Original: 2122

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10 October 2000

Mr. Mel Knowlton
Office Of Mental Retardation
PO Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Knowlton:

Thank you for the opportunity to provide written testimony for the proposed Regulations for Early Intervention.

I am a teacher providing special instruction for children, birth to three and their families in the city of Philadelphia. I work for Special People In the Northeast, Inc. I am also the parent of a daughter with Down Syndrome who received early intervention services many years ago. She is now eighteen.

My major concern is for families whose children are transitioning at age three. Transitions don't always go smoothly. A child with special needs ought to be insured of a place in a center-based program when he or she turns three, or even before, if necessary. When my daughter received e.i. services, there *was* no transition. She stayed at her center until it was time to go to Kindergarten. Perhaps we should go back to the old way.

Also, for the initial MDE assessments, MDE means *multi-disciplinary evaluation.* This means to me that there should be two professionals on the team in addition to a service coordinator. This provides a broader scope to assess the child's needs.

Further, I'd like to speak to the educational requirements for the "early interventionist" I don't feel that a Bachelor's Degree is necessary. What is necessary is dedication and talent. Two of my daughter's best teachers in early intervention did not have Bachelor's Degrees. They were wonderful and creative, and saw to my daughter's development. They *cared* about what they were doing and were well-trained by Ken-Crest. What's wrong with hiring good people and training them well?

Thank you for your consideration.

Sincerely,

R. Audrey McGovern

R. Audrey McGovern
Infant/Child Development Specialist
1105 Herbert Street
Philadelphia, PA 19124

Original: 2122

Mr. Mel Knowlton Program Chief
Division of Policy Development and
Program Support
Dept of Public Welfare
Office of MR
Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Knowlton,

I recently attended the public testimony session in Philadelphia County and also, in July, submitted testimony at the forum in King of Prussia. The following additional comments were to be included within a submitted testimony on October 2, but due to time restraints they were only touched upon. I therefore wish to further elaborate on this issue of concern.

My comments are in response to the directive that the IFSP is not to be interrupted. There are certain elements within this generalized statement, which I feel, need further clarification. As a legal document, I realize that the services agreed upon, with set frequencies and duration, and thus verified through signature, are entered upon in good faith by all team participants.
At times, nonetheless, events do occur which threaten to temporarily interrupt these services. Currently, within our agency, if therapists must cancel an appointment with a family, because of a scheduling conflict, it is the responsibility of the therapist to coordinate time with the family to make up this service within the current month if at all possible. Likewise if a provider of services is ill, I believe make-up sessions should be scheduled within a timely manner.

My concern is for the following reasons for an occasional interruption:

The first instance being when the family cancels due to child or family illness or a commitment conflict, and attempts to make up services within that week is not possible; or even more significant, when a therapist or developmental specialist arrives to a home and no one is there during scheduled times.

Secondly, the times of vacation by the family. It is certainly the rights of the families to take vacations, as it is for our therapists. On this topic I would like to add that accrued vacation time is a legal right which full time employees have, and one should not be penalized for exercising this right. If provider employees are being paid for vacation hours taken, and then are asked to work overtime to make up missed therapy hours, should they not get paid for the overtime required after the vacation?

It is not reasonable either to assume that every unexpected cancellation will be addressed through addendum of services. With this recommendation, many common interruptions would be missed. The idea of having substitutes provide services as the remedy to

guaranteeing continuation of the IFSP, has been proposed as a solution. As previously a developmental specialist, and now Program Supervisor, I am of the opinion that the rapport established between children, family members and therapists is unique and cannot easily be met by those unfamiliar with the child in question, no matter how skilled a professional. I fear that the substitute's time spent in the home would be counterproductive to the child's progress and to the IFSP purpose overall. It seems unnecessary to me to waste valuable therapy and family time for the sake of an occasional missed week, especially if the family has no problem with it.

My suggestion is to make clear in the final policies that if services are interrupted by family circumstances, attempts in good faith should be made to make up services where possible, but that this is not a legally binding directive. Interruptions by provider agency personnel (excluding vacations) should be made up at the request of the family. Please consider that the majority of families served are actively involved in the development of their children and are capable of follow through in general, and in particular, on the occasion of missed sessions. As we continue to strive to promote what EI services are meant to be---the support of family efforts to care for their child--- let us consider the importance of the open relationship among family and other team members, and serve in a manner which is less dependent on rigid compliance at all cost, and more concerned about the comfort level of the families and children served.

Thank you for this consideration.

Submitted by,

Denise Braun

Denise Braun
Program Supervisor, BARC Early Intervention 0-3 Services
Lower Bucks Early Intervention Center
721 Emily Avenue
Croydon, PA 19021 (215) 785-2120

Gina Randazzo, MS, CCC/SLP
Speech Language Pathologist
207 Chelmsford Drive
Marietta, PA 17547

October 9, 2000

Mr. Mel Knowlton
Office of Mental Retardation
PO Box 2675
Harrisburg, Pa 17105-2675

Dear Mr. Knowlton:

I am writing to you to express my concern over some of the proposed regulations for Pennsylvania's program for infants and toddlers, and also to voice my opinion about the current law that Mental Health Mental Retardation (MH/MR) runs under.

The early intervention program is very important to me. As a speech pathologist working for a pediatric rehabilitation center, I know first hand of the tremendous support that is given to young children with developmental delays or disabilities. Often times the parents of these children are scared, full of questions about their child's future, and in need of support themselves. We are there in their homes as professionals these parents can trust. We not only provide therapy for the child; we are there to teach parents ways to encourage development of language in their children, to answer questions about speech and language development, and even to lend our ears as some parents need to vent their troubles. I spent eight years in college and over 350 practicum hours in schools, hospitals, rehab centers and clinics, gaining experience in normal and abnormal speech-language development. I continue to attend seminars, conferences, and in-services in order to keep abreast of the most recent discoveries, practices and theories pertaining to my field. I am devoted to the children and families I work with.

I understand that a new position has been proposed; that of an "early interventionist", and that the person who holds this position can be hired with less than a bachelor's degree. What is this? How qualified would these people be compared to the professionals who, by law, must hold masters degrees in order to practice? I have devoted many years in school and have spent many hours with disordered children and adults in order to obtain my license. What kind of qualifications would this "early interventionist" have, that they could do our jobs just as well without a masters degree, without clocked practicum hours, and without a license. It is an insult to my entire educational career that someone could even suggest this idea. It makes me sad to think of all the children and families that would essentially be cheated out of the quality care and

support that the professional speech pathologist, or physical therapist, or occupational therapist could deliver.

It is hard enough for the therapist to work under the current MH/MR rules. We have very little freedom to exercise our knowledge or our voice for that matter. One major bone I have to pick is with the rule that we are not allowed to say or write anything "negative" about the children we are servicing. We can only inform the parents of all the "good" things their child is doing. We cannot mention a word about things he is not, but should be doing, in fact the very things a parent should be aware of. Many times parents have been shocked as their child transitions at the age of three into IU funding. Then they learn that little Johnny can do A, B, C, but not X, Y, Z. Or that he is presenting very much like an autistic child. Or that he really should be getting one hour of therapy twice weekly, not just half an hour weekly. Parents are "protected" from the reality of their child's condition, unless of course THEY ASK. Then we as therapists are allowed to exercise our right to inform them. But why would a parent ask? Ask for more therapy? "That's the therapist job to decide", one parent was heard to say. How would a parent know the red flags that signal possible autism behaviors? How would they know all the things their child should be, but isn't doing? Under MH/MR rules, we are not allowed to make written recommendations regarding therapy, goals, or frequency. I have actually witnessed an MH/MR service coordinator ask a parent how often they thought the occupational therapist should come out to provide therapy. This is comparable to a doctor asking his patient how often he would like to take his medication!

It is a disservice to our clients and families to be operating this way. In fact, it is a direct violation of our code of ethics which states that we "should seek to provide and expand services to persons with speech, language and hearing handicaps, as well as assist in establishing high professional standards for such programs." I am sorry to say that Pennsylvania should be ashamed because the true professionals are not permitted to fulfill this code based on the law.

Thank you for allowing me the opportunity to express some of my concerns to you.

Respectfully,

Gina Randazzo MSCCC/SLP

Gina Randazzo, MS, CCC/SLP
Speech Language Pathologist

Original: 2122

Rhonda Pritchette
1620 S. 16th St.
Phila PA. 19145

Good afternoon everyone

I will be sharing with you my experience in the early intervention program.

The circumstances that brought me to needing this type of program are not unique. Some of you may have heard stories similar to mine many times.

But maybe you have not heard the success that a program like early intervention has achieved.

My name is Rhonda Pritchette, I'm here today to share with you one of those successes. I am a single parent with a 2 year old daughter. She is now receiving services from Child Link an early intervention program.

My pregnancy was classified as high risk, and after a very difficult 2nd trimester, Ke'Yonna was born 2 months premature. To say that I was overwhelmed is an understatement. I had no idea of the scope of what her needs would be, what problems I could anticipate or where I would turn in my uncertainty. The difficulties of dealing with my own disability and having a premature newborn would prove challenging but not impossible.

Through supportive Child Adult Network, I learned about early intervention. I was taught in Child Link and together they provided the education and skills I needed to be a less apprehensive and more confident parent. Early intervention addressed the needs of my child, and reinforced what I was learning and how I should respond to her needs.

I was kept informed of her progress that was appropriate for her age level. I was shown how to assist her development.

I was told things to be aware of and what to look out for. This was a tremendous help. It helped to relieve my anxiety a lot.

Without the services and care they gave us. I don't know if my daughter would be doing as well as she is know. Learning to nurture her development was a help to us both. Without early intervention I don't know what I would have done. But I do know that Ke'Yonna and I are a success because of it and we are [illegible] Thank God that his has made all this possible.

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REVIEW COMMISSION

Suzanne H. Michel, MPH, RD
Nutrition Consultant
358 Trevor Lane
Bala Cynwyd, PA 19004

October 9, 2000

Mel Knowlton, Chief
Division of Policy Development and Program Support
Room 512 Health and Welfare building
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Knowlton:

Enclosed are three copies of my testimony from the hearings held on Monday, October 2, 2000 in Philadelphia. Thank you for the opportunity to share my thoughts regarding the nutrition needs of children and families in the Early Intervention System.

Sincerely,

Suzanne H. Michel

Suzanne H. Michel, MPH, RD

Phone: (610) 299-4505
E-mail: Smichel@aol.com
FAX: (610) 667-1704

Suzanne H. Michel, MPH, RD
358 Trevor Lane
Bala Cynwyd, PA 19004
Maternal and Child Health Early Intervention Nutrition Specialist
Philadelphia Department of Health
Division of Early Childhood, Adolescent and Women's Health
610-667-0146

The Individuals with Disabilities Education Act (IDEA) mandates that nutrition services be included in the Individualized Family Service Plan (IFSP) if "appropriate" for the child and family. Federal and state law includes health services, such as nutrition, necessary to enable the infant or toddler to benefit from the other EI services. Within this law registered dietitians (RD) are noted to be part of the EI management team, however the provision of nutrition services varies widely from state to state.

Nutrition services are often confused with food service provided at a center-based program or a "feeding" program provided by an speech therapist to teach a child oral skills necessary to eat. Although both aspects of care are critical to the child and are part of overall health management, they are not to be considered nutrition services. Nutrition services include both assessment and management strategies that optimize a child's growth and development. Assessments include: (a) nutritional history and dietary intake, (b) anthropometric (height, weight, head circumference), biochemical, and clinical measures, (c) feeding skills and feeding problems, (d) food habits and food preferences; and (e) drug-nutrient interaction. Once nutrition problems have been recognized, appropriate plans to address the nutritional needs of the child should be developed, implemented, and evaluated. **The services of registered dietitians are specifically outlined in the legislation and registered dietitians must be listed on page 17 (vi) "Provided by qualified personnel, including at a minimum, the following:" to provide nutrition services to children in early intervention programs who are in need of such service.**

Evidence of the benefits of nutrition intervention to the health and development of children with special health needs continues to grow. I have included a list of references. Improved growth and other nutrition markers have been extensively documented in children who have received needed nutrition services. The evidence ranges from metabolic disorders in which nutrition problems are primary, to conditions in which the nutrition problems or risks result from secondary biological factors, such as CP, epilepsy, myelomeningocele, Down's syndrome, Prader-Willi syndrome, fetal alcohol syndrome, and many others. Environmental and social factors further complicate nutrition status.

For some children, improved nutrition is the factor most critical for survival; for others it can reduce the potentially debilitating effects of their conditions. Improved nutrition and feeding may increase the level of independence the child is able to achieve, improve the child's perception of self, and improve care providers' perception of their ability to meet the child's needs. Parental frustration surrounding issues of feeding are documented in the video, "Right to Grow." Working in partnership with families to integrate nutrition services into a coordinated system with other EI services, mutual reinforcement and support can be achieved across disciplines and services to children and their families can be strengthened.

Unfortunately Pennsylvania does not currently have a system in place for integrating nutrition services into its EI programs. Barriers to implementing services include lack of knowledge by parents, EI specialists and physicians regarding the importance of nutrition for this population, lack of knowledge of appropriate roles for the RD on EI teams, and lack of economic resources to pay for nutrition services. Additionally, methods of referring infants and children for EI services do not allow for the identification of children suffering from or at risk for malnutrition.

The State of Massachusetts undertook a major project to identify the level of nutrition risk in their EI population and to design a state-wide intervention program based upon identified risk that is applicable to all families in EI. This extensive project is outlined in this volume entitled, "Early Start: Nutrition in Early Intervention." Their work included videos by RDs and parents for staff and parents discussing the role of optimal nutrition in a child's daily care.

I had the opportunity to undertake a similar evaluation within a local clinic providing medical services and developmental evaluations to a population of infants who were graduates of neonatal intensive care units. The clinic did not offer the services of an RD prior to the completion of the evaluation. I evaluated a consecutive series of 34 patients for growth, feeding difficulties, nutrient intake, medical and social complications. The group included 27 boys and 7 girls. The average length of gestation was 30.9 ± 3.5 weeks. Mean chronological and adjusted ages were 20.5 ± 2.5 months and 18.3 ± 6 months, respectively. Based on developmental evaluations 74% were eligible for EI services. Among those referred for EI services 15% were diagnosed with CP, 24% with developmental delay, 35% had feeding difficulties, and 75% had a medical diagnosis impacting nutrition status, such as, asthma, GER, anemia. Forty-four percent of the EI eligible group had feeding complications, such as inability to chew or swallow, feeding refusal, use of feeding tube, and/or use of proprietary formula. When comparing weight to length 44% of the EI eligible group was at the 10% or below, meaning they were very thin and malnourished. 94% qualified for WIC yet only 71% were enrolled; 93% qualified for food stamps and 90% were enrolled. Level of nutrition risk ranged from no risk in 6%, mild in 35%, moderate in 24% and severe in 35%.

The results of this study and evaluation of current nutrition services provided to EI eligible infants and children indicate:

1. There is also a very clear role for the inclusion of RDs as providers of direct nutrition services to infants, children, and families receiving EI services.

2. To improve nutrition outcome and optimize health, growth and development in this high- risk population of children, the involvement of a registered dietitian in EI programs in partnership with community health programs and families is essential and should be included in the legislation.

3. There is an urgent need for the provision of appropriate funding so that an RD can provide optimal nutrition services to infants and children in the EI system.

4. There is a need to redesign the EI referral form so that nutrition risk can be identified and referred for appropriate service.

If more time were available I could share many cases with you of children who were suffering from malnutrition from lack of appropriate nutrition intervention and families who were extremely frustrated in their attempts to keep their children growing and healthy, but did not know where to turn for help with their children's nutrition complications. I would be happy to discuss this with you further at your convenience.

Thank you for this opportunity to share my experiences and concerns regarding the nutrition needs of children receiving EI services.

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Suzanne H. Michel, MPH, RD
358 Trevor Lane
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For some children, improved nutrition is the factor most critical for survival; for others it can reduce the potentially debilitating effects of their conditions. Improved nutrition and feeding may increase the level of independence the child is able to achieve, improve the child's perception of self, and improve care providers' perception of their ability to meet the child's needs. Parental frustration surrounding issues of feeding are documented in the video, "Right to Grow." Working in partnership with families to integrate nutrition services into a coordinated system with other EI services, mutual reinforcement and support can be achieved across disciplines and services to children and their families can be strengthened.

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The results of this study and evaluation of current nutrition services provided to EI eligible infants and children indicate:

1. There is also a very clear role for the inclusion of RDs as providers of direct nutrition services to infants, children, and families receiving EI services.

2. To improve nutrition outcome and optimize health, growth and development in this high- risk population of children, the involvement of a registered dietitian in EI programs in partnership with community health programs and families is essential and should be included in the legislation.

3. There is an urgent need for the provision of appropriate funding so that an RD can provide optimal nutrition services to infants and children in the EI system.

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If more time were available I could share many cases with you of children who were suffering from malnutrition from lack of appropriate nutrition intervention and families who were extremely frustrated in their attempts to keep their children growing and healthy, but did not know where to turn for help with their children's nutrition complications. I would be happy to discuss this with you further at your convenience.

Thank you for this opportunity to share my experiences and concerns regarding the nutrition needs of children receiving EI services.

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UNITED CEREBRAL PALSY OF NORTHEASTERN PENNSYLVANIA

425 WYOMING AVE. SCRANTON, PA 18503 TELEPHONE 347-3357

Original; 2122

83

Mr. Mel Knowlton
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA
17105-5764

October 6, 2000

I am the past president of the Early Intervention Providers Association. I continue to be an active member of the regional Northeast group. Although we have had input regarding the statewide Associations comments, we feel it is imperative that we restate issues concerning the Proposed State Regulations for Early Intervention. Thank you for extending the comment period, allowing more of us, providers and parents, to make our views known.

4226.36 Preservice Training
Comment:

- We believe the terminology should be restated.
  Suggestion: The methods of working with families will encourage family involvement at all levels.

4226.37 Annual Training
Comment:

- This requirement is not clear. It is not clear whether this means CEUs, college credit hours or general inservice hours. We do feel on going training is important.
- If this is college credit hours, it will pose a hardship for employers and employees.
- Our recommendation is to clarify this training requirement.

4226.55 Early Interventionist
Comment:

- It is unclear whom this position is meant to describe. Is it meant to describe a "generalist", service coordinator, teacher and /or therapist? The definition of early interventionist needs to be stated clearly in the regulations.

4226.56 Requirements and Qualifications
Comment:

- We feel it is necessary to clearly state the qualifications of the individual as it relates to the responsibilities of an early interventionist.
  Suggestion: An early interventionist shall have one of the following requirements:
  1) A bachelor's degree in special education, early intervention or early childhood education

2) A bachelor's degree in a related field such as, but not limited to psychology, sociology, social work, counseling, early childhood, development or family studies

3) A bachelor's degree in an unrelated field plus additional college credit hours in the area of child development, or two years experience working directly with children and families.

4226.62 Evaluation and Assessment
Comment:

- Clarify the phrase "personnel independent of the service provision." We would suggest an exception where services are limited. This would include limitations of actual staff, as well as those trained in low incidence disabilities.
- Clarify (c) Is this a formal assessment in addition to any information gathered during the the MDE/IFSP process? We are curious who will be conducting this assessment, if this is formal?

4226.74 IFSP
Comment:

- It is recommended to add a statement that allows the IFSP team to justify services if they need to occur in a setting that is not considered a "natural environment"; This justification to be reviewed at each IFSP.

We appreciate the opportunity to provide written comments concerning the proposed regulations. As always we commend you in your efforts to best serve infants toddlers and families in the Commonwealth. Together we can provide quality services.

Respectfully submitted,

Cheryl A Astolfi

Cheryl A. Astolfi
on behalf of the Northast Early Intervention Providers Association
423 Center St.
Clarks Summit, PA 18411

Original: 2122

My name is Ilene Klein; I am the professional co-chair of the Philadelphia Interagency Coordinating Council and Center Director of Family Support Services Fairmount Early Intervention Program.

As representative of the PICC, I would like to offer comment regarding the proposed infant/toddler regulations.

Under the Requirements and Qualifications section, 4226.54 and 4226.56, I believe Service Coordinators and Early Interventionists should hold a minimum of a bachelors degree in Social Work, Education or a related field, with course work in child development. Service Coordinators and Early Interventions require a certain level of professionalism and expertise when working with the families in our system. The service coordinator is the first person a family meets; they should be capable of giving accurate, up to date information regarding child development, children with disabilities, and the early intervention system. The early interventionist is the person that families form ongoing relationships with. This person should also be knowledgeable about child development, children with disabilities and the early intervention system.

The requirement of 6 annual credit hours for the early interventionists suggests college credits, compared to the 24 annual training hours previously stated. This is unclear and would significantly impact the hours an early interventionist is available for direct service. Financially, this would be unattainable with the providers' current budget structure.

Under the Evaluation and Assessment section, 4226.62, I recommend a minimum of two professionals as part of the MDE team. It cannot be assumed that all professionals

are capable of thoroughly assessing all areas of development. Personally I believe that this would create the need for further evaluations by specific disciplines at other times.

Under the IFSP section, interim IFSP's are allowed. This practice is not supported. I believe that an MDE should always be conducted prior to developing an IFSP. How can any services be delivered prior to any evaluations?

In the current proposal there is no timeline from the IFSP to the start of services. The current wording is services should start "as soon as possible." This is very vague and allows for varying interpretations. I recommend that services must start within 14-days.

In closing, I would like to say that Phila has a very strong early intervention community. We all strive toward best practice and quality services for the families and children of Phila.

Ilene Klein
FSS - Fairmount EIP
2000 Hamilton ST
Phila Pa 19130

Original: 2122

KEN-CREST SERVICES

66

Children and Family Services: 3132 Midvale Avenue, Philadelphia, PA 19129 • 215-844-4620 • Fax: 215-844-4610

Department of Public Welfare
Proposed Rule Making for Early Intervention Services
Public Hearing
October 1, 2000

Oral Testimony
Proposed State Regulations

Good Morning! My name is Pam Schuessler. I am the Assistant Director of Ken-Crest Children and Family Services. We at Ken-Crest recognize the enormous amount of effort and time that has already been invested in the development of this draft and we appreciate the opportunity to make comment and potentially contribute to the final draft of the regulations.

Our recommendation for change, clarification and/or support in the Early Intervention Regulations are as follows:

4226.5 Definitions

Multidisciplinary - This definition states that the MDE should involve two or more disciplines or professions. We recommend the regulations state the service coordinator plus two additional professionals of different disciplines be involved in the MDE process, in order to insure a comprehensive and multidisciplinary evaluation.

4226.24 - Comprehensive Child Find System

We fully support the need for a comprehensive and coordinated Child Find System. We think that the earlier the children are identified as eligible for Early Intervention and families are provided with information about resources, the greater the opportunity for the child to make developmental gains.

4226.37 - Staff Training

We agree that annual training is a must. We would like clarification between 24 hours of required annual training and six required credit hours annually. Additionally, we would like to suggest that the need for fire safety, emergency evacuations and CPR be reconsidered. As early intervention staff should be providing services in natural environments such as family homes, community sites and day care centers with a parent or a primary care giver

present there is no need to have staff trained in these areas and doing so will lead to confusion around roles and responsibilities.

4226.38 - Criminal History Record Check

We agree that a Pennsylvania criminal history check be required. We also recommend that a check from the Pennsylvania Child Abuse Registry be required.

4226.54 / 4266.56 - Service Coordinator and Early Intervention Qualification

The minimum qualifications for both of these positions are too low. An associate's degree with three years experience is not sufficient. While we agree that it is possible to have someone with an associate's degree be knowledgeable and work well with children and families, we recommend that the minimum educational training should be accompanied by more extensive experience, at least five years working with children and families. We also recommend that the requirements need to relate directly back to a related field, including Early Child Development, Education, Human Development Family Studies, Social Work or Special Education.

4226.55 - Early Interventionists

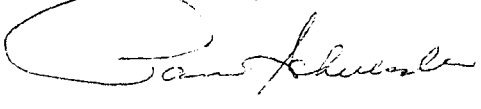
We would like clarification regarding whom this position is meant to describe.

4226.75 - Provision of Services Before Evaluation

This statement should clarify what circumstances would be appropriate to program for a child prior to evaluation and eligibility determination.

In closing, we at Ken-Crest would like to thank you for giving us this opportunity to provide input to the proposed Early Intervention Regulations. We recognize the energy and efforts that the Department has put into the development of these Early Intervention Regulations and we appreciate the fact that you have listened to our concerns.

Respectfully submitted,



Pam Schuessler
Assistant Director
Ken-Crest Services
3132 Midvale Avenue
Phila., PA 19129

MCP Hahnemann University

Operated by Drexel UNIVERSITY

Original: 2122

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Mail Stop 502 • 245 N. 15th Street • Philadelphia, PA 19102-1192
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85

October 6, 2000

Department of Public Welfare
Mel Knowlton
PO Box 2675
Harrisburg, PA 17105-2675

Dear Mel Knowlton,

As pediatric physical therapy service providers, researchers, and teachers, please consider the following comments in reference to the proposed rulemaking for early intervention services:

In reference to section 4226.37, 24 hours of annual training will be required of all personnel working directly with children in early intervention. However, section 4226.56 stipulates that early interventionists shall obtain a minimum of 6 credit hours annually. Three points need to be clarified: 1) is this academic credits or professional continuing education units?; 2) is this in addition to or part of the 24 hours referenced above; and 3) given the required nature of the training, are the expenses for the training or the training units themselves being provided by DPW or provider agencies?

In regards to 4226.62, MDE, we recommend eliminating the requirement that personnel independent of service provision conduct the initial MDE. With this current process we have experienced the need of the service providers to duplicate components of the MDE to develop with the family appropriate and meaningful outcomes, objectives, and intervention methods. In addition, we strongly recommend that at least two other professionals (along with the family and service coordinator) participate in the annual MDE. It is important to maintain the multidisciplinary approach in evaluation as well as intervention. Given the depth and breadth of professional training in the various disciplines, a multidisciplinary approach is needed to adequately evaluate and provide intervention for children and their families.

In regards to 4226.55, the role of the early interventionist on the team needs to be delineated and clarified especially as related to the other professional disciplines on the team, especially the service coordinator. Also, when would the early interventionist be responsible for implementing a child's IFSP rather than

the physical or occupational therapist or the child's early childhood coordinator? Until the role of the early interventionist is clearly defined it is difficult to determine the level of qualification. If the early interventionist will be used in the capacity to provide direct service with the child and family, then a minimum of a bachelor's degree and one year experience in the field should be mandatory.

In regards to the requirement of the service coordinator, 4226.54, we recommend the addition of training or experience in identifying and developing community networks for children and families. In our experience, service coordinators have efficient and effective in administration of IFSP documentation but have not had the training to serve a role in providing resource information and access.

In regards to transition from EI services, 4226.74, we recommend that the wording "to discuss" be revised to allow for implementation so that a child may transition to center-base preschool programming between the second and third birthday if agreed upon by the team.

In terms of financial management, 4226.13, clarification needs to be made regarding use of funds especially the order of sources of funding. Are the early intervention state funds the payor of last resort?

The content of the IFSP, 4226.74, should have a maximum timeline of when IFSP services must be initiated as opposed to the vague wording in paragraph 7 "as soon as possible".

The definition of physical therapy in section 4226.5 should be edited to include family support for caregiver-child interaction to promote family-centered care and child development.

Sincerely,

Lisa Ann Chiarello

Lisa Ann Chiarello, PT, PhD, PCS

Maggie O'Neil

Maggie O'Neil, PT, PhD, MPH

Original: 2122

77

Family Support Services, Inc.
201 South 69th Street, Upper Darby, PA 19082-4229 • (610) 352-7610 • Fax (610) 352-7617 • FamilySupportSrv@aol.com

October 3, 2000

Mel Knowlton
Independent Regulatory Review Commission
Office of Mental Retardation
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Knowlton:

As a provider of Early Intervention services to children in Philadelphia we are very concerned about the proposed State Infant and Toddlers' Regulations. We are aware that the Education Law Center has expressed their concerns in detail and we agree with their comments, particularly concerning legal safeguards and specific dates for compliance. The original Federal law and subsequent State Act 212 were originally written to safeguard the child and parents who receive services. The rules to hold the service system accountable for performing in a timely manner are good ones. All "systems" slow to their own inertia when permitted to do so. Please return the requirement for providing services within in 14 days of the IFSP and maintain all other time lines consistent with the Federal Law.

It is also important to remember that the emotional and financial burden of having a developmentally delayed child is irrespective of socio-economic status. The original legislation intended that special education services be available to all children irrespective of parental income – just like public education is to all children of the Commonwealth. Rich people are not asked to pay for public education, it is always their own choice to send children to private education. This principle should continue to be applied. No family should be compelled to use private insurance to pay for services. It may be their choice, over and beyond the services offered by the public system.

The other section which disturbs us deeply is the reduction on qualifications for both the Service Coordinator and Early Interventionist positions. It is absolutely imperative that professionals working directly with families and children have a comprehensive and thorough knowledge of child development and family dynamics. Reducing the standards to requiring only Associate degree qualifications for such people will lower the quality of the workforce. These positions require minimum of a Bachelor's degree education with substantial academic work related to education, special education, early childhood development and family dynamics. It is very short sighted to respond to the statewide crisis in hiring and retention in the human services by reducing standards. The answer

lies in providing incentives to recruit quality people into the service fields. Initiate scholarship programs for college students targeted to early intervention, raise county allocations and rates of reimbursement services so that we can pay people competitively. Your department has worked hard to raise levels of qualifications for Day Care workers and that is commendable. Please do not reduce the qualifications of staff working with some of the State's most vulnerable children.

One final thought, it is imperative that child finding activities and public education activities continue and are encoded in the regulations. When the entitlement Early Intervention system was beginning in the 1990's there was general public awareness because the press covered the legislative activities and there were public information campaigns. As the "system" has become established and settled into place, it is no longer news. However, for every new generation of parents there needs to be information and outreach activities available, new generations of pediatricians and family practitioners need to know about the resources available. This is one public information campaign which can not end or fizzle out, because babies are new each year. Saving money by ignoring children in need is immoral and should be illegal.

We respectfully offer these comments and suggestions for inclusion in the final version of the Regulations. Please send us a copy when they are published in final form..

Sincerely,

Virginia C. Peckham, Ph.D.
Executive Director

Original: 2122

Good Morning/Afternoon Ladies & Gentleman. My name is Jennifer Kendrick. I have been asked to speak to you by Children's Services on behalf of the Parents of Handicapped Children at Comhar. I feel we should oppose the proposed plan to change the MDE evaluation and assessment # 3 on the DPW regulations. AS a parent who had a handicapped child, I was personally involved completing MDE evaluations. I feel an MDE evaluation is a very important tool in obtaining the services a child needs. As you know handicapped children have multiple disabilities and need many services. It has been a past practice to have one therapist from each discipline present such as Speech, Occupational Therapy, Physical Therapy, Nursing, and Special Instruction during an MDE. Each Therapist's input is very essential in determining what specific services a child needs. Sometimes it is difficult to set specific goals for a child but having each discipline present a working goal can be determined that is best suited for the child. On a personal note my experience completing a MDE for my son was difficult because of his many problems and without the support and recommendations from each therapist involved I don't feel I would have been able to set appropriate goals for him. This was a long process and each persons recommendation was definitely needed. I strongly feel that if the practice is change to one person completing the evaluation some problems could be missed and the child would not get the specified services he/she needs, therefore putting the child's progress in great jeopardy. I also feel it would be a great injustice to ask one evaluator to asses the child's needs in all the specified areas where he/she might not be familiar with and maybe making the wrong recommendation thus preventing the child from obtaining the services that child really needs. I feel handicapped children deserve and need many services to motivate them and enhance their capabilities, therefore making the MDE an important and necessary process not to be left to one individual's decision. I thank Children's Services for having me speak to you on this very important issue. Thank-you for your time.

Original: 2122

Testimony on the EI draft regulations – October 2, 2000

Good morning, My name is Kathy L. Sykes. I am the Director of Mental Retardation Services for the city of Philadelphia. Thank you for the opportunity to comment on the draft EI regulations. I have had the opportunity to participate on the EI regulation work group over a number of years and am pleased to see that the regulations have reached this point. It is important that these regulations are finalized as soon as possible.

The proposed regulations, however, do raise a number of questions that need to be clarified prior to issuance of final regulations. I will comment on several of these areas today and will also address additional concerns in writing to the Department of Public Welfare.

4226.24 Comprehensive child find system.
F(1) provide clarification to the phrase once the legal entity receives a referral. The term referral should be defined to clarify if this is any contact on behalf of the family or if this is specifically contact with the family. There is often difficulty connecting with the family when the referral is made by a third party such as a Clinic, hospital, or medical service provider. The current interpretation is any contact on behalf of the child is the first step in the process and as such the 45 day timeline begins.

4226.37 Annual training. I strongly support the 24 hour requirement for training for all staff and contractors working in Early Intervention. Philadelphia instituted this requirement during last fiscal year and is continuing it on an annual basis. Our experience is that in-service training is both necessary and desirable to ensure that all personnel have the necessary expertise and knowledge to provide quality EI services. In order to remain current in practice, it is important to make the time to participate in annual training. In addition to the areas listed, I also suggest topics such as child abuse reporting, home visiting, community mapping, and family centered planning. This paragraph should also specify that therapists require training as well as service coordinator and early interventionists.

4226.54 Requirements and qualifications The regulations require minimal qualifications for the service coordinator. These are not adequate for the responsibilities required of these personnel.. While I wholly support a role for the para-professional it is to supplement the role of service coordinator not to replace this individual with someone of lesser education or formal experience.

4226.55 Early Interventionist. (2) The statement that the Early Interventionist is responsible for " implementing the child's IFSP directly or by supervising the services provided by other EI personnel" is confusing. It implies that the early interventionist is the team leader or coordinator and as such is confusing the roles of other team members and the service coordinator. (4) "written

communication reviews" needs further explanation if this is an ongoing requirement rather than as needed based on the child's development.

4226.56 Requirements and qualifications. The regulations require minimal qualifications for the Early Interventionist . These are not adequate for the responsibilities required of these personnel.. While I wholly support a role for the para-professional it is to supplement the role of Early Interventionist not to replace this individual with someone of lesser education or formal experience.

Further the requirement that each interventionist obtain 6 credit hour annually is not feasible. It is also not clear if this requirement is in addition to or in place of the 24 hour annual training requirement. I suggest that the education and experience requirements be raised to a bachelor's degree and 2 years of experience. Further , I believe that the annual 24 hour in-service training is sufficient.

4226.74 Content of IFSP (7) Dates; duration of services. The projected dates for initiation of services is shown as " as soon as possible". I recommend that the 14 day timeline that was identified in an earlier draft version of the regulations be included. It is important to include a specific reference to an actual number of days with the understanding that service can also be initiated before the designated time period.

4226.74 (8) Service coordination: The regulations are confusing in that they do not address the independent service coordination model that is in place in Pennsylvania. If PA is going to continue to use this model and I encourage that we do, then it is important to more clearly differentiate the role. The regulations, on the other hand, seem to follow the federal regulations that allow the family to choose the service coordinator from among the members of the team. Thus the service coordinator could be the teacher or the speech therapist.

Thank you for this opportunity to provide testimony.

72

Original: 2122

October 2, 2000

Sabra Townsend
215-276-1187

Good Morning,

As parents of a young son born with Prune Belly Syndrome (a physical condition) and diagnosed with Pervasive Developmental Delay (a cognitive condition), we want the best for our son. I speak for my husband and I when I ask that you thoroughly consider the following points, in regard to the proposed changes to Pennsylvania state special education regulations. We all need guidance at some point in our lives. That said, I ask the you act on the following issues:

To be eligible for services, early intervention should include all services needed, e.g., PT, OT, speech therapy, special instruction. If it weren't for my son's rare physical condition, his cognitive condition might not have been as readily identified. If a need exists for a speech therapist, then that need should be filled.

Enormous changes can occur in the development of a child from birth to three years old and older. It seems that the an evaluation period of one year would allow for clear assessment of the child's particular situation as they grow and mature.

The start date for services must be clearly identified. Services should begin a specific number of days after the services have been agreed upon. This will allow the child to receive services in a timely manner, and any adjustments that may have to be made can also be addressed.

Children with disabilities, both physical and cognitive, should be included in "regular" classrooms as often as possible. If this is indeed the goal, it can be achieved by identifying procedures and instructional support for each child as identified in the ~~IEP~~ IFSP. The age appropriate guidelines should also be specific to each child as outlined in the ~~IEP~~ IFSP.

The least restrictive environment must be just that. Learning for children is ever-present, 12 months a year. Until public preschool is available to every child, early intervention services should be provided to private regular preschools as well.

87

Original: 2122

Tisa Caslow, MS, CCC/SLP
Speech Language Pathologist
1402 Prospect Road
Mount Joy, PA 17552

October 4, 2000

Mr. Mel Knowlton
Office of Mental Retardation
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Knowlton:

After reviewing the proposed regulations for Early Intervention services, I noticed there was no mention of the authority of IFSP teams to make decisions regarding appropriate services and environments. I would like to relate the following from my professional experiences that highlights the importance of more specific guidelines that do not allow such a broad interpretation of the law. The MH/MR agency in the county where I work does not allow clinical/professional opinions to be used when providing services for children. Service providers (e.g. speech therapists) may not mention any delay or need the child has or recommend specific services unless the parent mentions it first. The following is one example of how this interpretation has affected one child and his family. As a speech pathologist, I worked with a family under MH/MR funding. The child, a 2-year old boy, exhibited signs and behaviors consistent with autism. The parents believed that their son simply had a behavior problem and a language delay. They never questioned the therapist about autism. I was not permitted under contract with MH/MR to discuss their child's behaviors as they related to autism. While a speech pathologist is not qualified to diagnose autism, we are qualified to treat a child with autism and are familiar with the typical behavior patterns that would indicate autism. As a therapist, I could have made a referral to the appropriate professional. Since the child was nearing 3-years of age and ready to transition to Intermediate Unit funding, it was possible to recommend a developmental evaluation with a psychologist. As expected, the psychologist indicated the child did display typical traits and behaviors consistent with a diagnosis of autism. The parents were shocked and wondered why "autism" was not mentioned previously. They understandably exhibited distrust toward me and the professional/parent relationship was affected. As a speech pathologist I became less credible in their eyes because it appeared I did not understand their child's true needs.

Happily, that child is now receiving appropriate services through the Intermediate Unit in a classroom designed specifically to treat children with PDD and autistic spectrum disorders. I believe a disservice was done to the family and more importantly to the child who could have begun receiving services much sooner. With more specific guidelines, each county in the State could uniformly allow clinical opinion to be used as the valuable tool it is, along with other methods such as standardized testing and parent report.

Thank you for allowing me to provide input regarding the regulations that impact the children I serve.

Sincerely,

Tisa M. Caslow, MS, CCC/SLP
Speech Language Pathologist

Original: 2122

71

Philadelphia Citizens for Children and Youth
Comments on Proposed State Infants and Toddlers Regulations for Early Intervention Services
October 2, 2000

My name is Pat Redmond, and I represent Philadelphia Citizens for Children and Youth, the region's general child advocacy organization. Thank you for the opportunity to comment today. Our comments are organized by subject area.

General Requirements and Personnel

We are concerned that the regulations do not include any reference to the federal requirements that there be a public awareness program, in addition to the child find system. Public awareness is essential, as there are many children in the state who might benefit from these services, but whose parents are not aware of them.

With respect to personnel, we note that the service coordinator's proposed qualifications do not include any training in child development, the needs of children with disabilities and their families, or other related subject areas. We support the "competency based" approach recommended by the Education Law Center and others, and urge you to value this function sufficiently to ensure that the professionals who fill it are qualified to meet the needs of children with disabilities.

Similarly, the "early interventionist" is described in only very general terms, and again, only minimal educational requirements and experience are mandated. We would appreciate another look at this clearly key position in the new service structure, and an analysis of the function and the specific qualifications needed to fulfill this function. The input of parents and professionals in the field of child development and disabilities is essential here.

IFSPs

We are concerned about timely implementation of IFSPs. In Philadelphia, this situation has led to litigation; in Montgomery County, the regional office has ordered corrective action. We concur with the recommendation of the Education Law Center that a deadline be set, probably no longer than 14 days. Without this kind of clarity, many children will be denied needed services.

Procedural Safeguards

The regulations make no mention of the complaint management system that is federally required. Parents often do not know that this system exists or how to use it. We recommend that the state insert the appropriate language here to match the federal language, and that some provision on accessibility of this information to parents be included. In addition, it is important, as a procedural safeguard, that parents have access to copies of their child's records without cost. We are also concerned about the limitations on foster parents serving as surrogate parents, which we are convinced can result in unnecessary delays in needed services for children. Providing services to children in foster care is very difficult; improving the surrogate parent process would help some children to access services without delays.

Conclusion

We appreciate the opportunity to comment, and look forward to regulations that will ensure the best possible system for Pennsylvania's young children.

Original: 2122

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REVIEW COMMISSION

Testimony

Early Intervention Proposed Rulemaking

Presented October 2, 2000 at the hearing of the Department of Public Welfare

Good morning, my name is Latanya Smith. I am the Program Director of BARC's Early Intervention 0-3 Homebased Program in Bucks County. We are the largest Early Intervention provider in the County serving close to 200 children. We provide quality E.I. homebased services in the Lower Bucks and Central Bucks areas. Thank you for giving everyone the opportunity to respond, comment and testify about the proposed rulemaking. The proposal shows that a lot of effort and detailed thinking has been implemented to get this proposal up and running.

After reviewing the proposal, I have several concerns and inquiries:

1. The 24 mandated training hours for Therapists and Developmental Specialists required prior to working with the families: how it can put providers who have independent contractors at risk of being liable by the IRS if they are being controlled as employees rather than independent contractors, and how it can cause delay in services.
2. Make-up services: how make up services are affecting staff's benefited vacation, sick and personal time and how make up services are non-billable if an IFSP is not written a certain way.

It is understandable that training is very important in maintaining and coordinating quality early intervention services for the families that we serve. However, we should carefully look at the 24hr training requirements for providers that use independent contractors and how it may hinder both the provider and the families. According to an article in the EMT magazine, summer 1999, "Are Your Independent Contractors Just That-Independent?" written by attorneys Jordan W. Siev and Kirsten M. Eriksson, there will be "great liability if it turns out that the independent contractors should be classified as employees" especially if we control them with our mandated training. Siev and Eriksson said, "employees under the common law is that their employer has the right to control the manner and means by which their work is performed". Although, "obviously, a certain amount of control by a company is inevitable in all employee and independent contractor relationships".

In addition, according to another article in the Legal Report magazine, November-December 1999 issue, "Independent Contractors and Employees: Do

You Know One When You See One?" written by Noreen E. McDermott, ESQ., page 2, "The greater the amount of training needed for the individual to complete an assigned task, the greater the likelihood that the individual will be considered an employee". The point that I am emphasizing is that as a provider that has over 30 independent contractors; training them, without pay of course, in order to adhere to the 24hr training, may put agencies at risk of falling into the category of employee-employer relationship. This may raise inquiries with the IRS regarding us controlling them as employees rather than independent contractors. To protect ourselves from any penalties or liabilities from the IRS, Seiv and Eriksson propose that companies "do not provide training in addition to general orientation, and do not include the worker in any employee training programs" if we want to continue to classify them as independent contractors. I share this information only to enlighten you of the possibilities and probable heavy fines by the IRS if we demand that all independent contractors receive 24hr training as an employee i.e., the IRS can likely review this as an employer-employee relationship instead of an independent contractor.

Mandating that all professionals receive 24hr training before beginning to work with the family can hinder the start of services which can cause delay in services. Example, if a family chooses to discontinue a therapist and the provider seeks and hires a replacement, the family has to wait until the therapist is trained causing more of a delay in services. The training can take up to 3-4 weeks, depending on availability of training and on individuals schedule. Another example, which actually happened, BARC recently was asked by ChildLink to provide speech services for five children in the Northeast section of Philadelphia. We accepted and were prepared to provide speech services for three of those five families but due to the 24-hr training requirements in Philadelphia; we could not provide the services. The speech therapist who had great credentials had a full time job, which prevented her from attending morning or afternoon trainings. She was available to provide the services in the evenings; however, she did not have the mandatory training requirements nor was she interested or able to pursue it. Therefore, sadly we had to turn down the referrals, but even more disappointing, the families were out of services. Services would have been in place if the requirements were lifted for these families.

According to MR Bulletin,EI services are not to be interrupted. If the provider interrupts services due to staff's vacation, personnel or sick time, we

are to make up those services. But according to Medical Assistance Early Intervention Provider Handbook, January 1997,Section IV Supporting documentation Requirements, page 56, if services are made up within a week, those made up services are not billable because of how the IFSP may be written. The note reads:"Even though the provider may have a clearly documented frequency on the IFSP, the service may still be non-billable. For example, if the IFSP documents Physical Therapy one hour each week and the child misses an appointment, even if the session is made up the following week it is not billable because of how it is defined on the IFSP. So everytime a session gets missed or interrupted, an addendum is needed in order to bill and get reimbursed from MA. Imagine sessions cancelled due to vacation, sickness or personal emergencies of the family, therapist or the developmental specialist. One cancellation on a Monday, Wednesday, Friday, etc. per family per service, that means that the therapist will have to reschedule sessions and service coordinators will have to do addendums in order to capture one or two missed session(s) per family. This will be and has been very overwhelming for the families, service coordinators, Program Supervisors, etc. It is recommended that the service page 6 of the IFSP be revised to capture make-up services.

We have been asking our staff to make up the missed session(s) within that month to avoid the addendum write up, but according to your note, not only won't we get paid for the missed service because the IFSP was not written a certain way, but also an enormous amount of addendums will be written for every missed service. Tracking this will be overwhelming for the Providers, therapists, developmental specialists, Service Coordinators and especially, the families. Families and staff get sick, take vacations, and may have personal emergencies on a monthly to bi-monthly basis: How can a service coordinator who has a case load over 50 families manage something like this?! This seems very unrealistic.

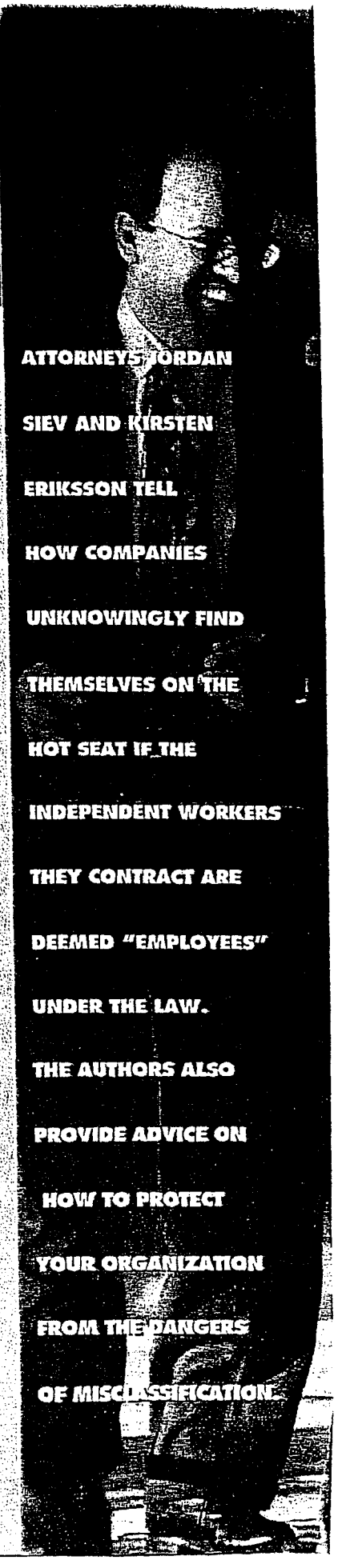
My last point is about staff making up interrupted services. The MA EI bulletin offers a generalized statement about services not being disrupted, but it avoids telling us how or what to do if those services are disrupted. Clearer process, procedures, steps or guidelines are needed to ensure that interrupted services are handled in a timely manner and there is consistency on how to handle them within the EI system. As I mentioned earlier in brief, therapists and developmental specialist have concerns about making up services when they return from their vacation time, sick time or personal emergencies. Upon their return, their workloads are doubled. This has been very overwhelming for our staff and for some of our families. Schedules have to be rearranged and services have to be shortened or lengthened. For example: ten children receive

special instructions 1 X a week. (10 hrs per week). The teacher of these families decides to go on vacation for one week, and the families want their services made up. When she returns, 10 hrs of services need to be made up, plus, the additional regular 10 hours of services. Our staff feels that they are being penalized for taking their benefited vacation, sick or personal time. It is often impossible to arrange for make-ups especially if a therapist or teacher presently carries a full-time caseload.

Thank you again for considering our requests, comments and recommendations.

Latanya Smith
Program Director Birth to three Homebased Program at BARC

Are Your Independent Contractors Just That—Independent?



ATTORNEYS JORDAN SIEV AND KIRSTEN ERIKSSON TELL HOW COMPANIES UNKNOWINGLY FIND THEMSELVES ON THE HOT SEAT IF THE INDEPENDENT WORKERS THEY CONTRACT ARE DEEMED "EMPLOYEES" UNDER THE LAW. THE AUTHORS ALSO PROVIDE ADVICE ON HOW TO PROTECT YOUR ORGANIZATION FROM THE DANGERS OF MISCLASSIFICATION.

BY JORDAN W. SIEV AND KIRSTEN M. ERIKSSON

More and more companies are using independent contractors to cut costs, use talent more creatively, and obtain the best knowledge and expertise available. While using independent contractors can create a competitive advantage, the practice can also create exposure to great liability if it turns out that the independent contractors should have been classified as employees.

Don't think it can happen to you? Between 1988 and 1995, 500,000 "freelancers" were reclassified as employees, and $830 million in back taxes and penalties were levied by the IRS.

Just look at Time Warner and Microsoft, two of the best-known companies involved in recent lawsuits challenging their treatment of certain workers as independent contractors. Time Warner has been sued by the Department of Labor, which is seeking to remove plan fiduciaries and to require payments to workers excluded from benefit plans. Microsoft was subjected to an IRS audit and forced to pay back taxes for improperly classifying workers as independent contractors. The IRS also could have required interest payments and imposed penalties on Microsoft.

The danger does not end with the government, however. After the IRS audit, Microsoft was faced with an ERISA-based class action lawsuit by workers who were not treated as employees and who successfully sought to obtain employee benefits from which they were excluded. Such claims can result in large payments of back benefits, as well as steep statutory penalties.

Thus, to avoid the perils faced by Time Warner, Microsoft and others, it's important to understand the basics of the law and take steps to ensure workers are correctly classified as independent contractors.

Employee or Contractor? The Test

The fundamental characteristic of employees under the common law is that their employer has the right to control the manner and means by which their work is performed. Obviously, a certain amount of control by a company is inevitable in all employee and independent contractor relationships. The determinative factor, however, is whether, under all the circumstances, the company has the right to control not only *what* work is to be done, but *how* it is to be done. If the company does not actually exercise this right is irrelevant; all that matters is that the right exists.

The question of control, while simple in theory, is difficult to assess



in practice. One of the most complete analyses of the common law test is contained in the IRS' training materials, which are used as a guide in this article. These materials focus on three categories of evidence — behavioral control, financial control and the relationship of the parties. No one category or factor is determinative, and in many cases, some factors pointing in both directions will exist. Ultimately, whether a worker is an employee or an independent contractor will be determined by balancing all of the factors in light of the relationship as a whole.

Behavioral Control

Behavioral control—the extent to which your company directs or controls how the specific tasks are performed by the worker — focuses on the instruction and training provided by the company.

Instructions. Two types of instructions are important—instructions as to what the final work product will be, and instructions as to how to achieve the desired product. Generally, the fewer details your company provides as to the completion of the work, the less control appears to be exerted, and the less likely that the worker is an employee. Thus, it is likely that an employer-employee relationship exists if you provide instructions as to the details of the work, such as:

- When to do the work
- Where to do the work
- What tools or equipment to use
- What workers to hire to assist with the work
- Where to purchase supplies or services
- What routines or patterns must be used, or what order or sequence to follow.

By contrast, because businesses often require a uniform end product and a specific date for delivery of the product, instructions concerning matters such as these are less indicative of control.

Training. Independent contractors should be workers who neither need nor receive periodic or ongoing training from a particular company. If your company pays to train a worker through a third party—such as paying for professional development courses—an employer-employee relationship generally will be found. However, companies commonly provide some limited training to independent contractors, such as general orientation information or information on new product lines. Again, as with the instruction provided, the more detailed and comprehensive the training provided, the more likely it is that control exists.

Financial Control

Financial control refers to whether your company has the ability to direct or control the economic or business aspects of workers' activities. There are five factors to consider in determining whether financial control exists: significant investment, unreimbursed expenses, services available to others, opportunity for profit or loss, and method of payment.

1. Significant Investment: Workers who purchase, rent or lease their own equipment or office space to perform a particular job are more likely to be independent contractors. Employees generally have equipment and office space provided to them by their employers.

2. Unreimbursed Expenses: Workers who pay for their own supplies are generally independent contractors. On the other hand, workers who receive such materials from the company, or who have such costs reimbursed, are likely to be employees.

3. Services Available to Others: Workers marketing their services to the public are likely to be independent contractors. Although employees who "moonlight" may have more than one employer, workers with a regular practice of working for different companies generally will be labeled independent contractors. This is particularly true if a worker provides services to competing companies in the same field, and even more so if your company has a policy prohibiting its employees from providing services to competitors.

4. Opportunity for Profit or Loss: If the worker makes decisions affecting his or her bottom line, he or she likely has the opportunity for a profit or loss, and will be considered an independent contractor. Examples of decisions that may affect a worker's bottom line include decisions about the type and quantity of inventory to purchase, the amount of capital investment, and where and whether to purchase supplies or equipment.

5. Method of Payment: Generally, compensation by the hour, day or week is evidence of an employer-employee relationship, while payment of a flat fee is evidence of independent contractor status.

Relationship of the Parties

The final category of evidence looks to what the parties intend their relationship to be. It must be emphasized, however, that the parties' intent, while persuasive, is not controlling. Even if both parties agree in writing that an independent contractor relationship exists, saying it's so doesn't make it so, and a court or the government could find otherwise.

The existence of a written agreement setting forth the terms of the independent contractor relationship is one of the clearest indicators of the parties' intent. Similarly, the worker's incorporation of his or her business, even if he or she is a sole proprietor, demonstrates an intent to be independent. The exclusion of a worker from employee benefit plans and the provision of a Form 1099 rather than a Form W-2 demonstrate the parties' intent to create an independent contractor relationship.

In addition to the above factors, the terms and length of the relationship may be important factors. A company's absolute right to terminate the worker without penalty, and a worker's right to quit, are generally evidence of an at-will employer-employee relationship. Conversely, an independent contractor relationship generally can be terminated only subject to certain limitations, sometimes including payment of a penalty. Moreover, independent contractor relationships generally exist for a definite term. The longer and more indefinite the term of the relationship, the more likely that an employer-employee relationship will be found.

Finally, if the work performed by the worker is part of the integral business activity of the company, it is likely that the worker is an employee. "Integral" in this context means that the work or project is part of the business' regularly conducted activity. For example, a store may retain workers to install electricity and plumbing in its building. This work, while necessary to the functioning of the store, is not the store's regular business activity. These workers are independent contractors.

How To Protect Yourself

As the preceding discussion makes clear, there is no sure-fire way to guarantee that your company is correctly classifying its workers as independent contractors. To increase this likelihood, you should develop a written contract that clearly lays out the terms of the relationship, and treat your workers as independent contractors. In drafting any such contract, keep the following checklist in mind:

- State explicitly that the worker is an independent contractor, not an employee.
- Make the independent contractor's company the party to the contract, even if the worker is the sole proprietor of his or her own company.
- Specify that your company will pay a lump sum amount for the work performed, rather than on an hourly, daily or weekly basis.
- Specify that the worker is not entitled to receive any benefits from your company or participate in any employee benefit plans.
- Specify that your company will not pay for or reimburse expenses such as supplies, equipment, office space, staff or assistants (though such costs may be built into the total cost of the contract).
- Avoid instructions regarding how the finished product should be assembled or when interim steps should be completed.
- Do not limit the worker's ability to provide services to other businesses, although you should provide protection for your company's trade secrets or other proprietary information.
- Specify that the contract is for a limited period of time, and renew or renegotiate the contract as and when necessary.
- Provide for termination of the contract by either or both parties, with a defined period of notice or for cause.

In addition, take care to treat your workers as independent contractors, not as employees:

- Do not provide the worker with an office, name plate, business cards or uniforms, unless necessary for security reasons.
- If the worker needs an office on site to complete the project, the worker should maintain another address as a business address.
- Do not offer the worker perks, such as employee discounts.
- Do not include the worker in company-sponsored events or activities, such as company picnics and parties.
- Pay the worker as you would an outside vendor and issue a Form 1099; do not issue a Form W-2.
- Do not provide training in addition to general orientation, and do not include the worker in any employee training programs. ■

in conflict w the proposed 24 hr training requirement

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LEGAL REPORT

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Independent Contractors and Employees: Do You Know One When You See One?

BY NOREEN E. MCDERMOTT, ESQ.

Perhaps the most basic question in the employment context is whether a worker is an employee or an independent contractor. Employee status triggers employer obligations under various federal and state statutes which do not apply to independent contractors. Despite the fundamental nature of this question, its answer is frequently elusive. Even courts have admitted that the distinction is not always clear. Nevertheless, the responsibility for making the correct decision falls squarely on the employer and making an erroneous decision can result in liability.

The problem was highlighted in a class-action lawsuit, *Vizcainio v. Microsoft Corporation*, where the court found that Microsoft had mischaracterized certain workers as independent contractors and "freelancers." Although the workers were hired for specific projects, some had been kept on, working on successive projects for a number of years. They were fully integrated into Microsoft's workforce, and worked on site and on work teams along with Microsoft's regular employees. They also shared the same supervisors, performed identical functions and worked the same core hours as regular employees. Microsoft provided them with admittance card keys and office equipment and supplies. However, as independent contractors, these workers were not eligible for the same employee benefits that Microsoft's regular employees received.

Microsoft's troubles started when the Internal Revenue Service ("IRS") performed an audit to determine whether Microsoft was in compliance with federal tax laws. Applying the relevant test for employee status, the IRS ruled that these freelancers and temporary employees were not independent contractors, but rather were regular employees. Microsoft was required to pay overdue taxes and issue retroactive W-2 forms.

Armed with the IRS decision, the newly-designated employees then filed a class-action suit demanding the same employee benefits as other employees at Microsoft had received. Finding that the test for employee status is the same under federal tax laws and under the Employee Retirement Income and Security Act ("ERISA"), the court held that these workers were also eligible to participate in the same employee benefits plans as Microsoft's regular employees. For Microsoft, this meant that the mischaracterized workers were entitled to retroactive medical benefits, pension and retirement benefits, and stock options. Thus, mis-

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construing the status of a worker can be a very expensive mistake.

It is not uncommon for the independent contractor/employee controversy to arise when a worker who has been treated as an independent contractor (contingent worker, freelancer, or temporary worker) goes to the Department of Labor ("DOL") with a claim that he or she has not received minimum wage and/or overtime. (These requirements apply only to employees, not independent contractors.) Alternatively, the IRS may initiate an audit to ensure that the employer is in compliance with withholding and tax obligations for all of its employees. Because these agencies share information regarding their investigations, generally both the IRS and the DOL become involved at some point.

The root of the confusion is two-part. First, there are multiple tests for determining whether an employment relationship exists, depending on which statute is at issue. These tests focus on different criteria. Thus, a worker may be considered an employee for purposes of one statute, and an independent contractor under another.

Second, courts applying these factors reach seemingly different results, even where the cases share very similar facts. There is no exact science to making the determination. Frequently it is the weight given to a particular factor that tips the scale in one direction, rather than another.

The Common Law Control Test

The traditional common law approach to determining employee status is the common law control test. This test was initially applied to determine whether an employer should be held responsible for the actions of its workers when they cause some injury to a third party. As new employment-related statutes were enacted, most courts continued to apply the common law approach, modified by the IRS 20-factor test, which is discussed below. Courts have weighed and applied the factors of the common law control test in the following manner:

- the greater the *skill required to do the job*, the more likely the individual is an independent contractor;
- the fact that the individual *supplies his or her own tools and materials* suggests independent contractor status;
- *the longer the relationship*, the more likely that there is an employer/employee relationship;
- the fact that the person who pays for the work has the *right to assign additional projects* to the worker without additional compensation and without altering the terms of a contract indicates employee status–an independent contractor relationship is generally contractual;
- the fact that the *employer determines the work schedule* suggests an employment relationship;
- an *individual who is paid by the hour or other time period* is more likely to be considered an employee, while payment by the job or project suggests independent contractor status;
- where the *employer hires, fires and pays the worker's assistants* (rather than the worker himself or herself), the worker will more likely be deemed an employee;
- an individual who works in a field that is *not the company's ordinary line of business* will be more likely to be found an independent contractor;
- the fact that a worker is *in business for himself or herself* and has all the appropriate licenses suggests independent contractor status;
- the fact that a worker receives *employee benefits* from the person who pays for the work suggests an employment relationship; and
- the fact that a worker is *treated as an employee for tax purposes* indicates an employment relationship.

The common law control test continues to be used in determining whether an employer should be held vicariously liable for the acts of its employees. Its application has expanded, although it is not generally used to determine employee status under anti-discrimination statutes.

The IRS Control Test

The Internal Revenue Service, building on the common law test, has set forth a more detailed test for determining whether an individual is an independent contractor for purposes of paying employment tax and withholding. These factors and their application are as follows:

- an individual who is *required to follow instructions* is more likely to be considered an employee;
- the greater the *amount of training* needed for the individual to complete an assigned task, the greater the likelihood that the individual will be considered an employee;
- where an individual is *integrated into the employer's business* to a great extent, the individual is more likely to be considered an employee;
- the fact that an individual *personally renders services* will weigh in favor of employee status;
- the fact that the *individual hires, fires and pays assistants*, and the employer has no right to do so, indicates independent contractor status;
- the existence of a *continuing relationship* is indicative of employee status;
- the establishment of a *set amount of work hours* suggests employee status;
- an individual whose time is sub-

stantially devoted to the job is more likely to be considered an employee;

- the fact that an individual *works on the employer's premises* suggests employee status;
- an individual who works according to a *sequence set by the employer* will more likely be deemed an employee;
- the fact that an individual *submits regular or written reports* to the employer will weigh in favor of employee status;
- an individual who is paid by the project, rather than by the hour, or other period of time, will more likely be considered an independent contractor;
- an individual who is *reimbursed for expenses* is more likely an employee;
- an individual who *furnishes the necessary tools and materials* for the job is more likely an independent contractor;
- that an individual *makes an investment in the facilities* in which he or she works weighs in favor of independent contractor status;
- the fact that an individual's work results in *the possible realization of a profit or the risk of a loss* suggests independent contractor status:
- an individual who *works for more than one firm* at a time is more likely to be an independent contractor;
- an individual who *makes his or her services available to the general public* is more likely to be considered an independent contractor;
- the fact that the employer has the *right to discharge* the individual suggests an employment relationship (independent contractor relationships are more likely to be contractual); and
- the fact that the *individual has the right to terminate the relationship* also suggests an employment relationship because independent contractors are usually bound by a contract.

This test is applied by the Internal Revenue Service and by some state tax agencies to determine liability for contributions for social security and Medicare benefits, unemployment taxes, penalties, and interest. Courts have also used this to determine employee status under the National Labor Relations Act ("NLRA"), the Employee Retirement Income Security Act ("ERISA"), and the Americans with Disabilities Act ("ADA").

The Economic Reality Test

The test that construes employee status most broadly is the "economic reality" test. This test first gained ascendancy in the context of federal wage and hour law, but has been generally used to determine employee status under a variety of federal and state statutes designed to provide employee protections. The economic reality test considers the circumstances of the whole activity, focusing on the degree to which the worker is dependent on the relationship. Among the factors weighed in the economic reality test are:

- the *right to control* the manner in which the individual performs his or her services suggests an employment relationship;
- the *opportunity for financial profit or risk of financial loss* on the part of the individual indicates an independent contractor relationship;
- the fact that an individual has made an *investment in the equipment to run the operation and employs workers* indicates an independent contractor status;
- the fact that a worker uses *special skills* suggests independent contractor status;
- the more *permanent and exclusive the relationship*, the more likely that the worker will be considered an employee; and
- where the relationship between the worker and the company is *integral to the company's operations*, the likelihood is greater that the worker will be deemed an employee.

The economic reality test as been used in determining employee status for purposes of Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act ("ADEA"), the Family and Medical Leave Act ("FMLA"). Some courts construing anti-discrimination statutes have combined the control factors of common law/IRS tests, along with the "whole activities" focus of the economic realities test to determine employee status.

Potential Liability

Employers looking to solve their staffing problems with temporary or contingent workers must carefully consider the legal implications of the relationship. A multitude of obligations flow from the determination that a worker is an employee. Therefore, the status of a contingent or temporary worker should be carefully evaluated, using the relevant factors, to ensure compliance with the various statutes that govern employment relationships. In addition, these factors should be reviewed from time to time to ensure that new circumstances have not created an employment relationship.

The following is a chart of some statutes under which employers commonly incur obligations depending on a worker's status as an employee or an independent contractor, and some potential liabilities for misclassification.

STATUTE	TEST USED TO DETERMINE EMPLOYEE STATUS	POTENTIAL LIABILITY FOR MISCHARACTERIZATION
Federal taxes	IRS control test	• Liability for unpaid taxes • Penalty (per month) • Penalty (failure to file payroll tax return) • Interest
Fair Labor Standards Act ("FLSA"): overtime and minimum wages	Economic reality test	• Liability for unpaid overtime or minimum wage • Liquidated damages • Fines • Criminal sanctions
Federal employment discrimination statutes (Title VII, ADEA)	Generally, economic reality test; sometimes both economic reality combined with common law/IRS control test	• Back pay • Front pay • Equitable relief • Attorneys' fees
Employment discrimination (federal contractors)	Common law/IRS control test, economic reality test	• Office of Federal Contract Compliance Program can bar company from obtaining federal contracts.
National Labor Relations Act ("NLRA")	Common law/IRS control test	• Reinstatement • Back pay • New bargaining unit election and expenses (where mischaracterized employees were not included in bargaining unit) • Cease and desist orders; other equitable relief
Immigration status: I-9 Forms	Common law/IRS control test	• Civil penalties • Criminal penalties
Worker Adjustment and Retraining Notification Act ("WARN")	Common law/IRS control test	• Fines for failure to give proper notice to employees and to local government.
Employee Retirement Income Security Act ("ERISA"): employee pension and welfare benefits under the law	Common law/IRS/Control test	• Liability for benefits not received • Equitable relief • Attorney's fees and costs

Original: 2122

My name is **Denise Taylor Patterson**, I am the director of Early Intervention Services for Philadelphia County. I would like to start by saying that I am pleased that the draft regulations for early intervention are moving towards being finalized after years of work and effort on the part of many across the state of Pennsylvania and specifically in the Philadelphia Early Intervention Community.

Overall I believe that having regulations to guide our practice is a good, however, there are many things contained in these draft regulations that are unclear and other things that could adversely affect the early intervention community. I will only speak about a few of those areas this morning, and give more exhaustive feedback in my written comments to the State.

4226.55 (2): The role of the Early Interventionist seems to supplant the role of the service coordinator. The way both positions are described, it is not clear who has the primary role of coordinating the service. In the draft regulations it is identified under point two that the Early interventionist is responsible for 'implementing the child's IFSP directly or by supervising the implementation of services provided by the early intervention personnel.' Certainly the early interventionist should be involved in this process but this role should primarily be the service coordinator's responsibility, given their overall function to "coordinate the ...IFSP implementation", as described in other places within theses same regulations. To reflect this, the regulations should read; An early interventionist is responsible for "implementing the child's IFSP directly or by supervising the implementation of services provided by the early intervention personnel, **in conjunction with the service coordinator.**'

4226.56 (b): The additional 6 credit hours of training annually that is required for the Early interventionist in the draft regulations is excessive. The 6 credit hours imply that college credit is necessary, which will put an undue financial burden on the early interventionist to maintain annually. Additionally, Philadelphia County has implemented 24 hours of required annual training for all service providers (also required in the draft regulations) that is conducted by the Teaching and Learning Collaborative (TLC). This along with whatever licensing, certification or continuing education units that are required by the particular field of study should be sufficient to insure ongoing staff growth and the continuous development of skills.

4226.13: The county should not be limited in its use of state funds to satisfy the financial commitment for services when a family declines the use of their private insurance to cover early intervention services for their child. Likewise, when a family exercises their right not to consent to the application for waiver funding for their child. In these situations, although funding might have been paid for by another source, that source becomes unavailable to the county when a family chooses not to access them for their child's service and state funds should therefore be made available.

Denise Taylor Patterson

Finally, under **4226.5**, Definitions, it is confusing to define the County MH/MR program (legal entity) as "...providing a continuum of care in the community for the mentally disabled." There needs to be a broader definition that recognizes that the County MH/MR program has responsibility for both children and adults. The children who are eligible for early intervention services through the County MH/MR may have a wider spectrum of conditions that do not include a cognitive delay. Therefore, the definition should be expanded to include these children, and I suggest that "people first" language be used and the population described as **persons with disabilities**.

Original: 2122

(1)

Good Morning, Everyone. My name is Debra Naso and I am the mother of a 2 year old deaf girl who hears every speech sound through a cochlear implant. Her oral teachers of the deaf expect her to be ready for the mainstream with minimal support by age 5. Oral teachers believe that sign language would distract her from her learning to listen to the new sounds, and instead train parents to provide an home environment that stimulates speech and hearing.

I am here because my deaf child's progress is typical for oral deaf implanted preschoolers , now that we finally have the technology to make the oral method work for nearly every child. Yet in the city of Philadelphia, many parents do not know this is possible. Why?

Because in Philadelphia, Childlink's untrained staff refers all deaf children to a staunch opponent against oralism, the Pennsylvania School for the Deaf, without regard to a child's level of hearing loss, their audiological prognosis, or of families' goals. Few newly diagnosed families are able to comprehend that their child is now a part of the most vicious methodology war known in special education: the century old war between the oralists, who believe that through modern science, most

deaf children will be able to belong to the hearing world, and the manualists, who believe that deafness is part of a child's identity to be celebrated and that it is immoral to take the deafness away. Childlink gives no warning.

Before calling for an evaluation, I researched and chose the method that I wanted. I called Childlink and told them that I did not want to be seen by PSD evaluators because they use different criteria to evaluate potential and risks, but even after naming an oral evaluator that I preferred and speaking to a Childlink supervisor, I was told that I would not be allowed to see a teacher from outside the county, only from PSD.

Following the evaluation, and despite my insistence that I was not ready, the team insisted that an IFSP be put in place that day. Instead of having a oral teacher there as I had intended, I settled for a phone consultation with her secretary. A few months later, a mother who lives in the same area asked for the same services and was told that she could not have them and that perhaps I had had a doctor's note. She now pays cash for a private teacher, as do many parents who've decided that training their service coordinator about Deaf education and advocating

for them to provide auditory/oral education was too overwhelming to even try.

City pediatric audiologists complain that some of their deaf patients have been fitted so well with modern hearing aids, that the children could certainly catch up with language delays with auditory/oral intervention. However, under Childlink & PSD, these children are taught to sign, instead of being stimulated to speak and listen. Their voice quality is poor, their English skills are limited, and their parents are absolutely certain that they should expect no more. Other children, who do begin to speak instead of sign, are simply dropped by PSD, yet Childlink's staff does not understand the need for continuing auditory & speech training, so no additional evaluations are done. These children still need help to be ready for reading at age 5, and quietly, even some of the PSD faculty are beginning to complain. However, for their administration, releasing children with hearing losses may ultimately result in the closing of their school.

I say, it is not a parent's choice when teachers are censored by their administration from telling parents that signing to some of these children

is not necessary. It is not a parent's choice when teachers who reject the idea of artificial hearing, and therefore, study little on the subject, present their opinions to parents as a professional representing facts. No teacher working for a school for the deaf, be it oral or manual, are free to be unbiased The evaluators should not come from the same method, and certainly not from the same private school.

Last month Elwyn opened a new oral program for these children, but will parents be told about this option or will they simply be transitioned into PSD again? And even for those children who are placed in one of the new oral preschool program, the damage may have already been done. The prime language years are from birth to three, and it is unrealistic to think that their voice quality, speech and auditory skills will ever reach the levels that they could have had Childlink's staff given the parents' options.

Area hospitals have now begun Universal Hearing Screening for newborns. Children will now be identified as hearing impaired within days after birth instead of the previous average age of 2 1/2 years If early intervention, ideally in the first six months of age, includes modern

audiological devices & good auditory/oral parent training, all deaf children may some day be sitting in the same classroom as the hearing peers. Parents need to know that their deaf child's identity does not have to be defined by damaged ear tissue and oral language need not take any longer to develop than in a normal hearing child--about 2-3 years. Sign is now a choice, not a necessity.

The Deaf Community have dealt with much heartache. It is a tribute to them as a people that despite it all they feel confident and whole. I respect a parent who chooses sign because they can't bear to see their child struggle. But it is a new era in Deaf Education and I will not sacrifice my child's voice, my child's literacy, and my child's taxpaying potential to the preservation of their language. English, the largest, most powerful and precise language on Earth is her birthright to own; silence is not. Parents have a right to choose. Childlink's administration has a moral duty to give the two sides of the Deaf Ed debate equal access to these children's futures.

Original; 2122

I find it ironic that at a time when the nation and the two major party candidates are clamoring for better schools with more qualified teachers that I am composing testimony to protest proposed changes that could possibly lessen the quality of E.I. services. It is inconceivable that parents of typical children would settle for classrooms staffed by inexperienced teachers whose degress are in any given field. The early interventionists, service coordinators and staff that come in direct contact with our children should be highly qualified. At the very least, they should have a degree in a field that has prepared them to work with children with special needs and their background of experience should reflect the same. It is also crucial that once a team of professionals has determined that a child is in need of services, those services should be delivered in a manner that reflects the name of the system - earli

intervention. If there is no definitive timeline for the start of services, a child who is already at a deficit is losing precious time - time in which they could be making significant gains. I truly believe that my daughter has rebounded so well from the infantile spasms that rendered her listless and vacant, because she received services in a timely manner from a group of well-trained, skilled and caring professionals. Every child in need of E.I. services deserves the same.

Respectfully,

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