. In Item B, add that the primary service provider should be the professional who is most immediately relevant based on the child’s needs. This also should be specified throughout Section 636 when referencing the coordination of services for children.

**Rationale:** One of the cornerstones of IDEA is the decision-making authority of the IFSP team under IDEA Part C and the decision-making authority of the IEP team under IDEA Part B. Allowing individual therapists (ABA therapists and other providers) to unilaterally assess and make decisions without input from other professionals about treatment usurps the authority and integrity of the team. In response to reports that a growing number of children with ASD may not be receiving much-needed speech and language services, ED issued guidance in the form of a “Dear Colleague” letter (Musgrove, 2015) to school systems nationwide and recognized the importance of speech-language pathology services and the necessary role that SLPs play in both evaluation and treatment of children with ASD. In its guidance, ED states that some IDEA programs may be including ABA therapists exclusively without including, or considering input from, SLPs and other professionals who provide different types of therapies that may be appropriate for children with ASD. ED clarifies that ABA therapy is just one methodology used to address the needs of children with ASD—and reminds states and local programs to ensure that decisions regarding services are based on the unique needs of each child. CMS previously issued relevant guidance on this topic as well: *Clarification of Medicaid Coverage of Services to Children with Autism* (Mann, 2014) and *Medicaid and CHIP FAQs: Services to Address Autism*. (Medicaid, 2014)

### General Recommendation #3

In Part B, Section 616, Monitoring, Technical Assistance and Enforcement, ASHA recommends adding the following language, in boldfaced text, on access to services:

- There should not be one treatment that is recommended or used for all children. Interventions should be based on individual needs.

This should also be addressed under “Compliance Monitoring” in the statute, to be sure that one treatment or service is not being recommended for all disabilities. This will help districts comply with IDEA FAPE requirements.



**Rationale:** ED’s 2015 guidance (the “Dear Colleague” letter) reminds states and local programs to ensure that decisions regarding services for a child with a disability are based on the unique needs of each child. This is also supported by CMS guidance on this issue. The publications are *Clarification of Medicaid Coverage of Services to Children with Autism* (CMS, 2014) and *Medicaid and CHIP FAQs: Services to Address Autism* (CMS, 2014).

#### General Recommendation #4

Ensure that technology needs of the parents and child are addressed in Section 636, Content of Plan, Item “(d) IFSP” by adding new paragraph “(9)” requiring a statement of the technology needs of the parents and child.

**Rationale:** It is important to provide access—including appropriate technology access (e.g., FM systems, augmentative and alternative communication (AAC), and speech-generating devices [SGDs])—to those who need it in order to successfully access the general education curriculum.

#### General Recommendation #5

Revise the “Transition and Eligibility” section as related to children who are hard of hearing.

- Confirm eligibility without duplicating assessments that have already been completed.
- Determine if assessments under IDEA are needed by the IEP team. If they are not needed, there should be an automatic referral for CEIS and/or accommodations under Section 504 that includes a schedule for monitoring through 3rd grade (or until age 7 years) by personnel with expertise in hearing impairment.
- Identify—and address for students with co-occurring disabilities—each disability in the transition plan from services under Part C to services under Part B.

**Rationale:** The transition from IDEA Part C early intervention services to Part B early intervention services often results in a delay in services and a loss of follow-up for children and families who are moving between programs. IDEA's Child Find procedures undercount the actual number of children who are hearing impaired or hard of hearing because hearing loss is viewed as secondary to other conditions or because it is assumed that personal technology (e.g., hearing aids, cochlear implants) are providing adequate access to classroom instruction. However, we know that this is all too often not the case. As mentioned above, hearing loss often coexists with other health and developmental conditions, and each disability should be identified and addressed in educational planning.

## Additional Resources

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ASHA recommends the following additional resources for background reading and familiarity with this important issue of IDEA reauthorization.

Caseload and Workload [Practice Portal Professional Issues document]

<http://www.asha.org/practice-portal/professional-issues/Caseload-and-Workload/>

*Backgrounder: Special Education Workload Analysis Model* [PDF]

[https://www.nea.org/assets/docs/19178\\_NBI27\\_Backgrounder\\_v2.pdf](https://www.nea.org/assets/docs/19178_NBI27_Backgrounder_v2.pdf)

American Occupational Therapy Association (AOTA): Caseload to Workload [web page]

<http://www.aota.org/Practice/Children-Youth/Caseload-Workload.aspx>

American Physical Therapy Association (APTA): Webinar Looks at Advantages of ‘Workload’ Model for PTs Helping Students [article from PT in Motion newsletter]

<http://www.apta.org/PTinMotion/News/2015/1/12/WorkloadCaseloadWebinar/>

ASHA 2016 Schools Survey: SLP Workforce and Work Conditions [PDF]

<http://www.asha.org/uploadedFiles/2016-Schools-Survey-SLP-Workforce.pdf>

Schools Survey Report: Trends in Educational Audiology 2010–2016 [PDF]

<http://www.asha.org/uploadedFiles/2016-Schools-Survey-Educational-Audiology-Trends.pdf>

ASHA Guidelines for Audiology Service Provision in and for Schools [ASHA policy document]

<http://www.asha.org/policy/GL2002-00005.htm>

Perceptions of Job Stress and Satisfaction Among School-Based SLPs: Challenges Versus Rewards  
Article from SIG16 Perspectives on School-Based Issues, 2008

<http://sig16perspectives.pubs.asha.org/article.aspx?articleid=1774198>

Predicting Job Satisfaction Among Speech-Language Pathologists Working in Public Schools  
Article from Language, Speech, and Hearing Services in Schools, 2002

<http://lshss.pubs.asha.org/article.aspx?articleid=1780292>

Speech-Language Pathologist Job Satisfaction in School Versus Medical Settings

Article from Language, Speech, and Hearing Services in Schools, 2011

<http://lshss.pubs.asha.org/article.aspx?articleid=1781946>

The Critical Shortage of Speech-Language Pathologists in the Public School Setting

Article from Language, Speech, and Hearing Services in Schools, 2006

<http://lshss.pubs.asha.org/article.aspx?articleid=1762934>

ASHA 2016 Schools Survey

<http://www.asha.org/research/memberdata/schoolssurvey>

Joint Guidance on Effective Communication for Students with Hearing, Vision, or Speech

Disabilities in Public Elementary and Secondary Schools [document from DOJ and ED]

<http://www2.ed.gov/about/offices/list/ocr/letters/colleague-effective-communication-201411.pdf>

“IEPs Must Be Aligned to Grade-Level Standards, Says New Federal Guidance”

[*Education Week* blog post]

[http://blogs.edweek.org/edweek/speced/2015/11/ieps\\_grade\\_level\\_standards.html](http://blogs.edweek.org/edweek/speced/2015/11/ieps_grade_level_standards.html)

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