Complaint Investigation Report
Parents v. York County CDS

June 29, 2009

Complaint #09.086C
Complaint Investigator: Jonathan Braff, Esq.

I. Identifying Information

Complainants: Parents
Address
City

Respondent: Brenda Gagnon, Board Chair
DHHS
161 Marginal Way
Portland, ME 04101

Site Director: Susan Motta

Child: Child
DOB: XX/XX/XXXX

II. Summary of Complaint Investigation Activities

The Department of Education received this complaint on May 18, 2009. The Complaint Investigator was appointed on May 19, 2009 and issued a draft allegations report on May 21, 2009. The Complaint Investigator conducted a complaint investigation meeting on May 28, 2009. On June 2, 2009, the Complaint Investigator received a 3-page memorandum including a list of proposed interviewees and 2 pages of documents from the Complainants, and from York County CDS (the "Site") received 47 pages of documents on May 28, 2009 and a 3-page memorandum and 24 pages of documents on June 3, 2009. Interviews were conducted with the following: Susan Motta, Site director; Joanne Wood, case manager; Yvonne Carter, special education teacher; Lynn Ruggieri, special education teacher; Danika Kuhl, speech therapist; Elizabeth Straka, speech therapist; Robert Faucette, M.D., physician; the Child's mother; and the Child's father.

III. Preliminary Statement

The Child is xx years old and is currently receiving early intervention services under the eligibility criterion Developmental Delay. This complaint was filed by the Child's Mother

("Parent I") and the Child's Father (Parent II)(collectively, the "Parents"), alleging violations of the Maine Unified Special Education Regulations (MUSER), Chapter 101, as set forth below.

IV. Allegations

1. Failure to provide early intervention services designed to meet the developmental needs of the Child in violation of MUSER §X.1;
2. Failure to include in the Child's IFSP of November 4, 2008 a statement of measurable results or outcomes expected to be achieved and the criteria, procedures, and timelines used to determine the degree to which progress toward achieving the results or outcomes is being made in violation of MUSER §IX.1.D(3);
3. Failure to provide early intervention services on or near the initiation date set forth in the Child's IFSP of November 4, 2008 in violation of MUSER §IX.1.D (6) and 34 CFR §303.344(f)(1);
4. Failure to fully and adequately implement the child's IFSP of November 4, 2008 with respect to provision of speech therapy and of a speech therapist as the primary service provider in violation of MUSER §§X.1 and X.1.A(2);
5. Failure to adequately consider the concerns of the parent in the IFSP decision making process before making the modifications to the Child's early intervention program described in the Written Notice of February 2, 2009 in violation of MUSER §§VI.1.B(1)(a) and VI.1.C;
6. Failure to provide requested education records regarding delivery of services to the Child in violation of MUSER §XIV.3;
7. Failure to include in the Child's IFSP of April 23, 2009 a statement of measurable results or outcomes expected to be achieved and the criteria, procedures, and timelines used to determine the degree to which progress toward achieving the results or outcomes is being made in violation of MUSER §IX.1.D(3);
8. Failure to include in the Child's IFSP of April 23, 2009 a statement of the specific early intervention services to be provided and the frequency, intensity and method of delivering those services in violation of MUSER §§IX.1.D(4) and X.1.A(4);
9. Failure to identify in the Child's IFSP of April 23, 2009 the professional discipline of the primary service provider in violation of MUSER §X.1.A(2);
10. Failure to include the Child's parents in decision-making regarding the specific early intervention services to be provided to the Child and the frequency, intensity and method of delivering those services in violation of MUSER §§ VI.1.B(1)(a), VI.1.C and Appendix 1, 34 CFR §300.501(b).

V. Complainants' Proposed Resolution (from Dispute Resolution Request form)

1. The Child would receive compensatory early intervention services commensurate with the harm done as a result of the Site's violations.
2. The Site staff would receive training about IDEA Part C and MUSER regulations, including writing measurable goals, the IFSP team role and parent participation, timelines in which to provide services, required components of the IFSP, and

providing early intervention services designed to meet the individual developmental needs of a child.

3. An IFSP team would convene to revise the Child's IFSP to ensure it meets her individual, developmental needs as well as the applicable regulatory requirements. Deliberations would include consideration of the appropriateness of direct services, speech/language in particular, and the appropriateness of a qualified speech/language professional acting as the Child's primary service provider.
4. The Site would reimburse the Parents for any services they sought privately from qualified providers that should have been identified in the Child's IFSP beginning November 4, 2008 to the present.

VI. Summary of Findings

1. The Child lives in Limington with the Parents. After the Child's pediatrician informed the Parents that the Child was exhibiting significant delays in speech and communication and recommended that the Child needed speech therapy, the Parents referred the Child to the Site for evaluation of her eligibility for early intervention services on March 18, 2008. The Parents withdrew the Child from the Site on May 23, 2008, but again referred her on October 3, 2008.

2. On November 4, 2008, the Child was evaluated and determined eligible for early intervention services under the category of developmental delay. The results of the evaluation showed scores of more than 2 standard deviations on the subtest areas of communication and adaptive, and of more than 1.5 standard deviations on the subtest areas of cognitive, physical and social/emotional.

3. An IFSP dated November 4, 2008 was developed for the Child specifying case management services once a month for 30 minutes, speech therapy services provided by the primary service provider once a week for 60 minutes and occupational therapy consultative services once a month for 60 minutes. The start date for all these services was listed as November 4, 2008.

4. The November 4, 2008 IFSP listed the following outcomes and objectives: "Outcome Statement: [The Child] will be able to communicate. Short Term Objectives: [The Child] will use signs or gestures to communicate; [the Child] will be able to identify her parents; [the Child] will use more consonant vowel combinations." "Outcome Statement: [The Child] will increase her oral motor awareness and tone. Short Term Objectives: [The Child] will use a spoon to eat; [the Child] will use a cup to drink without spillage; [the Child] will decrease drooling." "Outcome Statement: [The Child] will improve balance. Short Term Objectives: [The Child] will walk on uneven ground; [the Child] will transition from seated to standing without support."

5. The case manager, Joanne Wood, received the completed IFSP on November 19, 2008, and then referred the file to the referral coordinator to locate a speech therapist able to act as primary service provider.

6. On December 8, 2008, Ms. Wood was informed by the referral coordinator that no speech therapist was available to act as primary service provider. She promptly contacted Parent I with this information and asked whether Parent I would agree to have a special education teacher act as primary service provider. Parent I reluctantly agreed, stating that she continued to want a speech therapist in that role. The Parents would not agree to amend the IFSP to replace the speech therapist with a special education teacher as primary service provider.

7. On December 15, 2008, Ms. Wood contacted special education teacher Lynn Ruggieri to ask whether she would be willing to act as primary service provider for this family. Ms. Ruggieri agreed.

8. On December 19, 2008, Ms. Ruggieri spoke with Parent I about scheduling a time for her to visit the home. Parent I told Ms. Ruggieri that she wanted to be present during the visit, and that due to her work schedule the visit would have to be scheduled after 2:30 p.m. Ms. Ruggieri explained to Parent I that she was only available during school hours and could not accommodate Parent I's schedule. Ms. Ruggieri confirmed this in an e-mail to Ms. Wood on January 4, 2009.

9. On January 8, 2009, Ms. Wood spoke with special education teacher Yvonne Carter, who agreed to act as primary service provider for the family, and then notified Parent I. Ms. Carter then spoke with Parent I and scheduled an initial home visit for January 12, 2009. Ms. Carter was to be accompanied by speech therapist Elizabeth Straka, who consults with some of the Site's service provider teams. When Ms. Carter became ill shortly after having scheduled this appointment, Ms. Straka decided to do the home visit herself rather than having there be any further delay in getting early intervention services to the Child under way.

10. Ms. Straka made visits to the family's home on January 12 and 15, 2009, modeling and coaching various strategies for the Parents to use with the Child. She explained that she was not the primary service provider, but that she would continue to consult with Ms. Carter and would sometimes accompany her on future home visits. She also discussed with the Parents her belief that the Child would benefit from early intervention physical therapy services and possibly early intervention occupational therapy services, and encouraged the Parents to have the Child evaluated in these areas. Some time after these visits, Ms. Straka had a serious family medical issue arise that made her unavailable to the family for a time.

11. Ms. Carter made visits to the family's home on January 21, 2009 and February 4 and 9, 2009. Prior to the first visit, Ms. Carter exchanged e-mails and met with Ms. Straka to review with Ms. Straka what she had been working on with the family and her thoughts about the Child. Appointments were made for both a physical therapy and an occupational therapy evaluation for the Child.

12. On February 2, 2009, the Site issued: a revised IFSP with a new Supports and Services page that listed physical therapy as a support service with 2 visits per quarter; and a Written Notice in which the Site proposed to add 60 minutes two times each quarter for support of the physical therapist to the speech therapist, and proposed a four-person team (speech therapy, occupational therapy, physical therapy and special instruction) that would be available to the

speech therapist as needed for 60 minutes each month. The Written Notice further provided that at that time the Child's primary service provider would be a teacher, however her plan would not be changed to reflect this.

13. Parent I initially refused to sign the revised IFSP because it didn't specify physical therapy as an individual service for 60 minutes once a week. The team conferred and agreed that Parent I, the Child and Ms. Carter should have two visits with the physical therapist to help decide what early intervention support would look like and also meet with the occupational therapist, and then the IFSP team would meet again to consider further changes to the IFSP. Ms. Wood wrote to the physical therapist, Pam Winsor, and explained that the Child would have two visits as information-gathering appointments, and that afterwards the whole team would meet to discuss the most appropriate service provision for the child. The team agreed that the two physical therapy appointments could take place at Ms. Winsor's office to avoid any further delay.

14. Parent I called the Child's pediatrician, Robert Faucette, M.D., and reported that the Child was not getting speech therapy and not getting enough services generally. Dr. Faucette spoke with Ms. Motta on February 11, 2009, and then told Parent I that the Site was no longer providing services and she should arrange for the Child to get speech therapy privately.

15. On February 13, 2009, Parent I notified Ms. Wood that she was discontinuing services for the Child through the Site based on Dr. Faucette's recommendation.

16. On March 18, 2009, the Developmental Medicine Center of Children's Hospital in Boston, Massachusetts issued an evaluation report of the Child, containing diagnoses of macrocephaly and global developmental delays, and recommending early intervention services including speech therapy and occupational therapy or physical therapy in addition to her developmental therapy. Test scores were for the most part 1.5 or 2.0 standard deviations below the mean.

17. On April 23, 2009, the Parents returned the Child to the Site for further services, and an IFSP team meeting was held. A new IFSP was prepared, which listed under "Supports and Services" only case management and "specialized instruction," specifying 60 visits of 60 minutes each and identifying the primary service provider as "Early Intervention Provider." Most of the same outcomes and objectives were carried over, with a few additions such as "[The child] will be able to independently complete her shape sorter/3 piece puzzle; [the Child] will independently kick a ball; and [the Child] will climb up a ladder to play structure/onto furniture independently."

18. On March 26, 2009, the Parents' advocate, Karen Farber, requested documentation of services that were delivered to the Child. That request was not responded to until the filing of this complaint.

19. During an interview conducted by the Complaint Investigator with Joanne Wood, Ms. Wood stated the following: She is a case manager for the Site, and has been assigned to the Child since the Child came to the Site. After the IFSP team meeting on November 4, 2008, she first had to wait for the IFSP to be prepared, receiving it on November 19, 2009. At that

point, she referred it to the Site's referral coordinator. On December 8, 2008, the referral coordinator told her that no speech therapist was available to act as the family's primary service provider, and asked her to contact the family to ask whether they would accept a teacher in place of the speech therapist. That same day, she had that conversation with Parent I, who told her that although Parent I still wanted to have a speech therapist as the primary service provider, Parent I would accept a teacher instead for now. Parent I did not want the IFSP to be changed, however, as Parent I continued to want the speech therapist in that role. On December 15, 2008, she made a referral to Ms. Ruggieri to act as primary service provider. Four days later it was apparent that Ms. Ruggieri's and Parent I's schedules were in conflict and no mutually acceptable appointments could be made. Along the way, she was alerted by Ms. Ruggieri to an issue with regard to payment as the IFSP specified a speech person rather than a teacher as primary service provider. She promptly notified the billing department that they could approve payment to Ms. Ruggieri.

After the holidays, on January 8, 2009, she told the Parents that teacher Yvonne Carter was available to act as primary service provider and could accommodate their schedule. They agreed to this and appointments were scheduled for Ms. Carter and for speech therapist Elizabeth Straka. A referral was also made for a physical therapy evaluation. Her next contact with the Parents was on February 13, when the Parent told her that she had taken the Child to the pediatrician and she wanted to discontinue services through the Site because the Child needed more services than what the Site was able to provide. The Child reentered the Site on April 23, 2009.

With regard to the February 2, 2009 amendment to the IFSP, she prepared the amendment based on an e-mail she received from Ms. Straka. Ms. Straka wrote that she had discussed physical therapy with Parent I, and that Parent I was willing to add this service. She followed Ms. Straka's suggestion with regard to how the amendment should be written. On February 3, 2009, she spoke with Parent I about this subject, and explained that the two sessions with the physical therapist called for in the amendment would be for information gathering and that the team would afterwards consider further revisions to the program. She also asked Ms. Carter to discuss this with Parent I at Ms. Carter's next visit.

20. During an interview conducted by the Complaint Investigator with Danika Kuhl, Ms. Kuhl stated the following: She is a speech therapist, and has been working with the Child since March 9, 2009. She generally sees the Child once a week, and has had a total of about 8 sessions with the Child so far. Her first goals were to develop a consistent yes/no response for the Child, in both gestures and words, and to increase the Child's eye contact. The Child has been making substantial progress. The setting in which she works with the Child is very natural, and includes in it toys, games and snacks. She models for the Parents the interactions she wants them to engage in with the Child. Sometimes the Child's grandmother brings the Child to therapy. The Parents are very involved in the work and exhibit good follow-through. She believes that if therapy had started sooner, the Child would now be further advanced with her communication than she is presently.

21. During an interview conducted by the Complaint Investigator with Yvonne Carter, Ms. Carter stated the following: She is a special education teacher for young children employed by the Site, having a M.Ed. in special education and a B.A. in communication disorders. She is a

member of the Northwest provider team, which also includes a speech therapist, physical therapist and occupational therapist.

She was initially asked by the Site to be a primary services provider to the family in January, 2009. She believed that it made sense for her to be the Child's primary service provider because the Child needed global services, and a teacher provides a more global approach. In addition, she has a communications background, and the child's communications problems were of particular concern for the Parents. Shortly after she agreed to be the Child's primary service provider, she became ill and was unable to visit the Family with Ms. Straka on January 12 and 15, 2009. She first visited the Family on January 21, 2009, and met with them a total of three times. In her experience, the first few visits with a family are usually part of the evaluation process to determine what services the child requires, how best to deliver them and by whom. Here, a determination was made as a result of the initial visits with the Family that the Child's physical instability was a big part of the Child's problem, and that both the physical therapist and occupational therapist needed to be involved in developing the Child's program. Visits with these providers had been scheduled by the time the Parents decided to remove the Child from the Site.

She felt that the first 2 visits with the Family were very positive, and thought that the Parents would be able to carry over her suggestions. She told the Parents how important this was - that it was up to the Child's caregivers to provide the bulk of the therapy. At the third visit, Parent I said that she was not able to follow through with the suggestions due to her work schedule. She understood that the Parents still wanted the speech therapist to be directly providing therapy on a regular basis. Even so, she was a little surprised when the Parents decided to remove the Child from the Site. She felt that everything was coming together for the Child's program, but it just wasn't happening fast enough for the Parents.

With the primary services provider model generally, parents are involved in the initial eligibility determination, and in determining outcomes and objectives for the child. The identity of the initial primary service provider is not specified in the IFSP, and the parents are not usually included in the determination. Once services begin, the parents' input is solicited every time a provider meets with them, and sometimes in e-mails exchanged between visits. In this way, the parents are involved in the ongoing decision making, but not at a formal IFSP team meeting.

She believes that the primary service provider model has a real advantage over the traditional medical model in that, with the medical model, each therapist does his/her own specialty with the child without a lot of coordination among the different providers – the program can be disjointed. With the primary service provider model, the team members are in frequent contact and collaborate on which services are to be provided and in what way. This way, the team is better able to deliver a more comprehensive type of service to the family. Also, with the primary service provider model, the child doesn't just get therapy once a week or so – the therapy is embedded in the child's daily routines, and both the child's parents or caregivers and the primary service provider are trained by the team members to use the recommended strategies.

22. During an interview conducted by the Complaint Investigator with Elizabeth Straka, Ph.D., Dr. Straka stated the following: She is a speech/language pathologist that consults with the Site's Northwest and Midwest provider teams. She is aware that the Site has been looking for a speech/language person to cover those areas on a consistent basis, but is also aware that there is a shortage of speech providers in Maine. That is why the Site chose to put an educator in place as the primary service provider to the family.

She was first asked to become involved with the Child in December 2008 when she was contacted by the Northwest team educator who reported having a problem connecting with the family because they only had one time slot available. She offered to get in touch with the family while they were waiting to find a primary service provider who could meet the family's scheduling needs. She had to rearrange her schedule in order to fit into the 3:00 time slot available to the Parents, and met with them and the Child on January 12, 2009. She spent the time getting to know the Child and the Parents, and explaining to the Parents how the primary service provider model worked. She was aware that Parent I wanted the medical model, but she believes Parent I understood this different approach. They talked about the Child's day and routines. The rest of the time she engaged with the Child. She interacted with the Child and watched the Child interact with Parent II. She tried some different strategies with the Child and came up with strategies to help the Child using auditory and visual support. Parent II was willing to try what she was modeling and coaching. She told the Parents that early intervention physical therapy and early intervention occupational therapy would be helpful consultations. After the initial visit Ms. Carter was assigned to act as primary service provider, and she forwarded her notes from the visit to Ms. Carter.

She had a second visit with the Child and Parent I on January 15, 2009. She thought the visit went very well. She brought with her visual supports, and facilitated Parent I bringing out the visual supports during activities, using them to allow the Child to make choices and requests. The Child responded very quickly to the visual supports. She encouraged Parent I to take pictures of objects in the child's environment. She modeled strategies for interaction with the child, and showed Parent I how to use a chewing tube with the Child. Parent I seemed okay with the session, and reported that the Child had been enjoying a bubble activity she modeled the first visit, saying that it was helpful.

At the end of the visit, she told Parent I that she would try to see the Child or go to the home as a co-provider with the primary service provider when she was in the area. Unfortunately, after the second session her husband was discovered to have a serious illness, and she had to go on medical leave. She was available to consult with the primary service provider by e-mail.

She doesn't agree that a speech/language provider needed to be the Child's primary service provider. Not all speech therapists are adept at early intervention speech services, and some educators are actually better at this. Ms. Carter has a background in communications, speech and motor, and is very skilled in this area. She thought Ms. Carter was a really good match for this family. It ultimately may be better for the Child to have a physical therapist or occupational therapist as the primary service provider, as she believes the Child's sensory and

motor skill deficits are a big part of the speech/language problem, and that the Child's low muscle tone was affecting respiration and phonation.

23. During an interview conducted by the Complaint Investigator with Lynn Ruggieri, Ms. Ruggieri stated the following: She is a special education teacher contracted with the Site. She was initially contacted about the Child in December, 2008 shortly before the winter holidays. She spoke with Parent I about scheduling a home visit, and Parent I said she wanted to be present but was only available after 2:30 on Mondays and after 3:00 the rest of the week. She told Parent I she was not usually available during those hours, but she would see what she could do. She called Parent I back right after the holiday break and told Parent I she would not be able to accommodate Parent I's schedule, but could come on Tuesday or Thursday during school hours. Parent I never suggested that the visit could take place at any earlier hour. She wrote to Ms. Wood and told her she was not going to be able to make home visits.

She recently again became involved with the family, and has made two home visits on May 21 and June 2, 2009. A third visit was scheduled for June 9, 2009 but was cancelled by Parent I due to illness. Parent I informed her at the first visit that she wants a speech therapist providing therapy, and that she filed a complaint about it. She talked with Parent I about the primary services provider model, and tried to convince her that it really can work. Those first two visits were mostly just an opportunity to get to know the family, although she did share some strategies with Parent I about facilitating communication through signing and encouraging the Child to imitate sounds. She also discussed the importance of improving the Child's attention to activities, and suggested that Parent I bring the Child back to an activity when the Child walks away.

She has exchanged e-mails with Ms. Straka and she will soon be meeting with her so they can collaborate. Ms. Straka told her that she plans to come with her on some of the home visits. She will also be going with Parent I to visit with the physical therapist so she can incorporate physical therapy activities into her work with the Child as well as the speech activities. The Child has also had an occupational therapy evaluation and they are waiting for the results to determine what additional activities might be added in that regard.

24. During an interview conducted by the Complaint Investigator with Robert Faucette, M.D., Dr. Faucette stated the following: He is a pediatrician and the Child has been his patient since she was approximately xx old. When the Child was xx old, he noted that she was not developing at a normal rate, and at xx he suggested to the Parents that they refer the Child to CDS for evaluation. He told Parent I that he believed the Child needed speech therapy, as well as work with her gross and fine motor development.

Later, Parent I reported to him that she was frustrated with how things were going with the Site. Parent I told him that the Child was not getting much in the way of services, and that the Site was not providing speech therapy. On February 11, 2009, he spoke with someone at the Site about the Child's program. He was told that there had been a change in philosophy at CDS, that it was now using an "education model" instead of a "service model." This was the first time he had heard anything about a change in the way CDS was operating. He understood the new model meant that CDS was no longer providing services to the child, but

was instead teaching parents how to get those services themselves. He then told Parent I that she might be able to get private speech services covered by her insurance and encouraged her to look into this. The insurance companies, however, sometimes don't cover services where the child has had delays from the beginning based on it being a "preexisting condition."

25. During an interview conducted by the Complaint Investigator with Susan Motta, Ms. Motta stated the following: She has been the director of the Site since April 1986. When the initial IFSP team meeting was held on November 4, 2008, the primary service plan model was still fairly new to the Site. For billing purposes, it was necessary that the IFSP be written so as to identify the specific supports and services to be provided (in this case, speech therapy), the area of specialty of the primary service provider (in this case, speech/language therapist), and the frequency and intensity of the services (60 minutes once a week). Despite the appearance of the IFSP, it was always understood that the identification of the primary service provider was fluid, as was the frequency and intensity of visits by that person or any other team members. By the time the Child's second IFSP was written on April 23, 2009, the data entry system had changed so that the services could be described as "specialized instruction," the primary service provider identified only as "early intervention provider" and the frequency and intensity described as 60 visits of 60 minutes each during the following 6 months.

With regard to making the decision which team member will act as primary service provider, the Site certainly listens to parents and tries to make everyone happy, but it is ultimately the Site's decision. Sometimes the decision is driven by logistics – which provider is available to visit the family the earliest, a matter of matching resources with needs. Once the primary service provider is identified, the other providers on the team are available to support the primary service provider and the family. The IFSP team also tries to make the decision as to intensity and frequency of services as a group. The way the Child's current IFSP is written (60 visits in 6 months) allows for more frequent visits at the beginning and then less frequent later on. It also assumes that there will be ongoing discussion between the primary service provider and the parents on this subject, so that a parent might say "I need you more (or less) often for now." The parents are also encouraged to contact the primary service provider between visits to address any new concerns.

She believes that Parent I saw that a speech/language person was identified on the initial IFSP and became fixated on this component. In actuality, the Child requires the full array of services from the team, and will benefit from the more holistic approach of a teacher. The recent IFSP contains outcomes and objectives in all modalities, not just speech. She recognizes that the providers weren't able to arrange for a visit for a while due to logistics, but then once Ms. Straka and Ms. Carter did get out there they spent a lot of time talking with Parent I about why there weren't going to be regular visits from a speech therapist. She has been encouraging Parent I to give the process more time before making a decision about the new model. She believes that Dr. Faucette did the family a disservice by encouraging the Parents to discontinue with the Site and pursue private speech therapy. She believes that if the Parents had stayed with the Site the Child would be much further ahead of where she is now.

She spoke with Dr. Faucette about the Child on February 11, 2009. Dr. Faucette was unfamiliar with the primary service provider model, and kept reminding her that he had written a prescription for the Child to receive speech therapy. She thinks that under the old model, doctors would write out prescriptions and then it appeared to them that CDS would carry out what they wrote; it looked to them like they were calling the shots. The Site has had conversations with and sent out materials to physicians about the primary service provider model, but she believes that there needs to be more training in the state for physicians and other professionals to familiarize them with the new system.

She agrees that the objectives written into the Child's initial IFSP were not measurable. Staff members that are writing IFSPs are told they should use a family's language in developing outcomes and objectives, but families typically don't think in terms that are measurable. Also, parents often choose goals that are very far away from where the child is currently. Additionally, with the primary service provider model, it is often difficult to come up with measurable objectives after having spent only a short time evaluating the child; appropriate objectives often only become apparent after the work with the family has begun. She believes that the Site needs training on writing outcomes and objectives that are parent derived but clinically measurable.

26. During an interview conducted by the Complaint Investigator with Parent I, Parent I stated the following: The Parents were initially referred to CDS by Dr. Faucette for speech therapy, and that was their focus. She was pleased when the IFSP listed a speech therapist as the primary service provider and specified weekly speech therapy sessions. When Ms. Straka came to the home, she thought Ms. Straka was the primary service provider, but Ms. Straka told them she only consults and doesn't have a direct caseload. She then contacted the Site and spoke to Ms. Wood and Ms. Motta. She was told there were no speech therapists in her area, so the Child's primary service provider would have to be a teacher. She offered to travel outside her area and bring the Child to a speech therapist, but Ms. Wood and Ms. Motta wouldn't agree to this.

She thought the two sessions with Ms. Straka were good. Ms. Straka showed her some strategies and seemed to know her field. Ms. Straka also told her that she would like to continue to come out to the home along with the primary service provider, but then Ms. Straka's family medical emergency came up and Ms. Straka was no longer available. Ms. Carter came to the home next, but although Ms. Carter was nice she definitely noticed a difference between Ms. Carter and Ms. Straka in terms of their depth of knowledge about speech and language. Ms. Carter didn't seem to have as much insight into why the Child was having difficulty communicating and she could tell Ms. Carter was not an expert in the speech/language field. Ms. Carter did a lot of playing with the child, and was concentrating on holding up a picture while saying the word for the object in the picture. Ms. Carter used a lot of picture books and had a binder with photos of people and objects in the Child's world. She also played music and wanted the Child to blow cotton balls across the table. She didn't feel like Ms. Carter was providing enough for the Child, and as far as she could tell Ms. Carter was not even consulting with a speech therapist.

At that point, she spoke with Dr. Faucette and told him that the Child was not seeing a speech therapist and was not getting enough services. Dr. Faucette spoke with someone at the Site and then told her that the Site was now using the "teacher model" and was not providing services itself. Dr. Faucette said he didn't think this was good enough for the Child and recommended that she get speech therapy for the Child privately. She told the Site she was discontinuing their services and began taking the Child to see Ms. Kuhl.

When the Child goes to Ms. Kuhl, all the toys are out of the Child's reach. If the Child wants one of them the Child has to make a sign or sound to get it. Every time she goes to see Ms. Kuhl she learns something about why the Child isn't talking. Ms. Kuhl doesn't agree with the people at the Site that there is a strong physical component to the Child's speech problem. Ms. Kuhl describes the Child as "laid back" – not bothered when someone takes something away from her or makes it difficult for her to get something. Ms. Kuhl thinks the Child is stubborn, and not willing to do the work they are asking her to do. Ms. Kuhl does give her strategies to use with the Child between visits, like touching the Child's mouth to remind her how to make certain sounds. A lot of the time with Ms. Kuhl is spent talking about why the Child is the way she is. She believes the Child is making progress with Ms. Kuhl and is headed in the right direction, but it's going slowly. The Child is better at signaling "more" and "yes," and she now looks at the Parents in a way that indicates she knows they understand her.

The new primary service provider, Lynn Ruggieri, has been to the home two or three times, but hasn't really given her any strategies to use with the Child. The Child also had a physical therapy evaluation. She recognizes that the Child has low muscle tone and understands the benefits of physical therapy. She has no experience with occupational therapy, so she's not sure what that would consist of. If, however, there is a determination that the Child needs occupational therapy, then she wants that service to be provided by an actual occupational therapist. She doesn't understand how a teacher can be doing speech, physical therapy and occupational therapy – areas outside the teacher's training and expertise – and do them all in one hour.

She has found working with the Site to be very difficult. It has been like pulling teeth to get anything done or get questions answered. Every time someone from the Site came to the home she would tell them she didn't understand how a person could give speech therapy without proper certification in the specialty. She doesn't believe that the primary service provider model is right for the Child, though perhaps it's the right model for other children. She knows that the law puts a priority on the natural environment, but when a home visit can't be scheduled for some reason, the Site should be more flexible.

She was never told that the delay in getting services started was because of her schedule. She works during the day and is only available after 2:30. She wanted to be there to meet the service provider at the beginning. She thought the delay was due to Ms. Wood not calling people, so she got phone numbers and made the calls herself. When she spoke to Ms. Ruggieri and learned that Ms. Ruggieri was only available during school hours she knew it wasn't going to work. Then when Ms. Carter called on December 22, 2008, Ms. Carter told her that she couldn't start right away because the IFSP specified a speech person and therefore

the Site wouldn't be able to pay her. She didn't hear anything further until after the winter holidays. She had the impression that things weren't happening because people just weren't trying.

With regard to the February 2, 2009 amendment to the IFSP, she had spoken with Ms. Straka about physical therapy when Ms. Straka came to her home. Her understanding was that the physical therapist would evaluate the child, and then, if the Child was determined to need the service, would provide physical therapy and the therapist would have a say in how often it would be provided. Ms. Straka did not say the physical therapy would be a support service, or that it would only be twice a quarter, and she never had an opportunity to comment on these things until after she received the amendment.

27. During an interview conducted by the Complaint Investigator with Parent II, Parent II stated the following: The Parents are supposed to be part of the IFSP team, but the providers meet on the side and that is where all the decisions are made. Ms. Motta even told them this is how it works. The Parents didn't have any direct input into the decision to add physical therapy to the IFSP on February 2, 2009. He doesn't remember there being any discussion about what physical therapy would be specifically: what would be done and who would be providing it. Since the physical therapy evaluation, the physical therapist has been conferring with the other providers while not including the Parents.

There was a meeting on June 5, 2009 to discuss physical therapy and the Parents were given an opportunity to be heard, but it seemed like the rest of the team already had strong opinions. He doesn't think anything the Parents said made a difference. The Parents were still advocating for more speech therapy. The team decided to add 12 visits total with the physical therapist as a consulting service. Some of those visits will be in the physical therapy clinic rather than at home, because there is equipment at the clinic that would not be available in the home. He doesn't understand why the team would allow that, but not allow the Parents to bring the child to the speech therapist's office when there wasn't a speech therapist available to come to the home.

VIII. Conclusions

Allegation #1: Failure to provide early intervention services designed to meet the developmental needs of the Child in violation of MUSER §X.1
NO VIOLATION FOUND

MUSER §X.1.A(2) describes a system of delivering early intervention services termed "primary service provision" which entails the "provision of services that are embedded in everyday routines and activities by one principal service provider, in the child's natural environment at home or in the community." One key to this model is the fact that services are "embedded in everyday routines and activities," so that the child receives the benefit of the services not just for the 30 minutes or 60 minutes that a provider is present, but throughout the day. Thus, a complaint that considers the IFSP's provision of only one 60 minute visit a week by a provider insufficient may be overlooking the emphasis on the child's receiving the benefits of instruction during the entire rest of the week.

Another principal element of this system is the consultation services described in MUSER §X.1.A(1). Consultation services are provided both to families and teachers by the various early intervention providers. An IFSP can then specify that, in addition to the primary provider, the family will receive the benefit of consultation services by additional providers from one or more disciplines.

The Site implemented these regulations by forming teams of providers: a speech/language pathologist, a physical therapist, an occupational therapist and a special education teacher. At any given time, one team member would act as the primary provider, with one or more of the other team members acting as consultants to the family and to the primary provider. The consulting provider might visit the family with the primary provider, or meet separately with the family or primary provider. This arrangement is consistent with the federal IDEA Part C regulations, at 34 CFR §303.12(c):

> General role of service providers. To the extent appropriate, service providers in each area of early intervention services included in paragraph (d) of this section are responsible for--
> (1) Consulting with parents, other service providers, and representatives of appropriate community agencies to ensure the effective provision of services in that area;
> (2) Training parents and others regarding the provision of those services; and
> (3) Participating in the multidisciplinary team's assessment of a child and the child's family, and in the development of integrated goals and outcomes for the individualized family service plan.

This case presents a useful illustration of the operation of this system. The IFSP team responded to the immediate concerns of the Parents by designating a speech/language pathologist as primary provider (although due to a scarcity of providers in this discipline the primary was shifted to a teacher), with consultation by an occupational therapist. After the speech provider spent some time with the Child in the family's home, she consulted with the primary provider regarding speech and language activities. The speech provider also formed an impression that there was a marked physical component involved in the Child's speech delay, and discussed with both the Parent and the primary provider the importance of involving a physical therapist in the Child's care. Appointments were scheduled for the family to meet with both the physical therapist (at her office in order to avoid additional delay) and occupational therapist, with the expectation that after those had taken place the entire team would meet again to take another look at the Child's overall program. In the meantime, the primary provider continued to facilitate speech and language activities with the Child and the family in the home.

The foregoing suggests that the Site was indeed providing services "designed to meet the developmental needs of" the Child in natural environments to the maximum extent appropriate, as required by MUSER §X.1.

> **Allegation #2:** Failure to include in the Child's IFSP of November 4, 2008 a statement of measurable results or outcomes expected to be achieved and the criteria,

procedures, and timelines used to determine the degree to which progress toward achieving the results or outcomes is being made in violation of MUSER §IX.1.D(3)
Allegation #7: Failure to include in the Child's IFSP of April 23, 2009 a statement of measurable results or outcomes expected to be achieved and the criteria, procedures, and timelines used to determine the degree to which progress toward achieving the results or outcomes is being made in violation of MUSER §IX.1.D(3)
VIOLATION FOUND

Ms. Motta readily conceded that many of the outcomes and objectives listed in the Child's IFSPs were not measurable. Some of the more blatant examples include: the Child will use signs or gestures to communicate; the Child will use more consonant vowel combinations, the Child will decrease drooling and the Child will walk on uneven ground.

When the IFSP uses terms such as "more" or "decrease," benchmarks for comparison or numerical targets must be provided in order for the objectives to be measurable. Similarly, "using signs or gestures," or "walking on uneven ground" lack specificity as to number, kind, length and duration in order to be measurable. Without the ability to measure, the team cannot accurately assess whether the Child is making adequate progress.

While the preference for using parents' language in formulating outcomes and objectives is understandable, the early intervention professionals must still shape that language into workable, measurable bits of behavior. Likewise, while it may be true that over time the ideas about which outcomes and objectives are most important may change from what they were at the initial IFSP team meeting, the IFSP teams are able to revise existing measures when appropriate.

Allegation #3: Failure to provide early intervention services on or near the initiation date set forth in the Child's IFSP of November 4, 2008 in violation of MUSER §IX.1.D (6) and 34 CFR §303.344(f)(1)
NO VIOLATION FOUND

The projected dates for the initiation of services in the Child's IFSP were November 4, 2008. Under 34 CFR §303.344(f)(1), the IFSP must include projected dates for initiation of services "as soon as possible after the IFSP meeting." Although the regulations do not directly address the date when services are actually to be initiated, it may be fairly inferred from this language that they are expected to begin on or about the projected dates in the IFSP. Here, services to the Child did not begin until January 12, 2009, more than 60 days after the projected dates in the IFSP.

As a preliminary matter, it was unrealistic for the Site to list the date of the IFSP team meeting as the projected date for initiation of services. It took 15 days just to write up the IFSP, and then began the process of identifying the person who would act as primary service provider. Use of a more realistic date would have helped avoid creating expectations in the Parents that were likely to not be met. The Site then encountered difficulties locating a speech therapist able to act as primary service provider, resulting in the determination to substitute a teacher in that role. There followed a further delay caused by Parent I's very

specific time requirements, necessitating a further referral to a different teacher. The fact that the winter holidays were happening in the middle of all this led to still further delay.

Under all the circumstances, it appears that the site made reasonable efforts to get services under way, and is not found to have violated the regulatory requirement of starting services "as soon as possible after the IFSP meeting."

> **Allegation #4:** Failure to fully and adequately implement the child's IFSP of November 4, 2008 with respect to provision of speech therapy and of a speech therapist as the primary service provider in violation of MUSER §§X.1 and X.1.A(2)
> **VIOLATION FOUND**

There is no dispute that the Child's initial IFSP identified the primary service provider as a speech/language pathologist who would provide speech therapy services, and that the Site was unable to locate a provider from that discipline. The Site's failure to provide the services specified in the IFSP constitutes a technical violation. Once it became apparent, however, that there was no speech/language pathologist available to act as primary provider, the Site determined that it was appropriate to use a teacher in that position instead. Although Parent I did not agree with the decision, the choice is ultimately that of the Site and the Site should have proceeded to amend the IFSP to reflect that determination. In any event, the Site moved ahead with due haste to identify a teacher able to meet the Parents' scheduling requirements, and services began to be provided shortly thereafter. There was no evidence that the plan developed by the IFSP team was not working, or that the Child was not making progress toward the IFSP goals. Accordingly, no compensatory services will be required in connection with this violation.

It further bears noting that the speech/language pathologist (Ms. Straka), after visiting with the family on two occasions, believed that the Child's speech delay had a physical component and that the primary provider, whoever that might be, would require consultation from the team's physical therapist and possibly occupational therapist as well. A teacher was at least as well suited as a speech/language pathologist to synthesize all these different disciplines.

> **Allegation #5:** Failure to adequately consider the concerns of the parent in the IFSP decision making process before making the modifications to the Child's early intervention program described in the Written Notice of February 2, 2009 in violation of MUSER §§VI.1.B(1)(a) and VI.1.C
> **Allegation #10:** Failure to include the Child's parents in decision-making regarding the specific early intervention services to be provided to the Child and the frequency, intensity and method of delivering those services in violation of MUSER §§ VI.1.B(1)(a), VI.1.C and Appendix 1, 34 CFR §300.501(b)
> **VIOLATION FOUND**

MUSER §§ VI.1.B(1)(a) and VI.1.C provide that a child's parents are to be included as members of the IFSP team, and must participate in annual and periodic reviews of the child's IFSP. This requirement for parental participation does not preclude staffings by the provider teams regarding the nature and method of delivery of services to a child. The providers might

decide, for example, which strategies ought to be implemented, or that the occupational therapist should go with the primary service provider on the next home visit. What they do preclude are meetings (or e-mails) among providers where firm determinations are made regarding specific elements of the child's IFSP (e.g., area of practice of the primary service provider, intensity of services), which determinations are then presented to the parents for their comments.

When Ms. Straka had her two visits with the family in January 2009, she discussed with the Parents her belief that the Child would benefit from physical therapy consultation, and that there was a relationship between the Child's physical issues and speech issues. The Parents appeared agreeable to adding this service. Ms. Straka then made a recommendation to the provider team and case manager for adding physical therapy to the IFSP for two visits per quarter to allow the physical therapist to work with the Child, with the understanding that after those two sessions, the full IFSP team would meet to review the Child's program.

Based on this recommendation, the case manager prepared a written notice and IFSP amendment specifying physical therapy as a support at two times per quarter and delivered them to the Parents. Parent I rejected the amendment to the IFSP because she believed physical therapy services should be provided as direct service for 60 minutes once per week. More importantly, Parent I did not feel that she had had the opportunity to be heard on this subject, or to hear what the other team members were saying. Although 34 CFR §303.342(b)(2) provides that a periodic review of the IFSP may be carried out by "a meeting or by other means that is acceptable to the parents and other participants," a general conversation between a parent and a provider, followed by an e-mail from the provider to other members of the provider team, is not an adequate alternative means. Parent I, in her conversation with Ms. Straka, was not aware that she was participating in a decision-making process, and was not presented with the specific proposal ultimately endorsed so that she could comment on it.

The Parents similarly felt that the providers had already met and reached firm conclusions about physical therapy services prior to the June 5, 2009 meeting. While the fact that a meeting was held before revision to the IFSP represents an improvement over the process leading to the February 2, 2009 amendment, the Site is cautioned against the providers holding a "pre-meeting meeting" where the "real" decisions are made.

Note is also taken, on the other hand, that the Parents at all times resisted the multidisciplinary developmental approach that the Site believed was appropriate for the Child. From the outset, the Parents were focused solely on direct therapy, first with speech and then with both speech and physical therapy. The Site struggled to get a program in place despite the Parents' significant limitations on the Child's availability, and then the Parents withdrew the Child from services just as the Site's program was falling into place. The Parents then returned the Child to the Site, forcing the Site to build a program anew. The Parents' intransigent opposition to the model being utilized by the Site no doubt discouraged the very kind of collaboration the parents are seeking from the providers.

Allegation #6: Failure to provide requested education records regarding delivery of services to the Child in violation of MUSER §XIV.3
VIOLATION FOUND

MUSER §XIV.3 provides that each school administrative unit must "permit parents to inspect and review any education records relating to their child which are collected, maintained, or used" by it in connection with the special education regulations. §XIV.3.C expressly provides that the parents may have their representative inspect and review those records. The regulation further provides that the school administrative unit must comply with a request without unnecessary delay, and in no case more than 45 days after the request was made.

The records requested by Ms. Farber in her March 26, 2009 letter were records collected and maintained by the Site in connection with its delivery of early intervention services, and as such the Parents had a right to have their representative review them. The explanation provided for the delay from the date of the request until May 30, 2009 when the documents were provided, two months later, was that it was an oversight. Even assuming that the lack of response was not intentional, it nevertheless does not comply with the requirement of a response within 45 days from when the request was made.

Allegation #8: Failure to include in the Child's IFSP of April 23, 2009 a statement of the specific early intervention services to be provided and the frequency, intensity and method of delivering those services in violation of MUSER §§IX.1.D(4) and X.1.A(4)
NO **VIOLATION FOUND**

MUSER §IX.1.D describes the required contents of an IFSP, including (at §IX.1.D(4)) a "statement of specific early intervention services…necessary to meet the unique needs of the infant or toddler and the family, including the frequency, intensity, and method of delivering services." (emphasis added). MUSER § X.1.A(4) similarly provides that early intervention services provided to a child "shall be specified in the child's IFSP." (emphasis added).

The Child's initial IFSP clearly met the above regulatory requirements, by specifying speech therapy for 60 minutes once a week and occupation therapy as a consulting service for 60 minutes once a month. According to Ms. Motta, this presentation was dictated by billing and data entry constraints that were resolved by the time of the April 23, 2009 IFSP, so that the Site could then write that IFSP to provide for "specialized instruction" for 60 minutes 60 times over a 6 month period. "Special instruction" is particularly defined in the regulation (MUSER § X.1.A) to include "the design of learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas…that leads to achieving the outcomes" in the child's IFSP, and this designation satisfies the specificity requirement. It is expected that most IFSPs will use this designation to describe the type of service to be provided by the primary service provider, with consultation services to be provided by representatives of the other disciplines. Of course, in a given case, the IFSP team may decide to provide direct speech/language, physical or occupational therapy or some other service in place of or in addition to special instruction, and this will be written on a separate line in the IFSP. Where such services will be provided in a clinical setting rather than in the natural environment, the team will also present the justification for this in the IFSP,

The designation of frequency and intensity of services used by the Site in the April 23, 2009 IFSP is likewise sufficiently specific. It identifies the duration of instruction sessions and the number of sessions during the period, while retaining flexibility to permit an increase or decrease in the number of sessions per week as the Child's needs dictate. In the event that the specified 60 sessions are delivered prior to the expiration of the period, the IFSP team is able, where appropriate, to amend the IFSP to provide additional sessions.

Allegation #9: Failure to identify in the Child's IFSP of April 23, 2009 the professional discipline of the primary service provider in violation of MUSER §X.1.A(2)
VIOLATION FOUND

MUSER § X.1.A(2) states that the child's primary service provider "will represent one of a variety of professional disciplines, as determined necessary by the IFSP team to facilitate the child's progress towards specific IFSP outcomes." While perhaps not as clear as with regard to the specificity of services to be provided, this language suggests that the IFSP team (including the parents) is to make a determination as to the professional discipline of the primary provider. The Child's April 23, 2009 IFSP indicates only that the primary provider will be an "early intervention provider." When the Parents received this document, they had no way of knowing the discipline of the primary provider, at least at the outset. Furthermore, the designation "early intervention provider" does not reference a state-approved, certified or licensed professional discipline.

It is anticipated that in most instances an IFSP team will designate a teacher as the primary service provider. While flexibility is of great value in this endeavor, and a change in circumstances may lead the IFSP team to wish to change the discipline of the primary provider there are procedures in place that would allow the IFSP team to do so. At any given time, however, the primary provider's discipline should be ascertainable by reference to the IFSP.

IX. Corrective Action Plan

1. The Site shall arrange to have a State IEU-facilitated professional training conducted for its staff on the following subjects: writing measurable outcomes and objectives; properly recording IFSP team determinations on an IFSP form using the primary service provider model; procedures for amending an IFSP; and including parents in IFSP decision making. Documentation of the professional training shall include: the name and qualifications of the presenter; an agenda of the training; hand-outs for the training; names and job titles of those who attended the training; and anonymous evaluations of the training. The Site will submit this documentation to the Due Process Office, the Parents and the advocate.

2. The Site shall issue a written memorandum to all staff responsible for responding to requests for special education documents regarding the responsibility to comply with Maine Special Education Regulations regarding such requests. The Site will submit a copy of the

written memorandum, together with a list of the names and job titles of all those to whom the memorandum was issued, to the Due Process Office, the Parents and the advocate.