Approved 3/27/90
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

10:00 a.m./~~p.m.~~ on March 19, 19 90 in room 526S of the Capitol.

All members were present except:

Committee staff present:
Emalene Correll, Legislative Research
Norman Furse, Revisor's Office
Sandra Nash, Committee Secretary

Conferees appearing before the committee:

The Chairman called the meeting to order by asking the Committee's attention be turned to H.B. 2915. Chairman called the first proponent, Gary Haulmark, intern for Representative Nancy Brown.

Mr. Haulmark read a statement for Representative Nancy Brown in support of H.B. 2915(Attachment 1) The bill establishes the program for the Early Identification of Hearing Impaired Infants and High Risk Infants. Mr. Haulmark said the testimony included several letters in support from individuals at KU Medical Center, Wichita State University, Audiologists, Parents, Advocates of Better Communication, Kansas Commission for the Deaf and Hearing Impaired, the University of Kansas, Wichita Public Schools.

The Chairman called the proponet, Marnie Campbell, of Prairie Village, who appears as a parent of a child with an hearing impairment.

Mrs. Campbell said she was in support of H.B. 2915 and retold the problems she, as a parent, had in getting help for her son who has an hearing impairment.(Attachment 2)

The Chairman called the next proponent, Dick Vallandingham, Ph.D., an Audiologist in Shawnee, Kansas.

Dr. Vallandingham said he is appearing in support of H.B. 2915 because as an audiologist, he realizes the indepth problems of children with hearing impairments. The deaf and hard-of-hearing infants in Kansas deserve the best chance they can get.Attachment 3)

The Chairman called the next proponent, Lorraine I. Michel, Ph.D., Coordinator, Speech-Language-Hearing-Vision, Bureau of Family Health, Kansas Department of Health and Environment.

Dr. Michel said she is appearing in support of H.B. 2915 pointing out that presently Kansas does not have a program for the early identification of infants at risk for hearing impairments. This program would 1) have informational materials to families concerning the ramifications of hearing loss and 2) have follow-up hearing assessment procedures to determine the presence of a hearing loss as soon as possible and 3) have early intervention programs for the infant's language, speech, and psycho-social development, use of residual hearing, and other areas of need.(Attachment 4) Dr. Michel said KDHE couldn't support the bill from the fact of lack of funding for this program in the FY 1991 budget.

The Chairman asked what the fiscal note would be on the program.

Dr. Michel said that Michael O'Keefe, the Director of the Budget Division, said it is approximately $10,000.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

Senator Hayden said if there is no money for funding, would it be allright to change Line 39, on Page 1, the word "shall" to "may"?

Dr. Michel said you might want to talk with the sponsors about this in order to determine if they feel the bill would be equally effective if the "shall" was changed to "may."

Senator Burke said you indicated the fiscal note is $10,000?

Dr. Michel said it is as the note came from Mr. O'Keefe's office.

Senator Burke said we round off figures in access of $10,000 and is nothing to be concerned about. We would find the money for this program.

Senator Reilly said in view of the Surgeon General having a strong decision on this, whether there is any analysis on the Kansas Department of Health as to whether there is any federal funding available.

Dr. Michel said there has not been any to her knowledge. In the rough draft of the year 2000 guidelines, this is one of the goals for national health and environment. She was not aware of any monies at this time.

The Chairman called Chip Whelan, Kansas Medical Society.

Mr. Whelan said he is appearing in support of H.B. 2915, but is offering some amendments after talking with members of the Kansas Medical Society. They expressed their concern that creating a list of children with hearing impairments could cause them to be placed on a handicapped listing and could be detrimental to them. He said the professionals feel there are enough lists and should not be more. (Attachment 5)

The amendments as proposed would delete Sec. 6(b)(1),(2),(3), and add "subject to appropriations therefore," to (5) and also change the word "shall" to "may" in line 6 of page 3.

Senator Burke asked why it appears that some of the people who have children with hearing problems don't want to have contact with the state?

Mr. Whelan said that not all children have a primary care physician. It's a sad statement but the fact is that some children are brought into this world without the benefit of a pediatrician actively involved in their primary care or family practice physician. In that event, perhaps you do need a registery so you can keep track of them and make sure that there is follow up at a later time.

Senator Burke asked Mr. Whelan to tell him who identifies the high-risk child and what happens if we strike this out.

Mr. Whelan said he could tell from personal experience. My son was born approximately 6 months ago and he was screened for a possible hearing impairment. This is something that's being done in many hospitals on a voluntary basis. They have decided it's a good idea and they're doing it. It was an easy questionnaire, a young lady came in the room. She had a great deal of sensitivity and was very delicate in explaining that there was no reason to believe that my son was deaf or otherwise hearing impaired. But by going through the questionnaire and answering these questions, we could possibly identify whether or not he's at risk for an hearing impairment. We went through the process and it was painless. The questions were

easy to answer and, I'm confident from a personal experience, that it's very beneficial. The question is, if he had flunked that screening, so to speak, should his name be listed on a registry kept somewhere in the Department of Health and Enviroment, so in the event I do not have a good peditrician, who then follows up and says we need to perform the following tests to make absolutely certain that someone would insure that that infant was eventually evaluated and assessed so that they don't lose early years or early months of potential learning experience.

Senator Burke said what happens if they aren't born in a medical facility?

Mr. Whelan said hopefully they would end up at a medical care facility at some point in time and then be screened at that point in time. The way the bill is worded is "any new born infant in a medical care facility." It doesn't have to be delivered there. The bill language is very permissive. It says the "Secretary may take such other action as is necessary in the administration of the program." It gives a pretty broad discretion. But it does make it subject to appropriations. That fiscal note has been reduced from over $50,000 to less than $10,000.

Senator Burke said on Sub(2) that has been stricken, is that a concern that this would be done.

Mr. Whelan said no. It is somewhat duplicative even, because you will notice, earlier in the bill that it does require that parents be provided with a list of services available to them--Line 41 on Page 2. This language was worked out by the hospital association so that, if for example, you had a child listed or identified as high-risk, the parent would be made well aware of the facilities where they could have these follow-ups.

Senator Burke asked why Mr. Whelan had Sub (3) taken out?

Mr. Whelan said it would seem what would be the new Sub(2) "take such other action as may be necessary in the administration of the program," is pretty general direction to do whatever the Secretary sees fit. It seems to be rather encompassing.

Senator Burke said you think it's redundant?

Mr. Whelan said he thought so. It appears to be unnecessary. Mr. Whelan said he wanted to re-emphasize the balloon could be tossed in the trash and they still support the bill.

Staff Correll said we already have a law that allows any physician that is caring for a child under school age, to report to the Secretary any condition that puts that child at-risk or impairment or handicap. If, in fact, the physician who was caring for a child whose screening shows that child to be at risk, receive notice of that screening, would that physician not have to report under the other act.

Staff Furse said Page 2, lines 30 through 32 provide the information reported under this section not required be reported under the other act.

Staff Correll said what she was getting to is it seems as though we are getting half the kids in the state on a register somewhere at this stage. And she was curious as to feedback from physicians on the other register that has been in affect now for a couple years.

Mr. Whelan said he had not solicited that information specifically, but, perhaps, that is the reason that the physicians I talked with in regard to H.B. 2915 said we got enough lists already. I didn't know which lists they were talking about, but that may be the reason.

Senator Hayden said he had a question on Line 6 or page 3. You struck "may" but you then put another provision down on line 16, "subject to the appropriations therefore,". Why couldn't we leave this "shall" in there and say "subject to the appropriations"?

Mr. Whelan said that if you indicated "may" and then for some reason or other the Senate Ways and Means Committee and the House Approriations Committee did not include funding in the Ombudsman Bill, as result of the fiscal note, the Department could somehow proceed with implimentation of the program without the benefit of additional funding.

The Chairman call Tom Bell, Kansas Hospital Association.

Mr. Bell said he was appearing in support of H.B.2915 and that the hospitals in Kansas are willing to cooperate in setting up a program that would provide an efficient and effective way of screening and identifying hearing impaired infants.(Attachment 6)

Senator Burke said that his interest was as the technology grew and additional information became more available, and as our ability to deal with hearing-impaired persons increase, that a simple registry would provide the ability to notify parents on a regular basis of the technology and the changes going on and available.

The Chairman asked for the wishes of the Committee on H.B. 2915. Senator Burke made a motion to pass H.B. 2915 favorably out of Commmittee. Senator Strick seconded the motion. The motion carried. Senator Walker will carry the bill.

The Chairman called the Committee's attention to H.B. 2833 and called the first proponent, Marlene Finney, Community Base Services, S.R.S.

Ms. Finney said she is appearing in favor of H.B. 2833, because SRS cannot find enough providers of services as directed in H.B. 2012 passed last year. This bill would create a classification which, through the local SRS offices, could provide care for the consumers, as the Personal Care Attendant.(Attachment 7)

Staff Correll said the other legislation which basically relates to Attendant Care Services has been amended to delete any personal care attendants. If this is going to be a new category within the unclassified service, would there be any problem with doing away with the title "Personal Care Attendant" simply referring to all persons appointed to provide attending care services and keeping the definition Attendant Care Services as defined.

Ms. Finney said the only problem she has we envisioned these people would be doing the health maintenance activities.

Staff Correll said that's what Attendant Care Services are and if we define Attendant Care Services as it is in the bill as amended, to include those services, to say that Attendant Care Services and individuals in need of in-home has the meanings respectfully inscribed in 65-2101. I'm asking the questions, because personal care attendant has had other meanings and other usages within your programs and other programs and it seems to carry some connotations to make people uncomfortable. If possible, to use uniform language, it seems appropriate to do that.

Ms. Finney said she didn't think it would cause a problem.

The Chairman asked the Committee's wishes on H.B. 2833. Senator Hayden made the motion to pass H.B. 2833 favorably out of the Committee. Senator Burke seconded the motion.

The Chairman called Staff Correll for discussion.

Staff Correll said in order to accomplish the question I just asked, it would be necessary to amend the bill.

Senator Hayden conceptually is in favor of amending the bill according to Staff Correll. The Chairman asked if it was the concensus of the Committee. The Committee voted yes. The motion carried. Senator Walker will carry the bill.

The Chairman called attention of the Committee to H.B. 2630. The last time there was a hearing on this the Optometry people met and a handout was presented to each member of the Committee. (Attachment 8)

The Chairman called for the wishes of the Committee on H.B. 2630. Senator Hayden made a motion to adopt the amendments. Senator Burke seconded the motion. The motion carried.

The Chairman called for discussion on the motions.

Staff Furse said in addition to the balloon amendment, note that Mr. Robbins letter references a technical change on Sec. 15. On the bottom of Page15, Line 41 and 42. The current language is worded relating to the federal regulations, "from and after the effective date of such trade regulations rules." There's a problem with that because there is an effective date in those trade regulations rules, but they are not yet effective because there's a restraining order in federal courts making them not effective. So instead of saying "the effective date of the rules," we need to say "from and after the date such rules become effective." So it's clear that we're not talking about the date in the rules but the date they may or may not become effective depending on the court decision. So if that is agreeable with the Committee.

The Chairman said that is in a conceptual motion.

Senator Reilly made the motion to pass H.B. 2630 as amended out of the Committee favorably. Senator Langworthy seconded the motion. The motion carried. Senator Hayden will carry the bill.

The Chairman called the Committee's attention to S.B. 760. The Chairman said it was introduced by the Medical Association and in testimony we heard that they would like to see this placed in an interim study. The Chairman asked for the wishes of the Committee on S.B. 760.

Senator Hayden made the motion to delete Section 1 and renumber all the following Sections. The motion died for lack of a second.

Senator Langworthy made a motion to recommend S.B. 760 for an interim study. Senator Walker seconded the motion. The motion carried.

The meeting adjourned at 10:50a.m. The next meeting is March 20, at 10:00a.m. in Room 526S.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3/19/90

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Marnie Campbell, parent; Chair of Early Identification/Intervention Council	3408 W. 74th St. Shawnee Mission, KS 66208
GARY Robbins	KS Opt Assn
Dick Vallandingham Audiologist	Shawnee KS
Bill Curtis	KUA
Richard Morrissey	KDHE
Charles Konigsberg	KDHE
Lorraine I. Michel	KDHE
Keith R Landis	Christian Science Committee on Publication for Kansas
Chip Wheelen	Ks Medical Society
Ken Otte	D.P.S.
ALAN COBB	KS Resp. Care Soc
Nancy Echols	SRS
Marlene Toomey	KS/AS
Mike Lechner	KDHR/CDC
Tony Bell	Ks Hosp Assn
Kay Cole	Ks. Society of Med Tech
Paul M. Klotz	Assn. of CMHCs of Ks. Inc.
Robert Rice	KSOS

Please continue on next page

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE ____________________

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Bill Dean O.P. Ks.	Petersen & Associates

STATE OF KANSAS

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HOUSE OF
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MEMBER: GOVERNMENTAL ORGANIZATION
INSURANCE
CHAIRMAN, COMMUNITY DEVELOPMENT
BLOCK GRANT ADVISORY COMMITTEE
MEMBER, STATE EMERGENCY RESPONSE
COMMISSION

March 19, 1990

HB 2915

Mr. Chairman and Members of Public Health and Welfare -- Thank you for hearing HB 2915, Known as the Early Identification Bill for the Hearing Impaired.

Briefly, the bill establishes a program for the Early Identification of Hearing Impaired Infants and High Risk Infants. The Secretary of Health & Environment, after consultation with the Kansas Commission for the Deaf and Hearing Impaired, shall establish by rules and regulations New-Born Infant Hearing-Impaired Risk Criteria and shall develop a questionnaire to identify high-risk infants.

The Committee should know that the bill sponsors and others have worked with the Kansas Department of Health and Environment, as well as with the Kansas Medical Society and the Kansas Hospital Association. All three are supportive of the bill.

It has been my privilege to work with a number of individuals on this bill for the past year or so, and they are much more knowledgeable and articulate than I - so I will not take any of their time, but turn the podium over to the next conferee.

SPH+W
Attachment #1
3/19/90

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MEMBER, STATE EMERGENCY RESPONSE COMMISSION

Before I do so, I want the committee to know that I tried to limit testimony by encouraging written testimony to be distributed to the Committee, which includes support from individuals at the KU Medical Center, Wichita State University, Audiologists, Parents, Advocates of Better Communication, Kansas Commission for the Dear and Hearing Impaired, the University of Kansas, Wichita Public Schools among others -- I am not distributing copies to everyone, but would be happy to do so upon request.

Also included with my remarks is a list of the letters to be given to Chairman Ehrlich along with some information about Audiologic Screening of Newborn Infants, an explanation of the Auditory Brainstem Response Test and testimony from Health and Environment supporting the program.

Most of your questions will be answered through the testimony of others, but I will be available as well if I can provide further information.

* * * * *

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MEMBER, STATE EMERGENCY RESPONSE COMMISSION

HB 2915, HEARING IMPAIRED SCREENING PROGRAM - LETTERS OF SUPPORT

(Copy of actual letter presented to Senate Public Health Chairman Ehrlich)

Dr. Larry Marston, Associate Professor, Speech-Language-Hearing: Sciences and Disorders, The University of Kansas

Beth Dalton Moffitt, M.A., Speech Language Pathologist, The University of Kansas Medical Center

Marsha A. Gladhart, Clinical Instructor, Wichita State University

Molly Pottorf, M.A., Audiologist, USD 259

Don Oltean, Coordinator, Hearing Impaired Programs, Wichita Public Schools

Jame Schwartz, Teacher, Allen Elementary School, Wichita

Teresa Kennalley, M.A., Audiologist, St. Francis Regional Medical Center, Wichita

James A. Wise, Audiologist, Member of the Deaf & Hearing Impaired Commission

Heidi Reinthal, SE Kansas Education Service Center, Girard, Kansas

Kaye Webster, Hearing Impaired Teacher, McPherson County Special Education Cooperative

Karen Andregg, M.A., Clinical Audiologist, Marston Hearing Center, Lawrence

Wayne Clark, Teacher of Hearing-Impaired, Topeka Public Schools

Barry Mollineaux, M.A., KSHA (Kansas Speech, Language, Hearing Association)

Sandra Garms, Parent

Louisa Wilcox, Teacher, interpreter for deaf and hearing impaired

Ronald E. Schupner, Lenexa, parent of hearing-impaired child

Mr. & Mrs. Brian Peel, Parent, Overland Park

Terry Hostin, President, Kansas Asociation of the Deaf

David Rosenthal, Executive Director, Kansas Commission for the Deaf and Hearing Impaired

Marnie Campbell, Parent of deaf child, Chair of the KDHI Task Force on Early identification of Hearing Impaired, Early Childhood Programs Director, KU Med Center

3-90

State of Kansas
Mike Hayden, Governor

Department of Health and Environment
Division of Health

Stanley C. Grant, Ph.D., Secretary

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Testimony presented to

House Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill 2915

Congenital hearing impairment/deafness is most often a hidden disability. It can, unfortunately, remain undetected beyond the child's first, third and even fourth birthday. The severity of the problems resulting from hearing loss increases the longer the disability remains undetected. As noted in Promoting Health/Preventing Disease: Year 2000 Objectives for the Nation, "The ramifications of auditory handicaps are seen in developmental, educational, cognitive and emotional aspects of human life. Language delay and poor understanding of spoken speech...are invisible barriers that can be insurmountable for people with hearing impairments without early diagnosis and...support services."[1] To have a hearing loss go undetected is especially tragic since there are procedures available to help identify hearing loss even in newborns. We do not need to wait a year or several years. We do not need to wait until this hidden disorder becomes obvious to everyone because of severe delay in language development.

In 1986 Congress passed P.L. 99-457, the Education of the Handicapped Act Amendments,[2] that states "there is an urgent and substantial need...to minimize the potential for developmental delay." One of the key goals of P.L. 99-457 Part H, which pertains to Handicapped Infants and Toddlers, is the early identification of handicapping conditions and developmental delays. Hearing loss and speech-language delays and disorders are two of the targeted areas in this law. The early identification of hearing impairments and subsequent early intervention during the critical language acquisition stage result in: 1) reductions in the need for special education; 2) eventual increase in employment and earnings; 3) a decrease in dependence on governmental assistance programs; and 4) enriched educational attainment and lifestyle. Dollar savings can be estimated for some of these areas. No dollar values can be placed on other of these outcomes. However, hearing impaired/deaf persons, their families, and the taxpayers all gain from the early identification and intervention of hearing impairment.

Former Surgeon General C. Everett Koop, in his position paper Early Identification of Hearing Problems in Children Essential (see attachment) stated a national goal: that no child should reach the first birthday with an undetected hearing impairment. To attain this goal, he called on State agencies to help by initiating high risk screening programs for infants.[3]

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Charles Konigsberg, Jr., M.D., M.P.H., Director of Health (913) 296-1343

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Lorne Phillips, Ph.D., Director of Information Systems (913) 296-1415

Roger Carlson, Ph.D., Director of the Kansas Health and Environmental Laboratory (913) 296-1619

While incidence figures vary, it is estimated that one infant in 500 live births has a mild to severe sensorineural hearing loss and one in 1000 live births has a profound sensorineural hearing loss. The incidence of hearing loss in infants in neonatal intensive care units (NICU) increases sharply, with figures ranging from one in 25 to one in 50 births. This identification of high risk factors (such as prolonged stays in the NICU, and family history of congenital hearing loss) provides the opportunity to increase the early identification of hearing impairment. Approximately 10% of infants can be identified as high risk for hearing impairment. Of this high risk population, statistically 2.5% will have a hearing loss. Based on the 1988 figure of 37,574 live births in Kansas hospitals, 3757 infants would have been identified as high-risk for hearing impairment (10%), and 94 of those infants (2.5% of high-risk), statistically, would have a hearing loss.

At present, Kansas does not have a program in place for the early identification of infants at risk for hearing impairments. Having such a program in place would provide the opportunity for greater attention to the need for: 1) informational materials to families concerning the ramifications of hearing loss; 2) follow-up hearing assessment procedures to determine the presence of a hearing loss as soon as possible; 3) early intervention programs for the infant's language, speech, and psycho-social development, use of residual hearing, and other areas of need.

HB 2915 proposes a Kansas program to screen infants for high risk for hearing impairment. This program would be of greater long term benefit if it included follow-up of high risk infants to identify those with hearing impairments. With follow-up services, the opportunity is presented to develop early intervention programs appropriate for the needs of the hearing impaired infants and their families.

HB 2915 cannot be effective without adequate start up and maintenance funding. This bill was developed after the Department of Health and Environment's 1991 budget was developed. KDHE supports in concept the early identification of infants at risk for hearing loss, follow-up assessment to determine the presence of hearing loss, and early intervention for hearing impaired children to ameliorate problems and prevent an increase in the severity of these problems. However, no funds for the initiation of this proposed program are included in the Governor's Budget for the Department of Health and Environment and the agency can not support its funding for FY 1991.

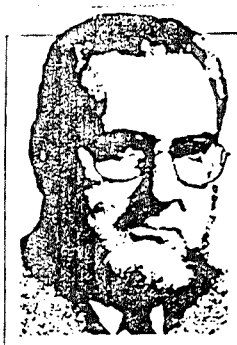
Testimony presented by: Lorraine I. Michel, Ph.D.
Coordinator, Speech-Language-Hearing-Vision
Bureau of Family Health
Kansas Department of Health and Environment
February 27, 1990

Bibliography

1. Promoting Health/Preventing Disease: Year 2000 Objectives for the Nation. Draft for Public Review and Comment; Public Health Service; U.S. Department of Health and Human Services; September 1989, p 17-4.

2. Public Law 99-457, Part H -- Handicapped Infants and Toddlers; Section 671. (a) (1).

3. Koop, C. Everett. Early Identification of Hearing Problems in Children Essential. Department of Health and Human Services, 1989.



FROM THE SURGEON GENERAL OF THE U.S. PUBLIC HEALTH SERVICE

C. Everett Koop, M.D.

Department of Health and Human Services

Early Identification of Hearing Problems in Children Essential

The harmful effects of childhood deafness are given little thought by many people because deafness is largely an invisible handicap. Most deaf infants are otherwise healthy-looking babies who develop relatively normally during the first year of life. But if deafness is not discovered in that first year . . . and the earlier the better . . . it can interfere tragically with the ability to learn to speak, to do well in school and to contribute productively to society. Helen Keller, who was born without sight or hearing, observed that she regretted her deafness more than her blindness.

Deafness in infants is a serious concern because it interferes with the development of language—that which sets humans apart from all other living things. The longer a child's deafness goes undiscovered, the worse the outcome is likely to be. Language remediation, which is what specialists call the process of teaching hearing impaired children to communicate, must begin as early as possible, because language develops so rapidly in the first few months of life. For example, by six weeks, a normally hearing infant is more attracted to human speech than to any other sound. A six-month-old baby already has an ability to analyze language—to break it down into its parts—to put those parts back together again and to store language in its brain and retrieve it. By 18 months, most children are producing simple sentences.

Fortunately, many of the negative results of deafness in babies can be prevented or substantially lessened. Many research studies have demonstrated that early intervention with hearing impaired children results in improved language development, increased academic success and increased lifetime earnings. Early intervention actually saves money, since hearing-impaired children who receive early help require less costly special education services later.

If it is to be effective, early intervention with deaf children should begin before the child's first birthday. Unfortunately, we are not doing a very good job of detecting infant deafness in the United States. A recent report to Congress and the President by the Commission on Education of the Deaf pointed out that the average age at which profoundly deaf children in this country are identified is 2½ years. In contrast, the average age at which such children are identified in Israel and Great Britain is 7 to 9 *months*.

Clearly, we must do a much better job of early identification if we are to reduce the unnecessary suffering, poor educational performance and lack of productivity that so often accompany deafness. Three groups of people must work together.

Parents are in the best position to identify their child's hearing difficulties. We need to do a better job of making parents aware of the danger signals and of the sources of help that are available to them.

Physicians need to become more responsive to parents' concerns about their child's hearing. Too often, those concerns are brushed aside or ignored. Yet, a recent study found that parents of hearing-impaired children knew about their baby's hearing loss an average of seven months before it was diagnosed and that almost half of them were given poor advice, such as "don't worry about it" or "wait until the child starts school," when they told their doctors about their concerns.

State agencies can help by initiating high-risk screening programs, such as those currently in operation in Utah, Colorado, Oklahoma, Tennessee and several other states. Research indicates that such programs are able to identify up to 75 percent of infants who are born deaf or with hearing impairments.

Many others can help, too, of course, from older brothers and sisters to grandparents and baby sitters. We in the federal government are committed to doing our part. The 1986 Education of the Deaf Act, which authorized the creation of the Commission on the Education of the Deaf, was a first step. At the National Institutes of Health, a new research institute, the National Institute of Deafness and Communication Disorders, has been authorized and is now in formation.

I am optimistic. I foresee a time in this country, in the near future, in fact, when no child reaches his or her first birthday with an undetected hearing impairment. It's a tall order, yes, but if we all work together, I believe we can fill it.

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AUDITORY BRAINSTEM RESPONSE (ABR)

The ABR is a painless test that involves applying 3 electrodes to the surface of the scalp or forehead and earlobes. Soft, spongy earplugs in the ear canal may also be used. This test is designed to measure the response of the inner ear, hearing nerve and auditory centers in the lower part of the brain (brainstem) to sound stimulation. The electrodes are attached and the test is performed with the patient seated in a comfortable, reclining chair in a sound proof room. Earphones are placed over the ears which will deliver click-type sounds to each ear. Soft earplugs are sometimes used instead of earphones. The clicks evoke a response from the ear that is picked up by the electrodes and fed to a computer where it is stored and displayed as a waveform. This waveform is then analyzed by the Audiologist. ABR is very useful in identifying the site and cause of certain hearing disorders stemming from a problem with the inner ear, hearing nerve or auditory brainstem. It is also used to help assess hearing function in newborns, infants and children.

The ABR is a painless, non-invasive test (no needles) and is performed when the patient is awake and comfortably seated. Sedation is often required for young children (i.e., 6 mos. - 3 yrs.) as the patient must remain still and quiet during the test. When sedation is required, the test is performed in the pediatric clinic, and sedation to the child is administered by a pediatric nurse. The sedation order must be provided by the child's referring physician.

COMPLIMENTS OF
ASSOCIATED AUDIOLOGISTS

Audiologic Screening of Newborn Infants Who Are At Risk for Hearing Impairment

The following guidelines were developed by the ASHA Committee on Infant Hearing and adopted by the ASHA Legislative Council in November 1988 (LC 28-88). Currrent and past members of the committee responsible for the development of the guidelines include Deborah Hayes (chair, 1988); Michael Sabo (chair, 1985-87); Fred Bess; Dianne Brackett; Frank Burns; Evelyn Cherow, ex officio; Brad Freidrich; Judith Gravel; Jack Kile; Marcia Kushner; Diane Meyer; Gary Thompson; James Thelin; and Ann Carey, ASHA vice president for professional and governmental affairs (1988-90) and Nancy Becker, vice president for professional and governmental affairs (1985-87).

Background

A Committee on Infant Hearing was established in 1984 by the Legislative Council (LC 27-84). The charge to that committee:

> To gather and synthesize information and policies generated by committees and Boards of ASHA which pertain to special aspects of hearing impairment in infants, models of service delivery to infants, and identification, diagnosis, and management of hearing disorders in infants; to identify and make recommendations on research needs regarding the development of auditory function and dysfunction in infants, prevention of hearing impairment in infants, and the identification, diagnosis, and management of hearing disorders in infants; to provide audiologic consultation to the Joint Committee on Infant Hearing on matters pertinent to prevention, identification, diagnosis, and management of infant hearing.

The initial activity of the committee was to determine procedures that, at the present time, are most appropriate for audiologic screening of infants at risk for hearing impairment. After consideration of the many issues related to infant hearing, the committee concluded that (a) all newborn infants who are at risk for hearing impairment should be identified, (b) infants identified at risk should receive audiologic screening by auditory evoked potentials prior to hospital discharge, and (c) those infants who fail initial audiologic screening or who fail to be screened should enter an audiologic evaluation, follow-up, and management system.

The purpose of this report is to set forth guidelines for the establishment of auditory screening programs for newborn infants who are at risk for hearing impairment.

Guidelines for audiometric evaluation, follow-up, and management of hearing-impaired infants will be considered in forthcoming activities of the Committee on Infant Hearing.

Definitions

Infants at risk: Infants who fall into one or more of the seven risk criteria identified in the 1982 position statement of the Joint Committee on Infant Hearing (1982) are considered at risk for hearing impairment and should receive audiologic screening.[1] The factors are:

1. A family history of childhood hearing impairment.
2. Congenital perinatal infection (e.g., cytomegalovirus (CMV), rubella, herpes, toxoplasmosis, syphilis).
3. Anatomic malformation involving the head or neck (e.g., dysmorphic appearance including syndromal and nonsyndromal abnormalities, overt or submucous cleft palate, morphologic abnomalities of the pinna).
4. Birthweight less than 1500 grams.
5. Hyperbilirubinemia at level exceeding indications for exchange transfusion.
6. Bacterial meningitis, especially H. influenza.
7. Severe asphyxia which may include infants with Apgar scores of 0-3 who fail to institute spontaneous respiration by 10 minutes and those with hypotonia persisting to two hours of age (Joint Committee on Infant Hearing, 1982).

For a more complete review of these risk criteria and their relation to hearing impairment, see Gerkin (1984).

Hearing impairment: Bilateral conductive and/or sensori-neural deficit in the frequency region important for speech recognition (approximately 1000 through 4000 Hz). Hearing impairment is defined as deficit in auditory sensitivity that interferes with speech recognition and for which intervention strategies are known and available.

The impact of childhood hearing impairment on speech and language development and academic achievement is well documented (Allen, 1986; Osberger, 1986). In general, hearing-impaired children demonstrate limited speech production skills (Osberger, Robbins, Lybolt, Kent, & Peters, 1986), significantly delayed receptive and expressive language skills (Moeller, Osberger, & Eccarius, 1986; Osberger, Moeller, Eccarius, Robbins, & Johnson, 1986), and reduced academic achievement, especially in language-related areas (Allen, 1986). To minimize these debilitating effects, professionals have urged early identification and habilitation of infants with hearing impairment. Efforts in both the public and private sector have been undertaken to develop screening, diagnostic, and habilitation programs to meet these goals.

In the public sector, passage of Public

[1] Investigators have also recommended audiologic screening of infants who manifest other health factors. These factors include: a) parent consanguinity (Coplan, 1987; Feinmesser & Tell, 1976), b) severe neonatal sepsis (Feinmesser & Tel, 1976), c) persistent pulmonary hypertension of the newborn [(PPHN) (Naulty, Weiss & Herer, 1986; Sell, Gaines, Gluckman, & Williams, 1985)], and d) length of stay in the intensive care nursery and gestational age (Halpern, Hosford-Dunn, & Malachowski, 1987). Some investigators have also advocated audiologic screening of all infants in neonatal intensive care units (Galambos, Hicks, & Wilson, 1984; Jacobson & Morehouse, 1984). In future risk registries, these additional factors and recommendations may be included. At this time, ASHA recommends, at a minimum, use of the Joint Committee on Infant Hearing 1982 risk criteria pending update of the register.

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Law 99-457, the Educaton of the Handicapped Amendment of 1986, created (in part) a new discretionary program to address the special needs of handicapped infants and toddlers from birth through 2 years of age and their families. By 1990-91, each state that wants to continue receiving federal financial assistance under the birth-through-2 program must have in place a policy to provide early intervention services to all handicapped infants and toddlers. Some components of this program include development of a Child Find system, referral to service providers, research and demonstration projects, and a comprehensive system of personnel development. Provision of services must be by qualified personnel meeting the highest state standards established for employment in each profession or discipline.

In the private sector, representatives from audiology and speech-language pathology, otolaryngology, pediatrics, and nursing have participated in a Joint Committee on Infant Hearing which, over the years, has developed a series of position papers. The most recent position paper (Joint Committee on Infant Hearing, 1982) states that "early detection of hearing impairment in the affected infant is important for medical treatment and subsequent educational intervention to assure development of communication skills." The Joint Committee recommended that infants at risk for hearing impairment be identified and that they receive appropriate evaluation and treatment.

Reliable data on incidence of significant hearing impairment in infants and young children are unavailable (Hotchkiss, 1987; Ries, 1986). National statistics indicate that approximately 3.7 million children are born in the United States each year (Wegman, 1987). Investigators estimate that 7 - 12% of all newborns are at risk for hearing impairment (Feinmesser & Tell, 1976; Jacobson & Morehouse, 1984; Mahoney & Eichwald, 1987). Moderate to profound hearing impairment is reported present in less than 2% to more than 4% of at-risk infants (Galambos et al., 1984; Jacobson & Morehouse, 1984; Mahoney and Eichwald, 1987; Stein, Ozdamar, Kraus, & Paton, 1983; Hosford-Dunn, Johnson, Simmons, Malachowski, & Low, 1987). Prevalence of milder degrees of hearing impairmnt in this population is unknown, Retrospective studies have shown that between 50 and 75% of hearing-impaired children were positive for at least one of the Joint Committee's risk criteria (Elssmann, Matkin, & Sabo, 1987; Feinmesser & Tell, 1976; Stein, Clark & Kraus, 1983).

In addition to infants who are at risk, infants with no known risk factors may have or develop hearing impairment (Feinmesser & Tell, 1976; Simmons, 1980). Prevalence of significant hearing impairment, including mild to moderate hearing impairment, for this population is not well defined.

The dearth of data on the prevalence of hearing impairment in both at-risk newborns and newborns with no known risk factors demonstrates the pressing need for well-controlled studies of the true impairment rate in these populations. Investigations on the prevalence of mild to moderate hearing impairment are especially needed.

Rationale

To prevent or reduce the debilitating effects of childhood hearing impairment, ASHA endorses an aggressive program of early identification and habilitation. Optimally, all newborn infants should receive audiologic screening to identify the majority of infants who require audiologic evaluation, follow-up, and management. At the present time, however, there are no data to indicate that newborn behavioral screening programs are sufficiently sensitive and specific (Durieux-Smith, Picton, Edwards, Goodman, & MacMurray, 1985; Feinmesser & Tell, 1976; Jacobson and Morehouse, 1984), or that evoked potential screening programs can be sufficiently low cost (Mahoney & Eichwald, 1987; Weber, 1987) to warrant mass screening. When cost-effective screening approaches are developed that are sensitive and specific, ASHA recommends evaluation of all newborn infants. In the interim, ASHA recommends audiologic screening of all infants at risk for hearing impairment.

Program Components

A successful program of early identification of hearing impairment in infants includes three components: (a) parent/caregiver education, (b) audiologic screening, and (c) evaluation, follow-up and management systems.

Parent/caregiver education. Parents/caregivers of all newborns should receive information about normal auditory and speech and language development, and should be informed of the importance of early audiologic evaluation of suspected hearing problems. They should receive information that will enhance their ability both to observe auditory and speech and language development, and to advocate prompt referral for appropriate audiologic evaluation (Elssmann et al., 1987).

Audiologic screening. All newborn infants at risk for hearing impairment by Joint Committee on Infant Hearing criteria (1982) should receive audiologic screening. Screening can occur prior to hospital discharge (Durieux-Smith et al., 1985; Galambos, Hicks & Wilson, 1982; 1984; Gorga, Reiland, Beauchaine, Worthington, & Jesteadt, 1987; Jacobson & Morehouse, 1984; Stein, Clark, & Kraus, 1983) or may be deferred until age 4 months (Alberti, Hyde, Riko, Corbin, & Fitzhardinge, 1985; Durieux-Smith, Picton, Edwards, MacMurray & Goodman, 1987; Hyde, Riko, Corbin, Moroso, & Alberti, 1984) or even older (Mahoney & Eichwald, 1987). Screening prior to hospital discharge ensures access to all infants who are identified at risk for hearing impairment (Downs & Sterritt, 1967) and, under appropriate test conditions, does not result in a significantly higher failure rate than deferred screening (Durieux-Smith et al., 1987). Substantial loss-to-follow-up can occur if screening is deferred (Coplan, 1987, Downs & Sterritt, 1967; Mahoney & Eichwald, 1987; Stein, Clark, & Kraus, 1983). In the absence of systematic nursery-based screening programs, there are data indicating that hearing impairment is typically not identified until age 18 months and older, even for infants at risk for hearing impairment (Elssmann et al., 1987; Stein, Clark, & Kraus, 1983). Further, if screening is deferred until the infant can be tested with operant conditioning behavioral test procedures, then the goal of identification and habilitation by age 6 months cannot be met for many at-risk infants because developmental age may lag behind chronological age for premature and compromised infants. For these reasons, ASHA recommends audiologic screening prior to hospital discharge.

Screening at-risk newborns (approximately 7-12% of the newborn population) should result in earlier identification and habilitation of approximately 50-75% of hearing-impaired infants (Elssmann et al., 1987; Jacobson & Morehouse, 1984; Mahoney & Eichwald, 1987; Stein, Clark, & Kraus, 1983). It is important to recognize, however, that the remaining 25-50% of hearing-impaired infants will not receive audiologic screening in the newborn nursery and will not, therefore, be identified by these procedures.

Audiologic screening is performed by an audiologist or under the supervision of an audiologist in accordance with current standards (Committee on Audiologic Evaluation, 1987). ASHA recommends that at-risk newborns receive audiologic screening using auditory evoked potential measures prior to discharge from the newborn nursery. At the present time, auditory brainstem response (ABR) provides a reliable and valid estimate of peripheral auditory sensitivity in newborns (Galambos et al., 1982, 1984; Gorga et al., 1987; Jacobson & Morehouse, 1984; Lary, Briassoulis, de Vries, Dubowitz, & Dubowitz, 1985; Schulman-Galambos & Galambos, 1975, 1979).

In addition to technically appropriate application of the ABR test procedure, the

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unilateral hearing impairment is confirmed and follow-up and management is initiated.

Comprehensive audiological evaluation may include additional evoked potential evaluation, behavioral testing, and acoustic immittance measures. These infants are also referred for medical evaluation specified by the Joint Committee on Infant Hearing (1982):

1. General physical examination and history including:
   a. Examination of the head and neck,
   b. Otoscopy and otomicroscopy,
   c. Identification of relevant physical abnormalities,
   d. Laboratory tests such as urinalysis and diagnostic tests for perinatal infections.

Habilitation of hearing-impaired infants should be initiated by age 6 months (Joint Committee on Infant Hearing, 1982). Estimates of peripheral sensitivity based on electrophysiologic procedures should be confirmed by behavioral techniques as soon as possible. Efforts to confirm electrophysiologic estimates of peripheral sensitivity may coincide with on-going habilitation. In general, precise behavioral estimates of hearing sensitivity can be obtained when the infant can respond to operant conditioning test procedures [(approximately 5-6 months developmental age) Thompson & Wilson, 1984)]. Management decisions made prior to defining the behavioral audiogram may require modification as more precise estimates of hearing sensitivity are obtained.

Summary

The importance of early identification of hearing impairment is well documented. The Joint Committee on Infant Hearing 1982 Position Statement established the goal of identification and habilitation of hearing-impaired infants by age 6 months but did not specify the procedure for initial audiologic screening. In these guidelines, ASHA specifies the recommended procedure for audiologic screening of infants at risk for hearing impairment that includes a) parent/caregiver education; b) audiologic screening by ABR; and c) referral to a comprehensive evaluation, follow-up, and management system for those infants who fail initial ABR screening. The procedures recommended in these guidelines are complex and require substantial involvement of a qualified audiologist. Identification programs should be instituted only when all components are available to provide appropriate services to the infant and his/her family. It is hoped that these guidelines will encourage implementation of programs for early identification of hearing impairment in at-risk infants.

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The University of Kansas

Speech-Language-Hearing:
Sciences and Disorders

February 1, 1990

Nancy Brown, Representative
House of Representatives
State Capitol
Topeka, Kansas

Dear Representative Brown:

I am writing to inform you that I strongly support the House Bill that you are currently sponsoring related to hearing assessment of hearing impaired infants. This bill is needed to assure that all infants born in Kansas are pre-screened by a high-risk register for hearing loss. Equally important, the bill makes allowance for a follow-up hearing assessment for infants identified to be at-risk for hearing loss.

You and the members of the committee that developed this bill are to be commended for its content. Hopefully, any concerns related to availability of hearing services, costs, or patient care considerations will require only minor changes in the bill's wording.

Please let me know if I may be of any assistance in passage of this important legislation.

Sincerely yours,

Larry E. Marston

Larry E. Marston, Ph.D.
Associate Professor

LEM/mh

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1-12

The University of Kansas Medical Center

School of Allied Health
Department of Hearing and Speech

January 3, 1990

Representative Nancy Brown
15429 Overbrook Lane
Stanley, KS 66224-9744

Dear Representative Brown:

I am writing to express my support for the proposed Kansas law to mandate early identification of hearing loss for high-risk infants. Although I am not a resident of Kansas, I am a speech-language pathologist and an employee of the University of Kansas Medical Center. This proposed law will have a positive impact on lives of some of the patients I serve.

Thank you for your thoughtful consideration.

Sincerely,

Beth Dalton Moffitt

Beth Dalton Moffitt, M.A., CCC-SLP
Speech Language Pathologist

BDM/jwr

STATE OF KANSAS
MIKE HAYDEN, GOVERNOR
STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

KANSAS COMMISSION FOR THE DEAF
AND HEARING IMPAIRED

WINSTON BARTON, SECRETARY

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800-432-0698 (VOICE/TTY)
KANS-A-N 561-2874

January 17. 1990

Rep. Nancy Brown
15429 Overbrook Lane
Stanley, KS 66224-9744

Dear Rep. Brown:

Please let me introduce myself as a member of the Kansas Commission for Deaf and Hearing Impaired and as a hearing impaired Kansan. I am also immediate past president of Wichita Self Help for Hard of Hearing. I also teach at Wichita State University.

As I have met hearing impaired children and adults in my various roles, I have been impressed again and again with the importance of early identification of hearing impairment. The personal stories of parents and children who have struggled to get an appropriate diagnosis are frightening to any parent and educator who sees the consequences of improper diagnosis. The proposed bill for establishing a program of hearing impairment identification and monitoring is one important step toward improving health care and education for children with hearing impairment.

Your work in co-sponsoring this bill is greatly appreciated. Kansas does not compare favorable to other states either in identification or services to deaf and hearing impaired. Recent efforts by KCDHI and Sec. Barton's staff indicate the state's willingness to address these issues.

Please accept my letter of support for this proposed bill. I will look forward to hearing of its progress.

Sincerely,

Marsha A. Gladhart

Marsha A. Gladhart

1-19

The
Wichita
State University
College of Education

Feb. 21, 1990

Rep. Nancy Brown
State House, Rm 183W
Topeka, KS 66612

Dear Rep. Brown;

I am writing as a member of the Kansas Commission for Deaf and Hearing Impaired and as a hearing impaired professional in education. I would like to express my support of House Bill No. 2915 which would establish a program of hearing impairment identification.

I believe this bill to be a very conservative approach to a serious problem. Early identification is a major problem in language and social development of hearing impaired children. It is imperative that children be identified and receive intervention early before their language skills are too far behind normal development.

Thank you for your efforts in this issue.

Sincerely,

Marsha A. Gladhart

Marsha A. Gladhart
Clinical Instructor

1-15

WICHITA
PUBLIC SCHOOLS

February 6, 1990

Rep. Nancy Brown
15429 Overbrook Lane
Stanley, Ks. 6224-9744

Dear Rep. Brown,

I am writing this letter to you to voice my strong support of the proposed bill regarding early identification and intervention services for hearing impaired children. As an audiologist, one who has been able to provide services to children from birth on up, I can tell you what a significant impact early intervention has on speech/language, cognition, hearing, family acceptance and involvement - the total habilitation process. The youngest child I have worked with has been age 7 months. The progress this child made is so much greater than the children I see who are age 3 or above and just being identified and served. I can't stress the importance of early identification enough! We must have these services provided across the State. I am very excited about this bill - I have long awaited its arrival! Please let me know if there is anything I can do to help the cause.

Sincerely,

Molly Pottorf

Molly Pottorf, M.A., CCC-A/SP
Audiologist, USD #259

1-16

Division of
Youth Services

WICHITA
PUBLIC SCHOOLS

March 7, 1990

Rep. Nancy Brown
State House
Room 183W
Topeka, Kansas 66612

Dear Ms. Brown,

I would like to express my support for the House Bill 2915 regarding implementation of a program for early identification of hearing loss. As a teacher with 17 years of experience teaching hearing impaired students, I must stress the importance of identifying hearing impairments at the earliest possible age. All too often I see the consequences of late identification.

In closing, I can only repeat my support for any bill which will facilitate early identification--and intervention--of children with hearing losses.

Sincerely,

Don Oltean

Don Oltean, Coordinator
Hearing Impaired Programs

DO/jc

1-17

WICHITA
PUBLIC SCHOOLS

2-14-90

Representative Nancy Brown
15429 Overbrook Lane
Stanley, Ks.

Representative Brown:

I am writing to express my support for the bill you are sponsoring concerning screening for possible hearing impairment in infants.

I have worked with hearing impaired children and their families for 15 years, the last of which have been in a Home Program through the Wichita Public Schools. We provide services to families of newly identified hearing impaired infants and toddlers. I cannot over-emphasize the importance of early identification, allowing the child to link up with services providing the potential for normal speech and language. Ages 0-3 have been identified as the critical period for learing speech and language, afterwhich remediation and special education are the only option. Hearing impaired adults have an average reading level of only 4th grade, mainly due to poor language skills. Early identification allows the parents and families to seek services necessary to take advantage of these crucial years.

A chance for normal speech and language should be the right of every child. Please work for this bill and take the beginning step in allowing every Kansas child this right.

Sincerely,

Jane Schwartz

Jane Schwartz

1-18

Allen Elementary School • 4814 East Mt. Vernon • Wichita, Kansas 67218

February 25, 1990

Representative Nancy Brown
State House
Room 183W
Topeka KS 66612

Dear Representative Brown:

I am writing in regard to H.B. 2915 , an act concerning identification of hearing impaired infants.

I am an Audiologist employed at St. Francis Regional Medical Center in Wichita. The hospital currently employs a high risk registry to identify those at risk for hearing loss. The registry has not been employed consistently by the nursing staff or other personnel despite the efforts of myself and the previous audiologist. For this reason I see a need to employ a state-wide high-risk registry. I believe the program would provide a good first step in the identification of hearing impaired infants.

I would like to see a bill that would also set up a system for actually testing the infants. From my experience, when a child has been identified as"at risk" and the physician and parent have been notified, less that half of the babies are ever seen for testing. I fear that the bill, as it currently is written, would not improve our identification rate significantly.

Thank you for your consideration of this issue. I will look forward to learning the results of the committee hearing.

Sincerely,

Teresa Kennalley

Teresa Kennalley, M.A. , CCC-A
4440 East English
Wichita KS 67218

1-19

ASSOCIATED AUDIOLOGISTS
Comprehensive Hearing Care

James Wise, M.A.
Rod McLennan, Ph.D.

Certified by American Speech-Language-Hearing Association

Olathe Office
225 W. 151st St., Ste. 202
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913/829-0891 Voice/TTD

Prairie Village Office
7301 Mission Rd., Ste. 140
Prairie Village, Kansas 66208
913/262-5855

Services include: Diagnostic hearing evaluations, Electrophysiological Assessments, hearing aid dispensing, assistive communication devices and aural rehabilitation.

TO: Representative Nancy Brown
State House Room 183 West
Topeka, KS 66612

FROM: James A. Wise, Audiologist
225 W. 151st Street, Suite 202
Olathe, KS 66061

DATE: February 21, 1990

RE: House Bill No. 2915 by Representatives Brown, Blumenthal, Pottorff and Snowbarger

Dear Representative Brown:

I am writing in support of House Bill No. 2915, an act concerning hearing impaired infants establishing a program of hearing impairment identification providing for administration of the program by the Secretary of Health and Environment.

I am responding in support of this bill from two positions: one is as a parent and one is as a professional. First, as a parent of a child who is mentally retarded and has Down Syndrome, I know of the importance of early identification and intervention for children with handicapping conditions. Early intervention has made a tremendous difference in the ability of our child. However, he happened to have a known handicapping condition which was identified at birth. Hearing impaired infants, unfortunately, don't have such a visual indication to identify hearing loss at as early a stage. Hearing loss in children is a silent, hidden handicap and if undetected and untreated it can lead to delayed speech and language development and to social, emotional, and academic problems. It is not necessary for a child to suffer because of hearing impairment; if detected early, the problem can be effectively treated. The current reasons for delays in identification include a lack of awareness, a lack of in-hospital testing of high risk infants, misinformation and poor use of existing services. This problem is very significant and in the United States today the approximate delay between a parent's suspicion of a child's hearing loss and its clinical confirmation by means of formal hearing evaluation is nearly two years. This delay places the child beyond a critical period for normal speech and language development. Among all newborns, it is estimated that 7% to 12% are at risk for hearing impairment, approximately one child in 1,000 will be born with profound deafness. An additional two children in 1,000 will acquire deafness during early childhood. Newborns who need intensive medical care are also at higher risk for hearing loss; one child in 50 will have significant hearing impairment.

From the standpoint of a professional audiologist, we know that severely hearing impaired children who escape detection until school age are confronted with the nearly impossible task of

trying to catch up with their normal hearing peer group, by telescoping four to five years of communicative development into a much shorter period. Delayed speech development is often the first indicator that draws parents' attention to their youngster's underlying hearing loss. However, waiting for demonstrated developmental failure to diagnose hearing impairment is inefficient and may severely limit the child's achievement potential.

During the past ten to fifteen years, much attention has been devoted to early identification and intervention programs for prelingually deaf children. High risk factors associated with prelingual deafness has been distilled from family histories, pregnancy and birth records, and neonatal histories to identify infants in need of special follow-up.

House Bill No. 2915 provides a start for a more efficient and improved way of beginning to identify infants with potential hearing impairment in hopes of identifying them at as early a stage as possible. The first step is identification; the next step is then providing a more effective rehabilitative track for making these Kansans more productive by providing them with the maximum rehabilitation available.

Thus, as a parent and as a professional, I wholeheartedly support the endeavors of this bill in hopes that this will provide a step in the right direction to work upon further development of additional services for the deaf and hearing impaired infants in the state of Kansas.

James A. Wise, M.A.
Audiologist

Southeast Kansas
Education
Service Center
P.O. Box 189
316—724—6281 Girard, KS 66743—0189

31 January 1990

Representative Nancy Brown
15429 Overbrook Lane
Stanley KS 66224

Dear Representative Brown

I am writing this letter in support of the bill you are sponsoring through the House Health and Welfare Committee on early identification of hearing impaired infants in Kansas.

As an educational audiologist in Southeast Kansas, I am directly involved in the assessment, identification, intervention and management of hearing impaired infants. The critical importance of early identification and habilitation in minimizing delays in language and academic deficits in infants with hearing impairment cannot be overemphasized.

Heidi Reinthal

Heidi Reinthal

McPherson County Special Education Cooperative

514 NORTH MAIN
PHONE: (316) 241-1650 McPHERSON, KANSAS 67460-3499
DIRECTOR: JOHN C. BLACK

March 6, 1990

Nancy Brown, State Representative
State House Room 183 W
Topeka, KS 66612

Dear Representative Brown;

Thank you, Nancy, for initiating House Bill 2915. This issue has greatly needed to be addressed. You are a champion of a most worthy effort to help the hearing impaired children of Kansas.

Early intervention is crucial to augment language development and increase educational success. The language acquisition years are zero to five.

I strongly support House Bill 2915. If there is anything I can do to help this become law, please let me know. Thank you for your concern and efforts for the education of hearing impaired children.

Sincerely,

Kaye Webster

Kaye Webster
Hearing Impaired Teacher
/cp

MARSTON HEARING CENTER
1112 WEST SIXTH STREET, SUITE 208
LAWRENCE, KANSAS 66044

TELEPHONE (913) 843-8479

March 3, 1990

Rep. Nancy Brown
State House Room 183 W.
Topeka, Ks. 66612

RE: H.B. 2915

Dear Ms. Brown:

I am writing this letter in support for a bill which would provide early identification of children at risk for hearing impairment. I feel that mandatory legislation that would inform parents and other health care professionals of infants at risk for hearing impairment would greatly aid us in reducing the debilitating effects of hearing impairment.

I am currently involved in testing infants who are at risk for hearing impairment and see a great need for definite standards identifing infants at risk on testing, follow-up, normative data, etc... I am also aware of what little knowledge parents and other health care professionals have regarding the availability of infant hearing screenings and what procedures they follow if a hearing loss is suspected. Educating parents and others involved with infant care will help expidite the habilitation process.

It is hoped that the Kansas Commission for the Deaf and Hearing Impaired task force move ahead for immediate legisaltion for identifing infants at risk for hearing impairment.

Thank you for taking the time for consideration of this important issue.

Sincerely,

Karen Andregg

Karen Andregg, M.A., CCC-A
Clinical Audiologist

1-24

CRESTVIEW ELEMENTARY SCHOOL, 2200 EVENINGSIDE DRIVE, TOPEKA, KANSAS 66614
TOPEKA PUBLIC SCHOOLS

State House
Room 183w
Topeka, Kansas 66612

Dear Representative Brown:

I am a school teacher for the primary level Hearing-Impaired class here in Topeka's 501 cooperative and I have just learned of a bill that you are supporting and that will be presented to the House. Your bill supporting an early identification of children with the possible risk of a hearing-impairment is beyond value.

Early identification not only aids the educational community that work with these children but more importantly it aids the parents of these children. The chief cornerstone many times for a successful education and provision of support services for all handicapped children rests upon early identication. Even something as simple as a questionare to families that have a high risk involving the genetic history for a hearing-impairment or other impairments can be of tremendous support and use. Please continue in your support of House Bill 2915 and let me know how it goes after debate. Thank you for your time in reading this and for your support.

Sincerly,

Wayne Clark

Teacher of the Hearing-Imoaired

1-25

KANSAS SPEECH – LANGUAGE – HEARING ASSOCIATION

March 3, 1990

Representative Nancy Brown
Kansas State House
Room 183W
Topeka, KS 66612

Dear Representative Brown:

I am writing to you on behalf of the 660 members of the Kansas Speech-Language-Hearing Association in support of House Bill 2915. The membership fully endorses a proposed plan for the early identification of hearing loss.

As communication specialists, KSHA members are very responsive to plans which are intended to identify hearing loss among infants and their families. This plan would potentially serve to prevent the increasing and devastating effects of a hearing loss because of lack of early identification. Many speech-language pathologists and audiologists serve infants and toddlers in early intervention programs. These professionals are well-are of the effects of hearing impairment on speech, language, and communication development. Many speech-language pathologists and audiologists can provide current case studies of toddlers who were not identified as exhibiting hearing loss due to lack of information or to lack of support for early referral.

One current case that I am personally aware of at the center where I work, involves a 30 month old child who was identified only recently as having hearing loss. The family was somewhat concerned for many months, but other immediate family members attributed lack of responding to "her father's trait of being quiet." However, after the Mother's push for more evaluation, the diagnosis of hearing loss was finally made. Services at this point will require an increased amount of time to assist this child in obtaining amplification, and changing the direction of service -- now serving a child with a hearing impairment.

KANSAS SPEECH - LANGUAGE - HEARING ASSOCIATION

This case-study supports the need for the other components of this bill. KSHA is favorably impressed with this complete process--early identification of the infants and in turn support by health care professionals who will be knowledgable of follow-up services to provide which is one part of the health care educationn program. The identification and education strategy would be fully complimented by the proposed state-wide high-risk registry which would be an effective consumer and educational agency planning procedure for the delivery of effective services. From the above case study, this registry would assist this young girl in her future educational program requirements.

I hope that the above comments are helpful to yourself and to the other members of the committee who are considering this bill.

Thank you.

Sincerely,

Barry R. Molineux

Barry R. Molineux, M.A., CCC/SLP
KSHA President 1990
The Capper Foundation
3500 SW 10th Avenue
Topeka, KS 66604-1995
913-272-4060

Sandra Garms
439 South Chestnut
Olathe, Kansas 66061

March 7, 1990,

Dear Representative,

This letter is in hope that you will support the bill that has been introduced by Rep. Nancy Brown, Gary Blumenthal, Joanne Pottorf and Vince Snowbarger, to implement a program for early identification of hearing loss.

Having a hearing impaired child that was misdiagnosed as mentality retarded, after a year and a half, three moves and two jobs later we found out she was deaf. People need to be more aware including Doctors, and Professionals that work with young children. The sooner these children are diagnosed the sooner they can start programs that will help them the rest of their lives.

Thank-You,

Sandra Garms

Sandra Garms
Parent

March 7, 1990,

To Whom it may concern:

As an Educator, Interpretor, and a child of Deaf parents, I'm asking for your support on the House Bill 2915 to implement a program for Early Identitication of Deaf Children.

Thank-You,

Louisa Wilcox

Louisa Wilcox
Teacher
Interpretor

439 So. Chestnut
Olathe, KS 66061

FEBRUARY 21, 1990

MR. & MRS BRIAN D. PEEL
7617 HAYES
OVERLAND PARK, KS. 66204

DEAR MS. BROWN,

OUR DAUGHTER REGINA WAS DIAGNOSED AS HEARING IMPAIRED WITH A 3 YEAR DELAY IN SPEECH JUST LAST YEAR PRIOR TO HER 8TH BIRTHDAY. THE SCHOOL THAT SHE ATTENDED HAD WRITTEN HER OFF AS MENTALLY RETARDED.

WE TRANSFERRED REGINA TO SANTA FE TRAIL HEARING IMPAIRED PROGRAM. THEY HAVE DONE GREAT THINGS WITH REGINA THIS YEAR. SHE HAS MADE GREAT PROGRESS. PLEASE VOTE AGAINST ANY PROPOSALS TO CUT SPECIAL EDUCATION FUNDING.

ALSO, WE ASK THAT YOU SUPPORT HB2915 - EARLY IDENTIFICATION AND INTERVENTION. OUR DAUGHTER WOULD HAVE BEEN SO MUCH BETTER OFF IF THE HEARING IMPAIRMENT COULD HAVE BEEN DETECTED SOONER.

SINCERELY,
MR & MRS BRIAN D. PEEL
7617 HAYES
O.P. KS. 66204

1-30

8022 Hall
Lenexa, KS 66219
February 8, 1990

The Honorable Nancy Brown
Kansas House of Representatives
Capitol Building
Topeka, KS 66601

Dear Representative Brown:

As the parent of a hearing impaired child in the Shawnee Mission School District, I am very concerned about a proposal that would reduce state reimbursement to school districts for special education. I understand that some lawmakers have proposed reducing this reimbursement for special education programs from 95 percent to 91 percent.

As a result, the district may cut its special education budget. That, in turn, would have serious, negative effects on the school district's ability to help me educate my child and make her a productive member of society rather than a drain on its resources. State support of programs such as speech, physical, occupational and other therapies, summer school, teachers' aides, paraprofessionals, not to mention diagnostic evaluations and ongoing monitoring, is absolutely essential to ensuring that special needs children receive appropriate services. Cutting funds for these programs will not save the State money. In the long run, it will guarantee that the State's AFDC, supplemental security income, Medicaid and other expenses will rise. Without adequate education and services now, these special needs children will grow up to become dependent, handicapped adults.

I am asking that you oppose any proposal or bill that would reduce State support of school districts' special education expenses. By cutting them, you are harming a high-quality program that is producing productive adults. By preserving them, you are helping ensure that these young people will become functioning adults who contribute to the tax base, rather than drain it.

Sincerely,

Ronald E. Schupner

Ronald E. Schupner

Kansas Association of the Deaf

Founded 1909
Chartered by State of Kansas in 1910
Cooperating with the National Association of the Deaf Since 1911

February 27, 1990

To whom it may concern:

On behalf of the Kansas Association of the Deaf, Inc., we strongly support the Early Identification Bill Act of 1990 (HB2915) to promote the establishment of a program for the early identification of hearing loss.

This bill, introduced by State Representative Nancy Brown and co-sponsored by Representatives Gary Blumenthal, James Pottoff, and Vince Snowbarger, will ensure necessary help to parents and deaf children by providing information, resources, and appropriate services. Many of these parents and children are denied a full access to the appropriate resources and services which are so routinely taken for granted by the hearing population. We, as deaf citizens, wish to see better programs and treatments for the child and parents in order to grow as "normally" as possible and avoid the frustration and mistreatment that so many of us experienced in the past.

This legislation addresses this situation by establishing a program for early identification of hearing loss. It would help to educate health care professionals about the importante of early identification of hearing loss and availability of methods to test shortly after birth, make the general public more aware of these issues, and establish a state-wide high-risk registry, which if implemented successfully would result in an improved data base for educational program planning by many agencies/organizations.

The Early Identification Act goes hand-in-hand with the deaf services/education program as a whole to break down the barriers and to provide full accessibility to the American society for all citizens. If we can be any assistance as you move forward on this legislation, please let us know.

Sincerely,

Terry D. Hostin, President
Kansas Association of the Deaf

Marnie Campbell
3408 West 74th Street
Prairie Village, Kansas 66208

February 19, 1990

Rep. Nancy Brown
State House, Room 183W
Topeka, KS 66612

296-4481

Dear Nancy:

I am writing in support of H.B. 2915. As the Chair of the Task Force from the Kansas Commission for the Deaf and Hearing Impaired on Early Identification and Intervention for Hearing-Impaired Children and their Families, I can speak collectively for the approximately 100 people who have been involved on this project since May 1988. All individuals volunteered, investing themselves to ensure a better start in life for future Kansas families with hearing-impaired children.

I have worked in the area of parent education and deafness for more than 10 years. In 1983, when I wrote my master's thesis in special education, I surveyed Kansas families and replicated a national study, finding that Kansas is about average in identifying hearing loss: roughtly half of the children are misdiagnosed, and generally a correct diagnosis is finally reached by age 3. This age is too late. Technology exists to identify hearing loss in the first days of life, and at least 50% of hearing-impaired children have high-risk factors that would indicate possible hearing problems. By establishing a program to identify hearing loss early, Kansas would join several states who have successfully implemented such a program and improved the identification of hearing loss in babies.

As a parent, I can also tell you how much this law is needed. For almost 3 years, our profoundly deaf son Chris was misdiagnosed as having central processing dysfunction. The audiologist thought Chris could hear but sounds did not process to the brain. There was no test available such as the auditory brainstem response (ABR), as there is today. So it was not until Chris was old enough to be "conditioned" for pure-tone testing with earphones that he was correctly diagnosed. He began wearing a hearing aid, which has made a tremendous difference in his life. But for those first 3 years, he had no auditory input. Those 3 years, which we know are the most important years for learning speech and language, are lost forever -- they can never be made up, even with the best of educational programs. This situation must not continue, when there are methods to prevent the irreparable damage such misdiagnosis causes in children, and the anguish their parents experience. Families need to know if their child has a hearing problem as early as possible, and they can help their baby learn if they get the help they need.

Sincerely,

Marnie

Marnie Campbell

1-33

ADVOCATES OF BETTER COMMUNICATION, INC.

Serving the Deaf and Hard of Hearing Community
Since 1959

February 6, 1990

Representative Nancy Brown
15429 Overbrook Lane
Stanley, KS 66224-9744

Dear Representative Brown;

Please count me personally, and the agency in which I am employed, solidly in support of the Early Identification and Intervention Bill that you are introducing in the House of Representatives.

I'm deaf, recently Cochlear implanted and a strong supporter of the earliest possible start for language and communication instruction for children who are born deaf/ hearing impaired.

Please advise me of any service I can perform to support the passage of this much needed bill into law.

Sincerely,

Mike Nunn
Executive Director

MN/se

1-34

730 N. Main, Suite 6, Wichita, KS 67203 264-8881 (V/TDD)

United Way

STATE OF KANSAS
MIKE HAYDEN, GOVERNOR
STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

KANSAS COMMISSION FOR THE DEAF
AND HEARING IMPAIRED

WINSTON BARTON, SECRETARY

BIDDLE BLDG., 1ST FLOOR
300 S.W. OAKLEY
TOPEKA, KANSAS 66606-1861
(913) 296-2874 (VOICE/TTY)
800-432-0698 (VOICE/TTY)
KANS-A-N 561-2874

January 20, 1990

Dear Rep. Nancy Brown,

Please help the proposed Bill (9RS 1527)

On the Early Identification / Early Intervention of Early Childhood Hearing Loss.

Thank You

Sincerely Yours,

Roberta De Moss
KCDHI Board
R#1 Box 119B
Wilson, Kansas 67490

1-35

February 27, 1990

To: Legislative Committee Chairperson and Committee Members

From: Kenneth E. Clark, 18610 W. 170th Terr. Olathe, KS. 66062
Chairperson of Kansas Commission for the Deaf & Hearing Impaired

RE: HB 2915 (Early Identification bill)

From my own personal standpoint as a deaf man and from my experiences and observations in my entire lifetime, I view this Early Identification bill as the ticket to sparing our future new-born infants with hearing loss, their parents, family members, and community members the agony and complications that result from pure public ignorance and lack of preparedness on deafness or acquired hearing loss. Such apathy and ignorance that are evident in this disability area also result in huge mismanagement of family income as well as tax payers' monies in correcting the situation. The negative aspects and unpreparedness of recognizing hearing loss at the earliest age possible and doing something positively about it are unmeasurable and unbelievable! We need to correct this now!

The passage of this bill would not only bring solutions to the serious problems of infants whose hearing loss are identified, but to the hearing population who are associated with deafness or hearing impairment as well. Such awareness of everyone involved could become more noticable that would help to establish a more meaningful and purposeful life altogether. Above all, deaf and hearing impaired people, from birth through adulthood, will have a greater sense of direction in their preparedness for life as self-supporting and independent citizens. We are not asking for sympathy votes but for your full cooperation and support to make understanding between deaf/hearing impaired people and hearing people possible.

I personally want to thank Representative Nancy Brown and her constituents for introducing this bill. For myself as a representative for deaf people and on behalf of the members of the Kansas Commission for the Deaf and Hearing Impaired, I humbly ask that each of you give this bill full consideration and vote of support. Thank you very much.

Kenneth E. Clark

Marnie Campbell
3408 West 74th Street
Prairie Village, Kansas 66208

March 19, 1990

TO: Senate Health and Welfare Committee

RE: H.B. 2915 (Early Identification of Hearing-Impaired Children)

Like most parents, my husband and I did not expect that our baby would be born with any problems. Neither were we prepared for Chris to be misdiagnosed until he was nearly 3 years old, and then to be told he was profoundly deaf. By that time, we felt great relief. We knew then he could be helped, and so could we, once we had the right diagnosis. Those years lost can never be regained, and they are the most important ones for learning speech and language.

That was 17 years ago, before hearing tests for newborns were available. After we knew Chris was deaf, he was evaluated for a special preschool program and fitted for a hearing aid. With this early education after he was correctly diagnosed, he benefitted greatly from the professionals and has been able to attend school in his home district. We have been very fortunate, but others have not.

In 1983, I surveyed Kansas families with hearing-impaired children. Nearly half of them had gone through what we had: a long period of time when our children were either not identified, or were misidentified as having another disability. In Kansas, 82 percent of the families were first to suspect their child's hearing loss, 46 percent of the parents were not satisfied with the child's initial diagnosis, and 27 percent reported a family history of deafness -- nearly 3 times the national average for hereditary deafness. For 13 percent of the families, the length of time between suspicion and confirmation of hearing loss was more than 2 years. Most children were finally identified by age 3, although 8 percent were age 5 or older. Unfortunately, the national average for diagnosis of hearing loss in young children is still 2 and 1/2 years, as reported by the 1988 Federal Commission on Education of the Deaf.

SPH+W
Attachment #2
3/19/90

From our own situation with Chris, I can tell you that those years of misdiagnosis are very difficult. From my survey, I believe it may be even more frustrating to know that your child has a problem, but you are unable to find out what it is. Comments on the survey included statements such as, "We lost 2 and 1/2 years due to the wrong diagnosis and no one would listen when we would ask why isn't he making progress." "My biggest fear was not my child being labeled but being mislabeled." "I felt lost, alone, and afraid."

As the parent representative on the Kansas Commission for the Deaf and Hearing Impaired from 1982 to 1988, I knew that situations like ours were still happening throughout Kansas. For nearly 2 years, I have worked with a committee set up by the Commission to study issues in early identification and intervention with hearing-impaired children and their families. Many people helped find out what screening procedures for high-risk infants and follow-up hearing evaluation and early education services for families are available. To determine the status of Kansas programs, we have worked collaboratively with the Kansas Department of Health and Environment, Kansas Department of Education, Kansas School for the Deaf, Kansas Speech-Language-Hearing Association, Kansas Educators of the Hearing Impaired, Kansas Division for Early Childhood, University of Kansas Medical Center Hearing and Speech Department, professionals, parents, and deaf adults. Because it was important to communicate our findings and develop a plan for our state, we have presented at several conventions and discussed proposed legislation. We reported about surveys showing that some areas of Kansas currently provide services to identify young hearing-impaired children, but most do not.

This is true even in Olathe, the largest concentration of the deaf community in the state. The audiologist in the public schools said last fall that after a regular preschool screening session, there were several youngsters to evaluate for hearing loss. Why? The families had been told their children were too young to test, or there was nothing to worry about -- not to be "overanxious" parents. And this is in Olathe, where there is general awareness in the community about deafness. Clearly, a state-wide program is needed for early identification of hearing-impaired children, which is why I am in support of H.B. 2915.

It is my hope that the Kansas Legislature will respond to this need, so that parents in any community of our state will be able to find out -- even in the hospital before they go home -- if their new baby is at risk for hearing problems. Then, they know what their situation is, and what to do about it. Kansas can now set up a system to prevent what has been happening for years: Like other states across the nation, Kansas can establish an early identification program, and thereby get our families off to the best start they can.

DICK VALLANDINGHAM, PH.D.

11111 W. 59th Terr.
Shawnee, KS 66203
(913) 268-4101

March 19, 1990

To: Senate Health and Welfare Committee
Re: Early Identification for the Hearing Impaired

As an Audiologist, I have had the opportunity to work with children of all ages with hearing loss, adults with hearing loss since birth, and families of individuals with hearing loss. I know first-hand the importance of early identification and intervention of hearing loss.

Without early identification of hearing loss, families are put through an enormous amount of uncertainity, frustration and desperation. Without early identification of hearing loss, children are robbed of the most important and most fruitful period of language learning. Without early identification of hearing loss, congential deaf adults are denied the opportunity to maximize their potentials in this hearing world.

Professionals in the field of deafness and hearing loss understand the importance of early identification. C. Everett Coop, former Surgeon General, called for our country to make early identification of hearing loss a priority. The American Speech-Language-Hearing Association, along with the American Academy of Pediatrics, has called for the use of a high-risk register as a means of identifying infants at risk for hearing loss. Closer to home, the Kansas Speech-Language-Hearing Association has given its support to the use of a high-risk register for hearing loss.

The impact of an early identification/high-risk register for hearing loss should be dramatic--early meaningful communication between parents and children reduces later family problems; early introduction to amplification maximizes potential use of residual hearing; early exposure to language reduces educational deficiences. The additional cost and labor involved in such a project is minimal. The savings in terms of later educational and rehabilitation needs will be great.

On behalf of audiologists and other professionals in the area of hearing and hearing loss, I strongly urge the passage of this vital legislation. The deaf and hard-of-hearing infants of Kansas deserve the best chance they can get.

dick vallandingham

SP H+W
Attachment #3
3/19/90

Testimony presented to

Senate Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill 2915

Congenital hearing impairment/deafness is most often a hidden disability. It can, unfortunately, remain undetected beyond the child's first, third and even fourth birthday. The severity of the problems resulting from hearing loss increases the longer the disability remains undetected. As noted in Promoting Health/Preventing Disease: Year 2000 Objectives for the Nation, "The ramifications of auditory handicaps are seen in developmental, educational, cognitive and emotional aspects of human life. Language delay and poor understanding of spoken speech...are invisible barriers that can be insurmountable for people with hearing impairments without early diagnosis and...support services."[1] To have a hearing loss go undetected is especially tragic since there are procedures available to help identify hearing loss even in newborns. We do not need to wait a year or several years. We do not need to wait until this hidden disorder becomes obvious to everyone because of severe delay in language development.

In 1986 Congress passed P.L. 99-457, the Education of the Handicapped Act Amendments,[2] that states "there is an urgent and substantial need...to minimize the potential for developmental delay." One of the key goals of P.L. 99-457 Part H, which pertains to Handicapped Infants and Toddlers, is the early identification of handicapping conditions and developmental delays. Hearing loss and speech-language delays and disorders are two of the targeted areas in this law. The early identification of hearing impairments and subsequent early intervention during the critical language acquisition stage result in: 1) reductions in the need for special education; 2) eventual increase in employment and earnings; 3) a decrease in dependence on governmental assistance programs; and 4) enriched educational attainment and lifestyle. Dollar savings can be estimated for some of these areas. No dollar values can be placed on other of these outcomes. However, hearing impaired/deaf persons, their families, and the taxpayers all gain from the early identification and intervention of hearing impairment.

Former Surgeon General C. Everett Koop, in his position paper Early Identification of Hearing Problems in Children Essential (see attachment) stated a national goal: that no child should reach the first birthday with an undetected hearing impairment. To attain this goal, he called on State agencies to help by initiating high risk screening programs for infants.[3]

SPH&W
Attachment 4
3/19/90

While incidence figures vary, it is estimated that one infant in 500 live births has a mild to severe sensorineural hearing loss and one in 1000 live births has a profound sensorineural hearing loss. The incidence of hearing loss in infants in neonatal intensive care units (NICU) increases sharply, with figures ranging from one in 25 to one in 50 births. This identification of high risk factors (such as prolonged stays in the NICU, and family history of congenital hearing loss) provides the opportunity to increase the early identification of hearing impairment. Approximately 10% of infants can be identified as high risk for hearing impairment. Of this high risk population, statistically 2.5% will have a hearing loss. Based on the 1988 figure of 37,574 live births in Kansas hospitals, 3757 infants would have been identified as high-risk for hearing impairment (10%), and 94 of those infants (2.5% of high-risk), statistically, would have a hearing loss.

At present, Kansas does not have a program in place for the early identification of infants at risk for hearing impairments. Having such a program in place would provide the opportunity for greater attention to the need for: 1) informational materials to families concerning the ramifications of hearing loss; 2) follow-up hearing assessment procedures to determine the presence of a hearing loss as soon as possible; 3) early intervention programs for the infant's language, speech, and psycho-social development, use of residual hearing, and other areas of need.

HB 2915 proposes a Kansas program to screen infants for high risk for hearing impairment. This program would be of greater long term benefit if it included follow-up of high risk infants to identify those with hearing impairments. With follow-up services, the opportunity is presented to develop early intervention programs appropriate for the needs of the hearing impaired infants and their families.

HB 2915 cannot be effective without adequate start up and maintenance funding. This bill was developed after the Department of Health and Environment's 1991 budget was developed. KDHE supports in concept the early identification of infants at risk for hearing loss, follow-up assessment to determine the presence of hearing loss, and early intervention for hearing impaired children to ameliorate problems and prevent an increase in the severity of these problems. However, no funds for the initiation of this proposed program are included in the Governor's Budget for the Department of Health and Environment and the agency can not support its funding for FY 1991.

Testimony presented by: Lorraine I. Michel, Ph.D.
Coordinator, Speech-Language-Hearing-Vision
Bureau of Family Health
Kansas Department of Health and Environment
March 19, 1990

Bibliography

1. Promoting Health/Preventing Disease: Year 2000 Objectives for the Nation. Draft for Public Review and Comment; Public Health Service; U.S. Department of Health and Human Services; September 1989, p 17-4.

2. Public Law 99-457, Part H -- Handicapped Infants and Toddlers; Section 671. (a) (1).

3. Koop, C. Everett. Early Identification of Hearing Problems in Children Essential. Department of Health and Human Services, 1989.

FROM THE SURGEON GENERAL OF THE U.S. PUBLIC HEALTH SERVICE

C. Everett Koop, M.D.
Department of Health and Human Services

Early Identification of Hearing Problems in Children Essential

The harmful effects of childhood deafness are given little thought by many people because deafness is largely an invisible handicap. Most deaf infants are otherwise healthy-looking babies who develop relatively normally during the first year of life. But if deafness is not discovered in that first year . . . and the earlier the better . . . it can interfere tragically with the ability to learn to speak, to do well in school and to contribute productively to society. Helen Keller, who was born without sight or hearing, observed that she regretted her deafness more than her blindness.

Deafness in infants is a serious concern because it interferes with the development of language—that which sets humans apart from all other living things. The longer a child's deafness goes undiscovered, the worse the outcome is likely to be. Language remediation, which is what specialists call the process of teaching hearing impaired children to communicate, must begin as early as possible, because language develops so rapidly in the first few months of life. For example, by six weeks, a normally hearing infant is more attracted to human speech than to any other sound. A six-month-old baby already has an ability to analyze language—to break it down into its parts—to put those parts back together again and to store language in its brain and retrieve it. By 18 months, most children are producing simple sentences.

Fortunately, many of the negative results of deafness in babies can be prevented or substantially lessened. Many research studies have demonstrated that early intervention with hearing impaired children results in improved language development, increased academic success and increased lifetime earnings. Early intervention actually saves money, since hearing-impaired children who receive early help require less costly special education services later.

If it is to be effective, early intervention with deaf children should begin before the child's first birthday. Unfortunately, we are not doing a very good job of detecting infant deafness in the United States. A recent report to Congress and the President by the Commission on Education of the Deaf pointed out that the average age at which profoundly deaf children in this country are identified is 2½ years. In contrast, the average age at which such children are identified in Israel and Great Britain is 7 to 9 *months*.

Clearly, we must do a much better job of early identification if we are to reduce the unnecessary suffering, poor educational performance and lack of productivity that so often accompany deafness. Three groups of people must work together.

Parents are in the best position to identify their child's hearing difficulties. We need to do a better job of making parents aware of the danger signals and of the sources of help that are available to them.

Physicians need to become more responsive to parents' concerns about their child's hearing. Too often, those concerns are brushed aside or ignored. Yet, a recent study found that parents of hearing-impaired children knew about their baby's hearing loss an average of seven months before it was diagnosed and that almost half of them were given poor advice, such as "don't worry about it" or "wait until the child starts school," when they told their doctors about their concerns.

State agencies can help by initiating high-risk screening programs, such as those currently in operation in Utah, Colorado, Oklahoma, Tennessee and several other states. Research indicates that such programs are able to identify up to 75 percent of infants who are born deaf or with hearing impairments.

Many others can help, too, of course, from older brothers and sisters to grandparents and baby sitters. We in the federal government are committed to doing our part. The 1986 Education of the Deaf Act, which authorized the creation of the Commission on the Education of the Deaf, was a first step. At the National Institutes of Health, a new research institute, the National Institute of Deafness and Communication Disorders, has been authorized and is now in formation.

I am optimistic. I foresee a time in this country, in the near future, in fact, when no child reaches his or her first birthday with an undetected hearing impairment. It's a tall order, yes, but if we all work together, I believe we can fill it.

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

March 19, 1990

TO: Senate Public Health and Welfare Committee

FROM: Kansas Medical Society

SUBJECT: House Bill 2915; Screening for Detection of Hearing Impairment

Thank you for this opportunity to express our support of the concept of screening newborn infants for purposes of detecting possible hearing impairment. We believe that such screening can assist physicians and other specialists who might be able to intervene early and provide the treatment necessary to correct the hearing impairment or to minimize any handicaps that result from such impairment.

We did collaborate with the Kansas Hospital Association in developing many of the amendments which were adopted by the House Public Health and Welfare Committee. Subsequent from that time, we have received additional input from a medical specialist who deals with hearing impairment, as well as pediatricians who have expressed concerns about the provision in the bill for development of a state-wide registry and contacting parents or guardians of so-called high risk infants. The indication we receive is that any decisions as to followup evaluation, assessment, and other testing should be a function of consultation between the infant's physician and the parents or guardian of that infant. It has been suggested that creation of a central registry of infants labeled as potentially hearing impaired might create unnecessary stigmatization. In addition, any contact of the parents or guardian by a person who is not medically trained might result in confusion on behalf of the parent or guardian and a potentially undesirable outcome. It is for this reason that we respectfully suggest that you consider the attached balloon amendment which would delete the requirement for a central registry and followup contact by personnel of KDHE. This would allow the screening program to be implemented and its success evaluated prior to any final determination as to the necessity for a statewide registry and contact between a state agency and the parents or guardians of so-called high risk infants.

Thank you very much for your consideration. We urge you to recommend passage of HB 2915.

CW:nb

SP H & W
Attachment #5
3/19/90

3/19/

screenings under section 2 and amendments thereto, the information required by section 4 and amendments thereto. The medical care facilities shall provide this information to parents of newborn infants discharged on and after January 1, 1991.

(b) In administering the provisions of the program established under this act, the secretary ~~shall~~ may:

~~(1) Develop a system to gather and maintain data, including a statewide registry to include, but not be limited to, the identification of high-risk infants;~~

~~(2) develop methods to contact parents or guardians of high-risk infants and to refer the parents or guardians to appropriate services;~~

~~(3) enter into contracts which may be necessary to administer the program;~~

~~(4)~~ (1) adopt rules and regulations as necessary to implement the program; and

~~(5)~~ (2) subject to appropriations therefore, take such other action as may be necessary in the administration of the program.

Sec. 6. Any person who reports in good faith and without malice, or who in good faith and without malice fails to report, the information required to be reported under this act shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed in an action resulting from such report. Any such person shall have the same immunity with respect to participation in any judicial proceeding resulting from such report.

Sec. 7. (a) Information obtained by the secretary under this act is confidential and shall not be disclosed except as provided in this section.

(b) The secretary may disclose information obtained under this act: (1) Upon consent, in writing, of the person who is the subject of the information, or if such person is under 18 years of age, by such person's parent or guardian; or (2) upon the request of an organization or individual conducting a scholarly investigation for legitimate research or data collection purposes, so long as such information is disclosed in a manner which will not reveal the identity of the persons who are the subject of the information or the identity of the officer or employee of the medical care facility reporting such information.

(c) The secretary may disclose information obtained under this act to officers and employees of the department of education who are designated by the state board of education to receive such information. Officers and employees of the department of education who receive such information shall be subject to the same degree of confidentiality as the secretary with respect to such information.

KMS

KANSAS MEDICAL SOCIETY

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Chip Wheelen

Director of Public Affairs

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

March 19, 1990

TO: Senate Public Health and Welfare Committee

FROM: Kansas Hospital Association

RE: House Bill 2915

The Kansas Hospital Association appreciates the opportunity to comment regarding H.B. 2915. This bill would establish an early intervention screening program to identify infants who are at risk of being hearing impaired.

We recognize that the literature suggests such screening programs can be helpful in identifying hearing impaired infants. In addition, it is clear that the sooner such discoveries are made, the better chance those infants have of receiving effective medical help for their condition.

In light of these facts, Kansas hospitals are willing to cooperate in an efficient and effective program to provide such screening.

In developing new programs such as the one in H.B. 2915, the emphasis must be on ensuring effectiveness of the screening process, while making it as efficient as possible. At a time when medical assistance budgets are being cut, lawmakers should be careful not to create new cost and liability burdens on the state's health care providers. We think the amendments made by the House Committee help to achieve these objectives.

Thank you for your consideration of our comments.

/cdc

SP H+W
Attachment #6
3/19/90

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

Kansas Department of Social and Rehabilitation Services

Testimony before

The Senate Committee on Public Health and Welfare

Regarding

House Bill 2833

on

March 19, 1990

at 10:00 a.m.

Room 526 S

Capitol Building

Marlene Finney, Administrator
Community Based Services
Telephone # 296-2459

presented on behalf of:

Jan Allen, Commissioner
Adult Services
Telephone # 296-6959

SPHW
Attachment #7
3/19/90

TESTIMONY ON HOUSE BILL 2833

The Kansas Department of Social and Rehabilitation Services (SRS) supports the passage of House Bill 2833.

The 1989 Kansas Legislature passed House Bill 2012. That bill empowers the consumer-as-employer in "the right to choose the option to make decisions about, direct the provisions of, and control their attendant care services including, but not limited to, selecting, training, managing, and dismissing of an attendant."

To facilitate this effort, SRS has explored a number of alternatives to accomplish its objective with regard to consumer involvement. One such alternative has been to reach agreements with such outside agencies as Centers for Independent Living to be provider agencies (employers) for the consumers' personal care attendants. Such agreements could preclude the State from being involved providing care. However, we are finding that not all areas of the State have an agency(s) that is able or willing to perform the functions of a provider agency while others may be able to do so on a very limited basis.

To date, we have contacted the State's nine Centers for Independent Living and have received no proposals for participation in implementing House Bill 2012. Additionally, our understanding is that their participation will be on a very limited basis. Presently, this would leave the vast majority of the current 37 interested consumers without a means to self-direct their care and possibly no alternative means of participation from rural consumers. Furthermore, we see the base of the consumer population expanding over the next year, particularly in rural areas, as consumers and advocacy groups become more knowledgeable of their choices.

House Bill 2833 places Personal Care Attendants in the unclassified service of the Kansas Civil Service Act. We believe the consumers and SRS will have much more flexibility in implementing House Bill 2012 if these employees are in the unclassified service. This is a way of bridging the gap for those consumers not served by a provider agency and make the difference in a consumer's choice to self-direct his or her care.

Should the consumers only alternative be the use of state employees, we would want to arrange for the consumers to work in concert with their local SRS office to select, train, manage and dismiss their attendants. Current classifications do not permit the employees to perform health maintenance tasks. Further, the State's merit system does not allow (in a practical sense) the consumer to direct or train the attendants in the performance of their activities, and certainly does not allow the consumer to decide disciplinary actions, including dismissal.

The unclassified position of a Personal Care Attendant would resolve this problem by allowing the consumer greater flexibility and actual involvement in the selection and dismissal process of the attendant. Also, a new classification would permit attendants to carry out those activities that may be medical in nature at the direction of the consumer. We envision the following approach in the selection and management of attendants:

- Prospective attendants would be referred to the consumer's local SRS office for processing. Attendants making application for employment not meeting the State's requirements would not be hired.

- In order for the consumer to direct the activities of his or her attendant, the physician must authorize the consumer to direct and supervise his or her own care in the home.

- The involvement and responsibilities of the case manager for consumers in a self-directed program will be the same as if they were recipients of other services through Home and Community Based Services.

- The consumers will still be required to follow the plan of care in the directions they give their personal care attendants.

SRS is seeking to implement a Consumer Directed Attendant Care Program that would place the responsibility with the consumer, and would be viewed as the least intrusive and still remain cost effective. SRS believes the appointments in the unclassified service would satisfy those requirements and would be cost neutral with respect to its fiscal impact on its operating budget.

Kansas Optometric Association

1266 S.W. Topeka Blvd., Topeka, KS 66612
913-232-0225

March 15, 1990

TO: SENATOR ROY EHRLICH, CHAIRMAN, SENATE PUBLIC HEALTH & WELFARE COMMITTEE

FROM: PHIL ERNZEN, O.D., PRESIDENT, STATE BOARD OF EXAMINERS IN OPTOMETRY
PAT HURLEY, MCGILL & ASSOCIATES
GARY ROBBINS, CAE, EXECUTIVE DIRECTOR, KANSAS OPTOMETRIC ASSOCIATION

RE: HOUSE BILL 2630

We have met and agreed to compromise language on House Bill 2630 which addresses all the concerns discussed during the hearing on March 13, 1990. We have met with Revisor of Statutes Norman Furse to review the language and determine where to insert the amendments. We have prepared a balloon of the agreed to amendments to House Bill 2630 in sections 2, 18(d) and 18(e). Norman Furse recommended a technical change in section 15 which is agreeable to all parties.

We would respectfully request that the Senate Public Health and Welfare Committee pass H.B. 2630 with the attached amendments and the technical change in section 15 being prepared by the Revisor.

Respectfully Submitted,

Phil Ernzen pf
Phil Ernzen, O.D., President
State Board of Examiners
in Optometry

Patrick D. Hurley
Pat Hurley, for Pete McGill
and Associates on behalf of
Cole Vision, Pearle Vision
Centers and LensCrafters

Gary Robbins
Gary Robbins, Executive Director
Kansas Optometric Association

cc Members, Senate Public Health & Welfare Committee

Affiliated with
American Optometric Association
TM

SPH&W
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3/19/90

that term in K.S.A. 65-425 and amendments thereto.

Sec. 2. K.S.A. 65-1502 is hereby amended to read as follows: 65-1502. ~~Any~~*Except as provided in K.S.A. 65-1508 and amendments thereto, a* person shall be deemed to be practicing optometry within the meaning of this ~~act, who shall~~ *the optometry law if such person* in any manner~~, except as provided in K.S.A. 65-1508; *first,* display any sign, circular, advertisement or device purporting or offering to in any manner examine eyes, test eyes, adapt lenses, or setting himself or herself forth as an optometrist, or as furnishing optometric services with intent to induce people to patronize himself, herself or any other person; *second,* who shall make in any manner:*

~~(a)~~ *Holds oneself out to the public as being engaged in or who maintains an office for the practice of optometry as defined in K.S.A. 65-1501 and amendments thereto;*

~~(b)~~ *makes* a test or examination of the eye or eyes of another to ascertain the refractive, the muscular or the pathological condition thereof; *third,* who shall in any manner adapt

~~(c)~~ *adapts* lenses to the human eye for any purpose, either directly or indirectly; or *fourth,* who shall conduct or perform

~~(d)~~ *conducts or performs* orthoptic exercises or visual training therapy for the correction, remedy or relief of any insufficiencies or abnormal conditions of the eyes.

Sec. 3. K.S.A. 1989 Supp. 65-1505 is hereby amended to read as follows: 65-1505. (a) Persons entitled to practice optometry in Kansas shall be those persons heretofore lawfully registered, and every person who is hereafter licensed in accordance with the provisions of this act. Every licensee at the time this act takes effect shall be deemed to be a licensed optometrist under this act, and every licensee certified by the board to use topical pharmaceutical drugs for diagnostic purposes at the time this act takes effect shall be deemed to be a diagnostic licensee under this act *the optometry law.* A person shall be deemed qualified to be licensed and to receive a license as an optometrist: (1) Who is of good moral character; and in determining the moral character of any such person, the board may take into consideration any felony conviction of such person, but such conviction shall not automatically operate as a bar to licensure; (2) who has graduated from a school or college of optometry approved by the board; and (3) who successfully meets and completes the requirements set by the board and passes an examination given by the board. All licenses issued on and after ~~July 1, 1987~~ *the effective date of this act,* to persons not licensed in this state or in another state prior to July 1, 1987,

(a)

(1)

(2)

(3)

(4)

(b) "Maintains an office for the practice of optometry" for the purposes of this section and the optometry law means:

(1) to directly or indirectly control or attempt to control the professional judgment or the practice of a licensee; or

(2) to bear any of the expenses of or to have, own or acquire any interest in the practice, books, records, files, or materials of a licensee

(c) Nothing herein contained shall be construed to prohibit a licensee from entering into leases, agreements, mortgages or other types of debt instruments not in violation of this section or any other section of the optometry law.

tion (j) of section 13, that a licensee submit to a mental or physical examination, the time from the date of the board's directive until the submission to the board of the report of the examination shall not be included in the computation of the time limit for hearing prescribed by the Kansas administrative procedure act.

New Sec. 17. At any time after the expiration of one year, application may be made for reinstatement of any licensee whose license shall have been revoked, and such application shall be addressed to the secretary-treasurer of the board. The board may promulgate such rules and regulations concerning notice and hearing of such application as are deemed necessary.

New Sec. 18. (a) A licensee may practice optometry under the name of a professional corporation, authorized by K.S.A. 17-2706 and amendments thereto. Such professional corporate name may contain a trade name or assumed name approved by the board.

(b) A licensee may practice as a sole practitioner or may associate with other licensees or health care providers licensed under the laws of the state of Kansas and may practice optometry as a sole practitioner or in such associations under a trade or assumed name approved by the board.

(c) A licensee may practice in a medical facility, medical care facility or a governmental institution or agency.

(d) ~~A licensee shall not practice pursuant to subsections (a), (b) and (c) in more than three practice locations from which the licensee derives any economic benefit. A licensee shall not have, maintain or derive any economic benefit pursuant to subsections (a), (b) and (c) in more than three practice locations exclusive of practice in governmental institutions.~~ In all office locations a licensee shall:

(1) Provide adequate staff during the hours of its operation and shall provide the necessary optometric equipment to enable a licensee to provide adequate optometric care on the premises; and

(2) provide that there shall be present at the office location a person licensed by optometry law when optometric practice acts requiring a license are performed at the office location.

(e) ~~Nothing herein contained shall be construed to permit the franchised practice of optometry~~.

New Sec. 19. The board in its discretion, in addition to any other remedies provided in this act, may apply to a court of competent jurisdiction for injunctive relief to restrain violations of the provisions of this act, lawful rules and regulations promulgated by the board under authority of this act.

New Sec. 20. Nothing contained herein shall be construed to

(d) A licensee shall not derive any economic benefit from nor have or maintain more than three practice locations pursuant to sub-sections (a), (b), and (c) except when practicing in governmental institutions.

(e) Nothing herein contained shall be construed to permit the franchised practice of optometry except that a licensee may purchase a franchise to engage in the business of optical dispensing separate and apart from any of the licensee's offices for the practice of optometry so long as the terms of the franchise agr[illegible]t do not violate the optometry law.