Date: February 11, 2017

To: House Committee on Health and Human Services

From: KSHA/KASEA School Based Tele Therapy State Task Force
Submitted by –
Stacie Clarkson, CCC-SLP,
Associate Executive Director, Southeast Kansas, Education Service Center

Re: Public Testimony on HB 2206

Honorable Rep. Daniel Hawkins and Committee Members,

My name is Stacie Clarkson, and for the last two years I have been the co-chairperson of a working task force comprised of members of the Kansas Speech Language Hearing Association (KSHA) and the Kansas Association of Special Education Administrators (KASEA). I thank you for the opportunity to represent this task force today as a proponent of HB 2206. This task force was formed to promote parity of tele health services delivered to students with disabilities receiving medically based services under IDEA in Kansas.

As a speech language pathologist and school administrator I would like to provide a glimpse of how medically based therapy services, such as occupational therapy, physical therapy and speech language therapy are provided to students in school settings supporting individual education plans and infants and toddlers in home settings supporting individual family service plans.

Therapists, such as speech language pathologists, working in the public schools provide various types of intervention to promote progress in the regular school curriculum. Therapy plans, similar to those in a medical setting, are based on individual needs. Additionally, progress monitoring and documentation guidelines for such services in the schools are similar to a medical model. Likewise, therapists in school-based settings must follow the same licensing requirements of therapists in medical settings. Due to shortages of speech language pathologists across our state, it is not uncommon for typical school based SLPs to have a workload of 60-80 students in two or three different buildings or locations. Schools are obligated by federal law to provide these medical related services if a child meets eligibility requirements. Currently, if an onsite therapist conducts these services, and the child receiving these services is eligible for Medicaid, the school can then submit for reimbursement of the service according to the school Medicaid provider manual. Tele- therapists have to follow the same scope of practice as onsite therapists, however schools are unable to submit for Medicaid reimbursement when using a tele-health model.

Therapists, providing intervention in home settings to serve infants and toddlers with disabilities must also adhere to the same practice guidelines as school based and medical based providers. Services provided by infant toddler networks (Tiny K networks) in

Kansas often support and/or facilitate coordination of physician orders. For example, a speech language pathologist may help the family of a child born with a cleft palate learn appropriate feeding strategies to prevent aspiration as per the recommendations following a barium swallow or modified barium swallow study conducted at a hospital. Although, families supported by infant toddler networks across the state have access to these skilled clinicians, the shortage of therapists in the state and the sheer geography of areas served may present barriers for efficiently delivering services. The Southeast Kansas Infant Toddler Network currently covers roughly 15,000 square miles, serves 230 families, and has only two part time SLPs. One SLP may drive over an hour one direction to see a medically fragile infant one time per month to consult on progress towards language acquisition goals. Again, those services are only reimbursed at this time through Kansas Medicaid if the consultation takes place with an onsite therapist when perhaps the same consultation could have taken place more efficiently and more frequently if provided by a tele-therapist.

For the last two years, the KASEA/KSHA task force comprised of school administrators and speech language pathologists have worked collaboratively to advocate for the use of a tele health service delivery model to effectively and efficiently meet the needs of students and children receiving medically related services as per the requirements of IDEA. This task force believes there is parity between tele health services and traditional services in terms of practice guidelines and quality of service. However, there is not fiscal parity in terms of Medicaid reimbursement.

On behalf of this task force, I ask you to move forward with HB 2206.