Roni Dinkes, AuD
Johns Hopkins Bayview Medical Center
4940 Eastern Ave
Baltimore, MD 21224

February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Pena-Melnyk, Vice Chair Cullison, and Committee Members,

I moved to Maryland in 1993 to start my career in audiology as intern at Johns Hopkins, then completed my fellowship at R Adams Cowley Shock Trauma Center 1995. I was hired by the University of Maryland Medical Center from 1995 to 1997. In 1997 I was brought back to Johns Hopkins were I still work to this day. While working at Johns Hopkins and raising two children, I was the first audiologist in the institution to receive the doctoral degree in Audiology.

Since 1997, I have diagnosed, managed and treated over 20,000 individuals with hearing loss, tinnitus, and dizziness locally, nationally and internationally. My patient population ranges from children through adult and into geriatrics.

I am involved actively involved with the Jerome L. Greene Sjogren's Syndrome Center and the Vasculitis Center. As well, I have been honored as Baltimore Top Audiology Doctor 2020-2023.

As a Johns Hopkins audiologist, I provide private insurance payers, Medicare, Medicaid and Medical Assistance individuals with diagnostic audiology care, tinnitus management, hearing aids and counseling. In order, for my fellow Otolaryngology colleagues to provide their medical care, we work collaboratively as a team to give each patient comprehensive hearing and balance care.

The Maryland Audiology Statute has not been updated since 2005. The almost 20-year-old statute does not reflect the rigorous didactic and clinical education required to practice. Where once a Master's degree was adequate, now a Doctoral degree is mandated to practice. Audiology is the branch of science and medicine concerned with the sense of hearing.

It is imperative to support and update our statute. SB 795

modernizes the practice definition of audiology to reflect the audiologist's didactic and clinical training. The legislation ensures the Statute language is broad enough to encompass services provided now and allows the Board to create regulations to provide specific rules. Additionally, the language codifies: Health screenings-which are pass/fail to help determine if management As an audiologist I do not heal patients, perform surgery or prescribe prescriptive medications.

is necessary to another provider who specializes in that area (e.g., vision screening, hypertension, etc.). The Board allows audiologists to complete health care screening, as they do not require a diagnosis. Individuals obtain screenings in many places, including Walmart (blood pressure), retail pharmacies, etc. Cerumen removal; already in Regulations.

The statue language modernizes removal of foreign bodies from the external auditory canals such as a hearing aid filter, dome, rock, crayon, etc. Since Diabetes impacts hearing allowing the Audiologist to order bloodwork (A1C). Consultation with patients, families and physicians about co-morbidities and to better identify/rule out a syndrome, disease, and/or a disorder. Finally, in an effort of delaying healthcare we as audiologists can order and performing non-radiographic imaging and scanning such as earmold scanners, video otoscopy, 3D ear scanning. This medical care is consistent with other non-physician, clinical doctors: such as Optometry- retina imaging and Dentists- teeth straightening scans.

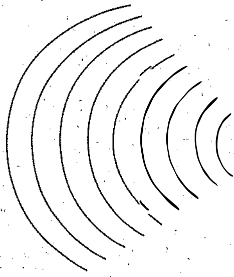
As an audiologist I do not heal patients, perform surgery or prescribe prescriptive medications. However, since 2005, Audiology Healthcare has modernized, and audiologists are doctors providing comprehensive hearing healthcare. Colorado, Alabama, and Illinois all have modernized the practice of Audiology. It is time Maryland do the same.

Thank you for your support of SB 795 legislation.

Sincerely,

Roni Dinkes, AuD

Maryland License #00738



HEARING SERVICES
Leslie B. Papel, Au.D., FAAA
Doctor of Audiology

◆ Hearing Health Care
◆ Audiology Services
◆ Hearing Aid Dispensing

February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller State Office Building
Annapolis, Maryland 21401

RE: **SB 795** Health Occupations-Practice Audiology-Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Kausmeier, and Committee Members,

As a private practice Doctor of Audiology for over 40 years, I have enjoyed a full career in Baltimore. I received my Au.D. from SALUS University in Philadelphia, Pennsylvania after working for twenty years with my Masters in Audiology. My primary focus throughout my career has been evaluation and treatment of hearing disorders in adults. These services include but are not limited to evaluation, diagnosis and treatment of various hearing and balance disorders. Throughout my career I have collaborated with physicians of many specialties such as primary care, family practice, otolaryngology, neurology, radiology, rehabilitation medicine, emergency medicine to name only a few.

Audiology is the science of the branch of science and medicine concerned with the sense of hearing. Maryland statutes were last updated in 2005 and have not kept up with the changing advances in clinical care nor the rigorous didactic and clinical education and training of licensed Audiologists.

SB 795 is necessary to modernize the practice definition of audiology to reflect the audiologist's didactic and clinical training. The Statute language is broad enough to encompass currently provided services and allows the Board of Examiners to create regulations such as:
Codifying health screenings
Cerumen removal through manual removal, suction, or irrigation

It also modernizes language addressing:
*removal of foreign objects from the EAC (external auditory canal)
*ordering of cultures and bloodwork to assist in proper diagnosis and continuum of care with other practitioners (PCP, ENT, and/or ER)
*ordering and performing non-radiographic imaging and scanning. These services may include those routinely offered such as 3D ear scanning, video otoscope, ear mold scanning.

SB 795 does not allow Doctors of Audiology to practice medicine, perform surgery, nor perform radiographic imaging.

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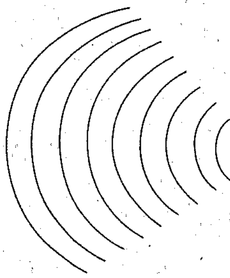

HEARING SERVICES
Leslie B. Papel, Au.D., FAAA
Doctor of Audiology

◆ Hearing Health Care
◆ Audiology Services
◆ Hearing Aid Dispensing

SB 795 allows consistency between other non-physician clinical doctors, such as dentistry, and optometry. This bill provides consistency with other states' definition of audiology but not limited to Colorado, Alabama and Illinois.

Thank you for your support of SB 795 legislation.

Sincerely,

Leslie B. Papel, Au.D.
Doctor of Audiology
License #00335

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February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East, Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members:

I am an audiologist licensed in the state of Maryland. My specialty area is academic audiology and I have been a faculty member at Towson University for 30 years, including serving as the founding director of Towson's Doctor of Audiology (Au.D.) program and as Department Chairperson. Our Au.D. graduates enter the workforce with advanced knowledge and skills in the areas of prevention, diagnosis, treatment, and management of hearing and balance disorders. They enter the profession capable of providing high-quality hearing healthcare care for Maryland residents who suffer with hearing loss, tinnitus, and balance problems. Our 99-credit curriculum includes 2,000 to 3,000 hours of direct patient care, extensive classroom and lab experiences, and an independent research project in an area of audiological care. They have clinical experience across the lifespan from birth through elder care; they have experience with basic through advanced diagnostics, treatment with hearing aids, cochlear implants, and other devices, and they have experience with informational and personal adjustment counseling.

I support this legislation because the current statute was last updated almost 20 years ago. Since that time, the entire profession transitioned from master's level entry to doctoral level entry. Thus, the knowledge and skills of our graduates, and the scope of practice of licensed audiologists, has expanded to provide a much higher level of patient care. SB 795 updates the definition of audiology practice and provides a clearer and more current description of the hearing healthcare functions of an audiologist. The language in this bill more accurately reflects the knowledge and skills of current audiologists and the high-level of care we provide for the citizens of Maryland. This bill does not extend our scope of practice into medical practice (e.g., surgical management), as that is the purview of otolaryngologist, with whom we work to provide comprehensive hearing healthcare.

In summary, this bill modernizes the description of audiology practice. The language in this bill aligns with the wording seen in many U.S. states, as they update regulations associated with the practice of audiology. I encourage you to support this bill.

Kindest Regards,
Diana C. Emanuel
Diana C. Emanuel, Ph.D., CCC-A,
Audiologist
Maryland License #00712

4512 N Chelsea Ln
Bethesda MD 20814

February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

Hello, I am an audiologist beginning to set up a small practice in Bethesda Maryland. I am a military spouse and have had several breaks in my career; hence I have had other challenges with moving, but I miss seeing patients and want to provide people with the latest hearing technology for individuals in need of these services. Private practice audiologists fill a vitally important space in hearing healthcare in partnership with physicians and other practitioners. The proposed legislation will stand to support and strengthen this role in Maryland, to provide access to those who need specialized care.

My background began with work in bioengineering and auditory research which I conducted for over 15 years. I have previously worked as a Fellow in Audiology at the National Institutes of Health (NIH) where I conducted research on hereditary hearing loss, sound processing and tinnitus involving neuro-imaging at the NIH Clinical Center.

The scope of my clinical practice will include evaluating, diagnosing, managing and treating hearing loss in children and adults within my expertise. I plan to fit hearing aids as authorized by State licensure through Maryland Statute and Regulations.

The current practice definition does not reflect the rigorous didactic and clinical education of licensed audiologists. SB 795 modernizes the practice definition of audiology to reflect the audiologist's didactic and clinical training.

The legislation ensures the Statute language is broad enough to encompass services provided now and allows the Board to create regulations to provide specific rules. Additionally, the language codifies:

- Health screenings, which do not require a diagnosis, and
- Cerumen removal.

In addition, the language modernizes several areas including:

- Removal of foreign bodies from the external auditory canal that could have been easily removed in the audiologist's office (e.g., hearing aid dome), and saves the patient a visit to another provider, often Urgent Care or the Emergency Department, and
- Ordering and performing non-radiographic imaging and scanning (e.g., video otoscopy.).

Ordering and performing non-radiographic imaging is consistent with other non-physician, clinical doctors, including but not limited to optometrists (retina imaging) and dentists (dental scans).

The proposed language does not allow audiologists to practice medicine, but rather modernizes the State of Maryland's definition to be consistent with other states' definitions of audiology, including but not limited to Colorado, Alabama, and Illinois. This language can also potentially help those military spouses seeking reciprocity in licensure as they move to different bases around the U.S. Last, it will be consistent with Maryland's practice definitions of non-physician, clinical doctors (e.g., dentist, optometry, podiatry and chiropractic).

Thank you for your time and consideration to support and modernize legislation for the practice of audiology in Maryland, through SB 795.

Sincerely,

Yvonne Bennett, Ph.D. M.S.
Maryland License #00911

February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

I chose to pursue a clinical doctorate in Audiology as it is a perfect combination of science, math, and technology, while also being a patient-centered field. I am lucky enough to enjoy coming to work and that is in part due to the fact that I am able to see the helpful and life-changing treatment we are able to provide to our patients. After obtaining my undergraduate degree in Speech-Language Pathology and Audiology at Towson University, I headed out west to obtain my clinical doctorate in Audiology at West Virginia University. After graduate school, I began working at a private practice in LaVale, Maryland and began focusing on vestibular and neurodiagnostic testing to help the dizzy and imbalanced population. I have become accredited by the American Institute of Balance in vestibular rehabilitation and treatment and our clinic is a Center of Specialty Care for said diagnostic testing and treatment.

At Allegany Hearing & Balance, we serve newborns to geriatrics. In a typical day, we conduct newborn hearing screenings, diagnostic hearing tests, hearing aid evaluations, vestibular and neurodiagnostic testing for balance and vertigo, and more. The six audiologists at our practice are devoted to providing evidence-based practices as well as exceptional service. Both our coursework completed when obtaining our doctorates as well as the continuing education and clinical training acquired through the years, we are able to evaluate, diagnose, manage, and treat hearing and balance disorders.

The legislation is in desperate need of updating. The statute has not been updated since approximately 2005. The current practice definition is not an accurate reflection of how much didactic education, clinical training, and continued education of licensed audiologists that is required to hold licensure. The goal of SB 795 is to modernize the practice definition of

audiology so that it truthfully reflects what audiologists practice on a daily basis. This legislation confirms the statute language is able to include services that audiologists provide now and also allows the Board to create regulations to provide specific rules.

The updated language will also codify audiologist's ability to conduct health screenings for things like dementia, vision, and hypertension. These health screenings are designed to be pass/fail which can help determine if a referral to the patient's PCP or a specialized medical practitioner is needed. Audiologists are not diagnosing or treating these disorders; these screenings are simply another tool to use to give the patient a more comprehensive evaluation that looks at the whole person rather than just hearing and vestibular function in the field of audiology. Patients are already able to obtain these screenings on their own without a healthcare professional. For example, the blood pressure machines located outside of pharmacies or at Walmart. There is no reason to limit a trained, doctoral level provider, to perform these screenings.

The language within the legislation also allows for the removal of foreign bodies from the external auditory canal. Several times a month, patients within our clinic come to our office after having a hearing aid dome become dislodged in their ear canal. This is something that can be completed easily in our office; however, with the current language, we are required to send the patients to an Ear Nose and Throat doctor, their PCP, or to the Emergency Room. The amount of time and money that the patient could save by having their audiologist complete this in office would be immense. Audiologists are already trained in cerumen removal and are more than qualified to remove foreign objects from ear canals.

In addition to removal of foreign bodies from the ear canals, it would also be incredibly beneficial if the language we are proposing in the legislation would allow non-radiographic and radiographic imaging and scanning. Non-radiographic imaging includes things like earmold scanners and visual otoscopy. Our office performs video otoscopy in order to show patients what we are seeing in their ear canals. This serves as a useful tool for patients to see what the doctor sees and a lot of patients find video otoscopy fascinating. Ordering radiographic imaging would be extremely beneficial to audiologists. This would not include completing the procedure or interpretation of the results. A perfect example of this would be when a patient has an asymmetric hearing loss. An MRI of the internal auditory canals is typically ordered by an ENT or PCP in order to rule out a vestibular schwannoma (a benign tumor that grows on the VIII cranial nerve). Patients will also need to most likely pay an additional office copay when they see yet another doctor. If audiologists were able to order the imaging, this would save time and money for the patients. Having this ability to order imaging would be consistent with other doctoring professions (dentists ordering and performing x-rays and optometrists ordering retina imaging).

In summary, I believe that the language currently being used in legislation is in desperate need of an update. It has been nearly twenty years since the legislation was updated. The updates to the language do not allow audiologists to practice medicine, rather it allows us to use our didactic and clinical training to provide ethical and comprehensive healthcare to our patients. Changing the language in the legislation would also be consistent with Maryland's practice definitions of non-physician, clinical doctors (optometrists, dentists, chiropractors).

Thank you for your support of SB 795 legislation.

Sincerely,

Alex Murray Au.D, F-AAA

Alex Murray, AuD
Maryland License #01553

February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

I am a doctor of audiology in the northern Baltimore area and I am eagerly requesting your support of SB 795. I was born with single-sided deafness and have multiple family members also affected by hereditary deafness. I use my personal experiences with hearing loss and hearing aids to fuel my passion to serve patients of all ages with hearing loss and tinnitus in an audiology clinic (The Hearing Wellness Center) that I co-own with my ENT physician partner.

As a licensed audiologist in the state of Maryland, I am also proud to be a member of the Maryland Academy of Audiology, where I have served on a board as: president, past-president, president-elect, convention chair, and other volunteer positions. The Maryland Academy of Audiology (MAA) is our state association that represents the voices of licensed audiologists in the state. The MAA serves as a resource for audiologists to ask questions and seek guidance. The MAA provides a space to network with one another for the betterment of our profession and for the benefit of our patients, both virtually over digital platforms throughout the year and physically at our annual convention where we can obtain continuing education units. Most importantly, the MAA has been a forerunner in setting standards for every other state for the autonomy of audiology and what our industry should look like.

I received my undergraduate (4 year) degree and my graduate (4 year) degree from an accredited university (James Madison University). I have received comprehensive training through my academic studies that reflect the full audiology scope of practice, including but not limited to: audiologic diagnostic

testing of all ages, vestibular diagnostic testing, hearing aid fitting/servicing, tinnitus testing, tinnitus treatment, cerumen (wax) removal, cochlear implant counseling/programming, bone-anchored hearing aids, newborn hearing screenings, and hearing conservation.

In this chapter of my life, I co-own an audiology private practice where I serve all ages (predominantly the geriatric population) by performing audiologic testing, hearing aid fittings/services, tinnitus testing/treatments, cerumen removals, hearing loss educational lectures, and hearing conservation. By virtue of my didactic and clinical training, it is my privilege and obligation to evaluate, diagnose, manage, and treat hearing loss as authorized by State licensure (Maryland Statute and Regulations, and as recognized by numerous insurance payers.

Audiology is the science of the branch of medicine concerned with the sense of hearing. Problematically, the statute has not been updated since (at least) 2005. The current Practice definition does not reflect the rigorous didactic and clinical education of licensed audiologists. While the required education level of an audiologist used to be an undergraduate degree, then a masters degree, it is now (and has been for over 30 years) a doctorate level degree. **SB 795** modernizes the practice definition of audiology to reflect the audiologist's current didactic and clinical training. The legislation ensures the Statute language is broad enough to encompass services provided now and allows the Board to create Regulations to provide specific rules.

In addition, the legislation codifies:

- Health screenings - which are pass/fail to help determine if management (triage) is necessary to another provider who specializes in that area (e.g., vision screening, hypertension, etc.). The Board allows audiologists to complete health care screening, as they do not require a diagnosis. Individuals obtain screenings in many places, including pharmacies and retail storefronts like Walmart (ex: blood pressure), therefore there isn't a logical reason to limit a trained healthcare provider from screening.
- Cerumen removal (already in Regulations)

In addition, the language modernizes:

- Removal of foreign bodies from the ear canal (commonly found on a daily basis are hearing aid dome tips or wax filters, or even q-tip pieces, bugs, and other tiny objects). Due to the nature of our scope and our extensive training, these objects can be easily removed by licensed audiologists. Direct access to audiologists is an efficient, logical, and affordable means to best practice for patients (removing the unnecessary current flow of having patients get referrals to their PCP, ENT, or the emergency room for this service)
- Ordering of cultures and blood work. This is another area that saves time, improves healthcare accessibility, reduces redundancy, and caters to best practice, by skipping the extra step of referring to a PCP by allowing audiologists to direct order blood work to rule out specific syndromes, diseases, and disorders in the process of evaluating, diagnosing, and treating hearing loss and balance disorders (ex: Lymes disease).

- Ordering and performing non-radiographic imaging and scanning. In a typical audiology office, it is common to provide services by using earmold scanners, video otoscopy, and 3D ear scanning, etc.) This privilege is consistent with other non-physician clinical doctors: optometry (retina imaging) and dentists (teeth straightening scans)
- Ordering radiographic imaging (without the performance or interpretation of the procedure, only placing the order and making necessary referrals to follow, which will prevent the patient from unnecessary waiting to see a physician for the same order)

This legislation is a necessary improvement to modernize the language of our scope to match our didactic and clinical training with other non-physician, clinical doctors in Maryland (e.g., optometry, dentistry, podiatry, chiropractic, etc). Overall healthcare in multiple industries and states have been modernized, and Maryland needs to keep the same pace in order to continue being a forerunner for our country. Just to make it absolutely clear, the language of the legislation:

- DOES NOT allow audiologists to practice medicine
- DOES NOT allow for Osseo- surgery
- DOES NOT allow for CI surgery
- DOES NOT allow for prep, operation, or performance of radiographic imaging

It is time - long overdue by a few decades actually - to modernize the language of the audiology scope of practice. It should be up to date with our current educational doctoral level training and education. It should be consistent with other state's definitions of audiology, including but not limited to: Colorado (a purple state), Alabama (red state), and Illinois (a blue state). It should be consistent with Maryland's practice definitions of non-physician clinical doctors (e.g., dentistry and optometry).

Please consider supporting this legislation for the betterment of the profession of audiology, and more importantly, for the improvement of the patient healthcare experience.

Thank you for your support of **SB 795** legislation.

Sincerely,

Sofia Roller, Au.D.
Maryland License #01411

February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

My name is Logan Fraser, and I am clinical audiologist working in private practice. I decided to pursue audiology in high school after having the opportunity to shadow an audiologist in high school. This experience allowed me to see the impact audiologic care has on an individual's hearing and quality of life. This experience is what led me to obtain a 4-year post-Bachelor clinical doctorate in Audiology from University of Maryland, College Park. University of Maryland's program combined a comprehensive education of hearing and balance healthcare with active experience in the university Hearing and Speech Clinic specializing in cochlear implant services, tinnitus evaluation and management, and hearing aid fitting and follow-up care.

During my time in the doctoral program, I completed a rotation at Fort Meade during which provided clinical training to evaluate active-duty service members hearing, diagnosed hearing loss and tinnitus, and implement treatment and management of the hearing loss and tinnitus. The treatment and management were completed through hearing aid fitting and a group education class that educates service members and provides strategies to reduce tinnitus audibility and impact on their quality of life.

I currently work in a private practice setting providing services to patients of all ages. I work with pediatric, adult, and the geriatric patient populations on a regular basis. I provide comprehensive audiologic evaluations to children and adults and diagnose hearing loss. I provide cochlear implant candidacy evaluation for adults to determine audiologic candidacy for cochlear implantation. I treat hearing loss by fitting hearing aids and cochlear implants and provide continued follow-up care. Through the hearing aid fitting process, the hearing aids are programmed utilizing real ear measures to ensure the patient is being treated appropriately for their diagnosed hearing loss. I also fit patients with custom

hearing protection and educate patients on how to prevent noise induced hearing loss. I frequently perform cerumen management utilizing a variety of methods.

Due to my didactic and clinical training, I evaluate auditory sensitivity in patients of all ages, which is included in our statute. I diagnose patients with hearing loss as included in COMAR 10.41.03.03 B.(4)(a). and I then counsel patients on their results in order to create the optimal treatment plan for the patient. I provide treatment for my patients by prescribing and fitting hearing aids and fitting cochlear implants as authorized by State licensure. Furthermore, insurance, such as Medicaid plans, require that the hearing aids are recommended by and fitted by a licensed audiologist. As a healthcare provider, I strive to provide comprehensive care to my patients in order to streamline their service and to reduce barriers to receiving care due to transportation, cost, and time constraints.

This legislation is needed in order to more accurately reflect the services audiologists are capable of providing to their patients given their comprehensive doctoral level clinical education and experience in patient care. The statute has not been updated since 2005, and it is time that the statute reflect the rigorous training required to become an audiologist, and branches from the definition of audiology itself which is “the science of the branch of science and medicine concerned with the sense of hearing” [Oxford language dictionary]. The statute allows the language to be broad enough to incorporate the services that audiologists are currently providing now, and allows the Board to create Regulations to provide specific rules.

This statute will help modernize audiology in a needed way as it codifies services that audiologists are equipped to perform and will improve patient outcomes by increasing access to care. For example, the statute allows audiologists to complete health screenings in order to determine if a referral to another healthcare provider is needed. This is a pass/fail screening which does not require a diagnosis. In order to provide holistic, person-centered care, an interprofessional collaborative team is in the best interest of the patient. Health screenings would allow the audiologist to ensure that the patient has all the members of the team included in their care.

Secondly, cerumen removal would be codified which is already included in Regulations. Audiologists are trained to perform cerumen removal utilizing various methods, and is often needed in order to continue with audiologic testing or hearing aid programming. If a patient needs to be seen by another provider for cerumen removal, they are often adding significant time to their diagnosis and treatment, as well as costs the patient more in copayments, time off of work, etc.

The statute language also works to modernize the removal of foreign bodies from the external auditory canal, ordering cultures and bloodwork, ordering and performing non-radiographic imaging and scanning, and ordering radiographic imaging. Patients frequently present with foreign bodies in their external auditory canals. Hearing aid domes and wax guards are typical objects in patients’ ears. An audiologist can easily remove these objects from the patient’s ear, but when a patient needs to be referred to their primary care provider, an ENT, or the ER/urgent care there is an issue of affordability and unnecessary emergency room visits. The need to go to another specialist or emergency/urgent care facility is not only costly to the patient in terms of copayments, but in time that they have to take off of

work and travel to the additional appointments. The patient will often have to wait days, if not weeks to get an appointment for the foreign object to be removed which would have taken minutes, if not seconds to be removed during their audiology appointment.

As technology improves, new methods become available for evaluating patients, and should be reflected in our language. For example, dentists are now able to take scans to show how your teeth can be straightened with Invisalign, and optometrists can perform retina scans. As audiologists, we have video otoscopes that can show the patient in the inside of their ear canal, and can provide a larger visual for the audiologist.

Audiologists ordering radiographic imaging for patients would streamline the differential diagnosis for patients who an audiologist determines is in need of imaging to rule out retro cochlear pathology. With the current method of referring back to primary care or to ENT, the patient is often waiting a significant length of time to be seen by another provider to order the imaging. I work closely with primary care providers to alert them to the concern found during audiologic testing in order to start the process for the patient to receive imaging ordered by their primary care provider. Patients are also less likely to have access to imaging if they have to go see another provider, as it is a larger cost in terms of making a copayment, and they would need to arrange time of off work or childcare to attend additional appointments. If the audiologist is able to order the imaging, the patient has a much quicker timeline for completing the testing with a reduced cost. The audiologist would then be able to review the results from the radiologist with the patient and refer to additional specialists as needed. I currently do cochlear implant candidacy testing, and imaging is required for their medical candidacy. It would save the patient and the otologist performing the medical evaluation and surgery time if the patient was given their order for required imaging at their candidacy appointment.

This statute aims to modernize the language for the practice of audiology to reflect the practices of other clinical doctoring professions (optometry, dentistry, etc) and to keep up with the modernization of healthcare. This statute does not allow audiologists to practice medicine, as practice of medicine means diagnose, healing, treatment, and surgery, and we are not healing and are not performing surgery. We would not be involved in the surgery of osseo integrated devices or cochlear implants. It does not allow us to prepare for, perform, or interpret the radiologic imaging.

Overall, this statute will allow Maryland to be more consistent with other state's definitions of audiology, while modernizing the language to reflect today's healthcare. This statute also would make audiology more consistent with Maryland's practice definitions of other non-physician, clinical doctors such as dentists and optometrists.

Thank you for your support of HB 464 legislation.

Sincerely,

Logan Fraser, Doctor of Audiology
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February 27, 2024

Chair Pamela Beidle
Finance Committee
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RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

I am a practicing audiologist and healthcare marketing/economic consultant based in Dallas, Texas. I have been practicing as an audiologist for nearly 30 years, having professional experiences in academia (former tenured professor at the University of Arkansas for Medical Sciences) and industry. My professional experiences have transcended hearing healthcare services to the medical (e.g., ENT-related, cochlear implants, ototoxic monitoring) and non-medical (e.g., amplification technology distribution, auditory communication rehabilitation) channels within the licensed scope of practice assigned to audiology with respect to evaluation, diagnostic assessment, management, and treatment (including the ability to prescribe hearing aids).

I am writing to lend my unwavering support for the passing of Maryland legislation SB 795 Health Occupations – Practice Audiology. SB 795 modernizes the profession's doctoral-level scope of practice definition to reflect the provider's didactic and clinical training, especially when providing services to patients whose hearing difficulties are being treated using osseo-integrated devices or with cochlear implants.

From an outsider's perspective, the proposed Maryland legislation (SB 795) ensures the Statute language is broad enough to encompass services provided now and allows the Board to create Regulations to provide specific rules. Furthermore, I was pleased to see that the language of SB 795 codified:

- Health screenings – defined as pass or fail that help determine whether co-management (triage) is necessary via a referral to a healthcare specialist for additional testing (e.g., vision screening, hypertension, etc.)
- Open access to screening venues, including retail pharmacies, big box retailers, etc.
- Hearing screenings (non-diagnostic) as part of the larger health screening.

In addition, I noted that SB 795 modernized language with respect to:

- Removal of foreign bodies from the outer ear canal that, in hearing care, becomes prohibitive to the overall function of listening in the open ear (i.e., wax blockage) and when wearing a hearing aid as a treatment intervention (e.g., clogged amplifier, moisture from ear wax affecting hearing aid microphone sensitivity).
- The accessibility to service patients in the audiologist's office to remove unwanted earwax and other debris. In the current CMS model—where audiologists are classified solely as suppliers—the ability to provide this routine service requires a referral to the patient's general physician or ENT, resulting in a non-cost-effective healthcare model and increasing opportunity costs to the patient.
- Ordering and performing non-radiographic imaging and scanning. Audiologists perform these tasks within their present scope of practice when they provide video otoscopy and 3D scanning that lends to the creation of a hearing aid's form factor. These hearing care practices are consistent with other non-physician, clinical doctors such as optometrists performing retina imaging and dentists performing imaging related to teeth straightening.

The ability for audiologists to order imaging is within their professional training when one considers that ordering radiographic imaging:

- Does not include the performance or interpretation of the procedure, only the order.
- The language in SB 795 does NOT permit audiologists to practice medicine (i.e., diagnosis, healing, treatment, or surgery).

In closing, Maryland legislation SB 795 is a win for the patient, a win for improving accessibility and reducing costs within the healthcare system, as services are provided by a doctoral-level profession—i.e., audiology—having the adequate training to provide these services within the intended scope of practice framework for the profession.

Thank you for your support of SB 795 legislation. Please feel welcome to contact should you have additional comments.

Sincerely,

Amyn M. Amlani, PhD
Texas License #51557

Melissa J. Segev, Au.D.
Briana Bruno Holtan, Au.D.
Mikayla Abrams, Au.D.
Kelly Anne Boylan, Au.D.
Lindsay Dennison, Au.D.
Leslie Gilbert, Au.D.
Logan Fraser, Au.D.

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Jennifer Kincaid, Ph.D.
Jessica Kreidler, Au.D.
Angela Lowe, Au.D.
Niki Razeghi, Au.D.
Candace Robinson, Au.D.
Corinne Waterman, Au.D.

February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

I am a licensed practicing audiologist for over 26 years and have seen the science of audiology change over the years. I am a small business co-owner of one of the largest and oldest private practices in the State of Maryland. I currently have 12 office locations, 10 in Maryland including the Eastern Shore, and have 11 Doctors of Audiology (Au.D.) primary health-care professionals who effectively evaluate, diagnose, manage, and treat auditory and balance disorders to patients of all ages at these locations. I would like to express my support for SB0795 as it will modernize the Audiology statute to reflect the audiologist’s rigorous didactic and clinical training and provide the most affordable, efficient healthcare.

The legislation is long overdue as the current Practice definition has not been updated for at least the past 20 years and does not reflect the extensive education and training of licensed audiologists. Our 12 Au.D. providers, including myself, have obtained at least a 3- or 4- year post-Bachelor clinical doctorate in Audiology from accredited universities including University of Maryland, Towson University, Gallaudet University, University of Buffalo, James Madison University, Kent State University, and Central Michigan University. Some have obtained specific didactic training to ensure quality patient care in specialized tinnitus diagnosis and treatment, cerumen management (wax removal), pediatric diagnosis and management and cochlear implant/Osseo-integrated management. All 12 Au.D. audiologists, including myself, are participating with most health insurances, including Medicare and Medicaid, that have already classified audiologist as a ‘Diagnostic Supplier’ and require us to do certain evaluations to make a diagnosis and provide management and/or treatment. The legislation is consistent with other similar non-physician Health occupations statutes and other state’s definitions of audiology. Maryland needs to keep pace!

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SB0795 is critical to improve access and affordability. We are currently seeing significant time delays in patient care and management across Maryland but particularly near our rural and underserved offices. Our patients need to wait months to see a physician or primary care provider to simply get an order to get radiographic imaging and/or a blood culture. The current process wastes time and money. The audiologist could simply provide the order, review the results with the patient, and manage the patient accordingly that may result in a referral to a primary care provider or specialist. The legislation only includes the order and does not include the performance or interpretation of the procedure. It does not allow audiologists to practice medicine or perform implant surgery.

The U.S. is facing a large healthcare professional shortage that is projected to get worse. Demands are already exceeding supply. Audiologists are capable of providing medical services to your constituents to the fullest capabilities of our education and licensure by the state. The time to pass the legislation is now!

Thank you for your support of SB0795 legislation.

Sincerely,

Briana Bruno Holtan, Au.D.
Maryland License #00909

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February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE: **SB 795**Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

As an audiologist in Maryland of almost 30 years, I have served many consumers for hearing and balance needs including treating hearing loss, tinnitus, dizziness, and removing cerumen. The ability to provide audiological care has been and continues to be extremely rewarding and led me to also serve on the Maryland Board of Examiners and as the Executive Director of the Board of Audiology, Speech-Language Pathology, Hearing Aid Dispensers & Music Therapists. As an audiologist, I believe is critical to ensure that the utmost ethical standards are held by practitioners serving our consumers, including myself.

In addition to the rigorous requirements to become a doctor of audiology, including a bachelor's degree, a doctorate degree, and over 1,000 clinical hours in order to earn the degree of Doctor of Audiology (Au.D.), audiologists are required to obtain 30 hours of continuing education every two years, to ensure that they are up to date on best practices. Our training and scope of practice allows us to evaluate, diagnose, treat, and manage hearing and balance disorders.

In a significant amount of cases, we work with other medical professionals in order to provide the most comprehensive medical care. In cases where a differential medical diagnosis is required, we refer patients to their primary care physicians, otolaryngologists, dentists, neurologists, etc., to order testing such as imaging studies to rule out pathologies of the inner ear, to obtain blood work to rule out, for example, thyroid disorder, to rule out issues with the jaw, or issues with the spine, which could be causing symptoms of dizziness, tinnitus, otalgia, etc. Far too often, the wait time for patients to get in to see their primary care physicians, otolaryngologists, etc., to obtain such orders, keeps them from receiving a timely diagnosis and treatment.

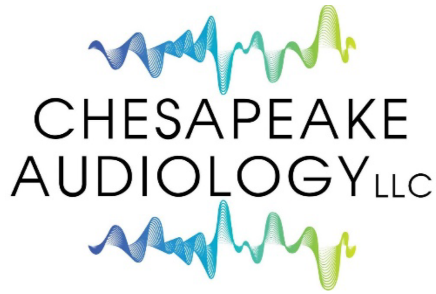
An audiologist can decrease the wait time endured by the consumers of Maryland to get a differential diagnosis, allowing them to be treated and managed sooner by ordering the tests needed to do so. The tests ordered by an audiologist, would be reviewed by a radiologist (if imaging is ordered), by a physician (if blood work is ordered) etc.; however, the barrier to timely management and treatment would be reduced. By virtue of our didactic and clinical training, audiologists who currently remove cerumen could also remove foreign objects from the ear, saving a visit to an ER, or a wait to an otolaryngologist to do so. As defined in our Maryland Statute, audiologists evaluate and treat patients with hearing and balance disorders, and as written in our COMAR regulations; we diagnose disorders of hearing and balance. Additionally, an audiologist is determined by Medicare as the diagnostic provider of hearing and balance assessment.

SB 795 would help to remove the barriers to care endured by consumers by allowing audiologists to order imaging, blood work, etc., to rule out pathology suspected based upon a diagnostic evaluation already completed by an audiologist. This legislation is also needed to ensure that our Statutes reflect all services that an audiologist provides, and allows the Board to create regulations for additional training requirements to allow audiologists to order imaging, blood work, and removal of foreign bodies from the ear. This legislation would also update the practice definition of audiology to reflect the rigorous didactic and clinical training required to earn and practice as an Au.D., Doctor of Audiology.

Thank you for your support of SB 795 legislation.

Sincerely,

Candace G. Robinson, Au.D., CCC-A, FAAA, CH-TM
Maryland License#00744



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February 27, 2024

Chair Pamela Beidle
Finance Committee
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Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

I have been an audiologist since graduating with a Masters in Audiology from The University of Tennessee in 2001. I then continued my education with a Doctor in Audiology degree from The University of Florida in 2008. Every day I feel fortunate to be able to work in a field I love, one where I am daily able to help people lead happier and healthier lives.

For 15 years I have owned a private practice in Leonardtown, Md. I am able to serve a variety of patients, aged from 0 to over 100. My training prepared me to evaluate, diagnose, manage, and treat these patients. We work with the Lions Club to provide hearing health care to underserved populations. We work with Veterans for disability exams. We provide the highest level of audiological care to our community.

SB 795 modernizes the practice definition of audiology to reflect the audiologist's education and clinical training. It is vital that the Statute language encompasses the services we are able to provide now. The legislation also ensures that cerumen removal, which is already in the regulations, is also in the Statue. The legislation would ensure audiologists are able to provide health screenings to better know where to triage a patient.

The legislation modernizes language to allow audiologists to remove foreign bodies from the ear canal. St. Mary's County does not have an Ear, Nose, and Throat (ENT) physician. Patients would need to travel at least 45 minutes to have a foreign body removed when my training has well prepared me to perform this. They may instead decide to go to the ER, at a much higher cost, where they will wait for hours.

The legislation allows for ordering of cultures and bloodwork. Now we must call the patient's ENT or primary care physician to have this bloodwork ordered and to receive the results. This takes more time in an already overwhelmed health care system. Often patients have comorbidities and bloodwork results are vital to the patient's treatment. The same is true for radiographic imaging. The patient must wait until we can speak to somebody who can order these, and then wait for results before proceeding with treatment. This legislation cuts down on unnecessary phone calls, faxes, and office visits for patients who must go back and forth between doctor offices for testing and results.

The legislation does not allow audiologists to practice medicine. It does not allow for cochlear implant surgery or surgery for osseointegrated devices. It does not allow for preparation, operation, or performance of radiographic imaging.

The legislation modernizes audiology in Maryland, it brings language up to par with other non-physician clinical doctors in Maryland. It also creates language that is consistent with the definition of audiology in other states. Audiologists are well trained with continual education to be able to provide these services.

Please feel free to reach out to me with any questions about audiology or this legislation.

Thank you for your support of SB 795 legislation.

Sincerely,

Leigh McCarthy, AuD
Maryland License #01069

Leslie Gilbert
Audiology Associates
79 Forest Plaza
Annapolis, MD 21401

February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

RE : SB 795 Health Occupations - Practice Audiology - Definition
Position: SUPPORT

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

I have worked as an audiologist in the state of Maryland for almost 6 years. Currently, I work in a private practice setting with hard of hearing adults and children. It is important for me to provide best care to my patients. This includes ensuring access and affordability of necessary procedures and exams. Frequently, I find that patients are unable to receive important medical assessments within a timely and cost effective manner. For example, patients who present with risk factors for an acoustic neuroma. Nearly all of these patients are unable to receive imaging within a timely manner as they must call to make a special appointment with an ENT physician who can order the assessment. In addition to waiting weeks for this appointment, they also pay an extra visit fee to see the specialist. The training involved in the audiology doctorate program ensures that audiologists are well versed in recommending imaging studies and referring appropriately when findings are abnormal. SB 795 would allow the audiologist to order the MRI and make the appropriate referral when needed, lowering the cost of healthcare and allowing patients increased accessibility to important evaluations and treatment.

The language in SB 795 does NOT allow audiologists to practice medicine. It allows the audiologist to better assist in the medical management of hearing and balance disorders, much like other non-physician, clinical doctors in Maryland (e.g. optometrists, chiropractors).

Please support the needs of our patients in your consideration of SB 795 legislation.

Sincerely,
Leslie Gilbert
Doctor of Audiology
Maryland License #01456

February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

I am a licensed Audiologist at The IMA Group, a practice that contracts with third party companies to help serve patients of the Veterans Administration, located in Baltimore, Maryland. My daily patient population includes active duty service members and veterans who I see for their hearing healthcare concerns and needs. I work with all branches of the military, including the Army, Marines, Navy, Air Force, Coast Guard, and the Public Health Service. I am writing in support of HB 464 which would modernize the definition of audiology.

Audiologists play a vital role in providing comprehensive hearing and balance healthcare services to their patients. Licensed audiologists in Maryland are required to earn a clinical doctorate degree (Au.D.) and have significant didactic and clinical training in the specialty of audiology and vestibular healthcare. Their degree and level of education are the same as other non-physician, clinical doctors.

In my current role, I perform comprehensive audiological evaluations in order to diagnose hearing loss and/or tinnitus in active duty service members and veterans. I am also responsible for reviewing military and medical records, as well as evidence-based research to formulate medical opinions regarding whether a patient's hearing condition is "at least as likely as not" due to their military service. Tinnitus is the most common condition in military members. An audiologist's expertise is essential to providing such important opinions, and I do not work alongside another medical or healthcare professionals to do my job. As an audiologist, I am the sole provider in the practice because audiologists are the most knowledgeable individuals in the evaluation and diagnosis of hearing loss and tinnitus. The Veterans Administration trusts my opinions and relies on me to provide significant information regarding my patients. I am essentially the first point of contact in a veteran's/service member's claim for hearing loss and/or tinnitus. Once a claim for either of those conditions is submitted, audiologists in the same position as myself, are the first healthcare providers to see those individuals. After an evaluation and confirmation of diagnosis, those veterans and service members' reports are formally submitted to the

Veterans Administration, where a decision is made regarding and treatment and/or compensation for their hearing condition(s).

In my current role, I do not provide management and treatment for hearing loss, tinnitus, and vestibular disorders. However, prior to taking on my current role, I used to work in private practice, where I was responsible for evaluating, diagnosing, managing, and treating hearing and vestibular disorders. I had professional relationships with various medical and healthcare professionals, including primary care physicians, otolaryngologists, and physical therapists. I used to refer my patients to those providers, as appropriate, and those professionals would also refer patients to me, as needed. Audiologists receive significant training to make them the experts on when to refer patients for additional testing, such as ordering imaging studies to help rule out certain retrocochlear pathologies or to confirm another pathology. Audiologists perform an array of testing and are well versed on when a referral is warranted for any particular hearing or vestibular condition. Despite having this knowledge, audiologists are still required to refer patients to Ear, Nose, and Throat Physicians to order any further testing to confirm any particular condition. This is often a very tedious and lengthy process for patients. This is simply an unnecessary step, as often the ordering physician will do exactly what the audiologist says, such as "order imaging studies." Clearly the ENT or PCP trusts the audiologist to know what to do, so it just does not make sense why we would need to refer to that other provider anyways. Making such decisions directly as audiologists and getting rid of the middle man will ensure that our patients are getting answers faster and it will entail lesser doctors' appointments. The definition of "practice audiology" needs to be modernized in order to best serve our patient population. Audiologists should have total autonomy in determining any steps necessary for the treatment of hearing and balance disorders, as we are the experts in our field.

This bill will not allow audiologists to practice medicine or perform surgeries, which are not within our scope of practice. Rather, this valuable piece of legislation would modernize audiologic healthcare in Maryland. The language in this bill for "practice audiology" is consistent with that of other non-physician clinical doctors.

Thank you for your support of HB 464 legislation.

Please note that the views expressed in this letter are my own as a licensed audiologist in the state of Maryland. I am writing this letter as an individual audiologist licensed in the state of Maryland, not as Board Chair for the Board of Examiners for Audiologists, Hearing Aid Dispensers, Speech-Language Pathologists, and Music Therapists.

Thank you for your support of SB 795 legislation.

Sincerely,

Arifa M. Qureshi, Au.D.

Doctor of Audiology

Maryland License #01319

UNC SCHOOL OF MEDICINE

THE UNIVERSITY *of* NORTH CAROLINA *at* CHAPEL HILL

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STEPHANIE SJOBLAD, AU.D.
Professor
Coordinator of Clinical Services

February 22, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

As a professor and educator of future doctors of audiology who go on to practice audiology across the United States upon graduation, including in Maryland, I am writing to pledge support for SB795.

The North Carolina Audiology Association just recently lobbied for successful changes in our licensing laws to keep up with the Federal changes that were made to the classification of hearing aids and the approved delivery models. We are familiar with the concerns that are often brought forward by other parties, particularly the medical society. Our audiology association, of which I'm a member, continues to successfully partner with the legislature to inform and lobby for instrumental changes in the laws and rules regarding the field of audiology, in efforts to ensure we can serve our patients in the best way possible. We work hard to keep up with the changing landscape in order to continue to provide access and affordability to our patients and community.

In North Carolina we define the practice of audiology as:
The application of principles, methods, and procedures of measurement, testing, evaluation, prediction, consultation, counseling, instruction, habilitation, or rehabilitation related to hearing and vestibular disorders of hearing for the purpose of identifying, preventing, ameliorating, or modifying such disorders and conditions in individuals or groups of individuals.

For the purpose of this subdivision, the words "habilitation" and" rehabilitation" shall include auditory training, speech reading, aural rehabilitation, hearing aid use evaluation and recommendations, and fabrication of earmolds and similar accessories for clinical testing purposes. related to disorders of the auditory and vestibular systems. Areas of audiology practice include, but shall not be limited to, the following, delivered to people across the life span:

a. Performing basic health screenings consistent with audiology training. Screenings that indicate the possibility of medical or other conditions that are outside the scope of practice of an audiologist must be referred to appropriate healthcare providers for further evaluation or management.

b. Eliciting patient histories, including the review of present and past illnesses, and current symptoms, reviewing tests, obtaining or reviewing patient history obtained separately, reviewing procedures, and documentation of clinical information in the electronic health record or other records.

c. Preventing hearing loss by designing, implementing, and coordinating industrial, school, and community-based hearing conservation programs by educational outreach, including screening, to the public, schools, and other health care professionals and governmental entities, and by counseling and treating those at risk with behavioral or nutritional modification strategies related to noise-induced hearing loss prevention or with active or passive hearing protection devices.

d. Identifying dysfunction of hearing, balance, and other auditory-related systems by developing and overseeing hearing and balance-related screening programs for persons of all ages, including newborn and school screening programs.

e. Conducting audiological examination and audiologic diagnosis and treatment of hearing and vestibular disorders revealed through the administration of behavioral, psychoacoustic, electrophysiologic tests of the peripheral and central auditory and vestibular systems using standardized test procedures, including, but not limited to, audiometry, tympanometry, acoustic reflect, or other immittance measures, otoacoustic emissions, auditory evoked potentials, video and electronystagmography, and other tests of human equilibrium and tests of central auditory function using calibrated instrumentation leading to the diagnosis of auditory and vestibular dysfunction abnormality.

f. Assessing the candidacy of persons with hearing loss for cochlear implants, auditory brainstem implants, middle ear implantable hearing aids, fully implantable hearing aids, bone-anchored hearing aids, and gene or stem cell therapy; and post-medical intervention, follow-up assessment, and treatment.

g. Offering audiologic decision making and treatment for persons with impairment of auditory function utilizing amplification or other assistive devices, or auditory training.

h. Selecting, fitting, evaluating, and dispensing hearing aids and other amplification or hearing-assistive or hearing-protective systems, and audiologic rehabilitation to optimize use.

i. Fitting and mapping of cochlear implants and audiologic rehabilitation to optimize device use.

j. Fitting of middle ear implantable hearing aids, fully implantable hearing aids and bone-anchored hearing aids, and audiologic rehabilitation to optimize device use.

k. Conducting otoscopic examinations, removing cerumen, and taking ear canal impressions.

l. Providing audiologic examination, audiological decision making, and treatment of persons with tinnitus, including determining candidacy, treatment selection and provision, and providing ongoing management, using techniques, including, but not limited to, biofeedback, masking, sound enrichment, hearing aids and other devices, education, counseling, or other relevant tinnitus therapies.

m. Counseling on the psychosocial aspects of hearing loss and the use of amplification systems.

n. Providing aural habilitation and rehabilitation across the life span, beyond the provision and counseling related to appropriate devices, such as amplification, cochlear implants, bone-anchored hearing aids, other assistive listening devices, which may include auditory, auditory-visual, visual training, communication strategies training, and counseling related to psychosocial consequences of hearing loss.

o. Administering of electrophysiologic examination of neural function, including, but not limited to, sensory and motor-evoked potentials, preoperative and postoperative evaluation of neural function, neurophysiologic intraoperative monitoring of the central nervous system, and spinal cord and cranial nerve function. An audiologist shall not perform neurophysiologic intraoperative monitoring except upon delegation from and under the overall direction of a physician, and the audiologist shall be qualified to perform such procedures.

p. Referring persons with auditory and vestibular dysfunction abnormalities to an appropriate physician health care provider for medical evaluation when indicated based upon the interpretation of the audiologic and vestibular test results.

q. Participating as full member of a team to prescribe and carry out goals of treatment of balance disorders, including habituation and retraining exercises and adaptation techniques, and providing assessment and treatment of Benign Paroxysmal Positional Vertigo (BPPV) using current diagnostic methods and canalith positioning maneuvers or other appropriate techniques for treatment.

r. Communication with the patient, family, or caregivers, whether through face-to-face or non-face-to-face electronic means.

s. Providing audiologic treatment services for infants and children with hearing impairment and their families in accordance with G.S. 90-294A.

As I understand from my colleagues in Maryland, your statute has not been updated since at least 2005 and the current Practice definition does not reflect the current rigorous didactic and clinical education of licensed audiologists. SB 795 modernizes the practice definition of audiology to do just that. The legislation ensures the Statute language is broad enough to encompass services provided now and allows the Board to create Regulations to provide specific rules.

Additionally, the language codifies:

- Health screenings which are pass/fail to help determine if management is necessary to another provider who specializes in that area (e.g., vision screening, hypertension, etc.).
- Cerumen removal; already in Regulations.

The language being proposed also modernizes:

- Removal of foreign bodies from the ear canal. It is not uncommon for hearing aid wearers to have a dome or wax guard (small part) become loose or lodge in the canal. Children are also seen with objects (toys, rocks, food) stuck in their ear canal. Currently, patients may only receive a referral to their primary care physician, ENT, and/or emergency room for this which are typically more costly and time consuming options.
- Ordering of cultures and blood work. Many patients present with comorbid conditions and exam results indicate further evaluation to identify or rule out a syndrome, disease, or disorder are needed. Currently, patients may only have access to this through their primary care physician or a specialist adding more cost and time.
- Ordering and performing non-radiographic imaging and scanning. With great advancements in technology we now have equipment available that allows for images and video of the ear canal as well as 3D scanning of the ear for custom built parts. This is consistent with other non-physician, clinical

doctors of optometry that provide retina imaging or dentists that provide teeth straightening scans.

- Ordering radiographic imaging only. This does not include the performance or interpretation of the procedure. By having ordering privileges it allows the patient to proceed with their evaluation without having to wait to see another ordering physician. Dentists already have the ability to order and perform x-rays.

The changes being recommended do NOT allow audiologists to practice medicine. Practicing medicine includes diagnosis, healing, treatment, or surgery. This language specifically does not allow for healing, surgery, or the preparation/operation/performance of radiographic imaging.

It is very challenging to keep up with the changing landscape of medicine and the needs of the patient community at large while maintaining access and affordability. Audiology as a profession has evolved to become a doctoring profession to keep up with the science and discovery surrounding our hearing and balance as well as its relationship to our mind and the rest of the body. By allowing for these changes, you will be providing Maryland residents with better access to extremely skilled, qualified, and caring audiologists to their medical teams.

Thank you for your support of SB 795 legislation.
Sincerely,

Stephanie J. Sjoblad, Au.D.,
Professor
Clinic Director

February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

I have been a licensed audiologist in the state of Maryland for 18 years. I chose the field of audiology while studying Communication Sciences and Disorders (CSD) at James Madison University (JMU) in Virginia. Originally, I entered the CSD major program with the intention of becoming a speech-language pathologist. **As I began taking audiology-related coursework, I found myself drawn to the medical aspects of audiology and the opportunity to make an immediate difference in my patients' lives.** Audiology allows me to work with people of various ages and backgrounds, perform evaluations to determine and explain the cause of a patient's complaints, and provide a solution for various hearing and balance conditions.

Upon completion of my Bachelor of Science degree, I continued in a 4-year clinical doctoral program in audiology at JMU. In this program, I completed extensive coursework in the anatomy and physiology of the ear, psychoacoustics, digital signal processing, hearing evaluations, auditory processing evaluations, balance evaluations, electrophysiology evaluations, aural rehabilitation, hearing aid technology and fitting strategies, counseling, and business management. I completed the following clinical rotations:

- Hearing and auditory processing evaluations on adult and pediatric patients in the JMU CSD Audiology Clinic
- Hearing evaluations, hearing aid fittings, auditory processing evaluations, and aural rehabilitation on special needs adult populations, including traumatic brain injury patients, at the Woodrow Wilson Rehabilitation Clinic in Stanton, VA
- Hearing evaluations and hearing aid fittings, care, and maintenance on pediatric patients at the Virginia School for the Deaf in Stanton, VA
- Hearing and balance evaluations and cochlear implant fitting, care, and maintenance on adult and pediatric patients at the University of Virginia Otolaryngology & Audiology Clinic
- Hearing, balance, and electrophysiology evaluations of adult and pediatric patients Harrisonburg ENT Associates as a paid clinical assistant.
- Hearing evaluations, hearing aid fittings, care, and maintenance, newborn hearing screening management, balance assessments, and aural rehabilitation on adult patients, including wounded

service men and women, at the National Naval Medical Center in Bethesda, MD as a one-year clinical resident

I completed my doctoral dissertation by performing research on an emerging hearing aid technology at the time (frequency compression), which required management of volunteer subjects, hearing evaluations, and extensive speech comprehensive evaluations.

Simply put, through 4 years of coursework, research, and clinical placements, I was trained to independently evaluate, diagnose, manage, and treat hearing and balance disorders.

Upon completion of my clinical doctorate degree in audiology, I began practicing as a licensed Maryland audiologist in the private practice sector. I spent 11 years with Hearing HealthCare, Inc. in Rockville and have been the primary provider in the Ellicott City office of Audiology Associates, Inc for the past 7 years. I work with patients of all ages. I have professional relationships with several primary care and otolaryngology physicians in my area who refer numerous patients to me for their hearing healthcare. I also maintain a network of various medical professionals to refer my patients to for other specialized needs.

By virtue of my daily practice and clinical training, I perform the following daily activities as authorized by the Maryland state licensure statute and COMAR regulations to provide quality care, access, and affordability to my patients and community:

- Perform various assessments (hearing, cochlear implant candidacy, tinnitus) on adult and pediatric populations to **evaluate** hearing as already included in the Maryland statute
- Explain test results to adult and pediatric patients and give my professional opinion on etiology (i.e. **diagnose** as included in requirements for licensure COMAR 10.41.03.03 B.(4)(a))
- Make appropriate referrals to specialists, such as cochlear implant surgeons, otolaryngologists for potential surgical treatments, mental health professionals for tinnitus-related mental health therapy options, dermatologists for concerning skin lesions in/around the ear, speech-language pathologists for development concerns (i.e. **manage**)
- Monitor patients' hearing loss, tinnitus, balance and other hearing-related concerns through repeat evaluations and preventative care (hearing protection) as needed (i.e. **manage**)
- Maintain hearing aid performance through regular device cleaning and assessment (i.e. **manage**)
- Prescribe, order, sell, dispense, and Fit hearing aids, which is already included in the Maryland statute (i.e. **treat**)
- Provide cochlear implant recommendations, initial activation, mapping, and maintenance (i.e. **treat**)
- Provide tinnitus counseling and device fitting as needed (i.e. **treat**)

As of 2008, a doctorate degree in audiology became required for all new professionals entering the field. However, the Maryland statute defining the practice of audiology has not been updated since that time, thus it does not reflect the expanded clinical training and knowledge of doctoral level audiologists. **This bill would modernize the definition of "practice audiology" in order to align the definition with the rigorous didactic and clinical education of licensed doctors of audiology.**

According to the Oxford dictionary, audiology is the branch of science and medicine concerned with the sense of hearing. According to the Miriam-Webster dictionary, audiology is a branch of science dealing with hearing, *specifically* therapy of individuals having impaired hearing. **My extensive clinical training and 18 years of clinical practice substantiate that the definition of practice audiology in the Maryland statute include the words evaluate, diagnose, manage, and treat in regards to hearing and balance.**

In addition to modernizing the language, the proposed legislation ensures the statute language is broad enough to encompass services that audiologists are capable of providing now and allows the Board of Examiners to create regulations to provide specific rules.

The language codifies health screenings, which are pass/fail, to help determine if a referral to another provider who specializes in that area is warranted (i.e., vision screening, hypertension, cognitive etc.). Individuals already obtain screenings in many places, including drug stores and at home. There is no reason to limit a trained healthcare provider from screening a patient.

The proposed legislation will help patients receive immediate care and reduce unnecessary visits to primary care physicians and other specialties. For instance, my licensure already allows for removal of cerumen from the ear canal. With current hearing aid designs, the temporary dome on the end of a hearing aid sometimes comes off in the ear canal. Removal is a simple process of using tweezers and a headlamp to remove the dome. Yet with the current statute, a situation that could have easily been handled in my office requires a referral to primary care, urgent care, or otolaryngology, thus creating an inconvenience for the patient and unnecessary billing to the patient and/or insurance company.

For patients with declining hearing, I may have concerns about cholesterol levels or blood sugar levels, both of which can be related to damage in the hearing system. If I were able to order bloodwork to assess these levels, I would remove a barrier and time delay in obtaining valuable information. My patients routinely see me every 6 months to maintain their hearing aids, yet many have not seen a primary care physician in years. The information I obtain can also be used to encourage a patient to seek potentially life altering care.

I often refer patients simply for the purpose of ordering radiographic imaging. The most common example is the presence of a significant asymmetry in hearing, which requires ordering an MRI of the internal auditory canal to assess for retrocochlear pathology. Under the current statute, I cannot order this imaging and the patient has to wait for an appointment with an otolaryngologist, which can take several weeks to months just to get the appointment. This creates delays in the process, undue stress for the patient, and additional insurance billing. I recently saw a patient for a follow-up audiologic evaluation after a local, Howard County otolaryngologist (ENT) ordered an MRI for asymmetry. At that time, I reviewed the MRI report, which indicated "right internal auditory canal mass, suggestive of a vestibular schwannoma." The local ENT told the patient that a referral to a neuro-otologist was unnecessary. I disagreed and referred the patient to a neuro-otologist. A subsequent MRI indicated surgery was recommended. If I had been able to order the MRI initially, I would have immediately referred to neuro-otology and saved this patient nearly a year of wasted treatment time.

In summary, audiologists have the training and clinical experience to evaluate, diagnose, manage, and treat hearing and balance patients. We are capable of non-surgical removal of a foreign object from the

ear canal, non-radiographic imaging, such as video otoscopy, and ordering cultures, bloodwork, and radiographic imaging in the interest of more direct, time-efficient, and cost-effective management and treatment. Other non-physician, clinical doctors in Maryland, such as dentists, podiatrists, chiropractors, and optometrists, manage and treat their patients in a similar fashion. Hearing and balance healthcare has modernized and Maryland needs to keep pace.

To be specific, this bill **does not** allow audiologists **to practice medicine.** We are not asking to perform healing practices or perform surgery. Surgery is specifically identified as **NOT** being included in the practice of audiology in this bill. The bill does not allow for the surgical component of cochlear implants or osseo-integrated devices. The bill also does not allow audiologists to perform or interpret radiographic imaging or interpret culture or bloodwork studies.

In conclusion, audiologists are asking for a long-overdue modernization of our practice definition. We want the law to recognize our ability to diagnose, manage, and treat, in addition to evaluate. We want a statute that is broad enough to encompass the duties we are capable of performing and allows for regulations to guide specific scope of practice responsibilities. These changes would make the definition of "practice" audiology consistent with other states, such as Colorado, Alabama, and Illinois and consistent with other non-physician clinical doctors.

Thank you for your support of SB 795 legislation.

Sincerely,

Jennifer Kincaid, Ph.D.
Maryland License #1084

Melissa J. Segev, Au.D.
Briana Bruno Holtan, Au.D.
Mikayla Abrams, Au.D.
Kelly Anne Boylan, Au.D.
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Jessica Kreidler, Au.D.
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Niki Razeghi, Au.D.
Candace G. Robinson, Au.D.
Corinne Waterman, Au.D.

February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

I have been a clinical audiologist for 17 years, receiving my Doctor of Audiology degree (Au.D.) from Central Michigan University. I became a medical professional because I wanted to help people, and I chose audiology because I enjoy the art and science behind treating hearing loss. In my time in this profession, I have worked in Pediatric Audiology with in the school systems. I have also worked with adults with hearing and balance disorders. I have received specialized training cerumen removal, tinnitus management and cochlear implants. And if I have learned anything from all of that, it is that there is no one-size fits all in this field, or when treating hearing loss specifically. I, as do most audiologists, treat a wide range of patients with a wide range of needs under my care, and our degree has grown overtime to reflect that. It is now time for our licensure to match our training and current scope of practice as Doctors of Audiology.

Currently I work as an audiologist in a multi-provider private practice. I am the sole clinician in my office and one of the few providers on the Eastern Shore of Maryland, where access to health care is much more limited. I evaluate, diagnose and manage hearing and balance function for the entire population, infant to geriatric and everyone in between. I provide newborn hearing screenings, pediatric evaluations for children with speech delays, cerumen removal, vestibular assessments, tinnitus treatment, hearing aid fittings and cochlear implant evaluations and mapping. Medicare classifies audiologists as a 'Diagnostic Supplier' within the Centers for Medicare and Medicaid System. I am often the first point of contact, and many times am the most frequent and consistent point of contact many of my patients have for any concerns related to their hearing health care needs. I provide this level of audiologic and vestibular care to provide access and affordability to my patients/community that are often times undeserved.

This legislation is needed, and has been needed for some time. For the entirety of the time I have been practicing, the entry level degree for the profession of audiology has been a clinical doctorate.

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In spite of this high standard, many of the skills I have been trained to do and are well within my scope of practice are not included in the current statute, which has not been updated since at least 2005.

The definition of Audiology is the ***science*** of the branch of science and medicine concerned with the sense of hearing. The current practice definition does not reflect the rigorous didactic and clinical education of licensed audiologists. SB 795 modernizes the practice definition of audiology to reflect the audiologist's didactic and clinical training. It allows for easier and better access to hearing health care by breaking down many barriers and obstacles patients must currently jump through in order to obtain the treatment they need, and that I am qualified to provide.

One example of this is the process involved in determining cochlear implant candidacy. As a provider in a rural area, I partner with a larger hospital in Baltimore to provided cochlear implant evaluations and services. The goal is to minimize the amount of times these patients must travel across the Bay Bridge and into the city, especially when transportation to and from may be a barrier due to age or finances. Upon completion of the evaluation the patient will need a prescription for a CT scan prior to the follow up with the surgeon as part of the pre-surgical procedure. This is something that currently I cannot legally provide, despite the fact that I am the provider determining the candidacy for the cochlear implant. They must obtain this from the surgeon in Baltimore, necessitating an extra trip across the Bay Bridge and back and hours of travel time, all for a brief appointment where the surgeon will review my notes and issue the prescription.

The language also modernizes such things such as removal of foreign bodies from the external auditory ear canal. These can include objects such as hearing aid filters, domes, rocks, etc. that can become stuck in the external auditory canal that audiologists can easily remove in the office and are trained to do so. This widens access and improves affordability as it can be completed right then and there without the need for an outside referral to their PCP, ENT, and/or ER.

Ordering of cultures and blood-work will also save steps in identifying and/or ruling out a syndrome, disease, disorder. If there is a significant asymmetry noted during testing, protocol is for a referral to obtain imaging (MRI) of the internal auditory canal, to rule out retro-cochlear pathology such as an acoustic neuroma. This is something we can ask the primary to order via our report or a phone call but cannot order this ourselves. It's another barrier and does nothing to serve the interests of the patient. Indeed, when I have called physicians in the past regarding this, they have been shocked it is not something we could just order on our own.

This language does not allow audiologists to practice medicine entailing diagnosis, healing, treatment, or surgery (Osseo or Cochlear implant surgery). It does not allow for preparation, operation, or performance of radiographic imaging.

Melissa J. Segev, Au.D.
Briana Bruno Holtan, Au.D.
Mikayla Abrams, Au.D.
Kelly Anne Boylan, Au.D.
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Logan Fraser, Au.D.

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Jennifer Kincaid, Ph.D.
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Candace G. Robinson, Au.D.
Corinne Waterman, Au.D.

In conclusion it is time to modernize the definition and scope of practice to remain in line with training and degrees held by audiologists. Healthcare has long since modernized and Maryland needs to keep pace. It has been almost 20 years since the Au.D. became the entry level degree. This will allow our definition to be consistent with other states' definitions of audiology, include but not limited to Colorado (a purple state), Alabama (red state), and Illinois (a blue state) and consistent with Maryland's practice definitions of non-physician, clinical doctors such as dentists and optometrists. This is what is needed to allow us to practice with in the full scope of our degree and training, to better serve our patients and provide the best access and affordability to hearing health care that we can.

Thank you for your support of SB 795 legislation.

Sincerely,

Corinne Waterman Au.D.

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February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

My name is Abigail Anne Poe, AuD and I am a licensed audiologist in the State of Maryland. I earned my Bachelor of Arts (BA) and Doctorate of Audiology (AuD) degrees from the University of Maryland, College Park. Their AuD program is a four-year, accredited program, which was recently ranked by US News and World Report as a Top 10 program in the country.

I discovered audiology in a round-about way during my sophomore year of undergrad and have not looked back since. Going into undergrad, I thought I wanted to be a civil engineer. I loved math and science, but I loved helping people and giving back to my community even more. I often achieved the latter through regular volunteering and community service activities throughout my life. Once I discovered that engineering was not right for me, I sought to find another degree that was a better fit. I soon inadvertently stumbled upon the field of Hearing and Speech Sciences while volunteering at an on-campus event. Although seemingly insignificant, this volunteering event, and the discovery of the degree in which I would later earn my undergraduate degree, changed the course of my life. It combined my love for STEM and my passion for helping others – the perfect combination.

While in graduate school, I completed didactic and clinical work simultaneously during my first three years. I completed courses covering a wide variety of subjects including, but not limited to, hearing science, amplification (hearing aids), aural rehabilitation, anatomy and physiology, electrophysiology, pediatric audiology, psychoacoustics, medical audiology, industrial noise, cochlear implantation, geriatrics, and vestibular assessment. In addition to working in the on-campus audiology clinic, I also completed multiple semester-long clinical rotations at local audiology private practices and otolaryngology (ENT) offices to gain real-world experience. These rotations afforded me the opportunity to hone my skills in the evaluation, diagnosis, management, and treatment of audiological and vestibular conditions in patients across the lifespan.

I now work as a staff audiologist in an ENT office where I have gained invaluable experience conducting diagnostic audiological and vestibular evaluations (e.g., vestibular evoked myogenic potentials (VEMP) and videonystagmography (VNG)) as well as managing rehabilitative care through the use of hearing aid selection, fitting, and follow-ups. I have learned how to be an efficient, yet effective clinician, while providing person-centered care of the highest quality to patients of all ages. I have also learned what it means to be a true team player in a fast-paced, interprofessional environment composed of otolaryngologists, audiologists, vestibular physical therapists, physician assistants, and numerous support staff. Thus far, I have most enjoyed assisting patients throughout all aspects of their hearing and vestibular healthcare journey by providing tailored recommendations based on each person's unique needs and lifestyle. Working alongside patients and their families in this manner has allowed me to aid them in improving their quality of life.

Audiology is the science of the branch of science and medicine concerned with the sense of hearing. The current State of Maryland statute has not been updated in almost two decades and is no longer accurate. The current Practice definition does not reflect the rigorous didactic and clinical education of licensed Doctors of Audiology. SB 795 modernizes the practice definition of audiology to reflect audiologists' didactic and clinical training. This legislation would ensure that the Maryland Statute language is broad enough to encompass services provided in 2024 and would allow the Board to create regulations to provide specific rules. Additionally, the language codifies health screenings, which are pass/fail to help determine if management (i.e., triage) is necessary to another provider who specializes in that area (e.g., vision screening, hypertension, etc.). The Board allows audiologists to complete health care screening, as they do not require a diagnosis. Individuals obtain health screenings in many places, including Walmart (e.g., blood pressure), retail pharmacies, etc. As such, there is no reason to limit a trained healthcare provider from screening.

SB 795 would allow for the removal of foreign bodies (e.g., hearing aid domes/filters) from the external auditory canal. I have personally seen many of these objects in patients' ears that I could have easily removed, only to have to say that they need to follow up with another provider because I legally cannot remove it. This results in said patients wasting valuable time and money in needing to visit their PCP, ENT, and/or emergency room instead. SB 795 would grant audiologists the opportunity to order cultures and bloodwork to cross-examine patients' co-morbidities, saving a step to identify/rule out a syndrome, disease, disorder. It would also allow audiologists to order much-needed radiographic imaging, although it would not include the performance or interpretation of the procedure, only the initial order. Again, this would save patients' valuable time and money by not needing to wait for a physician to obtain an order for imaging. Audiologists would review the findings with the patient and then assist in management, particularly the referral to a specialist (e.g., ENT, neurology), if necessary. If you think about it, dentists currently do even more by ordering and performing X-rays.

SB 795 would take into account the rigorous didactic and clinical training of audiologists, while keeping pace with modernized healthcare. Other states such as Colorado, Alabama, and Illinois have already adapted. This change would make our Statue consistent with Marland's practice definitions of non-physician, clinical doctors (e.g., dentists, optometrists). It is time that the State of Maryland followed suit, although to be clear, this legislation would *not* allow audiologists to practice medicine, perform Osseo

surgery or cochlear implantation, or prep, operate, or perform radiographic imaging. We are ready for the change and hope that you will support us in these endeavors, so we can better support our patients, society, and families to the best of our ability.

Thank you for your time and your support of SB 795 legislation.

Sincerely,

Abigail Anne K. Poe

Abigail Anne Poe, AuD
Maryland License #01633

February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

I am a licensed audiologist in the state of Maryland. My sister was born with congenital hearing loss, and her success with hearing aids and eventually cochlear implants is what led me to pursue a profession in audiology. I obtained a 4-year post bachelor clinical doctorate in Audiology from the University of Maryland College Park which included a 1 year externship at the University of Maryland Medical Center in downtown Baltimore. There I received special didactic training in tinnitus and hyperacusis management protocols, vestibular evaluations, and cochlear implants.

In my current role as an audiologist, I serve patients across the lifespan in a private practice setting. This involves comprehensive hearing and tinnitus evaluations, aural rehabilitation (including hearing aids and osseointegrated devices), and tinnitus management. By virtual of my didactic and clinical training, I evaluate, diagnose [already in COMAR 10.41.03.03 B.(4)(a).], and treat, [Prescribe, Order, Dispense, or Fit hearing aids is already in Statute] disorders of the auditory system as authorized by State licensure-Maryland Statute and Regulations. Many insurance carriers that we work with require that I, the audiologist, must be the one to provide certain evaluations, make diagnoses, and provide management and/or treatment. For example-Medicare classifies audiologists as a 'Diagnostic Supplier' within the Centers for Medicare and Medicaid System. Also, Medicaid requires that hearing aids be fitted by an audiologist. We provide this level of audiologic and vestibular care to provide access and affordability to our community.

This legislation is needed for many reasons. Audiology is the science of the branch of science and medicine concerned with the sense of hearing, as defined by the Oxford language dictionary. The statute has not been updated since (at least) 2005, and the current practice definition does not reflect the current rigorous didactic and clinical education of licensed audiologists. SB 795 modernizes the practice definition of audiology to reflect the audiologist's didactic and clinical training, which also

includes programming and fitting of surgical devices such as osseointegrated devices and cochlear implants.

This legislation ensures the Statute language is broad enough to encompass services provided now and allows the Board to create Regulations to provide specific rules. The language in this legislation also codifies health screenings which are pass/fail to help determine if management (triage) is necessary to another provider who specializes in that area (e.g., vision screening, hypertension, etc.). The Board allows audiologists to complete health care screening, as they do not require a diagnosis. Individuals obtain screenings in many places, including Walmart (blood pressure), retail pharmacies, etc. There is no reason to limit a trained healthcare provider from screening, when many others already do this without question.

The legislative language also modernizes cerumen management, including the removal of foreign bodies from the ear canal. I have personally had to remove foreign bodies from the ears of patients whose hearing aid dome or filter fell off into their ear canal. This is not an uncommon occurrence in our patient population. It is important that patients have access to this care at our offices, when they already referred to other professionals (such as primary care physicians or urgent care nurses) who may not frequently perform these services.

The legislation also modernizes language around ordering of cultures and blood work. As audiologists we are often the first to identify a patient's potential ear infection. Currently we cannot order cultures or blood work even when an infection is suspected. The patient then has to wait days or weeks to be seen by another provider, such as primary care or ENT, to get these tests ordered. If this barrier did not exist, the patient could receive care faster and without the need to pay for additional visits when the problem has already been identified. Similarly, the ordering and performing of non-radiographic imaging and scanning will benefit our patient population and improve access to timely and affordable healthcare. This is consistent with other non-physician, clinical doctors such as optometrists who order retina imaging, dentists who order and perform x-rays, and chiropractors who order imaging. Ordering radiographic imaging does not include the performance or interpretation of the procedure, only the order. Imaging is also already required when a patient is pursuing an osseointegrated device or cochlear implant. Our ability to order these scans would save the patient from additional appointments and healthcare costs and streamline their candidacy process to obtain these devices.

Ultimately, modernizing our field's language to reflect our didactic and clinical training will benefit our patients and reduce healthcare costs. Other non-physician, clinical doctors in Maryland (e.g., optometry, dentistry, podiatry, chiropractic) already provide these services. Healthcare has modernized in the last 20 years and Maryland needs to keep pace. This language does NOT allow audiologists to practice medicine – meaning diagnosis, healing, treatment, or surgery. It also does not allow for prep, operation, or performance of radiographic imaging. It's been decades since this language was updated, and our field has evolved significantly since that time. This legislation would create consistency with other state's definitions of audiology, include but not limited to Colorado (a purple state), Alabama (red state), and Illinois (a blue state). It also is consistent with Maryland's practice definitions of non-physician, clinical doctors (e.g., dentist, optometry).

Thank you for your support of SB 795 legislation.

Sincerely,

Mikayla Abrams, Au.D.

Maryland License #01459

February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

I am a licensed audiologist at Audiology Associates Incorporated, a private practice located in Lutherville, Maryland. I have been a licensed audiologist since May 2022. I have wanted to be an audiologist since I was a child. I was diagnosed with an auditory processing disorder by an audiologist when I was seven years old. Because of this thorough diagnosis, I was able to receive the appropriate services in school. Since then I have always been interested in the field of audiology and helping people improve their communication abilities.

I received my doctorate in Audiology from The University at Buffalo in New York. My didactic and clinical training involved diagnostic evaluations of audiological and vestibular disorders, as well as, cerumen removal and management and managing hearing loss and tinnitus with amplification. The University at Buffalo Audiology program took a special interest in the diagnosis and management of tinnitus and the diagnosis of auditory processing disorders. During my externship, I focused on vestibular testing and the management of benign paroxysmal positional vertigo (BPPV).

Currently, I provide diagnostic audiological evaluations on infants through geriatric patients, vestibular evaluations, and tinnitus evaluations and management. I also provide hearing aid assessments, electroacoustic analysis, and hearing aid fittings, all of which are authorized by State licensure-Maryland Statute and Regulations.

The Oxford Language Dictionary defines audiology as the science of the branch of science and medicine concerned with the sense of hearing. The Statute of Audiology in Maryland has not been updated in several years; at least since 2005. The current practice definition does not reflect the rigorous didactic and clinical education of licensed audiologists. In 2007, a doctorate of audiology became the entry-level degree for the clinical practice of audiology. Audiologists go through rigorous training and clinical practices to obtain their degree and license. The HB 464 bill modernizes the practice definition of audiology to reflect the audiologist's didactic and clinical training. This legislation ensures the Statute

language is broad enough to encompass services provided now and allows the Board to create Regulations to provide specific rules.

This language change would allow for faster care for patients. Such as, if there is a foreign object in a patient's ear, instead of sending them to their primary care physician or otolaryngologist it can be easily removed in the office. This allows for faster access to care, fewer trips, less wait time, and more affordability for the patients. This can also apply to ordering radiographic imaging due to asymmetric hearing loss and/or unilateral tinnitus. The audiologist would be able to manage the diagnosis, including a referral to a specialist, if necessary. As well as the ability to order lab/blood work for patients to help differentiate, identify, and rule out a syndrome, disease, or disorder. This change would allow audiologists to practice health care the way their didactic and clinical training had prepared them.

The time has come to modernize the Statue of Audiology in Maryland. This should reflect other states' definitions of audiology, such as Colorado, Alabama, and Illinois. It should also be consistent with Maryland's practice definitions of non-physician, and clinical doctors, such as dentistry and optometry. Your time is appreciated.

Thank you for your support of HB 464 legislation.

Sincerely,

Kelly Anne Boylan

Kelly Anne Boylan, Au.D
Maryland License #01610

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February 27, 2024

Chair Pamela Beidle
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Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

In 2013, I earned my Doctor of Audiology (Au.D.) degree from (now) Osbourne College of Audiology at Salus University in Elkins Park, PA, one of the premium accredited audiology programs in the United States. I have been a practicing audiologist for 11 years and a practice owner in Alaska for 9 years. Currently, I am licensed in 14 states to provide accessible, affordable hearing and tinnitus healthcare to individuals throughout the United States. Additionally, I am active in legislative and regulatory issues, as one of the few (less than 100) licensed audiologists in Alaska. My volunteer positions include Past-President of Audiology Practice Standards Organization (APSO) and current Board member of the American Tinnitus Association (ATA). To provide a high quality of education to the next generation of audiologists, I teach as an adjunct faculty member at University of Alaska's undergraduate program, Eastern State Carolina University's master program, and University of South Dakota's accredited Au.D. program.

Salus University is one, if not *the* only accredited biomedical audiology program. The didactic curriculum requires 129 semester credit hours and is on-par with the Doctor of Optometry (OD) and physician assistant (PA) programs. The optometrists and PAs have modern licensure laws in the State of Maryland; audiologists have been left behind. Additionally, Salus University's program requires a 50-52 week, full time externship (residency) in audiology prior to the Au.D. degree being granted. This clinical experience provides an opportunity to incorporate didactic knowledge with direct patient care, while still having a

supervising, licensed audiologist. Between the multiple internships and full-time externship experience, I had more than 2,000 hours of patient care prior to applying for licensure.

As a faculty member throughout the continuum of education, I can personally attest that audiology students are appropriately trained to evaluate, diagnose, manage, and treat auditory and vestibular conditions. One of my passions is tinnitus (ringing in the ears); therefore, I teach the Tinnitus & Tinnitus Management course at the doctorate level. Audiologists obtain more didactic and therefore more clinical education in this area than any other healthcare provider. As a phase 1 Neuromod Lenire tinnitus provider, I have seen a number of patients who are struggling with their quality of life due to tinnitus. Unfortunately, these individuals are often told to simply 'live with it' by other providers and are on the verge of giving up on life. Audiologists are specifically trained to provide the quality care these patients need. A comprehensive treatment plan typically requires health screenings, ruling out medical conditions (e.g., auto immune disorders), and physical changes of the ear/head/neck area. Not allowing Maryland audiologists to evaluate, diagnose, manage, and/or treat auditory/tinnitus disorders disregards a complaint of more than 50 million Americans.[1]

SB 795 would modernize the Audiology Practice definition in Maryland to ensure audiologists can and are providing the auditory and vestibular care to patients across the state, consistent with their didactic and clinical education.

Thank you for your support Maryland audiologists and SB 795 legislation.

Sincerely,

Emily McMahan , Au.D.
Owner, Alaska Hearing & Tinnitus Center

[1] https://my.clevelandclinic.org/health/symptoms/14164-tinnitus

February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

I am a private practice audiologist licensed to practice in the state of Maryland. I entered into the field of audiology over 10 years ago so that I could help provide exceptional care to my patients with hearing needs. Over the course of my career, I have done just that by working with both adults and children to improve their hearing abilities, communication with their loved ones, and thus, their quality of life.

Over the course of my career, I have worked in both private practice and medical clinical settings, working closely with medical professionals to provide the highest quality of care to our mutual patients. Our current statutes have not been updated to reflect the rigorous didactic and clinical training that audiologists complete in our to provide this unparalleled hearing healthcare to our patients. SB 795 would help to modernize the practice definitions of audiology to accurately reflect our clinical training and expertise in the field. This legislation ensures that the statute language is both broad enough to encompass services that are currently provided as well as to allow our board to create regulations to provide specific rules. Additionally, the language codifies services such as health screenings and cerumen removal to help determine the most appropriate course of treatment and to establish of if further diagnostic services are needed. The language also modernizes services such as foreign body removal, such as a hearing aid filter or dome, that may become lodged in a patient's ear and is easily removed in office without the need for emergency medical services. It also allows for the ordering of non-radiographic imaging and scanning which may include 3D scans of the ear canal for ordering custom hearing devices, noise protection, and coupling devices. The ordering of radiographic imaging studies such as an MRI, which will allow patients to expedite diagnosis and therefore treatment of sudden onset issues. Currently, patients may be waiting days to weeks to see their medical physician to simply order the testing and even more time before they are able to have the studies completed. This delays care for patients and can reduce the efficacy of treatment for time sensitive audiologic issues, such as sudden hearing loss.

This bill modernizes the language needed to accurately reflect our rigorous didactic and clinical training. It allows audiologists to be on par with other non-physician, clinical doctors in the Maryland

(e.g., optometry, dentistry, podiatry, chiropractic). Healthcare is modernizing and Maryland needs to keep pace with these changes. This bill does not allow audiologists to practice medicine, perform surgery, or perform radiographic imaging.

It has been almost 20 years since our statutes have been updated and it is time. These changes are consistent with other state's definitions of audiology, including but not limited to Colorado (a purple state), Alabama (red state), and Illinois (a blue state). It is also consistent with Maryland's practice definitions of non-physician, clinical doctors (e.g., dentist, optometry).

Thank you for your support of SB 795 legislation.

Sincerely,

Lindsay Dennison, Au.D.
Maryland License #01304

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February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

As a full-time practicing Doctor of Audiology in Howard County and a private practice, small business owner, I am deeply saddened to have to take time away from providing audiologic and vestibular (balance) healthcare to patients and write a letter of support for HB 464.

I had the fortune of being born into a medical and healthcare professional family. My maternal grandfather was a general physician after serving his country in World War II, my aunt was a dentist and put herself through dental school with 2 young girls, and both my parents were medical technologists. My cousins and I were naturally drawn to the medical profession and are now Registered Nurses, Nutritionists, and me, an Audiologist. My path to audiology is rather common; my cousin was born approximately 10 years after me and was misdiagnosed as Mentally Retarded. At age 4 years, a physician recommended a comprehensive hearing evaluation. The audiologist evaluated and diagnosed her with a bilateral (both ears) moderate to severe sensorineural hearing loss. She could simply not understand normal conversational speech and therefore was not developing speech, nor responding to spoken language. The treatment for sensorineural hearing loss (often termed "nerve deafness") is amplification and my cousin was fit immediately with hearing aids and assistive listening devices in the 1990s, by an audiologist. My cousin is doing very well and is a Veterinary Technician today. Much like physicians and surgeons, I knew that I wanted to be an audiologist when I saw my cousin's audiologist evaluate, diagnose, manage, and treat her. I was not yet 12 years old.

After earning a Bachelor of Arts degree from Michigan State University, I attended Gallaudet University in Washington, DC for my Doctor of Audiology (Au.D.) program. In 2002, the profession was transitioning from a Master of Science (M.S.) degree to a Doctorate degree as the first professional degree due to the breadth and depth of information related to the human ear. During my 3 years on campus obtaining more than 90 credit hours of didactic education, Gallaudet University was consistently in the top 5-10

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of accredited Audiology programs in the United States and one of two audiology doctoral programs that incorporated Deaf culture into the curriculum. My professors were considered "experts" not only in the profession of audiology, but also in the physical therapy and neurology fields.

Beyond the classroom, I completed multiple part-time internship rotations, including Bethesda National Naval Medical Center (now Walter Reed National Military Medical Center, Ft. Belvoir Community Hospital, and a private practice ear, nose, and throat (ENT) office, The Feldman ENT Group. My fourth-year externship (residency) was completed at the Mayo Clinic Arizona. It was there that I saw the entire healthcare system work efficiently to put the needs of the patients first. Providers at Mayo Clinic did not have egos that needed to be inflated by supervising or providing oversight of another provider. Each professional has her/his specialty and everyone worked together for the best outcome, not for individual income. The Audiology department worked closed with

- Physical Therapy who would provide vestibular treatment for hearing insurance coverage reasons (i.e., some health insurance would not allow patients to be treated by an audiologist for balance dysfunction and be reimbursed),
- Neurology who would evaluate, diagnose, manage, and treat patients referred for cognitive concerns,
- Optometry who would assist in diagnosing more-common syndromes with hearing and vision deficits, and evaluate and aid in diagnosing vestibular complaints, and
- Ear, Nose, and Throat (ENT) surgeons who would complete the surgical procedures for osseo-integrated bone anchored hearing devices (BAHD) and cochlear implants, and order radiographic imaging.

Each provider at Mayo Clinic focuses on the top of their scope of practice to best utilize the expertise. Audiologists evaluated, diagnosed, managed, and treated audiologic and vestibular care as the point of entry. Mayo Clinic Florida[1] published an article in 2010 that highlighted the majority of adults (95%) required audiologic care and those were the **only** services required (i.e., the patient did not have to be referred/treated by ENT, neurology, PT, etc.). The article also emphasized that treatment plans did not differ between audiologists and otolaryngologists (ENT physicians) for the same conditions. Furthermore, there was no evidence that audiologists missed significant symptoms of otologic (ear) disease, and there was strong evidence that audiologists referred (managed) appropriately. This article is now more than a decade old and was completed at a world-renowned medical center. None of the audiologists were didactically trained at Mayo Clinic; they were trained in the same accredited programs that Maryland audiologists are trained. Yet, the state otolaryngology (MSO) and medical

[1] https://pubmed.ncbi.nlm.nih.gov/20701834/

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(MedChi) associations cannot follow this peer-reviewed literature and work **with** audiologists.

The MSO edits struck the word 'Diagnose.' However, the words 'assessment/diagnosis/evaluation' are already in COMAR 10.41.03.03 B.(4)(a) as it relates to clinical training and the percentage of time a [student] must have in these areas. The MSO nor MedChi has **not** been seeking to change this Regulation via Regulatory updates or legislation.

Federal entities, such as the Veterans Administration (VA) cares for our service members who ensure our freedom. The VA wait times are monitored by Congress and when they are viewed to be too long, it makes national news. The VA has worked for the past few years to provide average appointment wait times at less than 44 days for any specialty. They can do this by again utilizing providers to the top of their didactic and clinical training. In fact, the VA describes Audiologists this way:

> "Audiologists are licensed health care professionals who care for veterans and service members through the prevention, *diagnosis, and treatment* of hearing disorders that include hearing loss, balance impairment, and tinnitus. Audiologists counsel patients and families regarding good hearing health practices and advise them on appropriate *management strategies*." (Emphasis added)

Baltimore has a VA Medical Center with a few satellite offices throughout the state. Audiologists working within the VA system in Maryland currently have a more modern job description than the audiologists **not** working in the VA system.

According to a Johns Hopkins website discussing over-the-counter (OTC) hearing aids:

> " A diagnostic hearing test completed with an audiologist will provide accurate information on both the degree and type of hearing loss." [2]

Johns Hopkins acknowledges the audiologist is completing a diagnostic hearing test. The website further discusses how the audiologist can help manage the patient to determine if OTC or prescription hearing aids (treatment) may be helpful. Maryland law should be modernized to be consistent with the State's institutions that also recognize the level of care an audiologist provides. The only non-medical hearing test that has been studied on adults and children is the Whisper Test.[3] Whisper test instructions are:

1. Stand 1–2 feet behind the patient
2. Have the patient cover one ear canal

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[2] https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/hearing-aids/over-the-counter-hearing-aids-faq

[3] https://geriatrics.ucsf.edu/sites/geriatrics.ucsf.edu/files/2018-06/whispertest.pdf

3. Whisper a word with two distinct syllables towards the patient's right ear
4. Ask the patient to repeat the word back
5. Whisper sets of either three digits or a combination of digits and letters
6. Start with consonants, followed by vowels
7. Whisper after a full, quiet expiration
8. A positive test is a failure to repeat at least three of the sets

The test is typically carried out in a quiet room (about 40 dBA or below). With the technology in 2024 and the validated hearing-quality of life questionnaires, any provider who is using a Whisper Test should be seriously questioned.

Finally, the suggested non-medical hearing evaluation is concerning for any provider who needs to make a diagnosis of hearing acuity. Without a medical evaluation, how will a diagnosis be made? If a diagnosis is made from a non-medical hearing test, is that provider completing malpractice?

At my practice in Howard Country, I see patients of all ages for evaluation and diagnostic testing. Many patients find my office in Highland, Maryland more accessible for tinnitus evaluations and treatment, auditory implantable pre- and post-surgical diagnostic and treatment services, and occupational and recreational hearing protection management. In fact, patients in Howard and Frederick country are able to save more than an hour, roundtrip for cochlear implant testing, programming (MAPping), and counseling compared to their prior requirement to drive to Baltimore, deal with traffic, and pay for parking at the Greater Baltimore Medical Center (GBMC), Johns Hopkins University (JHU), and University of Maryland Medical Center (UMMC). Not only is Designer Audiology more accessible, it’s also more affordable for the patients. The patients can save travel costs, return to work/employment quicker, and still receive the highest quality of care from an audiologist who was once at the Mayo Clinic Arizona.

Additionally, outside the “triangle” between Washington, D.C., Baltimore, and Annapolis, Maryland, healthcare is more difficult to access. Parts of Howard County are more rural, and patients cannot or choose not to going into the cities to receive any type of care. Audiologists who are accessible in these more rural areas can provide some healthcare for individuals, and some healthcare is better than no healthcare.

Outside the Senate and House walls, audiologists are providing valuable diagnostic and treatment services that ENTs are unable to provide. The Board of Examiners for Audiologists, Hearing Aid Dispenser, Speech-Language Pathologists (and now Music Therapists) published a May, 2016 newsletter that states any person not licensed by the Board who completes a hearing test in Maryland is breaking the law, under the Health Occupation Statute 2-401. According to the State of Maryland, physicians **cannot** complete a hearing test. Additionally, it would be ludicrous to ask a surgical specialist to

complete a 20-50 minute diagnostic audiologic evaluation and receive the average third-party payor (CMS) reimbursement of $37.28.[4]

Many private insurance companies look to the Centers for Medicare and Medicaid Services (CMS) for guidance of payment. Within the conservative CMS system, Medicare classifies Audiologists as 'Diagnostic-Other.' Ironically, the only other provider in that category is Radiology. The fact that Maryland Statute does not recognize audiologists to diagnose, when CMS- located in Baltimore, MD does, seems outdated.

The CMS has also been requiring all providers to report outcome data to provide better patient care. Audiologists have been eligible providers for the (now) Merit-Based Incentive Program (MIPs) as a 'Medical Specialist.'[5] The profession as a whole, when required and eligible to participate has one of the highest participation and highest outcome percentages across the MIPS (previously PQRS) system. Not only are audiologists evaluating and diagnosing appropriately, they are providing some of the best quality of care and managing the patients appropriately.

Additionally, the language passed in 2022 to allow Audiologists to

> "Prescribe, order, sell, dispense, or fit hearing aids to an 11 individual for the correction or relief of a condition for which hearing aids are worn"[6]

describes 'manage' and 'treat.' The MSO and MedChi were upset with the language in 2023 and will likely oppose again this year, despite the fact the Food and Drug Administration (FDA), the most conservative government agency, being the driving force of the words "prescribe, and order" hearing aids, which are the treatment for sensorineural hearing loss. The 2024 legislation does not Practice Medicine- defined in Maryland as diagnose, heal, treat, or perform surgery.

Physicians and surgeons are essential to my practice and patients. However, the MSO addition on page 2, line 28 (V) is completely inappropriate and unethical. The amendment provided implies that Maryland audiologists can only refer (manage) to a physician or *their* physician assistant (PA), or nurse practitioner (NP). Audiologists see patients for a variety of concerns. Requiring all referrals to go back to a physician creates a true Health Maintenance Organization (HMO). Physicians are already in dire demand; this amendment **increases** the pressure on the system for audiology patients who need a referral to a non-physician (e.g., optometry, physical therapy, dentist). In rural areas, NP often serve as a patient's medical home. However, with this amendment, audiologists would not be able to refer the patient back to her/his NP for medical

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[4] https://www.audiology.org/wp-content/uploads/2023/11/AudiologyMPFS-Final-CY-2024_Table.pdf
[5] https://www.cms.gov/mmrr/Downloads/MMRR2014_004_02_a04.pdf
[6] HB 401/SB 449.

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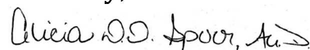
management (e.g., ear infection medication prescription). Again, is the edit about the MSO's members incomes that they require all the referrals so they can charge an office visit code?

Finally, at Designer Audiology, referrals to specialized providers are difficult and often comes with a significant waiting period. Within the past year, the office identified a hearing loss that required radiographic imaging to rule-out a serious medical condition that may have required surgery. Two audiologists from the practice had to call the ENT offices to request an appointment, as the patient was unable to obtain an appointment at any office within a 20-mile radius of Designer Audiology for 5 weeks. The window for successful treatment is 48 hours-7 days. Due to the short opportunity-period for treatment, the audiologist called the patient's primary care physician (PCP) to request the order for radiographic imaging, which was sent from the PCP to the patient directly. There are multiple (and sometimes extreme) causes that can be explained; but it does not seem unimportant when it happens to you. This situation could have been resolved with the modernized language of ordering radiographic imaging and benefited the patient, the audiologist, the PCP, and the outcomes.

The fears from the MSO's proposed amendments are unfounded with audiologist's didactic can clinical education. As a non-physician doctor, audiologists have an important role to evaluate, diagnose, manage, and treat patients; they are simply "the girl down the hall" anymore. With the population as a whole aging and individuals not entering the healthcare professions due to the time and expense of the educational requirements, along with the poor return on investment, all providers need to have modern licensure laws consistent with instruction. HB 464 used the other clinical doctors' (e.g., dentist, optometry) language to harmonize the Statute.

I ask for your favorable report on HB 464.

Sincerely,



Alicia D.D. Spoor, Au.D.
Doctor of Audiology
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February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Beidle, Vice Chair Klausmeier, and Committee Members,

My name is Dr. Melissa Segev, and I am in full support of SB 795, to modernize of the definition of audiology. I am a doctor of audiology and small business private practice owner in Maryland. I am co-owner of one of the oldest and largest private practices in the state. I have been practicing audiology for over 15 years and love being able to improve the quality of life for so many Maryland residents.

One of the best parts of my day is being able to talk to my patients and get to know them. In spending so much time with them throughout their years of treatment, I have been able to notice changes in their well-being. Changes such as gate changes in their walk, speech patterns, memory, and mental health.

SB 795 is to modernize our profession and allow myself to manage, diagnose, treat, and evaluate my patients to the level of my education and scope of practice. Audiologists are the best managers of hearing and balance healthcare. I attended Towson University for my undergraduate, Bachelors of Science (BS) degree, and then obtained my Doctor of Audiology (Au.D) degree from the University of Pittsburgh. I spent 8 years in universities to become an audiologist, as well as over 1000 clinical hours of training.

So many patients live in rural areas with limited healthcare, especially specialty physicians. Patients are also on very fixed incomes, which limits their travel and time spent on themselves. This bill has very little risk and a ton of benefits for Maryland residents. I also think if this was my mother, how would I want her treated and managed. This bill provides the level of care I believe each Maryland resident deserves.

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Thank you for your support of SB 795 legislation.

Sincerely,

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