Approved: 1.29.09
Date

MINUTES OF THE HOUSE EDUCATION COMMITTEE

The meeting was called to order by Vice-Chairperson Deena Horst at 9:00 a.m. on January 22, 2009, in Room 711 of the Docking State Office Building.

All members were present except:
Representative Clay Aurand- excused
Representative Melvin Neufeld- excused
Representative Marti Crow - excused

Committee staff present:
Sharon Wenger, Kansas Legislative Research Department
Reagan Cussimanio, Kansas Legislative Research Department
Theresa Kiernan, Office of the Revisor of Statutes
Dale Dennis, Kansas State Department of Education
Janet Henning, Committee Assistant

Conferees appearing before the committee:
Dr. Michael Wasmer, Kansas Autism Task Force
Bob Vancrum, Blue Valley School District #229
Donna Whiteman, Kansas Association of School Boards
Christine Tuck, President, Kansas School Nurses Organization
Cindy Galemore, Kansas School Nurses Organization
Sarah Tidwell, Kansas State Nurses Association
Dan Morin, Kansas Medical Society
Tom Krebs, Kansas Association of School Boards (written testimony only)

Representative Brookens made the motion to approve the minutes of January 15, 2009 and January 20, 2009 as sent via e-mail. Representative Winn seconded the motion. Vice-Chairperson Horst asked that the blogspot address furnished by the Kansas Teacher of the Year team be included in the minutes of January 20, 2009. The motion carried.

Vice-Chairperson Horst inquired of Committee members if there were any introduction of bills. None were reported.

HB 2002 - School finance; military children, determination of enrollment (continued)

Tom Krebs, Kansas Association of School Boards, provided written testimony as a proponent for **HB 2002.** The Kansas Association of School Boards believes all districts that can show significant enrollment growth should have the opportunity to use a second count date, which would reflect additional educational expenses a district would find necessary to absorb. (Attachment 1)

Vice-Chairperson Horst closed the hearing on **HB 2002.**

Kansas Autism Task Force Report

Dr. Michael Wasmer, Kansas Autism Task Force, spoke to Committee members and summarized the final report of the Kansas Autism Task Force. Dr. Wasmer advised the Task Force found the current barriers to individuals with autism and their families in Kansas include:

- The tiny-K network which provides the front line for early identification and intervention in Kansas is not adequately funded and provides no allowance for the high cost of early intervention.
- The qualified personnel who are available are concentrated in the urban areas and not accessible to vast portions or rural Kansas.
- Current funding for the newly created Autism Waiver is limited to fewer than 50 children. The current waiting list contains more than 3 times the current number served.

- The only source local school districts have for covering the expense of these high cost services is Catastrophic Aid funding through the Kansas Department of Education.

- Currently, the Kansas Insurance Department has no authority to require non-discriminatory coverage for Kansans with autism spectrum disorders.

- Most Kansas families of individuals with autism eventually will need to look to the Developmental Disability system for services. The current waiting list for service is 3,152 and growing each year, as appropriations have failed to keep pace with the need. In addition, the inadequacy of reimbursement rates to cover the cost to recruit and retain direct support workers of acceptable quality has further rendered this system a broken resource.

Dr. Wasmer advised that two of the final recommendations led to draft legislation that was submitted for consideration by the Legislative Educational Planning Committee (LEPC). Both were endorsed by the LEPC and introduced as **SB 10** and **SB 12.**

SB10, the Autism Services Scholarship Act, would pay tuition and fees for five students (approximately $50,000/year) who are getting their bachelors or masters degree in Psychology, Applied Behavior Sciences, Speech, and Language Pathology, Occupational Therapy or Social Work with training in autism who commit to working in programs for individuals with autism in areas identified as underserved by the state board of education and the secretary of SRS.

SB 12, the Accessing Autism Services Act (Kate's Law), would require that private health insurance companies cover the diagnostic evaluation and treatment for autism spectrum disorders for fully funded policyholders in Kansas. (Attachments 2 and 3)

A question and answer session followed the presentation.

HB 2008 - School medication aide act; certain persons authorized to administer epinephrine.

Sharon Wenger, Principal Analyst, Kansas Legislative Research Department, gave an overview of **HB 2008** to Committee members from the final report of the Legislative Educational Planning Committee (LEPC). (Attachment 4)

Bob Vancrum, Blue Valley School District #229, spoke to Committee members in support of **HB 2008** and stated the bill is intended to protect both students suffering from severe allergies and support the school nurses who want to deliver the best nursing care to prevent sudden death. (Attachment 5)

Donna Whiteman, Assistant Executive Director/Legal Services, Kansas Association of School Boards, spoke to Committee members in opposition of **HB 2008**. She advised this bill creates a new class of school employees and will increase costs due to the bill's broad language. She also advised that in a year where the 295 school districts across the state will be making tough decisions including reductions in teachers and other staff, additional costs and fees should not be imposed nor should a new class of employees be created and required in school districts. (Attachment 6)

Christine Tuck, President, Kansas School Nurses Organization (KSNO) and Health Services Director, Seaman USD #345, spoke to Committee members in opposition of **HB 2008.** Ms. Tuck advised that school nurses believe **HB 2008** is not needed due to existing delegation regulations (KAR 60-16-101 thru 60-15-104) that allows for delegation of physician prescribed medications and has been implemented for many years by the Kansas State Board of Nursing. These regulations are periodically reviewed, with the most current revision completed in December, 2008. KSNO believes that what this act is trying to establish already exists in Kansas.

Ms. Tuck advised that KSNO believes that **HB2008** would create another layer of bureaucracy which would involve increased administration costs and oversight at the state level, a very important factor to consider during these tough economic times for both state government as well as school districts.

Ms. Tuck also advised a recent survey conducted by KSNO President requesting input from other state affiliate Presidents, with only 9 states responding in the affirmative in relation to standing orders, and only one specifically stating that the administration was not limited to a registered nurse (Nebraska) demonstrates there is still no concensus across the nation regarding this issue. (Attachments 7 and 8)

Cindy Galemore, Professional Standards Chair, Kansas State Nurses Organization, and Director of Health Services for Olathe District Schools, spoke to Committee members in opposition of the Medication Aide Act (amendment to K.S.A. 2008 Supp. 65-1124), the first portion of **HB 2008**.

Ms. Galemore told Committee members she was in support of the suggested amendment to 65-2872 section (t) which would provide the permissive language, without being mandatory, for districts that want to implement standing orders working under a physician and carried out by a professional registered nurse, consisted with the national standard.

Ms. Galemore also advised she opposed to the suggested section(s) of 65-2872 regarding school medication aides and that KSNO would be willing to implement a tracking record similar to Massachusetts to track beginning data on school epinephrine use in the state of Kansas.

Ms. Galemore told Committee members she was in support of the suggested amendment to 65-2872 section (t) and believed that in order to bring the consensus needed to pass this amendment, it would be necessary to allow time for dialogue with both the Kansas Board of Healing Arts and Board of Pharmacy. (Attachment 9)

Sarah Tidwell, Kansas State Nurses Association (KSNA), addressed the Committee members in opposition of **HB 2008.** Ms. Tidwell advised that KSNA is opposed to establishing the category of a school medication aide that could administer epinephrine. Another concern with the bill is the term "medication" being defined as epinephrine. Mr. Tidwell stated although KSNA believes the responsibility for any category of nursing aide should be with the Board of Nursing, their organization cannot support adding additional responsibility and program expense to the Board at this time. Adding this category would require additional staff or add responsibility to the current staff, neither of which could be supported. (Attachment 10)

Dan Morin, Director of Government Affairs, Kansas Medical Society, addressed Committee members as neutral of HB 2008. Mr. Morin advised their organization, at first, did not oppose the request voiced when the topic was addressed by the interim LEPC meeting. However, their organization does have some concerns and would encourage further discussion on the interim recommendation for a bill to establish "school medication aides (a person who has satisfactorily completed training in the use of epinephrine and could include school nurses or others) to administer epinephrine to students having an anaphylactic reaction in cases whether or not the student has been diagnosed with anaphylasix.

Mr. Morin told Committee members of one recommendation or addition to any bill addressing the use of Epi-pens for non-patient specific emergency situations. He advised Ohio Revised Code 3313.718 addresses the use of Epi-pens at a school setting or event and mandates in statute that whenever an auto-injector is used, a school employee shall immediately request assistance from an emergency medical provider (e.g., call 911).

Mr. Morin advised their organization is in conceptual support of allowing school nurses the ability to store an appropriate amount of epinephrine and administer epinephrine in the rare emergency cases where Epi-pens have not previously been prescribed to students with a history of serious allergic reactions known as anaphylaxis. However, they are unsure of how its provisions will work in practice. (Attachment 11)

A question and answer session followed the presentations.

Vice-Chairperson Horst advised she would recommend to Chairman Aurand that a sub-committee be appointed regarding this matter.

The next meeting is scheduled for January 27, 2009. The meeting was adjourned at 10:45 a.m.

KANSAS ASSOCIATION OF SCHOOL BOARDS

1420 SW Arrowhead Road • Topeka, Kansas 66604-4024
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Testimony before the
House Education Committee
by

Tom Krebs, Governmental Relations Specialist
Kansas Association of School Boards

January 21, 2009

Mr. Chairman, Members of the Committee:

Thank you for the opportunity to testify as a proponent for **HB 2002**.

KASB believes, as expressed in a 2009 legislative resolution, all districts that can show significant enrollment growth should have the opportunity to use a second count date, which would reflect additional educational expenses a district would find necessary to absorb. **HB 2002** does not provide for that, but it does extend the opportunity to districts which can experience growth connected to growth in the district's military population, which does make sense given that group of students' needs given their transient rates. The bill would allow districts to use this authority for four years starting in the 2009-10 school year.

Thank you for your consideration.

House Education Committee
Date 1-22-09
Attachment # 1

Report of the Kansas Autism Task Force to the 2009 Kansas Legislature
Summary to House Education Committee
January 22, 2009

Michael L. Wasmer, DVM
Parent member of the Kansas Autism Task Force

I appreciate the opportunity to speak with you this morning and share a summary of the final report of the Kansas Autism Task Force. I am the parent of a child with autism and an appointed member of the Autism Task Force.

The Autism Task Force was created by Senate Bill 138 in 2007 and directed to study and conduct hearings on the issues relating to the needs of, and the services available for persons with autism spectrum disorders. As directed by statute, the final report to the Legislative Educational Planning Committee was filed prior to November 15, 2008 and includes recommendations for legislative changes.

The 20-member committee included parents of children with autism, medical professionals, services providers with expertise in autism, special educators, a representative of the insurance industry and four Kansas State legislators. Subcommittees were formed to address key topics such as:

- Health insurance for individuals with autism
- Best practices for treating children with autism
- Education
- Funding, and
- Qualified service providers

General Task Force meetings took place monthly and subcommittees met on an as needed basis throughout the term of the statute. Meeting minutes are available on the Kansas Legislature website.

- The tiny-K network which provides the front line for early identification and intervention in Kansas is not adequately funded and provides no allowance for the high cost of early intervention.

- The qualified personnel who are available are concentrated in the urban areas and not accessible to vast portions or rural Kansas.

- Current funding for the newly created Autism Waiver is limited to fewer than 50 children. The current waiting list contains more than 3 times the current number served.

- The only source local school districts have for covering the expense of these high cost services is Catastrophic Aid funding through the Kansas Department of Education.

- Currently, the Kansas Insurance Department has no authority to require non-discriminatory coverage for Kansans with autism spectrum disorders

- Most Kansas families of individuals with autism eventually will need to look to the Developmental Disability system for services. The current waiting list for service is 3,512 and growing each year, as appropriations have failed to keep pace with the need. In addition, the inadequacy of reimbursement rates to cover the cost to recruit and retain direct support workers of acceptable quality has further rendered this system a broken resource.

Clearly the scope of this problem is not one that can possibly be solved by a single entity or state agency. Families, public schools, state and federally funded programs, and private health insurance carriers must each be fully participating

partners. This 4-legged approach to the solution is reflected in the Task Force's recommendations to the legislature, which are detailed in the final report.

Two of the final recommendations led to draft legislation that was submitted for consideration by the Legislative Educational Planning Committee. Both were endorsed by the LEPC and introduced as Senate Bill 10 and Senate Bill 12.

Senate Bill 10

The Autism Services Scholarship Act

The Bill would pay tuition and fees for five students (approximately $50,000/year) who are getting their bachelors or masters degree in Psychology, Applied Behavior Sciences, Speech and Language Pathology, Occupational Therapy or Social Work with training in autism who commit to working in programs for individuals with autism in areas identified as underserved by the state board of education and the secretary of SRS.

Kansas has excellent university programs, many considered within the top 10 in the nation. Many students are being trained in autism in these programs from disciplines such as Psychology, Applied Behavior Analysis, Speech and Language Pathology, Occupational Therapy, and Social Work. Many of these students are leaving the State after graduation, in large part due to challenge of getting reimbursed for their services from health insurance carriers in Kansas. Students that do stay in Kansas typically elect to stay in metropolitan areas and are not going to underserved areas such as rural Kansas.

Education and SRS have developed excellent programs for children with autism such as the Autism Medicaid Waiver, Positive Behavior Supports, and Special Education. These programs could save Kansas millions of dollars by providing

effective treatment for people with autism and in turn prevent future costs associated with residential placement or one-on-one supervision.

Recruiting qualified services providers to underserved areas for these effective autism programs is very difficult. Senate Bill 10 would require a year of commitment for each year of the scholarship.

Status of SB 10

Referred to Senate Education Committee

A hearing date has not been scheduled

Senate Bill 12

The Accessing Autism Services Act (Kate's Law)

Inequities in health insurance coverage create one of the most significant obstacles to appropriate early intervention for children with autism spectrum disorders in Kansas. Enactment of Senate Bill 12 would require that private health insurance companies cover the diagnostic evaluation and treatment for autism spectrum disorders for fully funded policyholders in Kansas.

Senate Bill 12 states that health insurance companies cannot deny coverage on an individual solely because the individual is diagnosed with an autism spectrum disorder. Among the covered treatments, coverage for applied behavior analysis shall be subject to a maximum benefit of $75,000 per year through age 21. Small businesses, i.e. employers with 50 or fewer employees, may "opt out" of the provisions set forth in SB 12.

To date, nine states have enacted legislation similar to Senate Bill 12. Of these, Indiana's autism mandate has been in effect the longest - over 8 years. It has no age limits or financial caps on coverage, and applies to both large and small

businesses. To date, there has been no data presented by any government body or insurer to show that it has had negative effects upon the cost of insurance, the number of uninsured in the State, the viability of small businesses or the ability of the state to attract large and small businesses to the State.

Enactment of SB 12 would dramatically improve access to medically necessary treatment for children with autism spectrum disorders in Kansas without accessing State General Funds. In addition, reimbursement for their services would provide incentive for qualified service providers to remain in Kansas.

Status of SB 12

Referred to Senate Financial Institutions and Insurance Committee
A hearing has been scheduled for January 29

Report of the Kansas Autism Task Force to the 2009 Kansas Legislature

CHAIRPERSON: Bill Craig

LEGISLATIVE MEMBERS: Senators Donald Betts and Julia Lynn; and Representatives Melody McCray-Miller and Judy Morrison

NON-LEGISLATIVE MEMBERS: Sarah Bommarito, Kathy Ellerbeck, Jarrod Forbes, Denise Grasso, Louise Heinz, Linda Heitzman-Powell, Yeyette Houfek, Donald Jordan, Linda Kenney, Tracy Lee, Jim Leiker, Martin Maldonado, Dee McKee, Nan Perrin, Matt Reese, Colleen Riley, Michael Wasmer, Jane Wegner, and Jeanie Zortman

STUDY TOPIC

The Kansas Autism Task Force is directed statutorily to study and conduct hearings on the issues related to the needs of and services available for persons with autism. State law requires that the Task Force submit reports to the Legislative Educational Planning Committee (KSA 46-1208d).

December 2008

Kansas Autism Task Force

Final Report

Conclusions and Recommendations

As a result of its findings, the Kansas Autism Task Force recommends that agencies which serve as support systems for families and children with autism (Kansas Department of Health and Environment (KDHE), Department of Education, and the Department of Social and Rehabilitation Services (SRS)) should incorporate the guidance of the "Best Practices in Autism Intervention for Kansas" handbook (attached) produced by this Task Force into their administrative guidelines.

As a result of its findings in other areas, the Kansas Autism Task Force recommends the Legislature consider and adopt legislation as follows:

- Create a specific mechanism in the KDHE *tiny-k* funding formula to support local *tiny-k* providers who must provide high cost, intensive services when they are required by a child's Individualized Family Service Plan (IFSP).
- Expand funding of the Autism Medicaid Waiver to fully serve the current waiting list and transfer the future funding of this program to the consensus estimating process, where anticipated need will be the basis for funding. A waiting list is not an acceptable option.
- Pass legislation which requires that health insurance policies cover the diagnosis and appropriate treatment of individuals with autism.
- Pass legislation which creates and funds a scholarship program to support the education of professionals in the field of autism who agree to serve in underserved areas of the State.
- Pass legislation to fully fund the Mental Retardation/Developmental Disabilities Home and Community Based Waiver (HCBS) waiting list and create adequate rates for the Developmental Disability system.
- To complete the objectives set for it by the Legislature, the Kansas Autism Task Force must have its term extended for an additional year. The necessary legislative authorization to accomplish this should be made retroactive to January 2009. (Please see the "Task Force Activities" section, page 4, for the complete rationale for this extension.)

In addition, the Department of Education should strive to ease the access to Catastrophic Aid funds for school districts who serve high-cost students, such as those with autism.

It is incumbent on the three state agencies primarily responsible for services to individuals with autism (KDHE, Department of Education, and SRS) to collaboratively maintain a dynamic mapping website of the availability of services and supports across the state with current contact information. This site should be readily available and usable by parents seeking information and service.

Proposed Legislation: The Kansas Autism Task Force has no authority to introduce legislation.

Background

The Kansas Autism Task Force was established by 2007 SB 138 to study and conduct hearings into issues including but not limited to:

- The realignment of state agencies that provide services for children with autism;
- The availability or accessibility of services for the screening, diagnosis and treatment of children with autism and the availability or accessibility of services for the parents or guardians of children with autism;
- The need to increase the number of qualified professionals and paraprofessionals who are able to provide evidence-based intervention and other services to children with autism and incentives which may be offered to meet that need;
- The benefits currently available for services provided to children with autism;
- The study and discussion of an autism registry which would (a) provide accurate numbers of children with autism, (b) improve the understanding of the spectrum of autism disorders and (c) allow for more complete epidemiologic surveys of autism spectrum disorders;
- The creation and design of a financial assistance program for children with autism;
- The establishment of a hotline that the parents or guardians of children with autism may use to locate services for children with autism;
- Additional funding sources to support programs that provide evidence-based intervention or treatment of autism, including funding for the development of regional centers of excellence for the diagnosis and treatment of autism; and
- Develop recommendations for the best practices for early evidence-based intervention for children with autism.

Task Force Activities

The Task Force and its subcommittees met frequently in 2008. For a detailed description of the activities of the Task Force, refer to the minutes of meetings dated March 5, April 14, June 12, July 16, August 22, September 17, and November 12, 2008.

The Task Force decided to make a request to the 2009 Legislature to extend the term of its activity for an additional year for the following purposes:

- A final edition of the "Best Practices in Autism Treatment in Kansas" handbook must await the incorporation of the soon-to-be released national standards manual. Subsequently, a readily accessible version of this document will be made available to all interested families, providers, and others.
- The Task Force believes it must be available as a resource to the 2009 Legislature during the Session as it deliberates the recommendations of the Task Force.
- At the conclusion of the extension year the Task Force will make a recommendation to the Legislature for a mechanism to provide ongoing advice and oversight for the concerns of Kansans with autism.

Conclusions and Recommendations

Our Findings

- Autism spectrum disorders (ASDs) are biologically based, neurodevelopmental disabilities with a strong genetic component that are characterized by impairments in communication, social interaction and sensory processing. With varying degrees of severity, ASDs interfere with an affected individual's ability to learn and to establish meaningful relationships with others.

- The prevalence of ASDs in Kansas (and nationwide) is increasing in epidemic proportions. (The Centers for Disease Control currently report the prevalence of ASDs as 1 in 150 births. Ten years ago, this estimate was 1 in 2,500.)

- There is no proven "cure" for autism and the effects of this disability are typically lifelong. However, effectiveness of early, intensive intervention in reducing the effects of this disorder is supported by a growing body of scientific research. The costs of this intervention for at least three years during the crucial developmental age (1 through 7) may exceed $150,000.

- Half of the individuals who receive this level of intervention do not require subsequent special education services and 80 percent show measurable reduction in symptoms. The cost of supporting an individual with autism who does not receive such intervention through age 55 is estimated to average $4,400,000.

Current Barriers

The current barriers to individuals with autism and their families in Kansas include:

- Long wait times for thorough diagnostic assessments by properly certified professionals.

- The *tiny-k* network which provides the front line for early identification and intervention in Kansas is not adequately funded and provides no allowance for the high cost of early intervention.

- There is a dramatic shortage of qualified personnel to implement early intervention.

- The qualified personnel who are available are concentrated in the urban areas and not accessible to vast portions of rural Kansas.

- Current funding for the newly created Autism Waiver is limited to fewer than 50 children. The current waiting list contains more than three times the current number served.

- The only source local school districts have for covering the expense of these high cost services is Catastrophic Aid funding through the Kansas Department of Education.

- Currently, the Kansas Insurance Department has no authority to require non-discriminatory coverage for Kansans with autism.

- Most Kansas families of individuals with autism eventually will need to look to the public Developmental Disability system for services. The current waiting list for needed service (2,233 individuals waiting for HCBS services and an additional 1,279 awaiting other services, for a total of 3,512) is growing each year as appropriations have failed to keep pace with the need. In addition, the inadequacy of reimbursement rates to cover the cost to recruit and retain direct support workers of acceptable quality has further rendered this system a broken resource.

Vision Statement

The Task Force expresses the following Vision Statement for autism supports and services to which Kansas should aspire.

All children in Kansas will receive screening for a developmental delay within the first year of life and for an autism spectrum disorder (ASD) within the second year. Children with a positive ASD screen will be referred for evidence-based intensive intervention immediately while undergoing a thorough diagnostic assessment within six months. Evidence-based intervention services (defined as at least 25 hours a week of systematic intervention for a period of three years for a child under the age of 8) will be readily available for all Kansas children with an ASD.

High quality supports will be readily available to persons with autism who require them throughout the life span.

Families, public schools, state and federal programs, service providers, and private health insurance carriers must each be fully participating partners in the achievement of this vision.

Legislative Recommendations

As a result of its findings, the Kansas Autism Task Force recommends that agencies which serve as support systems for families and children with autism (KDHE, Department of Education, SRS) should incorporate the guidance of the "Best Practices in Autism Intervention for Kansas" handbook produced by this Task Force into their administrative guidelines.

As a result of its findings in other areas, the Kansas Autism Task Force recommends the Legislature consider and adopt legislation as follows:

- Create a specific mechanism in the KDHE *tiny-k* funding formula to support local providers who must support high cost, intensive services identified in a child's Individualized Family Service Plan (IFSP).

- Expand funding of the Autism Medicaid Waiver to fully serve the current waiting list and transfer the future funding of this program to the consensus estimating process, where anticipated need will be the basis for funding and a waiting list is not an option.

- Pass legislation which requires that health insurance policies cover the diagnosis and appropriate treatment of individuals with autism.

- Pass legislation which creates and funds a scholarship program to support the education of professionals in the field of autism who agree to serve in underserved areas of the state.

- Pass legislation to fully fund the Mental Retardation/Developmental Disabilities HCBS waiting list and create adequate rates for the Developmental Disability system.

- To complete the objectives set for it by the Legislature, the Kansas Autism Task Force must have its term extended for an additional year. The necessary legislative authorization to accomplish this should be made retroactive to January 2009. (Please see the "Task Force Activities" section, page 4, for the complete rationale for this extension.)

In addition, the Department of Education should strive to ease the access to Catastrophic

Aid funds for school districts who serve high-cost students, such as those with autism.

It is incumbent on the three state agencies primarily responsible for services to individuals with autism (KDHE, Department of Education, and SRS) to collaboratively maintain a dynamic mapping website of the availability of services and supports across the state with current contact information. This site should be readily available and usable by parents seeking information and service.

Attachment: Executive summary of the "Best Practices in Autism Intervention for Kansas" handbook.

Executive Summary

Best Practices for Autism Treatment in Kansas

Best Practices Subcommittee of the Kansas Legislative Task Force on Autism

Subcommittee members
Linda S. Heitzman-Powell, Ph.D., Convener
Adjunct Faculty, University of Kansas
Nanette Perrin, M.A.
Board Certified Behavior Analyst
Louise Heinz
Parent Representative
Jane Wegner, Ph.D.
Speech-Language-Hearing
Tracy Lee, M.S.
Special Education
Martin Maldonado, M.D.
Psychiatrist

Guest Members
Significant Contributors
Phoebe Rinkel, M.S.
University of Kansas Life Span Institute
Representing Kansas State Department of Education

Peggy Miksch, M.S., IMH-E™ (IV)
University of Kansas Life Span Institute
Representing Kansas Department of Health and Environment

Other Contributors
Nathan Yaffe, Student
Sarah Hoffmeier, MSW
Family Service and Training Coordinator
Diane Bannerman Juracek, Ph.D., BCBA
Senior Administrator
Community Living Opportunities, Inc.

EXECUTIVE SUMMARY
Best Practices Subcommittee

The purpose of this report is to (1) synthesize the evidence regarding effective evidence-based interventions that guide best practices for the treatment of individuals affected by ASD; and (2) based on the findings, make recommendations on best practices for children with autism. This report was generated from the ideology that our process and recommendations are based on the most current science.

Synthesis of Evidence-based Practices

The Best Practices subcommittee agreed to review: 1) other state documents; 2) other comprehensive reviews that have been completed; 3) discipline-specific comprehensive reviews that were submitted to the subcommittee by members of the committee or guest members, and 5) key reports or scientific documents that have been generated in the last 5 years. The subcommittee agreed with Horner and colleagues' (2005) definition of evidence-based practice:

> "[evidence-based] Practice refers to a curriculum, behavior intervention, systems change, or education approach designed for use by families, educators, or students with the express expectation that implementation will result in measurable educational, social, behavioral, or physical benefit (pg. 175)."

The Best Practices subcommittee also defined criteria for strong, moderate, emerging, minimal and no evidence of interventions, and these criteria were used to make recommendations. These criteria were developed based on published criteria for reviewing evidenced based practices by prominent researchers and national scientific reviews including the National Standards Project (National Autism Center – http://www.nationalautismcenter.org/), the National Research Council, the American Speech-Language-Hearing Association's National Center for Evidence-Based Practice, and the Council for Exceptional Children. The agreed upon criteria were:

- Strongest evidence: more than six studies with more than 20 participants, with beneficial effects and no conflicting results or harmful effects, using Randomized Control Trials or single subject designs, and conducted by 3 researchers in 3 geographic regions.
- Moderate evidence: more than nine studies and the same criteria as used for 'strongest evidence, however one study showing conflicting results.
- Emerging evidence: four to five studies with more than 10 participants, the same benefits and scientific design as for strongest evidence but no criteria for the number or location of research.
- Minimal evidence: one to two studies, with four participants and the same benefits and scientific design as for strongest evidence but no criteria for the number or location of research.
- No evidence: no methodological criterion and no experimental control

Once these sources were identified, the recommendations cited as evidence-based were then synthesized. Interventions and program recommendations that adhered to the committee's criteria for "evidence" were then included in this report. Due to time and resources constraints, the Best Practices subcommittee procedures DID NOT include: 1) a comprehensive, first hand search and review of the scientific literature; 2) a review of all disciplines that could provide services for individuals with an ASD; and 3) a review of alternative medicines or techniques.

Findings and Recommendations to the Autism Task Force

Recommendations in this report are made with the understanding that each individual on the spectrum is unique. Given early diagnosis and intervention, outcomes will vary for individuals with an Autism Spectrum Disorder (ASD) just as outcomes for any child will vary based on individual characteristics. Individualized programs are recommended based on child needs and best available evidence of effective practices.

Recommendations are based on common elements of reported "best practices" and evidenced based programs: data collection and data-based decision making, structured and well-defined teaching procedures, use of procedures to increase desirable behaviors, function-based treatment of problem behaviors, and use of developmentally appropriate and well-rounded curriculum including peers when appropriate. Examples of evidence-based practices included: Applied Behavioral Analysis and Discrete Trial Teaching (e.g., University of California at Los Angeles, and replication sites); and 2 other intervention programs cited in a meta-analysis conducted by Simpson and colleagues (2005) Pivotal Response Training (PRT; University of California at Santa Barbara), and Learning Experiences: An Alternative for Preschoolers and Parents (LEAP). Examples of emerging or probably evidence-based (needing more research) included: Treatment and Education of Autistic and Communication Handicapped Children (TEACCH; University of North Carolina); and individual interventions such as assistive technology, augmentative alternative communication (AAC), incidental and naturalistic teaching, joint action routines, peer mediation intervention strategy, social stories intervention strategy, developmental play/assessment teaching, Picture Exchange Communication System (PECS), and video modeling.

Recommendations are also inclusive of general characteristics of quality programs based on syntheses provided of *Model Early Childhood Programs for Children with ASD* (see Boulware, et al. 2006; Dawson & Osterling, 1997; the National Research Council, 2001). Programs considered high quality by the reviewers (i.e., using evidenced-based practices, favorable reviews by multiple professional organizations) found a range of 15-40 hours per week of service, with average of 25 hours week. They found that the characteristics necessary for an effective program are: use of a comprehensive curriculum sensitive to developmental sequence, use of supportive, empirically validated teaching strategies, involvement of parents, gradual transition to more naturalistic environments, highly trained staff, and a systematic supervisory and review mechanism.

Finally, a large project sponsored by the National Autism Center, recently completed the National Standards Project, as an effort to use scientific merit to identify evidence-based guidelines for treatments of individuals with ASD younger than 22 years of age. The focus of the project was limited to "interventions that can reasonably be implemented with integrity in most school or behavioral treatment programs. A review of the biomedical literature for ASD will be left to another body of qualified individuals." (Wilczynski, et al., 2008, p. 39). A panel of multidisciplinary autism researchers applied a rigorous scoring system to evaluate the quality and usefulness of interventions for individuals with ASD described in nearly 1,000 studies. Results of the project are expected before the end of 2008 (http://www. nationalautismcenter.org). A recent publication by those involved in the *National Standards Project* includes recommendations of the best practices listed above (e.g., discrete trial training). The report also recommends four key behavior support interventions including: antecedent (preventive) intervention, positive reinforcement to decrease challenging behavior, behavior-contingent (restrictive) intervention as a function-based approach, and family support.

The following recommendations are the results of the Best Practices subcommittee work for the Legislative Task Force on Autism.

Best Practice Recommendations based on a Synthesis of Sources

1. Use of a model based on the science of human behavior such as that found in an Applied Behavior Analysis model of intervention. Applied Behavior Analysis has been referenced throughout the literature as having the most scientific evidence to support the use of techniques found in intensive behavioral programs.
2. Entry into intervention as soon as an ASD diagnosis is seriously considered rather than deferring until a definitive diagnosis is made.
3. Intensive early intervention is recommended. Intensive intervention has been defined throughout the review as active engagement of the child at least 25 hours per week, 12 months per year, in systematically planned, developmentally appropriate community, home, and educational-based interventions designed to address identified objectives.
4. Instructional programs and curriculum address all areas of delay and specifically address core deficits of ASD (e.g., social, communication, and repetitive/stereotypic behaviors).
5. Ongoing measurement and documentation of the individual child's progress toward identified objectives are recommended.
6. Promotion of opportunities for interaction with typically developing peers.
7. Problem or interfering behaviors are targets for reduction and/or replacement by using empirically supported strategies to teach socially valid replacement behaviors.
8. The staff members delivering the intervention have received specialized training in ASD that includes an experiential component.
9. Inclusion of a family component (including parent training as indicated); must involve family participation in development of goals, priorities and treatment plans and provide on-going parent support, training and consultation.

This report offers a synthesis of evidence-based practices and program characteristics for young children with ASD. Examples of quality programs are referenced, and characteristics described. Single intervention strategies with evidence supporting their effectiveness are also described. Recommendations to the Autism Task Force are provided as guidelines for practitioners to

improve outcomes for children with ASD, and support for their families across the state of Kansas. Guidelines are based on current research and our review process of the research as described (review of state documents, reports from professional organizations, literature syntheses, and meta-analyses reports). A final recommendation is to provide periodic updates and supplements to the report as new research and treatment are developed.

Report of the Joint Committee on Legislative Educational Planning to the 2009 Kansas Legislature

CHAIRPERSON: Representative Deena Horst

VICE-CHAIRPERSON: Senator Jean Kurtis Schodorf

OTHER MEMBERS: Senators Marci Francisco, Roger Pine, Mark Taddiken, Ruth Teichman, and John Vratil; and Representatives Barbara Ballard, Owen Donohoe, Steve Huebert, Eber Phelps, Jo Ann Pottorff, and Valdenia Winn

STUDY TOPICS

The Committee was directed to plan for public and private postsecondary education, study preschool and K-12 education, and review State Department of Education implementation of legislation relating to educational matters.

- Supplemental State Aid for High Assessed Property Valuation Counties with Low Numbers of School-Age Children
- Federal Impact Aid to School Districts

Reports statutorily required to be submitted to the Legislative Educational Planning Committee

Included in this publication are the final reports from the Kansas Autism Task Force and the Kansas Technical College and Technical School Commission.

December 2008

Joint Committee on Legislative Educational Planning

Report

Conclusions and Recommendations

The Legislative Educational Planning Committee (the Committee) approved introduction of 13 bills to be considered during the 2009 Legislative Session. Those items as well as other recommendations are described below.

As recommended by the 2010 Commission, the Committee agreed to recommend legislation and introduce a bill extending through school year 2012-2013 the second-count date (February 20) provision for military children, modifying the existing provision so that only the net increase in children would be used when computing the general fund budget of the school districts.

The Committee agreed to recommend and introduce legislation related to a second recommendation of the 2010 Commission that would extend through school year 2012-2013 the provision which would increase the amount of state aid to school districts in an amount equal to the percentage increase in the consumer price index-urban.

The Committee recommends legislation and introduction of a bill establishing school medication aides (a person who has satisfactorily completed training in the use of epinephrine and could include school nurses or others) to administer epinephrine to students having an anaphylactic reaction in cases whether or not the student has been diagnosed with anaphylaxis.

The Committee agreed to recommend and introduce the postsecondary education initiatives described below and proposed by the Kansas Board of Regents. Those initiatives would accomplish the following:

- Permit a community college to own property outside its local community college taxing district, but within its assigned service area.
- Amend current statutes to fully fund KAN-ED from the Kansas Universal Service Fund (KUSF) at $10.0 million per year.
- Delete a provision in law which allows a person who is on a leave of absence from a university and working for the executive branch of state government to participate in the mandatory retirement plan.
- Include medical students enrolled at the University of Kansas Medical Center within the definition of employee under the Kansas Tort Claims Act.
- Codify language previously contained in an appropriations bill proviso regarding the

development of a funding model for postsecondary technical education, update references regarding the state plan for career and technical education and the federal Carl D. Perkins Act, and replace outdated "vocational education" terminology with the currently-used "career technical education" term where possible, and repeal wording or statutes no longer needed or obsolete.

- Delete the 12,000-pound limitation on moving expenses which may be paid by state universities when recruiting personnel.

- Allow state universities, as authorized by the Kansas Board of Regents, to provide tuition and fee waivers to undergraduates.

The Committee agreed to introduce, without recommendation, one additional bill requested by the Kansas Board of Regents. This bill would:

- Eliminate certain restrictions involved in the process of hiring architects, engineers, and contractors for the construction and renovation of state university buildings funded with non-state moneys.

The Committee recommended and authorized introduction of two bills recommended by the Kansas Autism Task Force. These bills would:

- Require health insurance policies to cover costs for the diagnosis and treatment of autism. The bill would exempt group policies offered by employers of 50 or fewer employees. (The Committee requested this bill be referred both to insurance and health standing committees); and

- Establish the Autism Service Scholarship Program Act, providing scholarships to students pursuing allied health care degrees and agreeing to provide services to individuals with autism located in underserved areas of the state.

The Committee requested Legislative staff review the possibility of whether any funding appropriated for a Kansas Center for School Preparedness and Safety could be counted as a match enabling the state to draw federal hazard mitigation funding, which could be used by school districts for preparedness activities, and provide that information to standing education committees during the 2009 Legislative Session.

LCC-referred Topics:

Supplemental State Aid for High Assessed Property Valuation Counties with Low Numbers of School-Age Children

The Committee recommended that this issue be reviewed by standing education committees during the 2009 Legislative Session, with proposed legislation developed at that time. The Committee expressed interest in various suggestions made by Senator Jim Barnett related to this issue and Chase County, in particular, and requested that legislative staff work with Senator Barnett to more

fully develop a recommendation.

Federal Impact Aid

At the final meeting in November, Representative Barbara Craft, who had requested the LCC refer a study on Federal Impact Aid to an Interim Committee, withdrew her request for a recommendation regarding Federal Impact Aid. Instead, she requested the LEPC recommend the extension of the second-count date. The LEPC made that recommendation and agreed to introduce a bill to implement the recommendation.

Proposed Legislation: The Committee will introduce 13 bills.

Background

The Legislative Educational Planning Committee (LEPC) is a statutorily-created committee with authority over preschool, elementary, secondary, and postsecondary education. The Committee is charged statutorily with monitoring the implementation and ongoing operation of the Kansas Higher Education Coordination Act (KSA 74-3201 *et seq.*). Legislation enacted by the 2005 Legislature changed the Committee's role to exclude matters relating to school finance from its purview. This action was intended to eliminate duplication between the LEPC and the 2010 Commission, an entity created by the 2005 Legislature which is responsible for monitoring school district funding.

The LEPC consists of seven House members and six Senate members appointed by the Legislative Coordinating Council (LCC). The Committee may initiate its own studies or be assigned proposals by the LCC. The LCC assigned the Committee the following two studies during the 2008 Interim:

Supplemental State Aid for High Assessed Property Valuation Counties with Low Numbers of School-Age Children. Review the amount of supplemental state aid provided to Chase County and other similarly situated counties that have a high assessed property valuation relative to other counties in similar situations with low numbers of school-age children. Study if the amount of supplemental state aid provided to these local school districts related to the local option budget is low. (Requested by Sen. James Barnett)

Federal Impact Aid to School Districts. Review the current federal impact aid to Kansas school districts. Study and compare the process that Kansas uses to qualify for federal impact aid to school districts with how other states apply for and qualify for federal impact aid to school districts. (Requested by Rep. Barbara Craft)

Committee Activities

Elementary and Secondary Education

Federal Impact Aid to School Districts

Representative Barbara Craft brought this topic to the attention of the Legislative Coordinating Council because of the impact of the growing number of military families in the Geary County School District, USD 375.

Federal Impact Aid (Impact Aid) was created in 1950 and designed to reimburse public school districts for the loss of traditional revenue sources due to a federal preserve or federal activity. Impact Aid is one of the only federal education programs in which the funds are sent directly to the school district. However, Impact Aid is subject to the same state regulations as

any other school funding. Federal law allows states to take Impact Aid into consideration when providing state aid to a school district if a state meets certain requirements. In general, those requirements include ensuring that the state aid equalizes expenditures for free public education. Specifically, a state must prove that the highest per pupil expenditures or revenues in the state do not exceed the lowest per pupil expenditures or revenues by more than 25 percent. Only three states have been approved under these requirements: Kansas, Alaska, and New Mexico. It is under this provision that Kansas requires school districts to count 70 percent of its Federal Impact Aid as a local contribution, thus lowering the amount of state aid the district receives. The remaining 30 percent can be used as miscellaneous revenue by a school district. New Mexico requires school districts to report 75 percent of the Aid and Alaska requires reporting of 90 percent.

Twenty-six Kansas school districts receive Federal Impact Aid. The three districts primarily affected by Ft. Riley and their most recent Impact Aid payments are shown below.

School District	Total Impact Aid (2006-07)	70% of Aid counted as local effort	30% of Impact Aid can be used as miscellaneous revenue
Manhattan-Odgen 383	$127,450	$89,215	$38,235
Riley County 378	$5,912	$4,138	$1,774
Geary County 475	$8,961,734	$6,273,214	$2,688,520

Ft. Leavenworth receives a large amount of Impact Aid, the majority under a different provision of the federal law. Because the totality of the Ft. Leavenworth School District is on the military base and more than 35 percent of its students live on the base, the District receives "heavily impacted" Aid. (There are only about six school districts in the United States receiving this type of federal aid.)

According to federal law (Section 8003(b)(2) of the Federal Impact Aid Act), this type of Impact Aid cannot be counted toward a district's local effort. The most recent year's receipts at Ft. Leavenworth include nearly $5.0 million of "heavily impacted" Aid which the District uses for capital outlay. Ft. Leavenworth School District receives another nearly $5.0 million of which 70 percent is counted toward the District's local effort when General State Aid is computed. (Ft. Leavenworth School District has only grades K – 9.)

In her testimony before the LEPC, Representative Craft requested the Committee consider making an alternative recommendation for distribution, such as increasing the percentage of Federal Impact Aid dollars that are considered miscellaneous income. Ron Walker, Superintendent, Geary County School District, told Committee members that the most important legislation passed by the Kansas Legislature was the second-count date. (The second-count date allows school districts to receive additional funding if enrollment increases from September 20 to February 20 if the increase is more than 25 full-time equivalent students or one percent of a district's total enrollment.) For the first time, the District was able to appropriately hire teachers, add support staff, and order necessary materials and supplies. Mr. Walker also stated the legislation allowing districts to keep 30 percent of the Federal Impact Aid, rather than the original 25 percent, has been the second most important legislation for his district.

The 2010 Commission made a recommendation related to this issue in its Report to the 2009 Legislature. It recommended that the second-count date legislation be extended for four additional school years. (The law expires with school year 2009-2010.) The Commission also recommended that the law be amended to make the second-count based upon the net increase in students which takes into account the students leaving between count dates.

Committee Recommendation

At its final meeting in November, Representative Barbara Craft, who had requested the LCC refer a study on Federal Impact Aid to an Interim Committee, withdrew her request for a recommendation regarding Federal Impact Aid. Instead, she requested the LEPC recommend the extension of the second-count date. The LEPC made that recommendation and authorization for a bill which would extend, through school year 2012-2013, the second-count date (February 20) provision for military children, modifying the existing provision so that only the net increase in children would be used when computing the general fund budget of the school districts.

Supplemental State Aid for High Assessed Property Valuation Counties with Low Numbers of School-Age Children

The Legislative Coordinating Council has referred to the LEPC the charge of reviewing the amount of supplemental state aid provided to Chase County and other counties in similar situations with low numbers of school-age children that have a high assessed property valuation relative to other counties. The LEPC was requested to study whether the amount of supplemental state aid provided to these local school districts related to the local option budget (LOB) is low. The study topic was requested by Senator James Barnett.

Under current law, the formula for determining supplemental general state aid (LOB state aid) is crafted to provide the highest proportion of aid to those school districts with the lowest assessed valuation (AV) per pupil, and to provide no aid to those with the highest AV per pupil.

Supplemental general state aid (or LOB state aid) is based on an equalization principle which is designed to equalize school districts up to the level of the district at the 81.2 percentile level of AV per pupil. Under this formula, districts having an AV per pupil at or above the 81.2 percentile level receive no supplemental general state aid. An example follows.

Example:

School District #1	
AV Per Pupil	$50,500
81.2 Percentile AV Per Pupil	$83,625
So:	$50,500/$83,625 equals 0.6039
Then:	1.000 minus 0.6039 equals 0.3961 State Aid Ratio used to calculate Supplemental general state aid (LOB state aid)

According to the Kansas Department of Education, 56 of Kansas' 295 school districts are not entitled to receive LOB state aid because their AV per pupil is equal to or higher than the amount established by the statutory formula. The Chase County Unified School District (USD 284) is among those that receive no LOB state aid.

In 2008, Senator Barnett sought the passage of SB 627 on behalf of the Chase County Unified School District. The bill, which died in the Senate Education Committee, would have authorized the district to receive LOB state aid in an amount equal to 50 percent of its LOB budget. Testimony presented in the hearing by district officials indicated that a number of factors negatively affected the district's ability to fund operations through the LOB. The district, which had consolidated previously, has been declining in enrollment for a number of years. It also has been increasing in AV. At the same time, the testimony indicated, what is required of the district educationally has increased. The combination of these and other factors has resulted in a 164.3 percent increase in the district's LOB mill levy over the past six years, from 8.8 mills in Fiscal Year 2001-02 to 23.2 mills in FY 2008. The district officials indicated

the district has eliminated or reduced spending in a number of areas related to maintenance and operation.

Authorizing the Chase County district by itself to receive LOB state aid at a rate of 50 percent, as in 2008 SB 627, would increase LOB state aid by an estimated $472,000 (based on data for the 2007-08 school year). Alternatively, revising the formula contained in current law by bringing the minimum LOB state aid rate to 50 percent for all school districts would mean all school districts would qualify for LOB state aid at the rate of at least 50 percent, including the 56 school districts that receive no LOB state aid currently. This would result in an increase in LOB state aid of approximately $137,500,000 (based on data for the 2007-08 school year).

Committee Recommendation

The Committee indicated an interest in reviewing this topic during the upcoming legislative session and recommended that legislative staff work with Senator Barnett and the Department of Education in developing proposed legislation that could be brought before education committees during the 2009 Legislative Session.

Teacher Shortages and Teacher Recruitment

Both the Legislative Educational Planning Committee and the 2010 Commission reviewed the issue of teacher shortages and recruitment of teachers at their August meeting. The two groups met jointly in an attempt to make more efficient use of their time during the 2008 interim session.

At the August 2008 meeting, Dr. Alexa Posny, Commissioner, Kansas Department of Education, set the stage for this discussion by highlighting the following statistics:

- 40 percent of Kansas teachers leave the field after seven years;
- 36 percent of Kansas teachers can retire within five years;
- 50 percent of reported personnel are over 45, and 36 percent are over 50;
- 12 percent fewer students have gone into teaching over the past six years;
- In June 2008, there were 846 teacher vacancies across the state; and
- In August 2008, there were an estimated 375 teacher vacancies.

Dr. Posny went on to state reasons teachers leave the teaching profession:

- Isolation from colleagues;
- Assignments outside their area of training;
- Lack of appreciation or respect;
- Feeling discouraged and frustrated;
- Feeling left out of the decision making;
- Poor school management and not enough support from administration;
- Lack of classroom resources;
- Too many regulations;
- Lack of mentoring or induction programs;
- Large class size;
- Undisciplined and poorly motivated students;
- Uninvolved parents;
- Unreasonable expectations; and
- Lack of resources.

Dr. Posny highlighted the numerous regulatory changes the Department has made in attempting to get teachers into classrooms more quickly while continuing to ensure a quality teaching force. Some of the licensure regulation changes are noted below:

- Removed the grade point average of 2.5 for conditional teaching license;
- Offered a restricted school specialist license;
- Recognized experience of out-of-state school counselors with teaching backgrounds;
- Expanded provisional license options;

- Offered a one-year nonrenewable license without an existing offer of employment;
- Offered three options for added endorsements;
- Expanded innovative and experimental programs for institutions of higher education;
- Created the new licenses of transitional and interim alternative licenses;
- Offered reinstatement based on out-of-state experience;
- Reduced renewal requirements for standard substitutes.

On behalf of the Kansas Board of Regents, Dr. Andy Tompkins, Dean of the College of Education at Pittsburg State University, spoke on teacher licensure. He highlighted the increasing number of collaborative efforts between Kansas institutions of higher education and the Kansas Department of Education that have been innovative and responsive to the state's needs. One example is the Pittsburg State University program that started in 2001 and currently contains 111 students teaching primarily in Kansas City, Kansas, public schools as well as 18 other school districts. This program has a nearly 90 percent retention rate. Dr. Tompkins indicated that the retirements of "baby boomers" and a highly competitive global marketplace presents an economy competing for talent in all sectors.

Dr. Leann Ellis, Vice President for Academic Affairs, Butler Community College (BCC), and Dr. Marilyn Reinhardt, Vice President of Instruction, Johnson County Community College, spoke to Committee members regarding the crucial role of community colleges in teacher preparation and professional development of educators. An example of this collaboration was described in the Emporia State University (ESU) and BCC "2 + 2" program. Students who enroll in this program will complete a two-year Associates of Arts degree from BCC and continue on to get a Bachelor of Science in Elementary Education from ESU.

The LEPC reviewed the 2008 Legislative Sessions' House Concurrent Resolution 5039 that set out objectives aimed at teacher preparation programs and teacher licensure targeted at the Kansas Department of Education and the Board of Regents. The resolution urged the restructuring of alternative teacher licensure programs in ways that would assist in alleviating the teacher shortages in mathematics, science, and special education.

Use of Epinephrine by School Nurses

In June 2008, the State Board of Nursing (Board) notified school nurses that the Kansas Nurse Practice Act (KSA 65-113 *et seq.*) does not allow school nurses to identify an anaphylactic reaction in a student who has not been previously diagnosed with anaphylaxis or to administer epinephrine to treat that student without receiving a physician's order to do so. The Nurse Practice Act authorizes a nurse to make a nursing diagnosis and to execute a medical regimen as prescribed by someone licensed to practice medicine and surgery. Identifying and labeling anaphylaxis requires medical judgment and is a medical diagnosis. Prescribing and administering a prescription drug is the practice of medicine.

Prior to the issuance of the letter by the Board, it was not unusual for a school nurse to have on hand epinephrine (epi pen) which had not been prescribed for a particular patient, but had been prescribed for use in the treatment of students suffering anaphylactic reactions. According to the Board, school nurses may continue to administer epinephrine prescribed for a student who has previously been diagnosed with anaphylaxis, but for the undiagnosed student, the nurse either will have to obtain authority from a physician to administer epinephrine or wait until a person who is authorized to administer medication arrives at the school.

Persons who may prescribe and administer drugs include: (1) A person licensed to practice medicine and surgery; (2) an advanced registered nurse practitioner issued a certificate of qualification pursuant to KSA 65-1131, and amendments thereto, who has authority to prescribe drugs as provided by KSA 65-1130, and amendments thereto; and (3) a physician assistant licensed pursuant to the Physician Assistant Licensure Act who has authority to prescribe drugs pursuant to a written protocol with a responsible physician under KSA 65-28a08, and amendments thereto.

Issues of concern discussed by the Committee included the need to provide immediate help to any student suffering an anaphylactic reaction. Another issue is whether to provide protection to a school nurse who risks disciplinary action if the nurse administers epinephrine, without direction of a physician, to a student who appears to be suffering an anaphylactic reaction, but who has not been previously diagnosed with anaphylaxis.

Committee Recommendation

The Committee recommends legislation and introduction of a bill authorizing school nurses to administer epinephrine to treat students having an anaphylactic reaction in cases where the student has not previously been diagnosed with anaphylaxis. In addition, the Committee instructed Revisor's Office staff to work with the Kansas Board of Nursing and the Kansas School Nurses' Association to make legislation apply to school districts without nurses as well as those districts having nurses.

Review of State Use Law

State law requires state agencies and school districts to purchase products from a list of vendors incorporated in Kansas who primarily employ blind or disabled people and who have been approved by the Director of Purchases. The law exempts school districts and state agencies from the requirement to purchase from these vendors under certain circumstances, such as when a qualified vendor is unable to supply the needed product or meet delivery deadlines. The Committee received testimony from some school districts regarding difficulties with this law.

Melany Barnes, Technical Assistant for the Operations Division, Wichita Public Schools, spoke to Committee members sharing some insights from the school district customer perspective. She stated the Wichita School District proposed a ten percent threshold for pricing and was willing to pay the extra ten percent for products it needed. The school district also wanted a timely, streamlined waiver or exemption process. Ms. Barnes stated that after numerous meetings, often with stalemate results, it was hoped the State Use Law Committee would be able to improve vendor offerings and sales volume through involvement and dialogue. Ms. Barnes recommended Kansas review Oklahoma use law which mandates only state agencies buy from certain vendors. School districts are exempt from this law.

Written testimony from the Salina School District indicated many state use vendors provided poor quality products. The Salina School District had requested exemptions from the law for the purchase of ink pens, pencils, binders, folders, air filters, digital print and ink cartridges.

Matt Fletcher, Associate Director, InterHab, and Chairman of the State Use Committee, gave an overview of the Kansas State Use Committee's origin and purpose. Mr. Fletcher stated the Kansas State Use Committee was created as part of compromise legislative language, to provide a forum for state use vendors and customers to discuss their differences and work together on improving the program. It was decided the Committee would assist the Director of Purchases in improving the system for customers and for vendors, but most importantly, for the purpose of

ensuring growth in this system of work training for persons with disabilities.

Mr. Fletcher stated the Committee has given great consideration as to how to improve the program in the areas of pricing and quality. Committee members were told the Committee is currently in the process of developing a "pricing matrix" which will provide a tool with specific price data that will be used to ensure prices are within a range of competitiveness. Mr. Fletcher further stated that state use vendors continue to improve the quality of their products. He stated products are reviewed annually and the Committee regularly receives briefings from the Director of Purchases on quality-related issues.

Colin McKenney, President, Cartridge King of Kansas, told Committee members that his company employs individuals with disabilities to remanufacture, recycle, and process toner and ink cartridges used in office machines. Mr. McKenney stated the program creates a circle of benefit for the state and its residents. One of the benefits most important is helping people to provide for their own needs as wage earners, to give back to their state as taxpayers, to support their local communities as consumers of goods, and to demonstrate the positive difference a little helping hand can make. He stated Cartridge King is one of the select few employers in the state that creates a next step for students with disabilities who are completing their education. While some of these employees may continue to work for Cartridge King for many years and pursue positions of increasing responsibility, others will take the skills they have learned and use them to work successfully for other community employers.

Recommendations regarding this issue were presented in a performance audit titled *Kansas Use Law: Reviewing Issues Related to the Quality and Price of Goods and the Compensation of Executives*. Recommendations were directed to the Director of Purchases regarding complaint follow up, processing waiver requests, and tracking sales of products and services.

Healthy and Prepared Schools Commission

Dr. Robert Hull, Chairperson, Healthy and Prepared Schools Commission, spoke to Committee members with an update on the work of the Governor's Commission on Healthy and Prepared Schools. Dr. Hull stated the Commission began in 2003 after members of the Kansas School Nurse Organization (KSNO), individuals from KU School of Medicine and individuals from the Kansas Department of Health and Environment (KDHE) met to discuss the role of school nurses in response to bioterrorism threats. This work led to a summit of 30 leaders from across the state recommending two major initiatives be carried forward. They were:

- Submit a proposal to the Governor asking for the creation of an interagency commission to provide leadership for school preparedness planning and response; and

- Develop strategies to establish and implement crisis standards, planning, training, and resources in all Kansas school districts.

The Governor's Commission on Healthy and Prepared Schools became a reality and is collaborative in nature with several state agencies being the principal players. Included in this group are the Kansas State Department of Education, Kansas Emergency Management Association, Kansas Homeland Security, Kansas Highway Patrol, Kansas State Attorney General, KDHE, and the Governor's Office. In addition, Commission membership is drawn from parents, a school nurse, a safety resource officer, a non-governmental organization, Kansas National Education Association, and local school administration.

Upon conclusion of its first year of business, the Commission presented to the Governor a summary report that provided a greater

understanding of the problems faced by Kansas educators and also gave recommendations that would help address the issues if implemented. These continuing issues were presented:

- Every educational setting is vulnerable to threats;
- Many educational decision makers have not fully grasped the seriousness to the 21st century threats to school health and safety;
- Kansas schools are not uniformly prepared or equipped to respond to emergency school events;
- Schools have immediate and pressing priorities that constrain their opportunity to engage in school crisis planning;
- State school preparedness planning lacks specificity and the force of law;
- Mission overlap and fragmentation of state and local agencies hinder development of school preparedness planning; and
- State and local communities have received substantial resources for local preparedness, but these benefits have not been extended to schools.

Among recommendations from the Commission given to the Governor were:

- Create and fund the Kansas Center for Safe and Prepared Schools;
- Provide the Center with a comprehensive mission enabling it to partner with Kansas schools to protect their health and safety;
- Organize the Kansas Center for Safe and Prepared Schools to foster collaboration among state agencies;
- Establish and enforce standards for school preparedness;
- Develop and pilot a model all hazards school crisis plan;
- Increase and improve school crisis drills;
- Provide training opportunities in school crisis management for all schools;
- Provide resources to increase the number of school nurses and school resource officers in Kansas' schools; and
- Create the annual Kansas School Preparedness Day.

Dr. Hull told Committee members that 20 states already have created some type of school safety/preparedness center. Kansas is one of the thirty states that does not have a center. In a recent survey, 83 percent of Kansas superintendents responded that they would see a benefit from a more uniform system in Kansas that would coordinate school crisis management response, training, standards, and provide crisis information.

Dr. Hull stated the next step is to have legislative authority and funding to establish a Kansas Center for School Preparedness and Safety. It is believed an annual funding level of $1 per student or roughly an initial investment of $500,000 will allow Kansas to take the next step.

Committee Recommendation

The Committee requested legislative staff to review whether any funding appropriated for a Kansas Center for School Preparedness and Safety could be counted as a match enabling the state to draw federal hazard mitigation funding which could be used by school districts for preparedness activities.

Virtual Education

Dr. Diane DeBacker, Deputy Commissioner, Kansas Department of Education, and Dr. Bill Hagerman, Director, Title Programs and Services, Kansas Department of Education, described the Department's virtual education programming to the Committee in October.

Dr. Hagerman told Committee members the Virtual Schools Advisory Council held its first meeting on September 16, 2008, and the virtual education requirements for Kansas were reviewed. Dr. Hagerman told Committee

members that it was important for members of this Advisory Council to get a broad perspective on what is needed in terms of virtual education. He also stressed that it is important to remember this (virtual and on-line) is the world in which our young people live.

Dr. Hagerman told Committee members that virtual schools use distance learning technologies which predominately use internet-based methods to deliver instruction. It involves instruction that occurs asynchronously or at different times with the teacher and pupil in separate locations. Dr. Hagerman advised virtual schools are serving a variety of students, for example, previously home-schooled students, any child in Kansas who has a need not fulfilled elsewhere in a school, and any learner without a high school diploma.

Dr. Hagerman advised the Advisory Council will be conducting additional meetings and topics of discussion could include at-risk (non-proficient) education plans, weightings including local option budget (LOB), and marketing.

Gary Lewis, Head of School, Lawrence Virtual School (LVS), addressed Committee members and stated LVS serves students in kindergarten through twelfth grade using the online curriculum of K12. Enrollment in LVS includes access to online curriculum, associated materials and resources, the loan of a computer, the expertise of Kansas licensed teachers and administration, and school activities, all within the student's community.

Mr. Lewis stated enrollment in LVS is open only to residents of the State of Kansas. He stated that all LVS teachers hold a Kansas teaching license, have had extensive teacher professional development, and represent a diverse spectrum of educational backgrounds and experience.

He also stated the online school provides a recommended schedule that will ensure all lessons in each content level are presented in one academic school year's time frame. The online school is flexibly designed to accommodate year-round schooling. Progress data is used by the teachers and parents to evaluate student progress and learning. LVS requires 80 percent mastery on learning objectives. Progression to the next level requires 100 percent completion in foreign languages, 95 percent completion of math and language arts lessons, and 85 percent completion of the remaining subject areas.

Brooke Blanck, Director, iQ Academy in Manhattan, Kansas, spoke to Committee members and advised that iQ Academy Kansas is a grades 7-12 online school. Students can choose from a complete curriculum of core and advanced placement (AP) classes, elective courses in world languages, art and music appreciation, and technology. Middle school students follow a grade-specific curriculum of core and elective courses that prepare them for high school and beyond. High school students in grades 9-12 have a broader range of electives that fit their interests and educational needs. Graduates earn high school diplomas from Manhattan-Ogden USD 383 and are accepted at colleges and technical schools throughout the United States. Manhattan-Ogden USD 383 and iQ Academy agreed to partner beginning in the 2007-08 school year. The iQ Academy is meeting the needs of a diverse student population ranging from at-risk students to high achieving students seeking additional course work.

Dr. Barton Goering, Superintendent, Spring Hill USD 230, spoke to Committee members on Insight School of Kansas. He advised Insight School of Kansas (ISKS) began classes on August 25, 2008, and is an online public high school serving students all across Kansas. The school offers over 130 courses to approximately 600 students and is divided into two schools within the school:

- An adult school serving students 20 years and older; and
- A teen school serving students ages 14-19.

4-12

Dr. Goering advised that Insight Schools, Inc. operates 11 high schools in ten states and a national school. They are a subsidiary company of the Apollo Group which also owns and operates the University of Phoenix. Insight School of Kansas is the second largest high school in the Insight family. He also stated that ISKS is piloting the first online vocational class for high school students in collaboration with the National Construction Center Educational Research (NCCER) and Crossland Construction of Columbus, Kansas.

Dr. Blake West, President, Kansas National Education Association, spoke to Committee members concerning issues of quality related to virtual education. Dr. West stated a National Task Force on Virtual Education had met and there were two criteria discussed: online high school courses and teaching online courses.

Dr. West stated there were two parameters for the work and included the limitations of what could be done for socialization, particularly with younger children. In the first parameter, it was determined through research, that elementary students need to be in a face-to-face environment. The second parameter spoke to the use of an entire high school curriculum. It was determined that while it is appropriate to do some high school work online, it probably would still be appropriate to have some of the programs done in a face-to-face environment.

Dr. West stated there are major areas for attention regarding virtual education which include:

- Learner Characteristics;
- Infrastructure;
- Evaluation and Assessment;
- Curriculum;
- Effective Teaching; and
- Teacher Quality including Licensure, Certification and Accreditation.

Measuring Student Outcomes-Blue Ribbon Schools

Representatives of all of the State's nationally recognized Blue Ribbon Schools appeared before a joint meeting of the 2010 Commission and the LEPC in October.

The No Child Left Behind Blue Ribbon Schools Program is a prestigious U.S. Department of Education program honoring some of America's most successful schools. Schools are nominated by each state's chief state school officer based upon national criteria in three categories, which is described below.

- Schools in the top 10 percent of the state in reading and math assessments with at least 40 percent disadvantaged students. (Disadvantaged is defined as eligible for free or reduced meals, Title I services, Limited English Proficiency, or migrant students.)

- Schools with at least 40 percent disadvantaged students that have dramatically improved student achievement to high levels. (Dramatically improving schools reaching high levels means that students are achieving above the 60th percentile in reading and math, the school must meet adequate yearly progress, and gains must have been dramatic over the past three years.)

- Schools in the top 10 percent of the state in reading and math assessments with fewer than 40 percent disadvantaged students.

The five Blue Ribbon Schools in Kansas are:

- Beeson Elementary School in the Dodge City School District;

- Lincoln Elementary in the Lincoln School District;

- Syracuse High School in the Syracuse

School District;

- Blue Valley North High School in the Blue Valley School District; and

- Ellsworth Elementary School in the Ellsworth School District.

Some of the most outstanding qualities present in all Blue Ribbon Schools included:

- Caring educators focusing on ensuring all students meet or exceed high academic standards, regardless of a student's ability, restraints due to poverty, disability, gender, race, or language barrier;

- Data-driven instruction ensuring individual students receive the most effective interventions for each need;

- Principals and teachers working as teams;

- Principals who clearly empower teachers; and

- Perseverance and positive attitudes in spite of great challenges, whether lack of resources in the districts or students with many personal challenges.

Commission members asked Blue Ribbon School representatives to explain how their schools had reached such a high level of achievement. Highly motivated and effective leaders and focused, hands-on professional development were two major reasons cited for Blue Ribbon School successes. Some examples from Blue Ribbon recipients are included below.

Principals with exemplary leadership abilities developing empowered teachers was one of the main factors sited for outstanding achievement in individual schools. For example, the principal from Syracuse High School told members that the teachers determine the curricula in that school. "This is not a top down decision."

One Blue Ribbon School principal takes all the school's students into the gym once a week allowing teachers more planning time together.

Successful principals seemed to have an attitude of collaboration, ability to communicate clearly, and a "servant-leader" mentality, encouraging teachers, staff, and students to achieve the best possible outcomes.

The majority of the Blue Ribbon recipients represented schools with high and growing numbers of disadvantaged students, which only seemed to spur school staff on to greater achievements.

Postsecondary Education

Kansas Board of Regents Legislative Initiatives

Reginald L. Robinson, President and CEO, Kansas Board of Regents (KBOR), presented an overview of the KBOR legislative initiatives proposed by the Board of Regents for the 2009 Legislative Session at the Committee's October and November meetings.

Highlights of the initiatives include:

- Community College Property Ownership—This would permit community colleges to own property outside their local college taxing district, but within their assigned service areas.

- KAN-Ed Funding—Would amend current statutes to fully fund KAN-Ed from the Kansas Universal Service Fund (KUSF) at $10 million per year.

- Kansas Board of Regents Mandatory Retirement Plan Amendment—This statute allows for retirement plan participants to

continue participation in that plan when they are on leave of absence from their educational institution and working for the executive branch of state government. New 403(b) regulations that apply to education retirement plans do not allow participation by employees who do not work for or provide services to an educational institution. Legislation is needed to clarify participation. If the amendment is approved, there would be no additional cost to the State.

- University of Kansas Medical Center (KUMC) Tort Claims—Enact in statute, as opposed to budgetary proviso, the inclusion of medical students enrolled at the University of Kansas Medical Center for purposes of the Tort Claims Act.

- State University Non-State Funded Construction—This would amend current statutes to modernize and improve the current method of constructing and renovating buildings on university campuses by eliminating the bureaucracy and restrictions involved in the process of hiring architects, engineers, and contractors.

- State University Reimbursement of Moving Expenses—Update KSA 76-727, by eliminating the 12,000-pound weight maximum for moving expenses, allowing the Board of Regents and state universities the discretion to pay full moving costs when recruiting chief executive officers and distinguished faculty.

- State University Student Financial Assistance—Amend current statutes to allow state universities, as authorized by the Board of Regents, more flexibility to provide scholarships, fellowships, and tuition and fee waivers to undergraduate students, as well as to graduate students for their educational programs.

- Technical Education Authority Amendments—Technical amendments to current statutes to clarify language.

Mr. Robinson reported that deferred maintenance projects at the Regents' universities are moving forward. KBOR is keeping the Joint Committee on State Building Construction informed of the progress and any problems that have arisen. The tax credit program, authorized by legislation enacted during the 2007 Legislative Session, became available on July 1, 2008. KBOR is working with prospective donors to generate support for the universities.

In response to questions from the Committee, Mr. Robinson indicated deferred maintenance issues and additional incentive to address them is not included in the proposed initiatives for the 2009 Legislative Session. With regard to the item related to KAN-Ed, Mr. Robinson noted that there has been some discussion as to how KAN-Ed could assist with the teacher shortage across the state; however, no proposal has come forth and none of the proposed funding has been directed to such a program. Mr. Robinson felt that KAN-Ed is fully utilized within the current framework.

Committee Recommendations

The Committee agreed to introduce all the postsecondary education initiatives proposed by the Kansas Board of Regents.

Report from the Technical Education Authority

Joe Glassman, Chairman, Technical Education Authority, spoke to Committee members in September, reporting progress toward the improvement of the postsecondary technical education system. Mr. Glassman stated the 2008 Kansas Legislature created the Kansas Postsecondary Technical Education Authority, under the auspices of the Kansas Board of Regents,

with the charge of reforming the postsecondary technical education system. Mr. Glassman also stated that legislation required the governing bodies of Northeast Kansas Technical College, Kansas City Area Technical School, Kaw Area Technical School, Salina Area Technical School and Southwest Kansas Technical School to submit to the Board of Regents a plan to merge or affiliate with a postsecondary educational institution or become an accredited technical college with an independent governing board. Four institutions have merged with other colleges effective July 1, 2008, and Salina Area Technical School has submitted a plan to become a stand-alone technical college with an independent governing board to become effective July 1, 2009.

Mr. Glassman stated the Authority has set a rapid pace toward the improvement of the technical education system. The Authority has hired a Vice President for Workforce Development; established an operational committee structure to address issues related to program alignment, finance, and marketing; and scheduled alternative meetings outside the Topeka area to better connect with local regions throughout Kansas. The Authority has approved a demand-driven approach that will better align technical program curricula with the needs of Kansas businesses, improve the seamlessness of the postsecondary technical education system, and utilize industry-based assessments to verify the skills of program graduates.

During the next year, the Authority plans to continue the refinement of the tiered funding model to ensure that the investment drives colleges to develop and offer critically needed technical programs supporting high-wage, high-demand industries. The Authority also will continue its focus on system accountability measurements such as return on investment for students and Kansas taxpayers, certification rates, and job placement percentage.

The final report of the Technical Education Commission is included as an attachment to this report.

State University Admissions Task Force

At its November meeting, Regent Gary Sherrer presented the following report: *State University Admissions Task Force Findings and Recommendations from October 2008*. The charge to the Task Force by the Kansas Board of Regents (Board) was to "advise the Board and make recommendations regarding optimal state university admissions policies for year 2010 and beyond." Regent Sherrer chaired the Task Force of 16 individuals from across the state with a variety of professional and civic backgrounds. The Task Force heard more than 14 hours of testimony from 16 groups and individuals. After a year of work, the Task Force made the following recommendations:

Admissions

- That the Board implement annual data collection and reporting on the impact of the specific qualified admissions criteria, with particular emphasis placed on tracking the success of students once they have enrolled in postsecondary education.

- That the Board continue annual collection and reporting of data on diversity, in particular data on student enrollment that reflects the state's changing demographics.

- That admissions standards be removed from statute and that the Board be given authority to establish admission standards.

- That resident and non-resident home-schooled and other students graduating from non-accredited schools be admitted with qualifying ACT or GED test scores.

- That the qualified admissions pre-college curriculum be updated, specifically the

technology requirement.

- That non-resident students admitted in the conditional admissions category be allowed to continue at the institution as long as they meet the academic requirements of the institution.

- That algebra taken in middle school count toward satisfying the Board's qualified admissions curriculum requirements. The Task Force further supports adoption of a pre-college curriculum that requires successful completion of a math course in the senior year.

- That the Board coordinate the electronic reporting the pre-college curriculum to the State Department of Education and enable transcripts to reflect this status.

Transfer

- That the Kansas Core Outcomes project be continued in light of the increasing trend of students who come to a university with transfer credits, or are earning transfer credits while enrolled at a university.

- That a separate exception window be developed for transfer students.

Concurrent Enrollment

- That the recently initiated concurrent enrollment program data collection process continue and expand with results used to assure a consistent level of quality.

Kansas Autism Task Force

The 2007 Legislature created the Kansas Autism Task Force, which is composed of twenty-four members. The Task Force is statutorily directed to study and conduct hearings on issues related to the needs of and services available for persons with autism. State law also requires that the Task Force submit reports to the LEPC. Unless extended, the term on the Task Force ends on December 31, 2008.

The Final Report of the Kansas Autism Task Force to the 2009 Legislature is included in the publication. Also included is the Final Report of the Kansas Technical College and Technical School Commission

Testimony to House Education Committee on House Bill 2608
Robert J. Vancrum, Government Affairs Specialist
Blue Valley USD 229

Chairman Aurand and Honorable Members of the Committee:

I appear today on behalf of the Blue Valley school district and its school nurses to testify in support of HB 2008. . I am particularly appearing instead of Laura Stief, RN, MSN, the school nurse at Harmony Middle School , who testified for this bill before the Legislative Educational Planning Committee this fall, which introduced the legislation before you. She couldn't be here today because of her duties to deliver care to her students.

In fact, that is why Laura Stief and so many school nurses believe this bill is overdue. It is intended to protect both students suffering from severe allergies and support the school nurses who want to deliver the best nursing care to prevent sudden death. As Nurse Stief testified in LEPC,

" I am emotionally invested in this issue for several reasons but especially because my father, Ralph Franklin, died at age 44 from anaphylaxis to a contrast dye. The emergency occurred in a hospital x-ray department after an IV injection of IVP dye to view kidney stones. There were many "what if" questions that still haunt many of us that felt cheated by losing this wonderful man from a fluke of an unknown allergy.

Unfortunately, our family experienced the horror of anaphylaxis prior to that episode. When I was 16 my younger brother, Cliff Franklin (a previous Kansas Legislator), took an aspirin for a sore throat. He immediately began to have a severe asthma attack and my parents rushed him out the door to the emergency room. I was to call the doctor and then meet them at the hospital. When I arrived I scoured the emergency room treatment areas and could not find him. The E.R. staff was busy working on the intubation (a tube placed in the airway) of what looked like an old man with a swollen, purple face. I was frantic thinking I went to the wrong hospital. Then I saw my mother who told me that the person I thought was the elderly man was my brother. She said the staff said they were worried he would not make it, but they would do what they could. I ran to the Chapel and prayed. When I returned I discovered that Cliff had recovered and was being taken up to ICU for close observation. We were told by several doctors that it was a close call."

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These examples not only show you how deeply many school nurses who've faced such crises feel about this issue. They also demonstrate better than anything else I've found the real point.

Emergency epinephrine is to an allergic person like CPR or an Defibrillator machine is to someone in cardiac arrest. But such modern and widely available treatments will do nothing for a victim of anaphylaxis. Why shouldn't school nurses be able to administer an epinephrine dose even if they had no prior notice the child had such a condition. Certainly we want to be careful that those serving our children have had at least some adequate emergency training, but don't we want them to have the necessary tools to respond immediately when needed. Some have and perhaps will argue that their arte risks of giving unnecessary doses. But in Laura Stief's words,

" The risk of an unnecessary epinephrine dose is typically no more severe than pounding on someone's chest or shocking them if their heart has not stopped. Lay persons are trained to do the latter. The risks of not giving the Epinephrine for severe allergic symptoms are far greater. Epinephrine's effects last only 20 minutes and the side effects are increased heart rate and shakiness. It is almost unfortunate that it is considered a prescription drug when it is such a lifesaver to allergic patients.

"In the school setting, where an RN is available, I believe it is within the scope of the Nurse Practice Act to assess symptoms., … and evaluate them as life-threatening allergic symptoms, [and] he/she should be able to administer life-saving epinephrine to students/staff with unknown allergies or no prescribed epi-pen available.

"Of course to decrease liability it would be preferable to have a non–specific patient doctor's order on file. It is not necessary for the nurse to make a formal diagnosis of "anaphylaxis", rather treat the student based on symptoms. Again with the analogy of CPR or the defibrilator , the nurse (or trained lay person) will not diagnose the cause of cardiac arrest, rather will assess that there is no pulse and act accordingly .

"According to the Food Allergy and Anaphylaxis Network there are 150-200 deaths per year related to food allergy. It is estimated that there are 1500-2000 deaths from anaphylaxis from all causes (including medications and bee stings) according to Dr. Hsieh at the Cleveland Clinic (http://www.clevelandcliniemeded.com/medicalpubs/diseasemanagement/allergy/anaphylaxis/anaphylaxis.htm#ref1). There are thousands of visits to emergency rooms resulting in hospitalizations for reactions to food allergies. According to Dr. Hsieh 'epinephrine is the drug of choice in the treatment of anaphylaxis and should be administered immediately upon diagnosis. **Fatality rates are the highest in cases where epinephrine administration is delayed**' .". …

… (discussion of an existing New York law allowing what is proposed here is deleted) …

Nurse Stief concluded by letting LEPC know how she would feel if she were continued to be deprived of the right to (1) notice very characteristic symptoms and (2) immediately administer an epipen. I don't think I'm capable of improving on her words:

"Based on my feelings, knowledge and personal history the worst case hypothetical scenario for me would be that the laws remain restrictive and I would not be able to use the tools at hand to treat a student who exhibits signs of an allergic reaction. I would call 911 but the symptoms would progress and I would know that it may be a matter of life or death for this child to receive epinephrine immediately. I would be acutely aware that there are life-saving epi-pens available nearby, both in my purse and in my medication cabinet (prescribed to other students). I would clearly know what this student needs but also realize I may risk my career should I give the proper emergency care. "

"To tell me withhold epinephrine is like telling me to deprive a student of CPR who has no pulse. I feel, like many other nurses, the risk of discipline by the nursing board/school district pales against losing a life I could have saved. If the outcome was death, it would be comfort to the family of the deceased that everything was done in a timely manner to save their loved one. In my opinion, the liability is greater if the result of an allergic reaction is a tragic death versus giving epinephrine without a patient specific order. "

Why should any Kansan ` possessed of power to save a life be put in the position of having to weigh, even for an instant the possible sanctions or loss of licensure or a career versus giving a simple treatment which to someone in anapylactic shock is like CPR or defibrillation to a victim of cardiac arrest ?

New Sections 2-5, New Section 9 and especially the amendments adding subsections (p) and (q) in Sections 11 and 12 of this bill, HB 2008 , contain the substantive changes we seek . And we are fine with the rest of the bill Some have apparently read this bill as permitting "untrained" school personnel to make diagnoses and administer medications. I certainly don't read it that way, and would hope people aren't just shooting from the hip on something this important. They have a legal opinion to back them up in making such a charge. . It looks clear to me that only trained school nurses, and trained school medication aides can do so – and the language specifically allows the Board of Nursing to determine what training is needed. Furthermore , Section 9 (a0 (2) and (3) are more restrictive on medication aides compliance with existing law.

Finally, if any district is still concerned about liability or training of their people, they don't have to grant this option to their aides or nurses. Although the bill as it stands is not written in permissive language , I believe this is easily within their ability to waive out. If their lawyer is still uncertain, the bill could be made permissive, but from a perspective of looking out for each of our state's children, I'd rather it didn't have to be.

I will be happy to answer questions or get further information for you, should you request.

KANSAS ASSOCIATION OF SCHOOL BOARDS

1420 SW Arrowhead Road • Topeka, Kansas 66604-4024
785-273-3600

Testimony on **HB** 2008
before the
House Education Committee

by

Donna L. Whiteman, Assistant Executive Director/Legal Services
Kansas Association of School Boards

January 22, 2009

Mr. Chairman, Members of the Committee:

The Kansas Association of School Boards appears in opposition to **HB 2008**. This bill creates a new class of school employees and will increase costs due to the bill's broad language as follows:

New Section 4:

Grants the State Board of Nursing broad rule and regulation authority including authority to set:

1. Minimum standards for competencies
2. Methods of assessment of competencies
3. Minimum qualification for persons seeking certification
4. Minimum qualifications and standards for school medication aide programs and courses
5. Continuing education requirements for school medication aide
6. Procedures for submitting applications for certification issuance denial, renewal, limitation and suspension, and revocation of school medication aide certificates
7. Storage, handling and disposal for medication in schools
8. Record keeping requirement
9. Reporting requirements for school medication aides
10. Any other provision deemed necessary by the board for the implementation and administration of school medication

New Section 5:

1. Certification as medication aide shall expire two years after date of issuance.
2. Maintain a registry of persons who hold a valid certificate

New Section 6:

1. The board may fix and impose fees for the initial certification and the renewal of certification of persons certified
2. Fees for late submission, application, training fees, fees for returned and insufficient fund checks

New Section 7:

1. Board may deny limit, suspend or revoke certificates

New Section 9:

The language in subsection (a) and (b) is very broad and appears to require schools to hire, train and pay for the cost certifying medication aides in the 360 high schools, 42 junior high schools, 180 middle schools and 817 elementary schools that educate 468,778 children across the state of Kansas.

In a year where the 295 school districts across the state will be making tough decisions including reductions in teachers and other staff, additional costs and fees should not be imposed nor should a new class of employees be created and required in school districts.

Thank you for your consideration.

January 22, 2009

To: Honorable Clay Aurand – House Education Committee Chair
Honorable Deena Horst – House Education Committee Vice-Chair
Members of the House Education Committee

From: Christine Tuck, RN, BSN, MS, NCSN – Health Services Director, Seaman USD #345 Topeka, President of Kansas School Nurse Organization
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Email: ctuck@usd345.com or chris.tuck06@yahoo.com

Testimony Opposing HB 2008 – School Medication Aide Act

Chairperson Aurand and Vice Chairperson Horst and members of the House Education Committee, I want to thank you for the opportunity to provide you with testimony opposing HB 2008 School Medication Aide Act. My name is Christine Tuck, and I am a practicing school nurse and Health Services Director for the Seaman USD #345 school district here in Topeka, and also the current President of Kansas School Nurse Organization. I have been involved in school nursing since 1990 and have been actively involved in my state professional school nursing organization since 1991. I have created some simple tables with definitions, time-lines of the topic at hand, as well as data specific for school nursing in Kansas, with the intent to assist you with present and future questions you may have on this legislative issue. I want to thank you for the opportunity to provide you with information which will include:

- a time-line with information on how we got to today's meeting
- the role of the registered nurse in the school setting
- current data specific to school nursing in Kansas
- reasons for opposition of HB 2008 School Medication Aide Act
- definitions for the issue at hand, including agencies and persons involved

Epinephrine in Schools:

Date	*Event*	*Participants*	*Outcome*
April, 2008	Phone Conference – School Nurse Regulation Review	KSBN, KSNO, KDHE	Further review of current regulations by School Nurse Task Force and KSBN
June 13, 2008	Ruling from KSBN	All Kansas school nurses and school districts	Current law in Kansas is not broad enough to allow a nurse to stock epinephrine, diagnose anaphylaxis and prescribe and use stock epinephrine independent of a physician order" KSBN 2008
September 18th, 2008	LEPC hearing – requesting more information on epinephrine administration in schools	KSNO, Olathe and Blue Valley schools, KSBN, Legislative Statute Revisor	Further discussion
November, 2008	School Medication Act First Draft	NA	To be determined
January, 2009	HB 2008	NA	To be determined

Issue at hand: A school nurse **can administer or delegate** epinephrine in the school setting, if prescribed by a physician for a specific student. A school nurse **cannot administer, nor delegate epinephrine, to an undiagnosed student following standing orders written by a physician.**

What is the role of the registered nurse in the school setting?

- Health care services must be provided in the school setting to students to meet requirements of federal laws and ensure the safety of students. These laws include the Individuals with Disabilities Education Act (IDEA), Section 504 of the

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Rehabilitation Act of 1973, and the American with Disabilities Act of 1990. Children with special health care needs have the right to be educated with their peers in the least restrictive environment.

- The registered nurse is the only school staff member who has the skills, knowledge base, and statutory authority to fully meet the health care needs of students in the school setting. This includes coordinating, developing, and implementing the student's individualized health care plan (IHP), Emergency Action Plan (EAP), 504 plan, or individualized education plan (IEP).
- Current delegation of nursing services, including medication administration, in the school setting by the registered nurse, based on the nursing regulations in the Kansas Nurse Practice Act can occur in Kansas. K.A.R. 60-15-101 through 60-15-104 specifically 60-15-101 (i & p) and 60-15-102 (a – h).
- Delegation regulations (K.A.R. 60-15-101 – 60-15-104) for nursing tasks, including medication administration, and rationale for support:
    1. Nursing supervision is necessary to ensure that adequate and appropriate accommodations are provided to students with health care needs.
    2. Nurses are prepared to respond to emergency situations. School nurses bring emergency preparedness skills and possession of knowledge about the special health needs of students in emergency situations. When students are unable to self-administer or self-monitor, nursing judgment and action are crucial. School districts must fund a registered nurse position to train and supervise unlicensed personnel.
    3. Liability and accountability issues need to be addressed for the protection of students, families and school personnel. School nurses have accountability to assess, use nursing diagnoses to plan, intervene and constantly survey the environment and observe for each known potential emergency situation.
    4. Educators focus on teaching and learning. It is unrealistic to expect them to provide the health care needed and also provide ongoing instruction to an entire class. Although school staff members and unlicensed assistive personnel (UAPs) play a role in the health care of students, they should not be expected to take on the responsibilities of a registered nurse.

School Nurse Data in Kansas:

School nursing data is difficult to ascertain, as there is not a centralized agency that collects this data on a mandatory basis. All data for specific health services personnel is voluntarily provided. There is currently no statue mandating school nurses in Kansas. National Association of School Nurses recommendations for school nurse to student ratio is:

- one school nurse per 750 regular education students
- one per 225 students that may require daily professional school nursing services or interventions
- one per 125 students with complex health care needs
- one per 1 may be necessary for individual students who require daily and continuous professional nursing services

State-wide: 824 (93%) RNs; 32 (3.6%) LPNs; 25 (3%) UAPs; 8 (.1%) unknown (Both public and private schools)	Participants who voluntarily register to receive email newsletter and information from KDHE Child and School Health Consultants from the Bureau for Children, Youth and Families (Dec. 2008)
State-wide: Approximately 700 school nurses. 57% work full time in frontier or rural counties. 86% work full time in semi-urban, and urban counties. Most school nurses cover more than one school. 97% were RNs/3% LPNs RN education: 24% Associate or Diploma; 58% Baccalaureate; 18% Masters prepared. 91% employed by local school board, 3% by public health department; 4% private practice and 2% local cooperatives. (Both public and private schools)	KDHE survey of 491 school nurses from 77 Kansas counties or about 58% of all school nurses listed in the KDHE database, May 2007.
State-wide: 530.9 certified FTE nurses 169.4 non-certified FTE nurses Reported by public schools only, and does not delineate by licensure. Only reports full time equivalent positions.	Kansas Department of Education query, January, of 2009.
Local – Shawnee County: 26,691 students 29 (35%) RNs, 16 (20%) LPNs, 37 (45%) UAPs	Information obtained from Shawnee County Health Services Directors in Public Schools
Olathe Public Schools – Johnson County – 27,000 students 49 full time RN's	Information obtained from Olathe Health Services Director

Reasons for Opposing HB 2008 School Medication Aide Act:

- Since the September hearing much discussion has ensued among KSNO Board members and practicing school nurses across the state with an overall consensus that school nurses are against a mandatory regulation imposed on schools and therefore against an additional category of "medication aide" in Kansas.
- School nurses believe that HB 2008 is not needed due to existing delegation regulations (KAR 60-15-101 through 60-15-104) that allows for delegation of physician prescribed medications and has been implemented for many years by the Kansas State Board of Nursing. These regulations are periodically reviewed, with the most current revision completed in Dec., 2008. KSNO believes that what this act is trying to establish already exists in Kansas.
- KSNO believes that HB 2008 would create another layer of bureaucracy which would involve increased administration costs and oversight at the state level, a very important factor to consider during these tough economic times for both state government as well as school districts.
- A recent survey conducted by KSNO President requesting input from other state affiliate Presidents, with only 9 states responding in the affirmative in relation to standing orders, and only one specifically stating that the administration was not limited to a registered nurse (Nebraska), demonstrates there is still no consensus across the nation regarding this issue.

State	Limited to RN Administration	Source of legislative authority for standing order
Arizona	DS	DS
California	DS	Education Code
Kentucky	YES	Several school nurses are health department nurses and have epinephrine on hand because they administer immunizations
Massachusetts	YES	State Dept of Health Medication Regulations
Missouri	DS	DS
Nebraska	NO	Dept of Education, Regulations for School Health and Safety
New York	YES	Physician Practice Act Memorandum 2001.1
New Jersey	DS	DS
Rhode Island	YES	No statewide standard or authority

DS indicates: Did Not Specify

Issue at hand: A school nurse **can administer or delegate** epinephrine in the school setting, if prescribed by a physician for a specific student. A school nurse **cannot administer, nor delegate epinephrine, to an undiagnosed student following standing orders written by a physician.**

KSNO suggests amending current language and allowing permissive language, to regulations in the current Kansas Nurse Practice Act, or the Kansas Board of Healing Arts Act. This would allow, but not mandate, standing orders in the school setting, working under a physician and carried out by a registered professional nurse. This would be consistent with the national standard that we are seeing in this introductory phase of standing orders. KSNO would be willing to implement a tracking record system of epinephrine use in Kansas schools, and to initiate dialogue with the Kansas State Board of Nursing, Kansas State Board of Healing Arts and the Kansas State Board of Pharmacy.

Because schools are a place where children spend a significant portion of each day, it is not only prudent but also an obligation of the school to have the expertise of the registered nurse, as well as the equipment necessary to minimally stabilize a sick or injured student, until emergency medical services arrive. Our number one priority in the discussions that evolve after today's testimonies should be to remember "the valuable assets, who walk in and out of the doors to our schools each and every day". We owe it to all the children and school staff in Kansas schools to create an environment that is safe, healthy and nurturing so that as we strive to educate these precious assets, we can do so successfully!
I want to thank you for the opportunity to testify today and for providing a venue for communication and collaboration. I would be happy to answer any questions you have today or in the future.

Definitions and Terminology for Epinephrine in Schools discussion:

Acronym, Term	*Definition/Explanation:*
Delegation	Transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains accountability for the delegation.
Delegator	The person making the delegation.
Delegatee	The person receiving the delegation.
Epinephrine	A chemical that narrows blood vessels and open airways in the lungs. It works by relaxing the muscles in the airways and tightening the blood vessels. It stimulates a series of actions of the sympathetic nervous system, known collectively as "flight or fight response", by increased heart rate and force of heart contractions, increased blood pressure, breakdown of glycogen into glucose, elevated blood glucose levels, and so fourth. In short, it prepares the body for action in perceived emergency situations, boosting the supply of oxygen and energy-giving glucose to the brain and muscles, while leading to suppression of some bodily processes not vital to the response.
KSBHA – Kansas State Board of Healing Arts	Licenses and regulates 13 healthcare professions and out-of state contact lens distributors to protect the public.
KSBN – Kansas State Board of Nursing	Licenses and regulates nursing practice in Kansas through the Kansas Nurse Practice Act to protect the public.
Kansas State Board of Pharmacy	Regulates the practice of pharmacy professionals and pharmacy-related entities conducting business with Kansas or shipment of pharmaceuticals directly to businesses or citizens in Kansas.
KSNO - Kansas School Nurse Organization	Professional specialty organization in Kansas serving school nurses.
Nurse Practice Act	Specific regulations for Kansas school nurses – K.A.R. 60-15-101 through 60-15-104.
School Nursing	A specialized practice of professional nursing that advances the well-being, academic success and lifelong achievement of students. - NASN 1999
Supervision	The provision of guidance or direction, evaluation and follow-up by the licensed nurse for accomplishment of a nursing task delegated to unlicensed assistive personnel.
UAP – Unlicensed Assistive Personnel	Any unlicensed personnel, regardless of title, to whom nursing tasks are delegated.

60-15-101. **Definitions and functions.** (a) Each registered professional nurse in a school setting shall be responsible for the nature and quality of all nursing care that a student is given under the direction of the nurse in the school setting. Assessment of the nursing needs, the plan of nursing action, implementation of the plan, and evaluation of the plan shall be considered essential components of professional nursing practice and shall be the responsibility of the registered professional nurse.

(b) In fulfilling nursing care responsibilities, any nurse may perform the following:

(1) Serve as a health advocate for students receiving nursing care;

(2) counsel and teach students, staff, families, and groups about health and illness;

(3) promote health maintenance;

(4) serve as health consultant and a resource to teachers, administrators, and other school staff who are providing students with health services during school attendance hours or extended program hours; and

(5) utilize nursing theories, communication skills, and the teaching-learning process to function as part of the interdisciplinary evaluation team.

(c) The services of a registered professional nurse may be supplemented by the assignment of tasks to a licensed practical nurse or by the delegation of selected nursing tasks or procedures to unlicensed personnel under supervision by the registered professional nurse or licensed practical nurse.

(d) "Unlicensed person" means anyone not licensed as a registered professional nurse or licensed practical nurse.

(e) "Delegation" means authorization for an unlicensed person to perform selected nursing tasks or procedures in the school setting under the direction of a registered professional nurse.

(f) "Activities of daily living" means basic caretaking or specialized caretaking.

(g) "Basic caretaking" means the following tasks:

(1) Bathing;

(2) dressing;

(3) grooming;

(4) routine dental, hair, and skin care;

(5) preparation of food for oral feeding;

(6) exercise, excluding occupational therapy and physical therapy procedures;

(7) toileting, including diapering and toilet training;

(8) handwashing;

(9) transferring; and

(10) ambulation.

(h) "Specialized caretaking" means the following procedures:

(1) Catherization;

(2) ostomy care;

(3) preparation and administration of gastrostomy tube feedings;

(4) care of skin with damaged integrity or potential for this damage;

(5) medication administration; ~~and~~

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(6) taking vital signs;

(7) blood sugar monitoring, which shall include taking glucometer readings and carbohydrate counting; and

(8) performance of other nursing procedures as selected by the registered professional nurse.

(i) "Anticipated health crisis" means that a student has a previously diagnosed condition that, under predictable circumstances, could lead to an imminent risk to the student's health.

(j) "Investigational drug" means a drug under study by the United States food and drug administration to determine safety and efficacy in humans for a particular indication.

(k) "Nursing judgment" means the exercise of knowledge and discretion derived from the biological, physical, and behavioral sciences that requires special education or curriculum.

(l) "Extended program hours" means any program that occurs before or after school attendance hours and is hosted or controlled by the school.

(m) "School attendance hours" means those hours of attendance as defined by the local educational agency or governing board.

~~(m)~~ (n) "School setting" means any public or nonpublic school ~~learning~~ environment ~~during regular school attendance hours~~.

~~(n)~~ (o) "Supervision" means the provision of guidance by a nurse as necessary to accomplish a nursing task or procedure, including initial direction of the task or procedure and periodic inspection of the actual act of accomplishing the task or procedure.

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~~(o)~~ (p) "Medication" means any drug required by the federal or state food, drug, and cosmetic acts to bear on its label the legend "Caution: Federal law prohibits dispensing without prescription," and any drugs labeled as investigational drugs or prescribed for investigational purposes.

~~(p)~~ (q) "Task" means an assigned step of a nursing procedure.

~~(q)~~ (r) "Procedure" means a series of steps followed in a regular, specific order that is part of a defined nursing practice. (Authorized by ~~and~~ K.S.A. 2007 Supp. 65-1124 and K.S.A. 65-1129; implementing K.S.A. 2007 Supp. 65-1124 and K.S.A. 65-1165; effective, T-89-23, May 27, 1988; amended, T-60-9-12-88, Sept. 12, 1988; amended Feb. 13, 1989; amended Sept. 2, 1991; amended Sept. 11, 1998; amended July 29, 2005; amended P-_____.)

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60-15-102. **Delegation procedures.** Each registered professional nurse shall maintain the primary responsibility for delegating tasks to unlicensed persons. The registered professional nurse, after evaluating a licensed practical nurse's competence and skill, may decide whether the licensed practical nurse under the direction of the registered professional nurse may delegate tasks to unlicensed persons in the school setting. Each nurse who delegates nursing tasks or procedures to a designated unlicensed person in the school setting shall ~~comply with~~ meet the ~~following~~ requirements specified in this regulation.

(a) Each registered professional nurse shall perform the following:

(1) Assess each student's nursing care needs;

(2) formulate a plan of care before delegating any nursing task or procedure to an unlicensed person; and

(3) formulate a plan of nursing care for each student who has one or more long-term or chronic health conditions requiring nursing interventions.

(b) The selected nursing task or procedure to be delegated shall be one that a reasonable and prudent nurse would determine to be within the scope of sound nursing judgment and that can be performed properly and safely by an unlicensed person.

(c) Any designated unlicensed person may perform basic caretaking tasks or procedures as defined in K.A.R. 60-15-101~~(b)~~ (g) without delegation. After assessment, a nurse may delegate specialized caretaking tasks or procedures as defined in K.A.R. 60-15-101~~(b)~~ (h) to a designated unlicensed person.

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(d) The selected nursing task or procedure shall be one that does not require the designated unlicensed person to exercise nursing judgment or intervention.

(e) ~~When~~ If an anticipated health crisis that is identified in a nursing care plan occurs, the unlicensed person may provide immediate care for which instruction has been provided.

(f) The designated unlicensed person to whom the nursing task or procedure is delegated shall be adequately identified by name in writing for each delegated task or procedure.

(g) ~~The~~ Each registered professional nurse shall orient and instruct unlicensed persons in the performance of the nursing task or procedure. The registered professional nurse shall document in writing the unlicensed person's demonstration of the competency necessary to perform the delegated task or procedure. The designated unlicensed person shall co-sign the documentation indicating the person's concurrence with this competency evaluation.

(h) ~~The~~ Each registered professional nurse shall meet these requirements:

(1) Be accountable and responsible for the delegated nursing task or procedure;

(2) at least twice during the academic year, participate in joint evaluations of the services rendered;

(3) record the services performed; and

(4) adequately supervise the performance of the delegated nursing task or procedure in accordance with the requirements of K.A.R. 60-15-103 ~~of this article~~.

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(Authorized by ~~and~~ K.S.A. 2007 Supp. 65-1124 and K.S.A. 65-1129; implementing K.S.A. ~~1997~~ 2007 Supp. 65-1124 and K.S.A. 65-1165; effective, T-89-23, May 27, 1988; amended, T-60-9-12-88, Sept. 12, 1988; amended Feb. 13, 1989; amended Sept. 2, 1991; amended Sept. 11, 1998; amended P-_____.)

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60-15-104. Medication administration in a school setting. Any registered professional nurse may delegate the procedure of medication administration in a school setting only in accordance with this article.

(a) Any registered professional nurse may delegate the procedure of medication administration in a school setting to unlicensed persons if ~~all~~ both of the following conditions are met:

(1) ~~The initial dose of a medication has been previously administered to the student, unless the medication is ordered for an anticipated health crisis.~~

~~(2)~~ The administration of the medication does not require dosage calculation. Measuring a prescribed amount of liquid medication, ~~or~~ breaking a scored tablet for administration, or counting carbohydrates for the purpose of determining dosage for insulin administration shall not be considered calculation of the medication dosage.

~~(3)~~ (2) The nursing care plan requires administration by accepted methods of administration other than those listed in subsection (b).

(b) ~~The~~ A registered professional nurse shall not delegate the procedure of medication administration in a school setting to unlicensed persons when administered by any of these means:

(1) By intravenous route;

(2) by intramuscular route, except when administered in an anticipated health crisis;

(3) through intermittent positive-pressure breathing machines; or

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(4) through ~~any~~ an established feeding tube that is not inserted ~~into the body; except through an established feeding tube~~ directly ~~inserted~~ into the abdomen. (Authorized by ~~and~~ K.S.A. 2007 Supp. 65-1124 and K.S.A. 65-1129; implementing K.S.A. 2007 Supp. 65-1124 and K.S.A. 65-1165; effective, T-89-23, May 27, 1988; amended, T-60-9-12-88, Sept. 12, 1988; amended Feb. 13, 1989; amended Sept. 2, 1991; amended Sept. 11, 1998; amended July 29, 2005; amended P-_____.)

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Date: January 22, 2009

Subject: Comments regarding HB 2008 "An enacting the school medication aide act; amending K.S.A. 2008 Supp. 65-1124 and 65-2872 and repealing the existing sections."

To: The Honorable Clay Aurand, Chairperson; The Honorable Senator Deena Horst, Vice Chairperson; and members of the House Education Committee

From: Cindy Galemore RN, MSEd, NCSN, KSNO Professional Standards Chair and Director of Health Services for Olathe District Schools
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I was pleased to be able to present testimony on September 18, 2008 for the Legislative Education Planning Commission on epinephrine standing orders in Kansas schools and to continue discussion since that time with members of the Kansas School Nurse Organization (KSNO) Board of Directors, with interested parties at the Kansas Department of Health and Environment and with the Board of Nursing Practice Committee. This testimony speaking to my support of allowing standing orders for use of epinephrine upon recognition of signs and symptoms of anaphylaxis can be found at www.ksno.org in the archives section. On January 8, 2009, I received an electronic copy of what is now HB2008 "AN ACT enacting the school medication aide act; amending K.S.A. 2008 Supp. 65-1124 and 65-2872 and repealing the existing sections." I want to thank the Legislative Educational Planning Committee for responding to our request for immediate assistance with this issue. The opinions I share today are based upon my many years of practice in school nursing and the knowledge I have gained from networking opportunities through service at both the national and state level.

Of pertinence to today's discussion is a brief review of the history of "Standing Orders" for epinephrine in Olathe District Schools. In a text on *Legal Issues for School Health Services* (Schwab, Gelfman, 2001), the definition of standing orders is as follows: "In schools, medical directives from an authorized prescriber (usually a school medical advisor), regarding the administration of a medication under specified circumstances, that are written for general application to a group of students, as opposed to an order for a medication written for one specific student by that student's health care provider." After reading articles on anaphylaxis in the early 1990's, visiting with Dr. Jeff Wald, a board certified allergist in the Kansas City area, discussing with our district medical advisor, and noting the increased number of students that we were serving with a history of anaphylaxis, we decided to become better prepared to manage anaphylaxis in the school setting through the use of a standing order.

The process that Olathe utilized for implementation of standing orders for epinephrine for unknown anaphylaxis was as follows:

- Annually the standing order was reauthorized by our school medical advisor including dosage specifications, signs and symptoms criteria (through nursing assessment)indicative of an anaphylactic event, and the requirement to call 911 whenever epinephrine was administered
- On the initial year of implementation, a comprehensive inservice was provided for all registered nurses. Each subsequent school year new registered nurses received a more thorough inservice as part of their new nurse induction, whereas, returning nurses received a review.
- Elementary schools were stocked with both a pediatric and an adult dose of epinephrine. Secondary schools were stocked with an adult dose. The stock medication was labeled per school, and the lot numbers and expiration dates recorded for monitoring through my office.
- Auto-injector epinephrine typically costs around $60/unit, and expires after 12 to 18 months of purchase. In a district of our size (35 elementary, 13 secondary schools) the annual cost of such a program is approximately four to five thousand dollars.
- When needed, the order for replacement stock epinephrine was made to a local pharmacy by our medical advisor. Our department was responsible for picking up the order, labeling and distributing to our school nurses while adhering to the temperature requirements.

The state of Massachusetts has completed the most impressive research available to date for implementation of epinephrine standing orders in schools. Schools are required to complete documentation when epinephrine is administered. During the 2006-2007 school year, 156 doses of epinephrine were administered among the 550,000 students, which equates to 1 in every 3,525 students. More pertinent to this discussion today is that in 37 of these cases (24%), the individual was not known to have an allergic condition at the time of the anaphylatic event (Data Health Brief: Epinephrine Administration in Schools, Massachusetts Department of Public Health, August 1, 2006 through July 31, 2007). The cited report is attached for your reference.

Similarly to Massachusetts, Kansas reports approximately 500,000 students; unlike Massachusetts, Kansas students are spread across 391 high schools, 226 junior high or middle schools, and 959 elementary schools (over 300 school districts compared with 71 in Massachusetts). Since 1997, epinephrine has been administered 2 to 3 times per year in Olathe District Schools. Our current student population is 27,000. Thus, our epinephrine administration rate ranges from 1 to every 8,000 to 1 to every 13,000 students per year. Our school nurses can recall five distinct situations over this same time period where the individual was not known to have an allergic condition at the time of the anaphylactic event (five out of approximately 25 incidents). These five situations are described next. Like our school district, the school nurses in Massachusetts truly believe lives have been saved.

1. **Student with history of problem many years prior with no current individual order for medication:** A high school student presented to the school nurse stating that he had just eaten a peanut butter cookie (mistook it for a sugar cookie); through he remembered being allergic to peanuts when he was younger. The nurse contacted the student's current guardians by phone (a court appointed guardian). They had no history of allergy on file. While the student remained being observed in the health room itching and swelling of his lips, tongue and complaint of difficulty swallowing developed. Epinephrine was administered and 911 summoned. The student's grandmother later confirmed the history of peanut allergy at an early age. The student recovered successfully.
2. **Student with no known history after taking common over-the-counter pain medication:** A junior high student was participating in a basketball game immediately after school. The school nurse was in attendance at the game. The student told the coach he was having trouble swallowing and breathing. The coach instructed him to go get a drink of water. The student saw the nurse and went to her stating his complaints. The nurse was already able to assess swelling of the lips commencing. She accompanied the student to the health room and began asking if he had any history of allergy. The student responded "no." She asked him if he had eaten anything different that day, taken medication – over-the-counter or prescribed. He then said he had taken 4 doses of ibuprofen that day due a muscle strain he had experienced at basketball practice the night before. During this time of questioning, the lips and tongue continued to swell at an alarming rate, with the student complaining of increasing difficulty swallowing and complaints of difficulty breathing. The nurse administered epinephrine and summoned 911. The emergency room doctor told her she likely saved the student's life.
3. **Student with no known history upon eating peanuts at school:** In the afternoon, a science teacher called form the classroom stating he was sending a junior high student to the health room who had eaten some cashews. Upon being asked, the student stated he had no knowledge of eating cashews before, that his mother never purchased them. He looked flushed upon entering the health room and could barely talk. He soon began having trouble breathing. He sat down on one of the cots in the health room and his breathing continued to become more difficult. He was soon gasping for air and was very agitated. The school nurse administered the stock epinephrine as well as immediately calling 911. EMS arrived and another dose of epinephrine was administered. The student required hospitalization for two days before returning to school.
4. **Student with reaction to combined exercise and seasonal allergies:** A junior high student entered the nurse's office complaining of swelling in both eyes after running a mile on the track during fall semester. He stated this had happened once before a few years ago. The nurse assisted him in rinsing his hands and face with cold water and applying cold packs to his eyes. He denied any difficulty breathing. An unsuccessful attempt was made to reach his mother in order for her to bring an over-the-counter antihistamine for him. Within another five to seven minutes the student stated his throat was feeling "clogged." Additionally, upon auscultation the nurse noted that the student was wheezing bilaterally throughout

his lung fields. Due to his difficulty breathing the nurse administered epinephrine and called 911. His symptoms subsided and he recovered successfully, and returned to schools with individual orders for potential future events.

5. **Student with no known history upon exposure to respiratory allergen:** A student presented to an elementary school nurse with difficulty breathing. Upon checking with the teacher, it was noted that a fresh flower arrangement and been delivered to the room that day. Particularly, the smell of lilies was very potent in the arrangement. As the nurse continued to assess the student in the next few minutes, his breathing became more distressed presenting with rapid respirations, difficulty talking, use of accessory muscles, hunched posture, increasing blue coloration of finger nail beds, and displaying general panic. The nurse administered the epinephrine without any resistance on the part of the child and called 911. The young child quickly responded with an ease in breathing.

Based on all of the above, and the additional information presented by Chris Tuck, I am not in favor of the **Medication Aide Act (amendment to K.S.A. 2008 Supp. 65-1124),** the first portion of HB2008. I believe that what this act is trying to establish already exists in Kansas **and** in a manner that does not create additional regulations for school districts and the need for increased administration costs and oversight at the state level, a very important factor in these tough economic times. While the **amendment to K.S.A. 2008 Supp. 65-1124** was drafted to allow epinephrine to be available in schools and administered in settings that do not have a full-time registered nurse, the survey KSNO has conducted since September, and presented by Chris Tuck, leads me to believe that a better starting point for Kansas would be to limit the implementation of standing orders to a registered nurse. It is relevant to emphasize that our current delegation regulations do allow us to delegate the administration of epinephrine for those students with known history and individualized orders.

I am **in support of the suggested amendment to 65-2872 section (t).** This would provide the permissive language, without being mandatory, for districts that want to implement standing orders working under a physician and carried out by a professional registered nurse, consistent with the national standard we are seeing in this introductory phase of standing orders for epinephrine. We continue to believe standing orders are essential, and the data from Massachusetts, with 24% of administrations of epinephrine given to individuals no known to have an allergic condition at the time supports this recommendation. I am **opposed to the suggested section (s) of 65-2872 regarding school medication aides** for the reasons cited earlier. KSNO would also be willing to implement a tracking record similar to Massachusetts to track beginning data on school epinephrine use in our state. Additionally, we are working to promote consensus through education and increased dialogue among our colleagues and with allied health professionals such as physicians and pharmacists. To conclude, I am **in support of the suggested amendment to 65-2872 section (t)** and believe that in order to bring the consensus needed to pass this amendment, it will be necessary to allow time for dialogue with both the Kansas Board of Healing Arts and Board of Pharmacy. I welcome the opportunity for further discussion or to answer questions.

DATA HEALTH BRIEF: EPINEPHRINE ADMINISTRATION IN SCHOOLS

Massachusetts Department of Public Health
Bureau of Community Health
Access and Promotion
School Health Unit
August 1, 2006 – July 31, 2007 (School Year 2006 – 2007)

This annual data health brief documents the epidemiology of epinephrine administration for the treatment of allergic reactions in Massachusetts schools. Data were reported to the Massachusetts Department of Public Health (MDPH), School Health Unit, during the 2006 – 2007 school year. During this period of time,71 school districts and 8 private schools reported 158 administrations of epinephrine for the treatment of allergic reactions in schools. Data on epinephrine administration in schools is submitted to the MDPH on a standardized form, Report of EpiPen® Administration, by the school district at the time of the occurrence. *

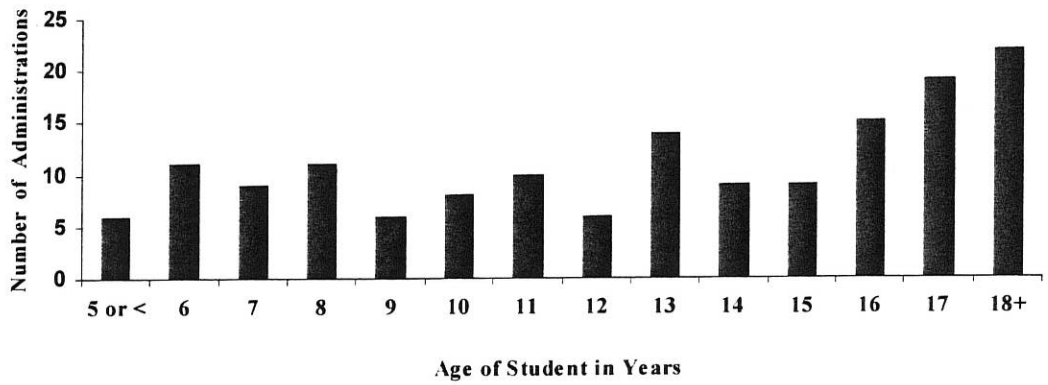
- All regions of the state reported epinephrine administration. The Southeast region reported the greatest number of administrations (27%), whereas the Boston region reported the fewest (6.3%).

- While most school districts reported only one administration of epinephrine, 18 school districts reported more than one and four school districts reported five or more epinephrine administrations during the school year.

Characteristics of Individuals Receiving Epinephrine

- Eighteen of the administrations were to staff members; the remaining administrations were to students ranging in age from 3 – 19 years (Figure 1).

Figure 1. Number of Epinephrine Administrations by Age
Massachusetts, August 2006-July 2007 (N = 155)



Data Source: Report of EpiPen Administration forms.

*Reporting of epinephrine administration in schools became mandatory under 105 CMR 210 for all public and nonpublic schools in November 2003.

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- The most frequently reported allergens were nuts and peanuts (Figure 2).

- 67 individuals receiving epinephrine (42%) reported having multiple allergies. Among these individuals, several different combinations of allergens were reported, including allergies to peanuts, tree nuts, dairy, egg, fish/shellfish, bees, sesame seeds, medication, latex, and others. The most common allergens reported by those with multiple allergies were peanut and nuts.

- In 37 cases (24%), the individual was not known to have an allergic condition at the time of the anaphylactic event.

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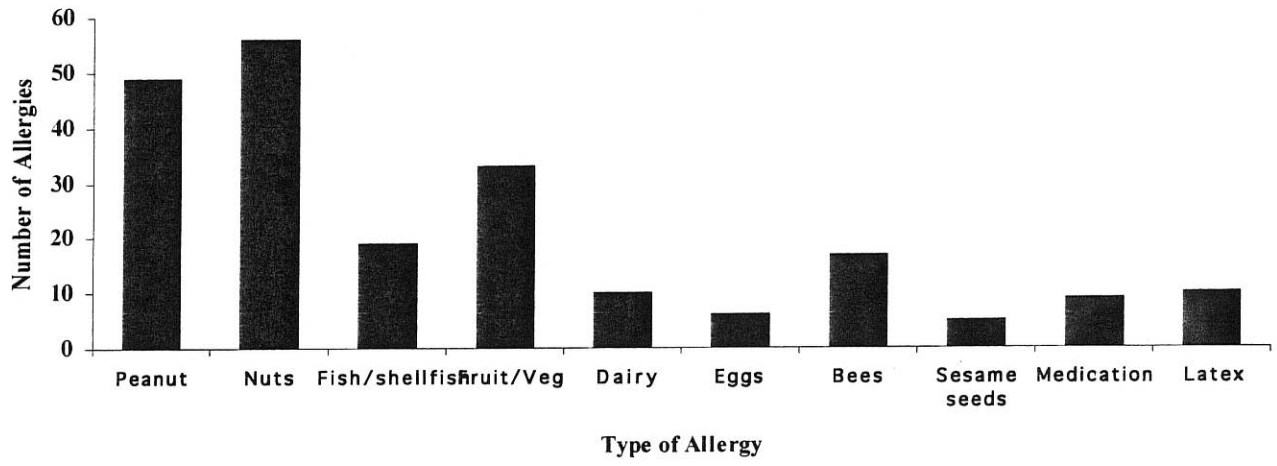
Figure 2. Number of Types of Most Common Allergies Reported by Individuals Receiving Epinephrine, Massachusetts, August 2006 - July 2007 (N = 158)**



Data Source: Report of EpiPen Administration forms.

**Since those with multiple allergies reported more than one allergen, the total number of allergies reported will be greater than the number of cases

Characteristics of Allergic Reactions

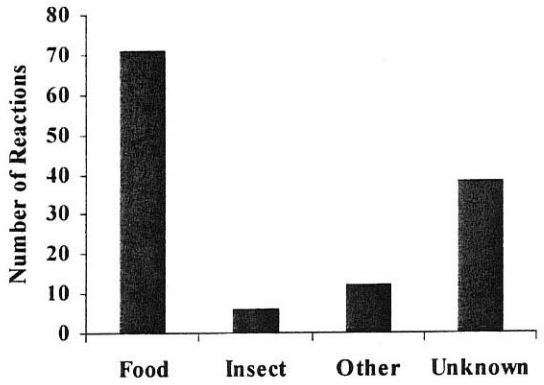
- Some type of food was believed to be the cause of 45% of the reactions (Figure 3).

- In 24% of the cases, the allergen that triggered the reaction was unknown (Figure 3).

- Reported symptoms involved multiple organ systems such as the skin, gastrointestinal, respiratory, cardiovascular, or neurological. 86 % of the cases involved symptoms related to the skin such as hives, itchy skin or facial swelling. In all cases the symptoms reported involved the respiratory tract such as a tightness of the throat, wheezing, shortness of breathe, or difficulty swallowing. In 14 cases cardiovascular symptoms were reported.

- Symptoms most frequently developed in the classroom (47%). Other locations included the cafeteria (14%), health office (7%), playground/outside/recess (10%) and various locations both inside and outside the school building.

Figure 3. Number of Allergic Reactions by Type of Trigger, Massachusetts, August 2006 - July 2007 (N=158)



Data Source: Report of EpiPen Administration forms.

- The majority of epinephrine administrations were performed by an RN (87 %). In 8 cases, epinephrine was administered by other types of personnel such as a teacher, coach, administrator and parent. All unlicensed personnel had been appropriately trained in the administration of epinephrine.

- Seven students, ranging in age from 6 years to 18 years, self-administered the epinephrine. In three cases, the RN coached the student to self-administer.

- The average time between development of symptoms and the administration of epinephrine for all individuals (with both known and unknown allergic conditions) was 11.6 minutes, with a range of 0-120 minutes.

- Of those students with known allergies, 74% had an individualized health care plan (IHCP) in place.

- Eight students were not transported to a medical facility via the Emergency Medical System. In six cases, the decision not to transport was made by a parent. In two cases, the reasons are not known.

Characteristics of Cases Involving Individuals with Unknown Allergic Conditions

- Thirty-seven (N=157) cases involved individuals with unknown allergic conditions (34 students and 3 adults).

- The average age of students with unknown allergic conditions was 11.5 years, with a range of 5-17 years (Figure 4).

- The average amount of time between onset of symptoms and administrations of epinephrine in those individuals with unknown allergic conditions was 18.5 minutes, with a range of 5-40 minutes (compared to an average response time of 11.6 minutes, with a range of 0-120. minutes for individuals with known allergies).

Figure 4. Number of Students with Unknown Allergies by Age, Massachusetts, August 2006 - July 2007 (N=34)

Data Source: Report of EpiPen Administration forms.

School Health Unit
Massachusetts Department of Public Health

Report of Epinephrine Administration (2008-2009)
Please mail form to: MDPH, School Health Unit, 250 Washington St., 5th Floor, Boston, MA 02108-4619

1 School District: _____ Name of School: _____

2 Age:_____ Type of Person: Student ☐ Staff ☐ Visitor ☐ Gender: M ☐ F ☐ Ethnicity: Spanish/Hispanic/Latino: Yes ☐ No ☐

3 Race: American Indian/Alaskan Native ☐ African American ☐ Asian ☐ Native Hawaiian/other Pacific Islander ☐ White ☐

4 Diagnosis/history of asthma: Yes ☐ No ☐ History of anaphylaxis: Yes ☐ No☐ Previous epinephrine use: Yes ☐ No ☐

5 Date/Time of occurrence: _____Known allergen(s):_____

6 Trigger that precipitated this allergic episode:_____

7 Symptoms:_____

8 Location of student when symptoms developed: Classroom ☐ Cafeteria ☐ Health Office ☐ Playground ☐
Other ☐ - specify: _____

9 Location of student when epinephrine administered: Health Office ☐ Other ☐-specify _____

10 Location of epinephrine storage: Health Office ☐ Other ☐-specify:_____

11 Epinephrine administered by: RN ☐ Other ☐
If other, please specify_____
Was this person formally trained? Yes ☐ No ☐ Date of training_____

12 If epinephrine was self-administered by a student at school or a school-sponsored function, did the student follow school protocols to notify school personnel and activate EMS? Yes ☐ No ☐ NA ☐

13 Approximate time between onset of symptoms and administration of epinephrine: _____minutes

14 Individual Health Care Plan (IHCP) in place? Yes ☐ No ☐ School Physician notified? Yes☐ No ☐

15 Written school district policy on management of life-threatening allergies in place? Yes ☐ No ☐

16 School district/school registered with MDPH for medication delegation?: Yes ☐ No ☐

If yes, please specify type: Full Registration ☐ Field Trip ☐ Epinephrine Training ☐

Disposition:

17 Transferred to ER: Yes ☐ No ☐ Discharged after_____hours. Biphasic reaction: Yes ☐ No ☐ Unknown ☐

18 Hospitalized: Yes ☐ No ☐ Discharged after_____days.

19 Student/Staff/Visitor Outcome: _____

20 Did a debriefing meeting occur? Yes☐ No ☐

21 Recommendation for changes: Protocol change ☐ Policy change ☐ Educational change ☐ Information sharing ☐ None ☐

22 Comments:_____

_____

23 Form completed by:_____ Date:_____
(please print)

24 Title:_____ Phone number: (_____) _____ - _____ Ext.: _____

25 School address:_____

Rev 9/05/08

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KSNA
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Decade of the Nurse in Kansas
2005 2015

Susan Bumsted, M.N., R.N.
President

The Voice And Vision Of Nursing In Kansas

January 23, 2008

Representative Horst and Members of the Education Committee, my name is Sarah Tidwell, M.S., R.N. and I am here representing the Kansas State Nurses Association (KSNA). KSNA is not supportive of HB 2008: School Medication Aide Act.

KSNA is opposed to establishing the category of a school medication aide that could administer epinephrine. Administering an epinephrine injection carries with it a greater level of accountability than just simply the injection itself. The recognition and interpretation of the signs and symptoms of anaphylaxis, and the knowledge and judgment of when the drug should not be given are the components that cannot be taught in a short course. Early intervention to a student with undiagnosed anaphylaxis may save a life; however serious injury may result in students with underlying health conditions in which epinephrine administration is contraindicated. The professional nurse has the knowledge to determine safe administration of the medication based on their level of education. Two categories of aide already exist in Kansas; Certified Nurse Aides (CNA's) and Certified Medication Aides (CMA's). CNA's and CMA's receive 90 and 75 hours of training respectively, however, they are not allowed to administer epinephrine in the case of anaphylaxis.

Another concern with the bill is the term "medication" being defined as epinephrine. The common lay definition of the term "medication" is much broader than epinephrine. Many powerful medications are administered in the schools, but are done so under the supervision and delegation of the school nurse. This bill creates the potential for school medication aides not supervised by a licensed medical professional to be given responsibility to administer other medications beyond epinephrine in the school setting. KSNA cannot support language that creates the possibility that school districts may consider employing school medication aides, rather than employing a licensed professional nurse, with the expectation that the school medication aide is qualified to provide comprehensive health care services.

Although we believe the responsibility for any category of nursing aide should be with the Board of Nursing, we cannot support adding additional responsibility and program expense to the Board at this time. Budget cuts have already taken approximately $50,460 and further cuts of around $75,000 are recommended to be deposited in the state general fund from this fee funded Board. Adding this category would require additional staff or add responsibilities to the current staff, neither of which we can support.

House Education Committee
Date 1-22-09
Attachment # 10

KSNA believes that the original issue of professional registered nurses in the school setting having the ability to diagnose anaphylaxis, treat students experiencing anaphylaxis, and have available access to a stock supply of epinephrine is not achieved through this bill. The problem can be resolved through collaboration between the Kansas State Board of Nursing, the Kansas Board of Healing Arts and the Kansas State Board of Pharmacy.

The Kansas State Nurses Association as you not to advance HB 2008. Thank you for your consideration.

KANSAS MEDICAL SOCIETY
KMS

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www.KMSonline.org

To: House Committee on Education

From: Dan Morin
Director of Government Affairs

Subject: House Bill No. 2008; An act enacting the school medication act

Date: January 22, 2009

The Kansas Medical Society appreciates the opportunity to submit the following comments today on HB 2008, which is intended to address the issue of administering epinephrine to students who have not previously been diagnosed with life-threatening allergies. Anaphylaxis is a serious allergic reaction that is rapid in onset and may cause death. Some of the allergens that most commonly trigger anaphylaxis are those found in foods, certain drugs, latex rubber, and insect stings. We believe it vital to teach patients and their caregivers strategies for avoiding anaphylaxis, as well as how to deal with acute anaphylactic episodes but we have some concerns about how the bill before you will be implemented.

First, we do not oppose the request voiced when the topic first was addressed this fall by the interim Joint Committee on Legislative Educational Planning. The intent was to authorize school nurses to administer epinephrine to treat students having an anaphylactic reaction in cases where the student has not previously been diagnosed with anaphylaxis. Signs and symptoms of anaphylaxis generally occur seconds to minutes after contact with an allergen, though symptom onset may not occur for a few hours. School nurses are uniquely positioned to assist in such situations as a result of their formal training and clinical experience in nursing diagnosis and knowledge of how to implement a medical regimen as prescribed by a physician.

We do, however, have some concerns and would encourage further discussion on the interim recommendation for a bill to establish "school medication aides (a person who has satisfactorily completed training in the use of epinephrine and could include school nurses or others) to administer epinephrine to students having an anaphylactic reaction in cases whether or not the student has been diagnosed with anaphylaxis." It is important to understand when not to administer epinephrine as well as when it is needed. While cutaneous manifestations (itching, hives, and angioedema, which is similar to hives but affects a deeper skin layer) are the most common symptoms of anaphylaxis, occurring in more than 90% of cases, it is important to note that they are not always present. Diagnostic confusion may occur if the student experiences gastrointestinal symptoms or cardiopulmonary collapse as a result of an allergic reaction. Many symptoms of anaphylaxis suggest other diseases and conditions such as:

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- Septic shock
- Acute anxiety
- Myocardial dysfunction
- Pulmonary embolism
- Systemic mast cell disorders
- Acute poisoning
- Hypoglycemia
- Seizure disorder
- Airway foreign body
- Asthma and chronic obstructive

Would a "school medication aide" as defined in the bill, even after completing a limited training program in medication administration, have the ability to mentally run through the accepted clinical criteria necessary for diagnosing anaphylaxis in a moments notice especially in a life-threatening emergency situation? Would they be able to rule out other dangerous conditions producing visible symptoms? School medication aides, although certified by the Kansas State Board of Nursing under HB 2008, also would seemingly be exempt from any type of licensure or oversight.

We do have one recommended amendment, or addition, to any bill addressing the use of Epi-pens for non-patient specific emergency situations. Ohio Revised Code 3313.718 addresses the use of Epi-pens at a school setting or event and mandates in statute that whenever an auto-injector is used, a school employee shall immediately request assistance from an emergency medical provider (e.g., call 911). Patients with a history of dangerous allergic reactions normally have a personalized emergency action plan drawn up by their personal physician which, among other things, emphasizes the necessity of going to an emergency facility after an epinephrine injection for follow-up care.

In summary, we are in conceptual support of allowing school nurses the ability to store an appropriate amount of epinephrine and administer epinephrine in the rare emergency cases where Epi-pens have not previously been prescribed to students with a history of serious allergic reactions known as anaphylaxis. However, we are unsure of how its provisions will work in practice. We would be more than willing to meet with the stakeholders in this issue and continue to work on language that advances the goals of the bill without creating problems that could actually make the assessment and treatment of anaphylaxis more problematic. Thank you for your time and attention to our comments.