MINUTES

LEGISLATIVE EDUCATIONAL PLANNING COMMITTEE

September 25-26, 2006
Room 514-S—Statehouse

Members Present

Representative Kathe Decker, Chairperson
Senator Jean Schodorf, Vice-Chairperson
Senator Marci Francisco
Senator Mark Taddiken (September 24)
Senator Ruth Teichman
Senator Roger Pine
Representative Barbara Ballard
Representative John Faber
Representative Deena Horst (September 24)
Representative Steve Huebert
Representative Eber Phelps
Representative Jo Ann Pottorff

Member Absent

Senator John Vratil

Staff Present

Carolyn Rampey, Kansas Legislative Research Department
Sharon Wenger, Kansas Legislative Research Department
Michele Alishahi, Kansas Legislative Research Department
Audrey Dunkel, Kansas Legislative Research Department
Theresa Kiernan, Office of the Revisor of Statutes
Art Griggs, Office of the Revisor of Statutes
Diane Minear, Office of the Revisor of Statutes

State Department of Education Staff

Dale Dennis, Deputy Commissioner

Conferees

Dr. Michael Wasmer, Parent of a Child with Autism, Co-founder of the Kansas Coalition for Autism Legislation
Dr. James Sherman, Department of Applied Behavioral Sciences, University of Kansas
Dr. Rich Simpson, Professor of Special Education, University of Kansas
Dr. Bruce Passman, Deputy Superintendent, USD 497 (Lawrence)
Dr. Gary Daniels, Department of Social and Rehabilitation Services
Dr. Larry D. Clark, Executive Director, Jones Institute for Educational Excellence, Emporia State University
Dr. Connie Briggs, Director, Reading Recovery Program, Jones Institute for Educational Excellence, Emporia State University
Mr. Roger Casswell, Director, National Board Certification Program, Jones Institute for Educational Excellence, Emporia State University
Dr. Scott Waters, Director, Future Teacher Academy, Jones Institute for Educational Excellence, Emporia State University
Alice Womack, State Child Care Administrator, Department of Social and Rehabilitation Services
Dr. Gayle Stuber, Education Program Consultant for Early Childhood, State Department of Education
Dr. Eva Horn, Professor of Special Education, University of Kansas
Charles "Chip" Wheelen, Kansas Association of Osteopathic Medicine
Jodi Mackey, Director, Nutrition Services, State Department of Education
Dr. Sally Roberts, Associate Dean, School of Education, University of Kansas
Gail Sprecher, Audiologist/State ATU Program Coordinator, Kansas School for the Deaf
Erin Schuweiler, Early Childhood Team/Parent-Family Services and Resources, Kansas School for the Deaf
Ruth F. Mathers, Campus Director, St. Joseph Institute for the Deaf, Kansas City Campus
Kim Klomfahs, Parent of a Hearing Impaired Child
Neil Guthrie, Director, Special Education and Support Services, USD 259 (Wichita)
Jim Hays, Research Specialist, Kansas Association of School Boards

Monday, September 25

Services for Autistic Children

The Legislative Coordinating Council directed the Committee to review services for autistic children at the initiative of Senator Dennis Wilson. Dr. Michael Wasmer, the parent of an autistic child, described the efforts his family has made to get services for his daughter (Attachment 1). He told the Committee that his daughter was officially diagnosed with autism when she was 27 months old. Dr. Wasmer and his wife decided to hire services directly for their daughter when the manager of the local Infant and Toddler Service told the family that the child did not need an intensive level of services. Dr. Wasmer said his family spent $35,000 per year, with no insurance reimbursement, for more than two years for a team of service providers. Dr. Wasmer said his daughter now is in the second grade and is doing well in a school district special education program. He told the Committee he believes her progress is due to the intensive early intervention she received. Based on his experiences, he identified several obstacles families with autistic children face:

- **Early and Accurate Diagnosis**. Early diagnosis of autism is critical, but the two places in Kansas where diagnoses are made are the Developmental Disabilities

Center at the University of Kansas Medical Center and the Section of Developmental and Behavioral Sciences at Children's Mercy Hospital. Both facilities have waiting lists of about four months. Further, many insurance companies do not pay for diagnostic evaluation for children suspected of having autism.

- **Early and Appropriate Intervention**. Dr. Wasmer cited research findings which report effective treatment of children with autism when children have early and intensive therapy. Dr. Wasmer noted the National Research Council's recommendation that educational services should begin as soon as a child is suspected of having autism and should include a minimum of 25 hours a week, 12 months a year. According to Dr. Wasmer, the Infant and Toddler Program, which is the point of entry for most newly diagnosed children with autism, does not always fully inform parents of best practices for autistic children and instead provides substandard therapy.

- **Insurance**. Parents who decide to pay for services directly often incur expenses in excess of $30,000 a year, which insurance companies usually do not pay. Companies also do not pay for related services, such as speech and occupational therapy.

- **School District Special Education Programs**. According to Dr. Wasmer, most school districts are not prepared to provide intensive programs for autistic children, primarily because of the cost. However, Dr. Wasmer contended that, given the increasing number of autistic children and evidence that early intervention saves money later on, the investment of money in intensive, early intervention services save money later.

- **Shortage of Trained Personnel**. The University of Kansas has two programs that train providers of educational services to autistic children–the Department of Applied Behavioral Sciences and the Department of Special Education. The State Board of Education licenses only graduates of the Department of Special Education to work in the public school system. According to Dr. Wasmer, it is often graduates of the Department of Applied Behavioral Sciences who provide intensive services to autistic children paid for by their families. Dr. Wasmer told the Committee he believes behavior analysts are leaving Kansas to work in states where they can be employed by the public schools, thus contributing to a shortage of trained personnel in Kansas.

Dr. Wasmer told the Committee the Legislature should enact legislation that would do the following:

- Create a **Legislative Autism Task Force** to recommend best practices for autistic children; align agencies that provide services for autistic children; access existing services for screening, diagnosis, and treatment for autistic children; and address the need to increase the pool of qualified professionals and paraprofessionals who can provide intensive behavioral therapy.

- Create an **Autism Insurance Task Force** to investigate insurance coverage of services for autistic children.

- Create an **Autism Registry** to provide accurate numbers of people with autism in Kansas in order to accurately budget for the cost of services, to improve current knowledge and understanding of autism spectrum disorders, and allow for complete epidemiologic surveys of the disorder.

- Provide an **additional funding source** for programs that provide evidence-based intensive behavioral therapy, including home-based programs provided by parents.

- Increase the **pool of qualified service providers** by enacting a scholarship program with a service commitment in order to encourage behavior analysts to stay in Kansas. In addition, encourage the State Board of Education to officially acknowledge behavior analysts in its certification process.

In response to a question, Dr. Wasmer said the increase in the number of autistic children could have several explanations, including more awareness of traits autistic children exhibit, a broadening of the definition of "autism," or an actual increase in autistic children because of medical and other conditions.

Dr. James Sherman, Department of Applied Behavioral Sciences, University of Kansas, reinforced many of Dr. Wasmer's points about the importance of early intervention and intensive services for autistic children (Attachment 2). Dr. Sherman told the Committee there are many conflicting theories about how to deal with an autistic child and many parents either do not know where to get information or are confused by information they get. Further, families do not know how to obtain services and often find that the services are expensive.

Dr. Sherman said some interventions for young children have been empirically evaluated and there is evidence that behavioral interventions (also called "applied behavioral intervention" and "applied behavior analysis") have "both the most evidence for its effectiveness and the most substantial amount of effectiveness." (Dr. Wasmer, the previous conferee, supports this treatment of autism.)

Dr. Sherman said research shows that the most successful interventions must be early, intensive, of sufficient duration (from two to four years), and systematic (building from simple to complex skills).

In response to a question, Dr. Sherman said an autistic child usually is spotted by the child's doctor. Diagnosis is made on the basis of observation, not on the basis of a medical test. Dr. Sherman said it takes four to six months to see someone qualified to make a diagnosis, which is one of the problems in getting early treatment for autistic children.

Dr. Rich Simpson, Professor of Special Education, University of Kansas, began his presentation by describing the spectrum of disorders and various classifications of autism (Attachments 3 and 4). He told the Committee there is "fierce debate" over what causes autism and how it should be treated. While there are many intervention and treatment choices, there is little scientific support for a clearly effective treatment plan.

According to Dr. Simpson, while there is validation of some treatments and interventions, there is no widespread consensus that there is a single best-suited and universally effective method or program for all autistic children. What this means, in his opinion, is that those treatments that do produce desired outcomes ought to be integrated to address the needs of individual children.

Commenting specifically on the level of services advocated by Dr. Wasman, Dr. Simpson said 25 to 40 hours a week year-round is unrealistically intensive on both the child and parent's part and leaves no time for other activities, such as speech and occupational therapy.

Dr. Bruce Passman, Deputy Superintendent, USD 497 (Lawrence), offered his perspective as an educator with experience in the field of special education (Attachment 5). Dr. Passman pointed out that Kansas and federal law dating back to the 1970s require school districts to provide special education services for all children with disabilities. According to Dr. Passman, the teaching practices and procedures that have developed over the last several decades apply equally well to all children, regardless of their area of exceptionality.

Dr. Passman singled out New York State as having an effective autism program, which emphasizes key areas in which treatment must be provided, but which does not require adherence to a particular intervention model. The key areas are the following:

- Communication skills;
- Social development;
- Behavioral and emotional training;
- Cognitive development;
- Sensory and motor development;
- Preacademic and academic development; and
- Parent training and support.

Dr. Passman told the Committee he believes there is consensus among special education directors in Kansas regarding the following:

- There is no single methodology that can be applied to each student;
- There is no "25 or 30" hour magic bullet;
- Periodic monitoring of student progress is an expected feature of good programs for students with autism;
- Parents and educators must form positive, cooperative, and collaborative relationships;
- Community agencies should be on the team and work toward expanding those resources that are limited or unavailable;
- For students with autism, there should be a bias toward the most inclusive method of providing services;
- Special education administrators should be viewed as special education advocates, not as the "enemy"; and

- Students, teachers, parents, and members of the Individual Education Plan (IEP) team should form good relationships.

Dr. Gary Daniels, Secretary of Social and Rehabilitation Services, described the Department's initiative to implement an early childhood program for autistic children (Attachment 6). Dr. Daniels explained that the Department and the Governor's Commission on Autism held public meetings across the state and identified needs of families with autistic children. These include respite care, parent support and training, attendant care, social skills training, behavioral intervention, therapeutic daycare, and case management. Dr. Daniels reinforced the point made by other conferees about the importance of early, intensive intervention and discussed the likelihood that the investment of money early on would reap savings later.

The specific proposal is that the Department would explore the option of obtaining a Medicaid waiver that would allow services for children to be provided without regard to parental income and also would waive certain requirements in order to provide more services. Under the proposal, funding provided under the program could not be used to provide services which already are mandated to be provided by other agencies.

Report on Activities of the Jones Institute for Educational Excellence: Emporia State University

Dr. Larry Clark, Director, Jones Institute, introduced his staff. (All staff presentations are contained in Attachment 7.)

Reading Recovery Program

Dr. Connie Briggs, Director, Reading Recovery Program, reported that 66 school districts in Kansas use the Reading Recovery Program, which is a reading intervention program for first-grade students who find learning to read and write difficult. In 2005, 1,069 students were served by the Program. In that same year, 80 percent of those students completing an average of 18 weeks of intervention were finally able to read and write within the average or above compared to their peers. There were 138 Reading Recovery teachers in Kansas in 2005. It costs about $7,500 to train a Reading Recovery teacher.

Dr. Briggs responded to a question regarding sustained gains indicating that evaluation has shown that reading and writing gains are sustained at least through the fourth grade. She told the Committee that seven other states have shown similar outcomes.

Dr. Briggs reviewed information on Reading Recovery successes and cost savings, which are contained in Attachment 7.

National Board Certification Program

Mr. Roger Caswell, Director of the National Board Certification Program, told the Committee that the National Board for Professional Teaching Standards was formed in 1987. Its mission is to advance the quality of teaching and learning by developing professional standards for accomplished teaching, creating a voluntary system to certify teachers who meet those standards, and integrating certified teachers into educational reform efforts. The rigorous performance-based assessment takes between one and three years to complete and measures what accomplished teachers should know and be able to do.

There are more than 47,000 National Board Certified Teachers nationwide, including 204 in Kansas. A Kansas map presented in Attachment 7 shows the location of current Board Certified teachers as well as 2006-07 National Board candidates.

In answer to a question regarding the Program's successes at recruiting rural area teachers, Mr. Caswell told the Committee that he is working to recruit rural teachers and that some financial aid to assist in paying for the process is available.

Future Teacher Academy

Dr. Scott Waters, Director of the Future Teacher Academy, reported that over the past 17 years, the Kansas Future Teacher Academy has graduated more than 840 Kansas juniors and seniors. A Kansas map presented in Attachment 7 shows that the vast majority of Kansas school districts have been represented in the Academy. A survey of 335 participants attending the 1989 – 1997 academies indicated the following:

- 92 percent of the participants stayed in Kansas to attend college; and
- 65 percent selected teacher education as their field of study.

The Academy recruits the "best and the brightest" of Kansas students, with 80 percent having GPAs above 3.25.

Development and Implementation of Kansas Early Learning Guidelines

Alice Womack, State Child Care Administrator, Kansas Department of Social and Rehabilitation Services, described the early childhood initiative, "Good Start, Grow Smart" which was developed to help strengthen early learning for young children, age birth through five (Attachment 8). "Good Start, Grow Smart" complements the "No Child Left Behind" requirements.

In an effort to improve a child's readiness for kindergarten, a collaborative effort in Kansas has resulted in the Kansas Early Childhood Guidelines. These are voluntary guidelines aimed at helping child care providers for those children through five years of age standardize and promote early learning efforts.

Ms. Womack told the Committee that Kansas' efforts at collaboration between state agencies and other partners are legendary among other states.

Dr. Gayle Stuber, Education Program Consultant for Early Childhood, Kansas Department of Education, explained how Early Learning Guidelines and Standards will provide a framework for

developing curriculum development and selection (Attachment 9). The Guidelines and Standards are designed to help attain the goal of preparing children to begin school ready to learn and succeed in school. Dr. Stuber stressed how the Guidelines and Standards were developed collaboratively with all early childhood partners participating, including Head Start, Parents as Teachers, State Departments of Education, the Department of Health and Environment, and the Department of Social and Rehabilitation Services, Smart Start, and the Kansas Association of Child Care Resource and Referral Agencies (KACCRRA). The hope with this collaboration was to align all guidelines and standards among all the programs and agencies educating young children.

These Guidelines and Standards currently are being finalized, and will be sent to all those affected very soon. The KACCRRA will do training for child care providers. (Details of the Guidelines and Standards are included in Attachment 10.)

Dr. Stuber indicated that the state's four-year-old at-risk programs also would be using these guidelines and standards. She said that teachers of autistic children also would be given direction via the Early Learning Guidelines and Standards.

Dr. Eva Horn, Professor of Education, University of Kansas, explained that Early Learning Guidelines and Standards will guide early educators in planning curriculum for young children and assessing the children's progress in achieving those expectations (Attachment 10). The Guidelines and Standards provide a common language and understanding for all early educators, including child care providers, to communicate regarding children's learning expectations, accomplishments, and capabilities.

Response to Committee Questions about the Osteopathic Medical Service Scholarship

Charles "Chip" Wheelen, Kansas Association of Osteopathic Medicine, responded to information presented at the August 25, 2006, Committee meeting indicating the Osteopathic Medical Scholarship Program had a lower compliance rate than other scholarship programs (Attachment 11). The Committee requested the Kansas Association of Osteopathic Medicine respond regarding this issue.

Mr. Wheelen told the Committee that he tells students who call him requesting information about this scholarship program that it is "indentured servitude." He explained that the term "noncompliance" with program requirements is a misnomer. He said that the majority of those included in a category of "noncompliance" actually have paid the scholarship money back plus interest.

Requirements to fulfill the service agreement are graduation from medical school, receipt of a Doctor of Osteopathy degree, and practice of primary care in a rural Kansas county. The term of primary care practice in a rural county is one year for each year of scholarship.

Mr. Wheelen indicated a student's path may not meet these requirements for several reasons:

- A student may decide that he or she wishes to pursue a different graduate degree;
- A student may not succeed academically;
- A student may decide to pursue a different medical specialty, such as surgery or radiology; or
- A student may decide not to return to Kansas after completion of training.

If any of these situations occur, a student is required to repay the state every dollar of scholarship received plus interest, which currently is at 13 percent. Interest accrues from the date the scholarship money was first received (several years retroactive).

Mr. Wheelen told the Committee that he has known of instances when a practice in an area of the state or in a state other than Kansas was willing to pay off the scholarship and interest in order to entice the student to practice at the clinic or in the other state.

Mr. Wheelen concluded that the current status could be viewed in several ways. Because about two of five scholarships have been repaid, the program could be viewed as having failed its objective. If the Legislature were to amend the laws to repeal the primary care or rural practice requirements, the compliance rate would increase.

On the other hand, the Legislature could be seen to have made a wise investment of public funds because the original scholarship has been repaid, in many instances, with interest.

Representative Ballard pointed out that the state is not a bank and the purpose of the Osteopathic Medical Scholarship Program is not to make a good return on investment, but rather to locate medical professionals in rural communities.

According to information provided by the Kansas Board of Regents at the August 25, 2006, meeting, there have been 355 Osteopathic Scholarships awarded. Of that total, 124 students now practice in rural Kansas communities and 118 have been repaid with interest.

Mr. Wheelen suggested that an alternative approach encouraging students to stay in Kansas might include providing grants or loans to students once they had graduated and were ready to begin their practices. That might be a time to entice graduates to practice in rural areas.

Committee members asked that information regarding current needs in medically under-served areas be presented at the next Committee meeting.

Tuesday, September 26

School District Nutrition Programs

Jodi Mackey, Director of Nutrition Services, State Department of Education, gave the Committee an update on school district nutrition programs (Attachments 12 and 13). Ms. Mackey explained that the United States Congress, alarmed about childhood obesity and other health programs that affect children, enacted legislation that requires “local wellness policies.” These policies were implemented by July 2006, and require state education agencies to develop policies that address the following:

- Nutrition guidelines for all food available on the school campus during the school day;
- Assurance that school meals meet United States Department of Agriculture requirements; and
- Goals for nutrition education, physical activity, and other school-based activities designed to promote student wellness.

Legislation enacted in Kansas also directs the State Board of Education to develop nutrition guidelines for all foods and beverages made available to students in Kansas public schools during the school day. These guidelines must address providing healthful foods and beverages, physical activities, and wellness education with the goals of preventing and reducing childhood obesity.

Ms. Mackey told the Committee that the State Board developed three levels of goals: basic (which meet the federal requirements for food service programs), advanced, and exemplary. These goals were developed with input from national and Kansas experts. A main feature of the guidelines is that it is up to local boards of education to select their own wellness policy. The only requirement is that they have a policy and that, in developing it, they take into account the State Board's guidelines.

Ms. Mackey said that the State Department of Education had held 12 training sessions around the state to educate food service workers and other school personnel about the guidelines. These sessions were sponsored by the Kansas Health Foundation and were attended by more than 1,100 persons. Topics discussed included the childhood obesity crisis, the role of schools, requirements for a wellness policy, how to develop a wellness policy, and resources available to help.

Ms. Mackey said activities underway in school year 2006-07 include the development of a new website which links the guidelines to additional resources and ongoing technical assistance from the State Department of Education.

Ms. Mackey illustrated one district's wellness policy by including in her packet of information an article from the *Lawrence Journal World* which describes a three-year plan proposed by officials in the Lawrence school district (Attachment 14):

- **Year One**. Cut back on most of the fatty and sugary items sold a la carte in elementary schools and in vending machines and school stores at the junior and high school level.

- **Year Two**. Require that food for classroom rewards, parties, snacks, and celebrations will have to meet the same guidelines as Year One for a la carte and vending machines.

- **Year Three**. Require school employees to adhere to the vending machine guidelines adopted for students.

Ms. Mackey also gave an example of how a wellness policy can improve student achievement. She described Anthony Elementary School in USD 453 (Leavenworth), which is an urban school with 63 percent minority enrollment and 83 percent of its students on free and reduced lunch. After implementation of a wellness policy, test scores improved, more parents became involved, and teacher turnover went down. In addition, there are fewer incidents of vandalism and student bullying. Ms. Mackey said there is structured physical activity and teachers eat at school with the students. She said the State Department of Education has a grant to try to replicate the success at Anthony Elementary School at four or five other schools.

As a point of interest, Dale Dennis, Deputy Commissioner, State Department of Education, said that Kansas is the only state in the nation that gets cash in lieu of surplus agricultural commodities. He said Senator Robert Dole is responsible for Kansas being the exception.

Educational Programs for Children with Cochlear Implants

Dr. Sally Roberts, Associate Dean of the School of Education, University of Kansas, explained how deafness has been dealt with historically and, in particular, how the two philosophies of how to deal with deafness–sign language and spoken communication–developed (Attachment 15). She explained that manualism (sign language) developed in order to enable monks who had taken a vow of silence to communicate. She said the controversy in Europe as to which was better—manualism or the oral method—came to the United States and resulted in bitter debates among, for example, Alexander Graham Bell and Edward Minor Gallaudet, the son of the founder of an institution to teach deaf students in Connecticut. At the 1880 Congress of Milan, participants voted to proclaim the German oral method the official method used in the schools of many nations.

According to Dr. Roberts, most states in the United States established schools for the deaf by the first half of the 1900s. (Kansas established a school in 1861.) The enactment of the Education of All Handicapped Children Act in 1975 changed the primary location for educating students with hearing loss from residential schools to programs in local school districts.

Dr. Roberts said that many states now require that infants be screened for hearing loss. This, and the requirement that special education services be provided for children by three years of age, have resulted in early intervention for children with hearing losses.

With specific reference to cochlear implants, Dr. Roberts defined them as follows:

> A cochlear implant is a surgically implanted electronic device that can help provide a sense of sound to a person who is profoundly deaf or severely hard of hearing. Unlike hearing aids, the cochlear implant doesn't amplify sound, but works by directly stimulating with electrical impulses any functioning auditory nerves inside the cochlea. External components of the cochlear implant include a microphone, speech processor, and transmitter.

Dr. Roberts said cochlear implants are somewhat controversial and have tapped into the old controversy about which mode of communication is best. She said the medical model views deafness as a disability that requires a "fix," while the cultural model views deaf people as a cultural minority with their own language, history, and heritage. Dr. Roberts emphasized that a cochlear implant will not cure deafness or hearing impairment, but is a prosthetic substitute for hearing. She said adults who have grown up deaf often find the implants ineffective or irritating. Results with small children are mixed. She cited several studies of academic achievement of children with implants, which focused on both how well the students performed and what mode of communication they used.

One particular study in Scotland showed that children with cochlear implants performed better than nonimplanted profoundly deaf students, but cautioned against attributing the difference to the implants. Older deaf students with implants were further behind their hearing peers than younger deaf students. The most prevalent placement of the students in the study was in a mainstream setting, but a number of the students moved from mainstream schools to other types of placements over time, leading the researchers to conclude that the students had a continued need for access to specialized training and educators despite having a cochlear implant. The researchers found it extremely difficult to categorize the different linguistic environments of deaf students because the students were in such a variety and combination of communication modes. According to Dr. Roberts, they concluded that "what determines the use of Total Communication is local values and

beliefs, knowledge, skills, experience, policies, and politics."

Dr. Roberts told the Committee that a cochlear implant costs about $60,000 for the implant and $6,000 to replace the processor. She said a problem educating deaf children is a shortage of deaf educators, which is more acute in some parts of Kansas than in others.

Dr. Gail Sprecher, Audiologist, Kansas School for the Deaf, and Erin Schuweiler, Early Childhood Team/Parent-Family Services and Resources, Kansas School for the Deaf, emphasized that a cochlear implant does not restore or create normal hearing and does not amplify sound like a hearing aid (Attachment 16). Dr. Sprecher told the Committee a cochlear implant can improve access to sound, but does not guarantee that a child will develop spoken communication or be able to rely on auditory information alone to acquire language.

Dr. Sprecher said the Kansas School for the Deaf supports a bilingual approach to educating deaf children and uses American Sign Language as the child's first language, with the development of English as a second language through reading, writing, and spoken language. She said children with cochlear implants may become efficient oral communicators for social situations, but need sign language for critical or abstract thinking, problem solving, and assimilating new information. She said "one size does not fit all" and educational choices should be determined based on the needs of each individual child.

Dr. Sprecher said 15 students at the Kansas School for the Deaf (11.7 percent) have had cochlear implants, of whom ten are still using them. Implants are not specified by a child's IEP or paid for by school districts.

Dr. Roberts responded to a question about whether there are lawsuits pending to require school districts to pay for cochlear implants by saying she knows of no pending suits, but there are always "rumblings."

Ruth Mathers, Campus Director of the St. Joseph Institute for the Deaf in Kansas City, described the Institute's program, which is based completely on oral communication (Attachment 17). Ms. Mathers told the Committee it costs $26,000 per student per year at the St. Joseph Institute, compared to $40,000 in a public school and $59,000 at the Kansas School for the Deaf.

Ms. Mathers told the Committee that advancements in technology, including cochlear implants, provide a greater opportunity for deaf children to grown up in a hearing world. According to Ms. Mathers, an auditory-oral education allows children to be placed in the local school setting at an early age with minimal support services. However, many school districts continue to emphasize sign language, in part because newly-trained teachers cannot provide auditory-oral services.

Ms. Mathers provided the following facts about St. Joseph:

- The early intervention program has auditory-verbal emphasis and serves children year round from birth to three years old;
- The academic program has auditory-oral emphasis with auditory-verbal speech therapy while following a typical school calendar and academic curriculum. Children three years through 12 years attend school five days a week from 8:30 until 3:30;

- Teachers hold baccalaureate or masters degrees in deaf education with an emphasis on auditory-oral education;

- Therapists are specialists in teaching spoken language and speech to deaf

children utilizing auditory-verbal techniques and strategies;

- The Institute employs the only certified Auditory-Verbal Therapist in Kansas;

- The Institute is the only deaf education program in Kansas with an Educator of the Deaf as acting administrator; and

- The Institute is the recognized habilitation and rehabilitation center of excellence in the Kansas City area for children and adults with varying degrees of hearing loss–specifically for individuals utilizing a cochlear implant.

Ms. Mathers told the Committee that the maximum amount of time a child stays at the Institute is six years. Half of the 60 students at the Institute have come from school districts. Ages of children served range from three to nine years old.

Kim Klomfahs, a parent of a hearing-impaired child, spoke in support of the education her child is receiving at the Institute.

At the conclusion of her presentation, Ms. Mathers showed a video about "Reagan," a child with cochlear implants. The video showed Reagan at different ages and demonstrated the growth in Reagan's ability to communicate.

Neil Guthrie, Division Director of Special Education/Support Services for USD 259 (Wichita), discussed educational programming for children with cochlear implants (Attachment 18). Mr. Guthrie said school districts are not financially responsible for providing surgically implanted devices for students with disabilities. However, school districts are enrolling more students with cochlear implants because early identification of hearing loss is finding children at a younger age who will benefit from the implants and physicians are making parents aware that early implantation may help a child enter school with near-age appropriate speech and language skills. He said that, as a result, more and more parents may be asking school districts to provide their children with speech and listening skills as opposed to sign language.

Mr. Guthrie listed the types of services that are typically provided to deaf and hard-of-hearing children who have cochlear implants:

- **Speech languages services** usually provided in a pull-out setting with the goal of transitioning skills to the classroom setting;

- **Audiology services** to provide direct auditory training services or assist in the development of goals and objectives for the student;

- **Services from a teacher of the deaf/hard of hearing** as part of the educational team to provide direct or indirect services when there is significant language delay;
- **Services provided by general education staff** if the child is close to age-appropriate language skills;

- **Services of an English based sign language interpreter**;

- **Services of a language facilitator** to provide verbal clarification of items not understood, to help the general education staff deal with equipment issues, and to monitor the auditory learning environment;

- **Services of a child study team** to do evaluations to ensure the child is learning

the curriculum; and

- **Parental input and participation**.

Mr. Guthrie acknowledged that controversy exists as to the proper method of educating children with cochlear implants. He said school districts must work with a variety of children who have different needs and cannot wed themselves to one single service delivery model. He said if cochlear implants are not done early enough, the child cannot be educated using the auditory-verbal method only and some sign language must be used. He said his school district currently is looking for a teacher for a group of deaf students who will be taught using the auditory-verbal method, but one of the most difficult problems a school district faces is parents who demand only one teaching method and refuse to allow the district to use an alternative method. He said his school district tries to accommodate parents who want their deaf children educated using only the auditory-verbal method, but he said the district cannot guarantee that the child will not be around deaf children who use sign language.

Shared Schools and School District Collaborative Efforts

Theresa Kiernan, Office of the Revisor of Statutes, reviewed the contents of 2006 House Bills 2625 and 3012 (Attachment 19). Both bills were identical in their original version and would have authorized school districts to enter into interlocal agreements in order to operate shared schools. Participating districts would have authority to combine the assessed valuation of the participating districts for the calculation of the payment of the cost of new facilities and to divide debt evenly among the participants. The bills included a procedure for the issuance of bonds for capital projects, subject to protest and election.

The House Committee on Education amended HB 2625 to require that the debt service be divided among the school districts based on each district's enrollment; require that any protest petition in order to be sufficient must be signed by at least 5 percent of the electors of the district in at least 50 percent of the participating districts; and clarify the language concerning the school facilities weighting.

HB 3012 was introduced by the House Select Committee on School Finance, which amended the bill to require an election prior to the issuance of any bonds; provide that if a majority of the voters in the participating districts vote in the aggregate to approve the bond issue, each district may issue the bonds; provide that the aggregate amount of outstanding bonds issued by each district would be subject to a statutory debt limit; provide that the debt service for any new facilities would be divided proportionately among the districts based upon the enrollment of each district; provide that the combined assessed valuation of the participating districts may be used when calculating the amount of state aid for bond and interest; and limit the school facilities weighting to two years.

The bill was further amended on House General Orders by Representative Ward Loyd. Among other things, his amendments would have required the closing of at least one school in each of the participating districts and eliminated the requirement that a school administrator be employed to administrate at the shared schools.

Neither bill was enacted by the 2006 Legislature. According to Dale Dennis, Deputy Commissioner, State Department of Education, school districts in Doniphan County which requested that the bills be introduced have reached another agreement, and will request that the 2007 Legislature enact legislation which is different from that proposed during the 2006 Session.

Jim Hays, Research Specialist, Kansas Association of School Boards, presented information on school district collaborative activities (Attachment 20). Mr. Hays showed how certain categories of school personnel, such as superintendents, assistant superintendents, and administrative assistants, have decreased, while other categories, such as reading specialists, kindergarten, and pre-K teachers, have increased.

Mr. Hays reported that superintendents in many school districts have additional duties, such as serving as director of Quality Performance Accreditation, as principal, director of transportation, business manager, or other position. Twelve districts share superintendents.

Mr. Hays told the Committee that the purpose of consolidation is to provide a better education for students, not to save money. In fact, consolidation may not save money.

Minutes

Upon a motion by Representative Ballard, seconded by Representative Pottorff, the minutes of the August meeting were approved.

Prepared by Carolyn Rampey
and Sharon Wenger

Approved by Committee on:

November 16, 2006
(date)