

**BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA**

In the Matter of:

PETITIONER,

vs.

EASTERN LOS ANGELES REGIONAL CENTER,

Respondent.

Case No. 2014080400

California Early Intervention
Services Act (Government Code
§ 95000 et seq)

DECISION

This matter was heard by Glynda B. Gomez, Administrative Law Judge with the Office of Administrative Hearings, on August 25, 2014, in Alhambra, California. Petitioner¹ was represented by his mother (Mother) and father (Father) (collectively, Parents). The Eastern Los Angeles Regional Center (ELARC or Respondent) was represented by Carmen Vazquez, Early Start Program Manager.

Oral and documentary evidence was received, and argument was heard. The record was closed, and the matter was submitted for decision on August 25, 2014.

ISSUE

Whether ELARC must fund three hours of speech and language therapy for Petitioner each week.

FACTUAL FINDINGS

1. Petitioner is a 33 month old girl. Petitioner was referred to ELARC's Early Start Program² based on communication delays. Petitioner lives with her parents and two older sisters, ages 4 and 5. Petitioner is affectionate, likes to play with her sisters and engage in outdoor sports with her family.

¹ The consumer and her parents are referred to as "Petitioner" and "Mother", "Father" or "Parents" to protect their privacy.

² "Early Start" is another name for the California Early Intervention Services Act (Gov. Code, § 95000 et seq.)

2. Petitioner's Individualized Family Service Plan (IFSP) dated June 15, 2014 contains four outcomes as follows:

- (1) [Petitioner] will remain in stable health;
- (2) [Petitioner] will transition out of Early Start services at age three;
- (3) [Petitioner] will improve her speech and language development with her sisters and parents; and
- (4) [Petitioner] will improve her expressive language development to express her needs and wants. (Exhibit G)

3. Based upon a psychological assessment and speech and language assessment by an ELARC vendored speech and language pathologist and psychologist, and pursuant to the IFSP, ELARC agreed to provide speech therapy to Petitioner for one hour once per week (1 hour total) with ELARC vendor, DG Therapy Group, for the period of January 1, 2014 to June 30, 2014. Effective July 1, 2014, and continuing through November 29, 2014, ELARC agreed to increase Petitioner's speech and language therapy to one hour, twice per week (2 hours total) based upon recommendations from DG Therapy Group. (Exhibit G) Petitioner's parents both credibly testified about her tremendous progress in speech therapy and the increase in her vocabulary since the increase in therapy time. Petitioner's father expressed his concern about the 5 to 15 minutes of therapy time each session that is typically consumed with administrative matters and getting Petitioner to settle in and engage in a therapy session.

4. Mandy M. DeArmond (DeArmond), a speech and language pathologist working with DG Therapy, has been Petitioner's speech and language pathologist for eight months. In a Progress Report/Request to Increase dated July 29, 2014, DeArmond requested authorization from ELARC to increase Petitioner's speech and language therapy from twice per week (2 hours total) to three times per week (3 hours total). (Exhibit F)

5. DeArmond noted that Petitioner had shown greater progress with the increase from one to two hours of therapy per week and her "compliance and willingness" to engage in therapy had improved. In her report, DeArmond opined that Petitioner had "significant difficulties with speech sound sequencing." DeArmond noted that Petitioner requires "numerous repetitions of a two-syllable word" and "there is a significant amount of variability in her production across trials of the same word." DeArmond also noted that Petitioner was compliant and willing to complete therapy tasks on a regular basis including high frequency speech repetition drills. Based upon Petitioner's progress, willingness, and severe deficit, DeArmond recommended that Petitioner's therapy be increased to three one-hour sessions per week. (Exhibit F)

6. As support for her recommendation, DeArmond wrote that:

[Petitioner] is showing characteristics associated with Childhood Apraxia of Speech. ASHA (American Speech and Hearing Association) states that research indicates that children demonstrating difficulties with motor speech planning have more success when they receive frequent and intensive treatment (3-5 times a week). In addition to [Petitioner's] speech

and motor planning difficulties, she continues to show delays in her receptive language skills. Therapy will target the aforementioned areas of deficit with emphasis on intensive practice with speech sound sequencing. (Exhibit F)

7. On July 31, 2014, ELARC, through its Early Intervention Supervisor Noriko Ikoma (Ikoma), provided Petitioner with a Notice of Proposed Action (NOPA) which provided notice of ELARC's intent to deny the request for an increase in speech and language services to three times per week because ELARC had determined that Petitioner was receiving the appropriate services to enhance her speech and language skills through the speech and language therapy provided by DG Therapy (two one-hours sessions per week) and attendance at the Infant program at the Tracy Infant Center. According to the NOPA, on July 30, 2014, ELARC speech consultant Myrna Ramirez provided a recommendation to the interdisciplinary team as follows: "An increase in speech is not recommended at this time. If SLP wants more frequency/intensive treatment the current 2 hours can be broken down into 4/30 minute sessions."³ Petitioner's parents filed a fair hearing request appealing ELARC's NOPA on August 8, 2014. (Exhibit A)

8. Myrna Ramirez (Ramirez), a certified speech and language pathologist with 20 years of experience, is an ELARC consultant. She reviewed the Progress Report/Request for Increase and spoke to DeArmond by telephone. Ramirez has never met Petitioner or her family. The extent of her knowledge of Petitioner is the information contained in the Progress Report/Request for Increase, a review of ELARC's file, and a telephone conversation with DeArmond.

9. In a memorandum dated August 18, 2014, Ramirez described "Childhood Apraxia of Speech" (CAS) as a neurological childhood speech sound disorder in which the precision and consistency of movements underlying speech are impaired in the absence of neuromuscular deficits (e.g. abnormal reflexes, abnormal tone.) Ramirez noted that CAS may occur as a result of known neurological impairment, in or as an idiopathic neurogenic speech sound disorder. The core impairment in planning and/or programming spatiotemporal parameters of movement sequences results in errors in speech sound production and prosody. Ramirez noted that CAS is formally diagnosed by a certified speech and language pathologist after an evaluation which assesses the child's oral-motor abilities, melody of speech, and speech sound development. Such an assessment consists of review of case history, speech characteristics, parent report, oral motor evaluation, and informal and formal testing. (Exhibit C)

10. In the August 18, 2014 memorandum, Ramirez wrote:

The request is being denied because the SLP [Speech and Language Pathologist DeArmond] has not completed a comprehensive evaluation in order to render the diagnosis of CAS and therefore the treating SLP cannot make treatment recommendations for a disorder that has not been formally diagnosed. Secondly, according to the research on CAS, shorter and more frequent sessions are

³ The referenced July 30, 2014 recommendations were not offered into evidence at the fair hearing.

recommended in treating CAS and the treating SLP has not attempted to implement this treatment model prior to requesting an increase in a service. (Exhibit C)

11. In reaching her conclusion, Ramirez relied upon excerpts form a Technical Report by the American Speech-Language and Hearing Association (ASHA) regarding the treatment of CAS (Exhibit D). In relevant part the ASHA Technical Report excerpt provides:

Given the need for repetitive planning, programming, and production practice in motor speech disorders, clinical sources stress the need for individualized treatment of [CAS], especially for children with very little functional communication. There is emerging research support for the need to provide three to five individual sessions per week for children with apraxia as compared to the traditional, less intensive, one to two sessions per week....Individual differences among children will also underlie rationale for changing the form, content, and intensity of treatment throughout the course of intervention.

12. Petitioner has not received a formal diagnosis of CAS. Petitioner's parents and ELARC agree that an assessment for CAS would be useful. ELARC acknowledged that any such assessment for CAS would generally be conducted by the speech and language pathologist that had been working with the consumer. In this case, the assessor would be DeArmand. Although Petitioner agrees that an assessment would be useful, Petitioner does not want an assessment in lieu of the requested one hour per week increase in therapy because of concerns about Petitioner missing important opportunities for progress at a crucial time in her development. Petitioner's parents are also reluctant to increase the frequency of therapy to four times a week with a concomitant reduction to 30 minutes per session (2 hours total) because of the 5-15 minutes per session that is typically consumed by administrative matters and waiting for Petitioner to engage in a therapy session.

LEGAL CONCLUSIONS

1. Jurisdiction for this case is governed by the Individuals with Disabilities Education Act (IDEA), which is federal law (20 U.S.C. § 1431 et seq.); and the California Early Intervention Services Act (CEISA) (Gov. Code, § 95000 et seq.), which is state law that supplements the IDEA. Each act is accompanied by pertinent regulations.

2. The burden of persuasion to establish entitlement to services not agreed upon by a regional center is on a petitioner's family in an administrative matter under the IDEA. (See, e.g., *Schaffer v. Weast* (2005) 546 U.S. 49, 51; see also, 34 C.F.R. § 303.425(b) (1999).)

3. The California Legislature has found that early intervention services represent an investment of resources, "in that these services reduce the ultimate costs to our society, by minimizing the need for special education and related services in later school years and by minimizing the likelihood of institutionalization." (Gov. Code, § 95001, subd. (a)(2).) The Legislature has recognized that time is of the essence and that "[t]he earlier intervention is

started, the greater is the ultimate cost-effectiveness and the higher is the educational attainment and quality of life achieved by children with disabilities.” (*Id.*)

4. Early intervention services are defined as those services “designed to meet the developmental needs of each eligible infant or toddler and the needs of the family related to the infant or toddler’s development.” (20 U.S.C. § 1432(4)(A); Cal. Code Regs., tit. 17, § 52000, subd. (b)(12).)

5. A regional center service coordinator shall continuously seek the appropriate services and service providers necessary to enhance the development of each infant or toddler being served for the duration of the infant’s or toddler’s eligibility. (Cal. Code Regs., tit. 17, § 52121, subd. (a)(6).) The service coordinator shall also monitor the delivery of services and the degree to which progress toward achieving outcomes is being made through the periodic review of the IFSP. (Cal. Code Regs., tit. 17, § 52121, subd. (a)(9).) An initial individualized family service plan (IFSP) shall be developed within 45 days of eligibility, and thereafter reviewed every six months or more frequently if a parent so requests. (Cal. Code Regs., tit. 17, § 52102, subd. (b).)

6. Pursuant to Government Code section 95004, subdivision (a), the provisions of the Lanterman Act, located at Welfare and Institutions Code sections 4500 through 4846, also apply to the Early Start program. Under the Lanterman Act, the equivalent of an IFSP is the individual program plan (IPP). The planning process relative to an IPP (and therefore an IFSP by analogy) is supposed to be collaborative. (Welf. & Inst. Code, § 4646.) The IPP is created after a conference consisting of the consumer and/or his family, regional center representatives and other appropriate participants. Services and supports are only funded by the regional center after such collaboration and where both parties agree. (Welf. & Inst. Code, §§ 4646 & 4648.)

7. Here, ELARC has provided funding for speech and language therapy for Petitioner’s severe communication deficits. The speech and language therapy is provided because Petitioner has an assessed need for speech and language therapy and she benefits from the services provided. Although she has neither been specifically assessed for CAS nor diagnosed with CAS, her speech therapist has identified some characteristics of CAS. Consistent with the literature cited by ELARC’s speech and language consultant, Petitioner’s speech and language therapist, DeArmand, requested an additional increase in frequency and duration of therapy to provide more intense therapy to Petitioner. Neither Ramirez nor DeArmand testified at hearing, so no findings are made as to the credibility of either. However, DeArmand, having served as Petitioner’s speech therapist for eight months, has superior knowledge of Petitioner’s needs, progress and responsiveness to various treatment modalities. In contrast, ELARC’s consultant Ramirez has never met or even seen Petitioner. Because DeArmand has not only the professional expertise of by virtue of her certification as a speech and language pathologist, but also the actual experience of eight months of therapy with Petitioner, her analysis of Petitioner’s needs is more persuasive than that of Ramirez.

8. Petitioner has established by a preponderance of the evidence that she needs three hours per week of speech and language therapy to address her needs. Petitioner’s needs may ultimately be related to a diagnosis of CAS, but a specific assessment for CAS must be

conducted before a formal diagnosis is made. Both parties agreed at hearing that an assessment for CAS should be conducted. ELARC has established that the literature and current practice surrounding the treatment of CAS support provision of frequent and intense therapy sessions rather than weekly lengthy sessions. Based on the foregoing, Petitioner's needs for additional therapy and ELARC's concerns about the duration of each session shall be addressed by the provision of three hours per week of speech and language therapy delivered in four 45-minute sessions per month. In addition, Petitioner shall be formally assessed to determine whether she has CAS.

ORDER

ELARC shall fund four-45 minute sessions per week of speech and language therapy for Petitioner until such time as an assessment for Childhood Apraxia of Speech and recommendations for further treatment are made or Petitioner is no longer eligible for Early Intervention Services, whichever is first.

DATED: September 4, 2014

_____/s/_____
Glynda B. Gomez
Administrative Law Judge
Office of Administrative Hearings