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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 SB 795.

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. My fourth-year externship (residency) was completed at the Mayo Clinic Arizona. It was there that I saw the entire healthcare system worked 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.

Providers at the Mayo Clinic focused 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 Maryland otolaryngology (MSO) and medical (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 [audiology] clinical training and the percentage of time a

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

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[student] must have in these areas. The MSO nor MedChi have **not** been actively seeking to change this Regulation via Regulatory updates or legislation.

Federal entities, such as the Veterans Administration (VA) care 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 of less than 44 days for any specialty. They can do this by 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.
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.

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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

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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 2024 technology 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?

Additionally, healthcare is more difficult to access outside the "triangle" between Washington, D.C., Baltimore, and Annapolis. My practice is in Howard County and parts of Howard County are more rural. Patients cannot or choose not to travel into 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. At my practice in Howard County, I see patients of all ages for evaluation and diagnostic testing. Many patients find my office in Highland 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 counties can 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).

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 stated 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 without being a licensed audiologist. 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. Medicare classifies Audiologists as 'Diagnostic-Other.' Ironically, the only other provider in that category is Radiologist, a specialized physician. 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

[4] https://www.audiology.org/wp-content/uploads/2023/11/AudiologyMPFS-Final-CY-2024_Table.pdf

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Specialist.'[5] The audiology profession 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 also providing some of the best quality of care and managing the patients appropriately.

Additionally, the language passed in 2023 that allows 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 are opposing again this year, despite the fact the Food and Drug Administration (FDA), ***the*** most conservative government agency, was the driving force of the words "prescribe, and order" hearing aids. Hearing aids are the treatment for sensorineural hearing loss. The 2024 legislation does not Practice Medicine- defined in Maryland as diagnose, **heal**, treat, or **perform surgery**. (Emphasis added)

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, nurse practitioners (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 management (e.g., ear infection medication prescription) unless the NP was supervised by a physician. Again, is the edit about the MSO's members practice 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 mutiple 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 who obtained the procedure from a radiographic imaging center. There are multiple (and sometimes extreme) causes that can be explained; but it does not seem unimportant when it happens to you.

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[5] https://www.cms.gov/mmrr/Downloads/MMRR2014_004_02_a04.pdf
[6] HB 401/SB 449.

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This situation could have been resolved with the proposed, modern 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 audiologists extensive didactic and clinical education. As a non-physician doctor, audiologists have an important role to evaluate, diagnose, manage, and treat patients; they are simply not "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. SB 795 used the other clinical doctors' (e.g., dentist, optometry) language to harmonize the Statute.

I ask for your favorable report on SB 795.

Sincerely,

Alicia D.D. Spoor, Au.D.

Alicia D.D. Spoor, Au.D.
Doctor of Audiology
MD License: #01145

Holtan Oral Testimony SB 795.pdf
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February 27, 2024

Chair Pamela Beidle
Finance Committee
3 East
Miller Senate Office Building
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RE**: SB 795** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

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

My name is Briana Bruno Holtan and I am here in strong support of SB 795, Health Occupations – Practice Audiology – Definition. On behalf of the Maryland Academy of Audiology (MAA), we are pleased to be working with Delegate Martinez to modernize the Audiology statute to reflect the audiologist's rigorous didactic and clinical training and provide the most affordable, efficient healthcare to your constituents.

I am a licensed practicing audiologist for over 26 years and 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 on staff who play a critical role in the screening, evaluating, diagnosis, management, and treatment of hearing, balance and other related disorders to patients of all ages.

Health Screenings of many varieties are located in public shopping centers. Wedged between shelves of cough drops and the pharmacy at Walmart is a screening station that allows shoppers to screen their eyesight, weight, and blood pressure. Hearing screenings can be performed online at home that are far from accurate, yet MSO feels audiologist cannot perform more comprehensive screenings without further 'audiology training'? This simply does not make any sense. Allowing a clinical doctor to complete screenings does not introduce any more harm than a screening that an individual completes themselves. There is no need for audiologists to be further trained to screen.

Screening courses are already required as part of the standards set forth from our two accrediting bodies of Au.D. programs in our country. The Counsel on Academic Accreditation (CAA) and the

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Accreditation Commission of Audiology Education (ACAE) are the two accrediting bodies who ensure Doctor of Audiology programs incorporate all standards that a first professional degree requires, including screenings.

Audiologists currently develop and oversee screening programs to detect changes in hearing and/or balance function. Other screening measures used daily to manage patients are speech understanding, cognitive screenings, and depression screenings. Fall risk screenings are used for dizziness patients to determine the need for ambulatory devices (canes and walkers) to prevent major life change falls. This amendment would not allow me and our audiologists to run a basic falls risk balance screening. Falls are a serious event as they are costly to overall health. Over 800,000 patients a year are hospitalized because of a fall injury and falls are 2.4 times more likely among patients with hearing loss than among those with normal hearing so it is a must that these screenings be performed to identify early problems. We all know that prevention is the best cure so it is critical that there are no more barriers to health screenings.

Screenings can help with referral to appropriate providers for treatment in their area of specialty. The previous Medicare Physician Quality Reporting System (PQRS) and current Merit-Based Incentive Payment System (MIPS) requires qualifying audiologists to conduct multiple health screenings and report the outcomes. It was determined to NOT be a scope of practice issue as it does not require a diagnosis. Health screenings are necessary for the prevention or early detection of an illness or disability. The Johns Hopkins University ACHIEVE trial, a study of the effect of hearing intervention on the brain health in older adults, shows a reduction of cognitive impairment of high-risk patients with hearing aids. The amendment from MSO would add more barriers to obtaining health screenings, including our cognitive function screenings we perform on an almost daily basis, and will cause more harm to your constituents.

Audiologists remove cerumen (ear wax) and other foreign bodies from the external auditory canal (ear canal) on an almost daily basis. Patients will come to the office with multiple hearing aid domes, wax filters, and Q-tip cotton in their ears that need to be removed. Most patients, including my husband, will self-clean their ears using all sorts of objects including pen caps and bobby pins. There are self-care guidelines for my patients posted all over the internet. Portable video otoscopes (a small camera that shows the inside of the external auditory canal otherwise known as the ear canal), that attach to your phone using an app AND INCLUDES self-wax cleaning attachments, are sold online and can be delivered to our patient's home within 1 day. Individuals can self-clean their own external auditory canals with whatever object they have laying around yet MSO is suggesting that

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doctors of audiology cannot use medical micro instrumentation that they have been using for years to manage their patient's excessive wax buildup? Again, this simply does not make any sense. Patients will oftentimes report that they go to Urgent Care, and not otolaryngologists or other physicians, for treatment.

Cerumen management is already part of the Maryland audiology regulations and simply needs to be codified. Once again audiologists receive extensive education and training in cerumen management by our two accrediting bodies. Some audiologists obtain additional certification in completing extensive cerumen management training. The amendment from MSO is redundant and unnecessary. MSO stated in their amendments that audiologists can only remove 'superficial' debris, yet this is already defined in regulations as the 'external auditory canal'. There are no other barriers in that portion of the ear that needs to be cut, broken, or removed to get to the cavity. We are already using 'micro instrumentation', including tweezers, to remove the cerumen. Audiologists utilize sophisticated equipment to measure the ear canal volume indicating the current condition of the external auditory canal in addition to binocular headlamps and/or microscopes to carefully inspect the area. This amendment would not allow us to use the appropriate medical tools and light source to remove the cerumen thus harming our patients and not providing the level of treatment that they deserve.

Thank you for your time and consideration, and to Delegate Martinez for sponsoring this legislation. I ask for a favorable committee report on SB 795 to help your constituents.

Briana Bruno Holtan, Au.D.
Doctor of Audiology
Maryland License #00909

SB795_AudiologyDef_KennedyKrieger_Support.pdf
Uploaded by: Emily Arneson
Position: FAV

Kennedy Krieger Institute

DATE: **February 27, 2024** **COMMITTEE: Senate Finance**
BILL NO: **Senate Bill 795**
BILL TITLE: **Health Occupations – Practice Audiology – Definition**
POSITION: **Support**

Kennedy Krieger Institute supports Senate Bill 795 - Health Occupations – Practice Audiology – Definition.

Bill Summary:
Senate Bill 795 alters the definition of "practice audiology" in the Maryland Health Occupations Statute.

Background:
Kennedy Krieger Institute is dedicated to improving the lives of children and young adults with developmental, behavioral, cognitive, and physical challenges. Kennedy Krieger's services include inpatient, outpatient, school-based, and community-based programs. Over 27,000 individuals receive services annually at Kennedy Krieger. We employ more than 2,600 persons who play a vital role in our mission to transform the lives of children with disorders of the brain.

At Kennedy Krieger, our audiologists offer a wide variety of evaluations and services to assess and treat a child's ability to hear and process sounds at all stages of their development. Our comprehensive approach includes collaboration with specialists in speech language pathology, developmental medicine, and other disciplines to provide specialized care tailored to each patient's unique set of needs**.**

Rationale:
The American Academy of Audiology (AAA) defines audiologists as, "independent practitioners who, by virtue of their postgraduate education, training, and license to practice, engage in the profession of audiology." While audiology is one of the youngest health careers it is rapidly progressing; new technologies are developed, implemented, and improved at an accelerated pace. Along with these technological developments, the skillset and requirements of audiology practitioners have grown to match. To become an audiologist, a person must attend an accredited clinical doctoral program, where they obtain education and several hundred hours of hands-on supervised training.

An audiologist's primary objective is to improve a person's quality of life by preventing, identifying, diagnosing disorders of hearing and balance, as well as providing evidence-based, nonmedical treatments of those disorders. The American Speech-Language-Hearing Association (ASHA) defines the audiologist's scope of practice as "complex, dynamic, and constantly evolving." ASHA acknowledges the audiologist's roles in patient care including "clinician, educator, consultant, researcher, and administrator." This care can encompass a number of services such as the prescribing, ordering, and/or management of amplification devices such as hearing aids, osseo-integrated devices, and cochlear implants; cerumen management; and/or the removal of foreign bodies from the external auditory canal, in addition to many other skills which are defined as alterations under the proposed bill.

The proposed changes delineated in HB 464 would allow the legal interpretation of an audiologist's **scope of practice (SOP) to better reflect a current and comprehensive description of the profession**, such as those defined in AAA's and ASHA's SOP documentation (see below for references). This alteration can support an audiologist in their ability to provide equitable and culturally responsive person-centered care as a licensed professional of the state of Maryland.

Kennedy Krieger Institute requests a favorable report on Senate Bill 795.

References

1. American Speech-Language-Hearing Association. (2018). *Scope of practice in audiology* [Scope of Practice]. Available from www.asha.org/policy/.
2. American Academy of Audiology. (2023). *Scope of Practice*. Available from https://www.audiology.org/practice-guideline/scope-of-practice/.

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Brown Oral Testimony SB 795.pdf
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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 Pena-Melnyk, Vice Chair Cullison, and Committee Members,

I am testifying today as an individual licensed Doctor of Audiology in the State of Maryland, not as a current member of the Board of Examiners.

I have been a practicing audiologist for over 40 years now. I was also a private practice owner (Allegany Hearing & Balance) for over 20 years until this past October when I sold my practice to one of my very talented colleagues. I am now working part-time for this practice and am semi-retired. We have two office locations. One is in Cumberland and the other is in Oakland. I graduated with a Master of Science degree from West Virginia University in 1983 and received my Doctor of Audiology degree in 2006, from the Arizona School of Health Sciences at A.T. Still University in Mesa, Arizona. I worked at a steel mill and then a nuclear shipyard as an industrial audiologist for the first 7 years of my career. I performed hearing screenings, diagnostic testing, managed our employees by referring to appropriate physicians when necessary, and treated their hearing loss with amplification when appropriate.

I then accepted a job with Allegany Hearing & Speech, which was owned by two individuals who were dually certified in Audiology and Speech Pathology. This company was a for profit rehabilitation company which also employed speech pathologists, physical therapists, and occupational therapists. In the early 2000's, they sold the company to a now large rehabilitation company. About two years after this sale, due to my disagreements with how they expected me to treat our patients and their lack of concern about patient outcomes, I bought the Audiology portion of the business in late 2003.

I grew the practice from three audiologists seeing roughly 30 patients per day to six audiologists in our two locations seeing anywhere from 60 to roughly 80 patients per day. I also expanded our services from doing audiological evaluations and fitting hearing aids, to also providing full neurodiagnostic evaluations, cochlear implant activations and programming, fitting bone anchored hearing devices, and auditory processing evaluations.

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I saw a 32 year old female for an audiological evaluation in September 2007. She was pregnant and was referred to our office by an ENT physician. She was experiencing vertigo, ringing in one ear and had begun to notice hearing loss in the same ear. I did a full diagnostic hearing evaluation which showed hearing in her right ear to be slightly worse than her left ear in the mid to high pitches. Her word understanding test also showed a slightly reduced score in her right ear compared to the left ear. After doing further specialized audiological testing, and based on her history and results, and my education and training, I was extremely suspicious that she was suffering from a tumor called an acoustic neuroma. This is a tumor that typically grows along the acoustic and/or the vestibular nerve in the inner ear.

I advised the patient to make sure she got an MRI and that if her ENT would not order an MRI, to let me know as I would then contact her primary care physician and have them order one. I did not want to tell the patient that I was 95% sure she had a tumor, but wanted to express the urgency of her getting an MRI.

She did not return to my office for another hearing test until May of 2008, again referred by an ENT. Her hearing in the right ear had deteriorated from a mild hearing loss to a total profound permanent hearing loss with 0% word understanding. I was now 100% certain that she had an acoustic neuroma. She told me that her physician did not think she needed an MRI as she thought she had a different disorder, namely otosclerosis. Otosclerosis is a condition that can be exacerbated by pregnancy. Otosclerosis test results look nothing like test results with an acoustic neuroma. I then advised her that I thought she had an acoustic tumor and that she HAD to have an MRI. Her physician finally ordered one and she did, in fact, have an acoustic neuroma. She had surgery at Johns Hopkins Hospital to remove her tumor.

About two years later I was sued by this patient for two reasons. One, because I had not ordered an MRI. Two, because she thought the ENT was my employee. I was NOT permitted to order imaging as it is not currently permitted in the State of Maryland for audiologists. Had I been able to order an MRI when she initially presented to me, she would have gotten the appropriate health care that she needed and her outcome may have been different with regards to salvaging her hearing.

In my now 41 years of serving my patients, I have countless times strongly urged my patients that I felt needed an MRI or CT scan based on their history and test results, to ask their ENT for one if they did not order one. If the ENT refused, I advised my patient to contact me and I would then ask their primary care physician to place the order.

Right now in my local area, there are two ENT physicians, both located in Allegany County in Western Maryland. One of them takes appointments in Garrett County one day per month. His next appointment is in mid April. Just under 100,000 residents of these two counties have access to 2 ENT physicians. It takes a minimum of three weeks to get an appointment.

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Updating **SB 795** Health Occupations – Practice Audiology – Definition, will bring our profession up to date with our current educational and licensure requirements. It will also result in a reduction of healthcare costs, reduce wait times at physician offices for appointments, enable to ENTs to see those patients that truly need to see them for the more severe pathologies, and result in better outcomes for the patient.

If the patient comes to Audiology first, less than 5% are shown to need an ENT or medical referral. Most do not need to see a physician for their hearing loss. If they see the ENT first, the ENT will typically order a hearing test. They come to our office, get the evaluation, then we send them back to the ENT for the follow up appointment. The ENT then orders imaging if necessary, which means they then need to go back to the ENT again to get those results. Allowing audiologists to order imaging will reduce office visits for the patients, reduce health care costs, and most importantly, provide better outcomes and healthcare for the patient.

We are not interested in a turf war. We want to evaluate, diagnose, manage, and treat our patients as our education and training have prepared us. Updating definition will allow us to practice at the top of our scope, which will allow the ENTs to also provide the best care for those patients that need their care. Our goal again, is to reduce costs to the healthcare system and the patients, provide the best possible care as quickly as possible, and provide better outcomes for our patients by allowing us to evaluate, diagnose, manage, and treat our patients as our education and training have prepared us for and as we have been doing for years.

I ask for your favorable report on SB 795.

Best Regards,

Jana Brown, AuD, FAAA

Jana Brown, AuD
Board Certified in Audiology

SB795_FAV_MSHA.pdf
Uploaded by: Lisa Smith
Position: FAV

February 26th, 2024

Bill: HB 464/SB 795 - Health Occupations – Practice Audiology – Definition

Position: SUPPORT

Dear Chair, Vice-Chair, and Members of the Committee:

The Maryland Speech Language Hearing Association (MSHA) represents speech language pathologists and audiologists across Maryland. Collectively, we elevate and engage members to strive for excellence in serving those impacted by communication and related disorders through advocacy, equity, education, interprofessional collaboration, and leadership development. As the American Speech-Language-Hearing Association (ASHA)-affiliated state association, MSHA represents the professions of audiology and speech-language pathology, including over 350 ASHA certified audiologists who work in the state.

MSHA is in support of HB 464/SB 795 which would clearly delineate the scope of practice for audiology in Maryland. Osseointegrated devices, cochlear implant fitting, cerumen management, removing foreign objects bodies from the ear canal, and additional screenings of mental health and cognitive impairment to assess, treat, and refer are part of ASHA's Scope of Practice in Audiology. These are skilled services desperately needed by Marylanders and well understood to be included in the practice of audiology. Ordering cultures, bloodwork testing, and radiologic imaging, as regulated to the diagnosis, management, and treatment of auditory or vestibular conditions in the human ear, enhances audiology practice. For these reasons, MSHA supports House Bill 464/SB 795. We appreciate your consideration of our position.

Thank you,

Megan Miskowski

Megan Miskowski, M.S., CCC-SLP
MSHA Director of Advocacy and Public Policy

Sarah Sparks, Au.D., CCC-A, CH-TM

Sarah Sparks, Au.D., CCC-A, CH-TM
MSHA Director of Audiology

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Segev Oral Testimony SB 795.pdf
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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 the definition of audiology. I am a doctor of audiology and small business private practice owner in Maryland. I have been practicing audiology for over 15 years and love being able to improve the quality of life for so many Maryland residents. I am going to discuss how audiologists can increase patient care with minimal risk by ordering radiographic imaging and lab work when appropriate. Not doing so is a huge inconvenience to my patients, as they need on average 4 extra appointments for the referral appointment and results, costing extra money with each visit at the referral's office and often co-payments, and time for the patients who do not always have it. Often patients need rides, especially as they age. Or they are working and time away from work is not always an option.

Ordering lab work during a medical history assessment can show underlying conditions that may impact hearing and balance. Hearing loss or dizziness may be associated with autoimmune disorders, diabetes, heart problems, neuropathy, infections, medications, etc.…

Certain medications are ototoxic, meaning they can cause hearing loss and/or dizziness. Medications such as antibiotics, chemotherapy agents, erectile dysfunction medicines, or even high doses of over-the-counter pain relievers, like ibuprofen and aspirin are known to cause hearing loss and/or dizziness. Monitoring blood levels of these patients is very important as the dosage or duration between taking the medicines can often be adjusted to prevent further damage. Many of these patients are not ENT patients. Furthermore, they are referred from primary care, oncologists, cardiologist, dermatologist, dentists etc… Referrals to an otolaryngologist are not always necessary since they are not the current physician prescribing the medication or managing their treatment.

Blood work can often aid in screening for systemic diseases that can manifest in the ear, either with hearing loss or dizziness. Balance disorders may be caused from metabolic or hormonal disorders. Having those

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results while treating, evaluating, diagnosing, and managing patients with dizziness can aid in differential diagnosis. Tinnitus may also be caused from metabolic or hormonal disorders.

Blood work results can provide a great deal of information, while collaborating with other health care professions in the treatment of patients. Having a qualified healthcare professional order, not perform, blood results can help lower cost per visits, and increase patient care.

Radiographic imaging is also important when managing patients. Unilateral hearing loss, dizziness and tinnitus are symptoms of an acoustic neuroma. Acoustic neuromas are benign tumors that grow on cranial nerve VIII. Imaging studies are the only way to confirm this, although audiologic testing can suggest a tumor is present. If an acoustic neuroma is identified, those patients will be referred to a neurotologist, a physician who specializes in the treatment of acoustic neuromas. They are rarely handled by local ENT offices, especially in rural areas of Maryland. I have 2 offices in rural areas where patients drive over an hour to see our providers. If they had to travel further, I truly believe they would not seek treatment. If other abnormalities are seen, a referral would be made to a local ENT physician if appropriate, who can further manage their treatment. On occasion, monitoring of the acoustic neuroma is necessary and this is done through audiologic testing and imaging studies.

MSO is suggesting that audiologists check in with the board to tell them what they intend to provide and demonstrate proof of training when treating patients. My proof is the education I received which you can see further on the attachments. We have two accrediting bodies who manage and set the didactic and clinical standards of all Doctor of Audiology programs in the country. They are the Council on Academic Accreditation (CAA) and the Accreditation Standards for the Doctor of Audiology (Au.D.) Program (ACAE). As you can see from the enclosures at the end of this testimony, the CAA and ACAE include professional practice competencies in the areas of diagnosis, management, treatment, and evaluation, which is what our bill states. Both programs use those words when preparing the curriculum for our doctorate degree. You can see the rigorous education, training, and clinical hours (over 1000 clinical hours) spent to obtain the Au.D. degree.

This further leads to MSOs other amendment, which is the referral of a person with auditory and vestibular dysfunction where audiologists would need to refer to a physician, physician assistant, or nurse practitioner. Both a physician assistant and nurse practitioner have less education and clinical training of the ear than a doctor of audiology. Furthermore, the referral to those suggested by MSO when not appropriate, will significantly increase patient cost. How insulting of MSO to suggest doctors of audiology are uneducated, unqualified, and redundant in the healthcare system. We are more than the 'girl down the hall', which is how some ENT physicians view audiologists and the care they can provide. ENT physicians often make suggestions to patients on hearing aid treatment, which is out of their scope and most always incorrect.

MSOs amendments make it appear that there is a turf war and lack of respect between the professions, but on the practice level there is not. There is a huge amount of respect between the professions. This is attempting to perpetuate fear that patients can be harmed when the opposite is true. This appears to be a concern of

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money and how MSOs is suggesting inappropriate referrals just to increase their salaries, rather than what is best for patient care. There is always a story about a patient who was mismanaged or someone dropped the ball, but those are few and far between. Referrals are made often when patients need further testing or treatment to ENT physicians, however, our point is that this a huge problem in the system and those patients can be safely managed by doctor of audiologists. Everyone has a story to tell about how they saved a patient or helped a patient who was mismanaged previously.

The Johns Hopkins ACHIEVE trial was the first of its kind. It is a multicenter randomized trial to determine if treating hearing loss in older adults reduces the loss of thinking and memory (cognitive decline) that can occur with aging. The ACHIEVE study looks at other health outcomes, results of which will be published over time, including: mental health and well-being, physical function, and health care use. The fitting of hearing aids in the study was by audiologists only, and the results revealed that hearing intervention reduced cognitive change by 48% over 3 years and hearing intervention benefited the heart heath study participants the most. In older adults at increased risk for cognitive decline, hearing intervention with audiologic counseling and hearing aid fittings by audiologists slowed down cognitive decline. MSO suggests that audiology is a non-medical profession and we are unable to perform health screenings on patients. The FDA classifies hearing aids as class I and class II medical devices. The ACHIEVE study showed a massive impact on the aging population in our country and accessibly to audiology care. Audiologists are the exact professionals who can perform cognitive screenings, blood pressure monitoring, and treatment of hearing loss via hearing aids that will have a massive impact on Maryland residents.

The amendments to this bill presented from MSO are not only offensive, suggesting that audiologists are uneducated, but highly unrealistic. I hope this helps understand the importance of the audiologist in the healthcare system and how modernizing our profession is crucial in the future of healthcare. This would give patients the ability to be managing in a more comprehensive and less expensive way.

I ask for your favorable report on SB 795. This would be a huge improvement in patient care for all Maryland residents. And as you can see, doctors of audiology are highly qualified to work along ENT physicians to help all who need us.

Sincerely,

Melissa J. Segev

Melissa Segev, Au.D.
Doctor of Audiology
MD License: # 01149

Enclosures (2)

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- CAA Accreditation Standards for Au.D. Programs
- ACAE Standards for Au.D. Programs

CAA Accreditation Standards for Au.D. Programs

Offer a plan of study that encompasses the following domains:

- professional practice competencies;
- foundations of audiology practice;
- identification and prevention of hearing loss, tinnitus, and vestibular disorders;
- assessment of the structure and function of the auditory and vestibular systems as well as the impact of any changes to such systems;
- intervention to minimize the effects of changes in the structure and function of the auditory and vestibular systems on an individual's ability to participate in his or her environment.

DIAGNOSIS, AND EVALUATION

3.1.2A Foundations of Audiology Practice: The program includes content and opportunities to learn so that each student can demonstrate knowledge of the

- embryology, anatomy, and physiology of the auditory, vestibular, and related body systems;
- normal aspects of auditory and vestibular function across the lifespan;
- normal aspects of speech production and language function across the lifespan;
- normal aspects of speech perception across the lifespan;
- effects and role of genetics in auditory function, diagnosis, and management of hearing loss;
- effects and role of genetics in vestibular function, diagnosis, and management of vestibular disorders;
- effects of chemicals and other noxious elements on auditory and vestibular function;
- effects of pathophysiology on the auditory, vestibular, and related body systems; August 2017, rev. January 2023 Standards for Accreditation Page 11 of 41
- medical and surgical interventions that may be used to treat the results of pathophysiology in these systems;
- interaction and interdependence of speech, language, and hearing in the discipline of human communication sciences and disorders;
- effects of hearing loss on the speech and language characteristics of individuals across the life span and the continuum of care;
- effects of hearing impairment on educational, vocational, social, and psychological function and, consequently, on full and active participation in life activities;
- physical characteristics and measurement of simple and complex acoustic stimuli; • physical characteristics and measurement of non-acoustic stimuli (e.g., EEG, tactile, electrical signals);
- methods of biologic, acoustic, and electroacoustic calibration of clinical equipment to ensure compliance with current American National Standards Institute (ANSI) standards (where available) and other recommendations regarding equipment function;
- principles of psychoacoustics as related to auditory perception in individuals with normal hearing and those with hearing loss;
- principles and practices of research, including experimental design, evidence-based practice, statistical methods, and application of research to clinical populations.

EVALUATION

3.1.4A Assessment of the structure and function of the auditory and vestibular systems as well as the impact of any changes to such systems The program provides academic content and clinical education experiences so that each student can learn and demonstrate knowledge and skills in order to

- evaluate information from appropriate sources to facilitate assessment planning;
- obtain a case history;
- perform an otoscopic examination;
- remove cerumen, when appropriate;
- administer clinically appropriate and culturally sensitive assessment measures; August 2017, rev. January 2023 Standards for Accreditation Page 12 of 41
- perform audiologic assessment using behavioral, physiological (e.g., immittance, wideband reflectance, evoked potentials), psychophysical, and self-assessment tools;
- perform audiologic assessment using techniques that are representative of the challenges listeners may face in everyday communication situations;
- perform assessment to plan for rehabilitation;
- perform assessment to characterize tinnitus;
- perform balance system assessment and determine the need for balance rehabilitation;
- document evaluation procedures and results;
- interpret results of the evaluation to establish type and severity of disorder;
- generate recommendations and referrals resulting from the evaluation processes;
- provide counseling in a culturally sensitive manner to facilitate understanding of the hearing loss, tinnitus, or balance disorder of the individual being served;
- maintain records in a manner consistent with legal and professional standards;
- communicate results and recommendations orally and in writing to the individual being served and other appropriate individual(s);
- engage in interprofessional practice to facilitate optimal assessment of the individual being served;
- assign the correct Common Procedural Terminology (CPT) code(s) and the correct International Classification of Diseases (ICD) code(s);
- apply the principles of evidence-based practice;
- select and use outcomes measures that are valid and reliable indicators of success in assessment protocols and in determining the impact of changes in structure and function of the auditory and vestibular systems
- administer clinically appropriate and culturally sensitive self-assessment measures of communication function and functional assessment tools for individuals across the lifespan and the continuum of care,
- administer clinically appropriate and culturally sensitive scales of communication function to communication partners of the individual being served,
- determine contextual factors that may facilitate or impede an individual’s participation in everyday life.

TREATMENT AND PREVENTION

3.1.3A Identification and prevention of hearing loss, tinnitus, and vestibular disorders The program provides academic content and clinical education experiences so that each student can learn and demonstrate knowledge and skills in

- the prevention of the onset of loss of auditory system function, loss of vestibular system function, development of tinnitus, and development of communication disorders;
- the use of protocols to minimize the impact of the loss of hearing, tinnitus, loss of vestibular system function, and development of communication disorders;
- the use of screening protocols, including clinically appropriate and culturally sensitive screening measures, to assess individuals who may be at risk for hearing impairment and activity limitation or participation restriction;
- the screening of individuals for speech and language impairments and other factors affecting communication function using clinically appropriate and culturally sensitive screening measures;
- the use of screening tools for functional assessment;
- administering programs designed to reduce the effects of noise exposure, tinnitus, and agents that are toxic to the auditory and vestibular systems;
- applying psychometrics and principles of screening;
- applying the principles of evidence-based practice;
- selection and use of outcomes measures that are valid and reliable indicators of success of prevention programs.

3.1.5A Intervention to minimize the effects of changes in the auditory and vestibular systems on an individual's ability to participate in his or her environment The program's curriculum provides academic content and clinical education experiences so that each student can learn and demonstrate knowledge and skills in order to

- perform assessment for aural (re)habilitation;
- perform assessment for tinnitus intervention;
- perform assessment for vestibular rehabilitation;
- develop and implement treatment plans using appropriate data;
- counsel individuals served, families, and other appropriate individuals regarding prognosis and treatment options;
- develop culturally sensitive and age-appropriate management strategies;
- perform hearing aid, assistive listening device, and sensory aid assessment;
- recommend, dispense, and service prosthetic and assistive devices;
- provide hearing aid, assistive listening device, and sensory aid orientation;
- conduct audiologic (re)habilitation and engage in interprofessional practice to maximize outcomes for individuals served;
- serve as an advocate for individuals served, their families, and other appropriate individuals; August 2017, rev. January 2023 Standards for Accreditation Page 13 of 41
- monitor and summarize treatment progress and outcomes;
- assess efficacy of interventions for auditory, tinnitus, and balance disorders;
- apply the principles of evidence-based practice;
- document treatment procedures and results;
- maintain records in a manner consistent with legal and professional standards;
- communicate results, recommendations, and progress in a culturally sensitive and age appropriate manner to appropriate individual(s);
- select and use outcomes measures that are valid and reliable indicators of success in determining the impact of the interventions used to minimize the effects of changes in structure and function of the auditory and vestibular systems.

ACAE Standards for Au.D. Programs

The primary purpose of the ACAE accreditation is to recognize, reinforce and promote high quality performance in Au.D. educational programs through a rigorous verification process. This process will produce evidence that Au.D. programs have prepared graduates who are qualified to be doctoral-level and independent practicing audiologists. Graduates will be at the pointof-entry to the US and international healthcare systems for the diagnosis and treatment of hearing and balance disorders.

Accreditation also assures communities of interest that graduates will be able to function according to the national scope of practice, as defined by the profession. In the 2016 ACAE Educational Standards, there are added measures and expectations in the scope of practice. New and/or enhanced competency areas found in Standard # 22 include pharmacology, genetics, business/ personnel management/finances, psychosocial impact of hearing impairment and balance disorders, empathy and active listening, self-advocacy skills for patients and families and health and infection control. Programs must now demonstrate how their students have a working knowledge of all competencies as well as the ability to incorporate them into practice.

DIAGNOSIS, MANAGEMENT, AND TREATMENT

The student will be able to:

1. Diagnose, triage, treat and manage auditory and vestibular/balance conditions and diseases for patients over the lifespan, including newborns, infants, children, adolescents, adults, elderly and special needs individuals.

2. Apply audiologic diagnosis, treatment and management principles in diverse settings including, for example, private practice-based, educational and occupational/industrial environments.

3. Apply critical thinking skills to assess the patient's auditory and vestibular status.

4. Prescribe, perform and interpret clinical, laboratory and other diagnostic procedures and tests in consultation with other health professionals as may be required for proper management of the patient.

5. Interpret and synthesize the findings from the patient's history, examination and other diagnostic tests and procedures in order to identify the etiology, the pathogenesis of the condition, and the diagnosis.

6. Formulate a treatment plan and understand the implications of various treatment options.

7. Explain any relevant limitations for diagnosis and treatment and formulate a plan for consultation or referral, as appropriate.

8. Discuss the findings, diagnosis and treatment options with the patient, parent or guardian, family, other health care or service providers, as well as any modifications or consequences that may occur over the course of treatment.

9. Discuss pharmacological treatment options with the patient, parent or guardian, family or other health care or service providers as it relates to the prevention of hearing and balance disorders and, specifically, as it relates to appropriate vestibular system functions.

10. Plan and implement treatment and rehabilitation methods used for the management of auditory and vestibular disorders, including all forms of personal amplification and hearing assistance technology.

11. Present the patient with the sequence of treatment (including preventive care), estimated fees, payment arrangements, time requirements, and the patient's responsibilities for treatment. Apply the informed consent process as it relates to clinical procedures.

12. Characterize and implement evidence based practice methods and a critical evaluation of the literature to provide optimal outcomes for diagnosis and treatment of auditory and vestibular disorders.

13. Integrate all aspects of a patient's life (development, participation, environment and culture), as identified by the International Classification of Functioning (ICF), World Health Organization (WHO) and World Health Assembly, May 2001, into the treatment management of patients with hearing and/or balance disorders (See Explanations).

14. Explain the basic concepts of probability and disease susceptibility, and the influence of genetic factors in the maintenance of health and development of disease, as it applies to patients with hearing and/or balance disorders.

ACAE STANDARDS EVALUATION

The student will be able to:

1. Explain basic cell, organ, and body systems, with special emphasis on the auditory and vestibular/balance systems and their interrelationships to the body as a whole over the lifespan, including newborns, infants, children, adolescents, adults, elderly and individuals with special needs.

2. Describe the development of normal auditory and communication processes, 8 Accreditation Commission for Audiology Education (ACAE) including the embryology and development of the auditory/vestibular, central nervous and related systems.

3. Explain theoretical and applied principles of acoustics, psychoacoustics, non-acoustic stimuli, and electronics as applied to the normal and disordered auditory and vestibular systems.

4. Identify the various localized and systemic processes that lead to dysfunction and disease.

5. Describe the effect that disease processes can have on the body and major organ systems, with special emphasis on the auditory and vestibular systems.

6. Recognize the mechanisms of the various classes of pharmaceutical agents, their interactions, and safe, effective use for the treatment of disease and conditions affecting the ear, the auditory and vestibular systems, central nervous system and related systems.

7. Describe the structures and processes contributing to the development of auditory, vestibular and communication disorders and abnormalities.

8. Explain the impact of hearing disorders on communication for newborns, infants, children, adolescents, adults, elderly and individuals with special needs.

9. Explain and demonstrate the impact of genetics on the development and preservation of auditory function as well as the impact on the development of disorders of the auditory, vestibular, and related systems across the lifespan.

10. Explain the psychological and neurological bases for auditory and vestibular dysfunction and remediation.

11. Describe the science and methods employed, e.g., acoustical and pharmacological, for the preservation of hearing and balance disorders.

12. Critically evaluate the research foundation for hearing, balance and communication sciences.

ACAE STANDARDS CLINICAL EXPEREINCES

Description The goal of clinical experiences is to provide the necessary instruction to assure audiologists can act independently at graduation in any practice environment. This standard addresses the need for a program to assure that the clinical experiences available allow a student to gain the requisite skills and competencies to be able to provide those services at graduation. The program must demonstrate (e.g. measure, document, etc.) that every student has reached this goal. Externships in particular should be chosen with the expectation that a student can achieve independent practitioner status at the end of their program.

Description Standard 23 describes the breadth of clinical experiences that students must have during their training. Programs must describe and demonstrate how the required standards for clinical education are being met at externship sites. Programs must be able to demonstrate that students not only have experience in a diversity of clinical settings and with a diversity of patient populations, but that all of the experiences have a level of quality that allows students to develop skills necessary to provide the full scope of practice.

Association- Audiology Support Letters SB 795.pdf
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Position: FAV

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 write to you today on behalf of the Academy of Doctors of Audiology (ADA), a professional association representing audiologists in Maryland and across the United States, to support and endorse SB 795, which will make important updates to Maryland's audiology practice act to bring it into alignment with evidence-based practices in the delivery of hearing and balance care.

Audiologists are clinical doctoring professionals who are trained to evaluate, diagnose, and treat hearing and balance conditions, and to identify conditions that require additional diagnostic testing and/or a referral to a physician or another clinical specialist. A Doctor of Audiology (Au.D.) degree is the first professional degree, required to become a clinical audiologist in all 50 states, including Maryland.

SB 795 will create greater consistency between existing Maryland regulations and statutes. For example, licensed audiologists are already authorized under Maryland regulations to perform cerumen management procedures. Audiologists' formal clinical training and education is consistent with, or more advanced than other providers who are authorized to order cultures, blood tests, and radiographic imaging under Maryland statutes. SB 795 also includes appropriate statutory limitations on audiologists' scope of practice, by explicitly prohibiting audiologists from performing surgery, radiographic imaging, and other services that are outside of their education and training.

Maryland has a documented shortage of both physicians and nursing professionals.[1] In a recent Baltimore Banner article, MedChi reported that the shortage of primary care physicians is the "most acute shortage of healthcare workers statewide." According to Maryland Healthcare Commission data, the ratio of primary care providers to Maryland residents is fewer than 80 providers to every 10,000 residents.[2]

Updating Maryland's audiology practice act to recognize audiologists' full expertise, will help alleviate some of the existing physician and nursing shortages, by better deploying audiologists within the

[1] https://www.thebaltimorebanner.com/community/public-health/maryland-doctors-hard-to-find-TGPPWBIXYFCVBIXYA75ASGMWBY/
[2] See 1 above.

healthcare system and ensuring that patients are able to receive safe, timely access to the care that they need. Audiologists routinely perform non-radiographic imaging and scanning (earmold scanning and video otoscopy), using advanced techniques and technologies.

Audiologists are highly qualified to remove foreign bodies from the external auditory canal. They routinely encounter foreign bodies such as hearing aid filters, hearing aid domes, insects, rocks, and jewelry. Improving access to audiologists and codifying their authority to remove foreign bodies in the outer ear canal can help reduce the number of emergency room visits, which result in higher cost care, delivered by lesser trained providers.

The much-needed updates to Maryland's audiology practice act, as incorporated in SB 795, will improve access to safe effective audiologic care for the citizens of Maryland, provide greater patient choice, reduce cost, and improve outcomes.

SB 795 will assure consistency between regulations and statutes governing the practice of audiology, appropriately reflect the education, training, and skills that audiologists possess, while establishing appropriate consumer protections by limiting the practice of audiology to those services for which audiologists are educated and trained.

ADA encourages swift passage of SB 795. Please contact me at sczuhajewski@audiologist.org if I can provide additional information about the merits of SB 795 or if I can assist you in any way.

Respectfully,

Stephanie Czuhajewski, MPH, CAE
Executive Director

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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,

The Maryland Academy of Audiology (MAA) represents the more than 525 licensed audiologists who practice in the state of Maryland and the patients they serve. The MAA's goal is to enhance the ability of members to achieve career and practice objectives by fostering professional autonomy, providing quality continuing education, and increasing public and consumer awareness of hearing and balance disorders and the value of audiologic services[1]. By virtue of education and licensure, Audiologists are the most qualified professionals to diagnose and treat hearing (auditory) and balance (vestibular) disorders.

An Audiologist is a state-licensed professional who specializes in evaluating, diagnosing, managing, and treating patients with hearing loss, tinnitus, and balance disorders. Audiologists work in a variety of settings including, but not limited to private practices, hospitals, medical centers, universities (teaching and research), the Veterans Administration, and the U.S. Military and work closely with federal, state, and private third-party payers to optimize coverage of services provided for the evaluation and treatment of the patients in their care.

The MAA was founded in the 1990s to offer licensed audiologists a professional home, as they were not being served by other state-professional associations. It is one of the nation's oldest state audiology academies. Dr. Craig W. Johnson, Audiologist, provided a strong foundation for the MAA to be active in state legislative and regulatory initiatives. Additionally, other states often look-to the MAA to be the leader in the profession of audiology and for support when modernizing audiology legislation in their state.

[1] https://www.maaudiology.org/about/

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At the state level, the MAA provides counseling and advocacy to help members achieve career and practice objectives, offers an annual convention for audiologists to network and continue their education in the profession, and provides resources to patients who are seeking hearing and balance healthcare.

Maryland has two accredited residential Doctor of Audiology (Au.D.) programs, Towson University (TU) and University of Maryland- College Park (UM). After their rigorous didactic instruction, students from these two programs are placed with licensed audiologists around the state to obtain their clinical practicum hours. Audiologists demonstrate and supervise the students' skills. Without the Statute modernization, students are learning skills that cannot be provided to patients. Additionally, after graduating with a Doctor of Audiology degree, individuals often seek states that allow them to practice at a clinical-doctorate level. Maryland is not currently one of those states, which means individuals who are appropriately trained to provide the highest level of audiologic and vestibular care are moving to other states (e.g., Alabama, Colorado, Illinois) to provide healthcare. The loss of these graduates contributes to the state's accessibility issues, especially in rural areas, and is detrimental to the state's overall income and growth.

As clinical doctors, audiologists are well-educated to conduct health screenings. When the Centers for Medicare and Medicaid Services (CMS) added audiologists as eligible providers to the (then) Physician Quality Reporting System, health screenings were required when a certain type of patient was seen for care by an audiologist. The current Merit-Based Incentive System (MIPS) requires audiologists to screen for clinical depression, medication, tobacco use, alcohol, elder maltreatment, and more.[2,3] The CMS recognizes audiologists to complete this level of screening, a pass/fail outcome, as they classify audiologists as 'Diagnostic Suppliers.' Maryland Statute lags behind the CMS' definition!

Cerumen removal is currently within the audiologist's scope of practice, as noted in the Regulations.[4] However, it is not uncommon for audiologists to work with patients who utilize hearing amplification. The small parts of a hearing device can periodically come off. Audiologists are able to visualize foreign objects in the external auditory canal. The removal procedure is non-invasive (no anesthetic) and mirrors the procedure for cerumen removal. However, without a direct statement codifying this procedure, audiologists must refer (manage) their patients to another, often less-trained provider for this removal. Many patients choose Urgent Care as the accessibility and affordability is better compared to surgical specialists (e.g., ear, nose, and throat).

[2] https://audiologyquality.org/about-mips/
[3] https://audiologyquality.org/measures/
[4] https://health.maryland.gov/boardsahs/Pages/regulations.aspx

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As healthcare learns more about humans, the link to ears and hearing has expanded greatly, even in the past 5-10 years. Comorbidities of hearing loss include, but are not limited to cardiovascular disease, hypertension, elevated glycosylated hemoglobin levels[5], diabetes, kidney disease, and cognitive decline.[6] When evaluating hearing or balance concerns, an audiologist may be the first to identify a disorder that could be linked or caused by another human body system. The ordering of bloodwork testing and cultures would allow a patient to obtain more diagnostic information, without the need to present to another ordering physicians. [Audiologists would NOT be performing the bloodwork.] Removing the extra step would save the patient time and finances.

Besides the improvement in healthcare knowledge, technology has also vastly improved. Audiologists are now able to utilize non-radiographic scanning and imaging equipment in their offices. The scans and images provide better documentation of a patient's auditory/vestibular concern and give better details to assist the audiologist in creating a treatment plan or making a referral. Maryland Statute is currently unclear if these safe, in-office procedures are accessible by audiologists. SB 795 would confirm that technology advancements are able to be purchased and utilized, when medically necessary, by audiologists. It also conforms the Statute language to other non-physician providers who provide non-radiographic imaging and scanning, such as optometrists.

Finally, in the most extreme cases, patients may present to audiologists with complaints and evaluation results consistent with a retrocochlear (beyond the ear) pathology. This possible diagnosis requires the individual to obtain radiographic imaging to confirm/rule-out the finding. Johns Hopkins University's website indicates that a hearing test (audiometry), speech reception thresholds, speech discrimination, and imaging scans of the head are required to diagnose retrocochlear pathologies.[7] Audiologists are providing all of this evaluation, except the ordering of the images. Currently, audiologists work closely with primary care physicians (PCPs) to obtain an order for this type of procedure. [Audiologists are NOT performing or interpreting the procedure.] If imaging confirms a retrocochlear site of lesion, the patient is then referred to a sub-specialist in the area of ear/brain surgery, neuro-otology. The Mayo Clinic estimated that 2-4 in 100,000 Americans will be diagnosed this type of retrocochlear pathology.[8] Due to the low incidence of positive cases, waiting for a highly specialized surgeon for an order is ludicrous. SB 795 would provide access to the ordering of the radiographic imaging for patients with this suspected cause.

[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6439817/
[6] https://www.asha.org/siteassets/ais/ais-comorbidities-and-hearing-loss.pdf
[7] https://www.hopkinsmedicine.org/health/conditions-and-diseases/brain-tumor/vestibular-schwannoma
[8] https://www.mayoclinic.org/medical-professionals/neurology-neurosurgery/news/acoustic-neuroma-treatment-and-quality-of-life/mac-20429300

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SB 795 makes the desperate updates to modernize the Audiology Practice Definition and harmonizes it with other non-physician clinical doctors in Maryland. Audiologists are trained in both didactic and clinical skills and have been shown to be safe providers in the management of even the most extreme cases.[9] Ultimately, the modernization completed with the passage of SB 795 provides better access to auditory and vestibular healthcare, and affordability of healthcare to patients across the entire state.

Thank you for your support of SB 795 legislation.

Jennifer Kincaid, Ph.D.
President

Alicia D.D. Spoor, Au.D.
Legislative Chair

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

ILAA
ILLINOIS
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AUDIOLOGY

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,

On behalf of the audiologists in the Illinois Academy of Audiology, we are writing to pledge our strong support for SB795.

The Illinois Academy has been advocating for audiologists in Illinois and colleagues across the United States since its inception in November 1992. Our first on-site hearing screening campaign for Illinois legislators at our Capitol building was in 1995! Since then we have continued to successfully partner with the legislature to inform and lobby for instrumental changes in the laws and rules regarding the field of audiology, often leading the way for other states as an example. We work hard to stay up-to-date with the changing landscape in order to continue to provide access and affordability to our patients and community. Our own Speech-Language Pathology and Audiology Practice Act was recently reviewed and revised to keep up with the Federal changes that were made to the classification of hearing aids and the approved delivery models.

In the State of Illinois' Speech-Language Pathology and Audiology Practice Act, we define the practice of audiology as:

> "The practice of audiology" is the application of nonsurgical methods and procedures for the screening, identification, measurement, monitoring, testing, appraisal, prediction, interpretation, habilitation, rehabilitation, or instruction related to audiologic or vestibular disorders, including hearing and disorders of hearing. These procedures are for the purpose of counseling, consulting and rendering or offering to render services or for participating in the planning,

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directing or conducting of programs that are designed to modify communicative disorders involving speech, language, auditory, or vestibular function related to hearing loss. The practice of audiology may include, but shall not be limited to, the following:

(1) any task, procedure, act, or practice that is necessary for the **evaluation** and **management** of audiologist, hearing, or vestibular function, including, but not limited to, neurophysiologic intraoperative monitoring of the seventh or eighth cranial nerve function;

(2) training in the use of amplification devices;

(3) the **evaluation**, fitting, dispensing, or servicing of hearing instruments and auditory prosthetic devices, such as cochlear implants, auditory osseointegrated devices, and brainstem implants;

(4) **cerumen removal**;

(5) performing basic speech and language screening tests and procedures consistent with audiology training; and

(6) performing **basic health screenings** in accordance with Section 8.3 of this Act.

We understand that your Statute has not been updated since at least 2009 and 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 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); and
- Cerumen removal, which is already in Maryland's Regulations.

The language also modernizes:

- Removal of foreign bodies from the ear canal. It is not uncommon for hearing aid users to have a dome or wax guard (small part) become loose or lodge in the external auditory canal. Children are also seen with objects (e.g., toys, rocks, food) stuck in their ear canal. Currently, Maryland Statute only allows patients to receive a referral to their primary care physician, Urgent Care, ear, nose, and throat (ENT), and/or emergency room for this procedure, which is typically a more costly and time consuming option.
- Ordering of cultures and blood work. Many patients present with comorbid conditions and examination results indicate the need for further evaluation to identify or rule-out a

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ILLINOIS ACADEMY of AUDIOLOGY

syndrome, disease, or disorder. 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 audiologists now have equipment available that allows for images and video of the ear canal as well as 3D scanning of the external 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 (radiographic) x-rays.

These changes 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 in order to keep up with the science and discovery surrounding hearing and balance healthcare, 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 add the extremely skilled, qualified, and caring audiologists to their medical teams.

Thank you for your support of SB 795 legislation.

Sincerely,

Joshua Sevier, Au.D., LL.M.

President, Illinois Academy of Audiology

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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,

On behalf of the audiologists in the South Carolina Academy of Audiology, we are writing to pledge our support for SB795.

The South Carolina Academy has been advocating for audiologists in South Carolina and colleagues across the United States since its inception in 1989. As the first state academy, we have continued to successfully partner with the legislature to inform and lobby for instrumental changes in the laws and rules regarding the field of audiology, often leading the way for other states as an example. We work with our lobbyists to keep up with the changing landscape in order to continue to provide access and affordability to our patients and community. Our own practice act is actively being revised alongside our speech pathology colleagues to keep up with the Federal changes that were made to the classification of hearing aids and the approved delivery models.

While we are working on updating the language in the State of South Carolina' Speech-Language Pathology and Audiology Practice Act, we currently define the practice of audiology as:

> "Audiology" or "audiology service" means screening, identifying, assessing, diagnosing, habilitating, and rehabilitating individuals with peripheral and central auditory and vestibular disorders; preventing hearing loss; researching normal and disordered auditory and vestibular functions; administering and interpreting

behavioral and physiological measures of the peripheral and central auditory and vestibular systems; selecting, fitting, programming, and dispensing all types of amplification and assistive listening devices including hearing aids, and providing training in their use; providing aural habilitation, rehabilitation, and counseling to hearing impaired individuals and their families; designing, implementing, and coordinating industrial and community hearing conservation programs; training and supervising individuals not licensed in accordance with this chapter who perform air conduction threshold testing in the industrial setting; designing and coordinating infant hearing screening and supervising individuals not licensed in accordance with this chapter who perform infant hearing screenings; performing speech or language screening, limited to a pass-fail determination; screening of other skills for the purpose of audiological evaluation; and identifying individuals with other communication disorders.

We understand that 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 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.

These changes 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 in order 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 add the extremely skilled, qualified, and caring audiologists to their medical teams.

Thank you for your support of SB 795 legislation.

Sincerely,

Alexandra Tarvin, Au.D.

SCAA Professional Liaison, Former SCAA President, Technology Chair and Webmaster
South Carolina license AUD.4004

Audiology Support Letters SB 795.pdf
Uploaded by: PRESIDENT Kincaid
Position: FAV

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, AuD
Maryland License #01553

THE Hearing WELLNESS CENTER

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.

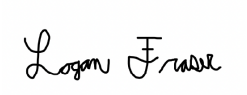
Audiologists ordering radiographic imaging for patients would streamline the differential diagnosis for patients who an audiologist determines is in need of imaging to rule out retro cochlear pathology. With the current method of referring back to primary care or to ENT, the patient is often waiting 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
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 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.

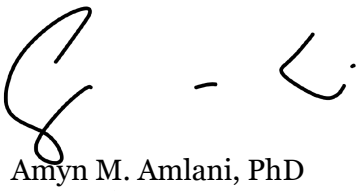
The ability for audiologists to order imaging is within their professional training when one considers that ordering radiographic imaging:

- 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.

Audiology Associates
INCORPORATED
aaiaudiology.com

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

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Finance Committee
3 East
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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 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!

Melissa J. Segev, Au.D.
Briana Bruno Holtan, Au.D.
Mikayla Abrams, Au.D.
Kelly Anne Boylan, Au.D.
Lindsay Dennison, Au.D.
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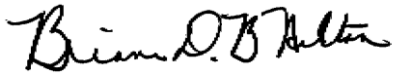
Corinne Waterman, Au.D.

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

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.

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
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 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

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STEPHANIE SJOBLAD, AU.D.
Professor
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February 22, 2024

Chair Pamela Beidle
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3 East
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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,

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.
Lindsay Dennison, Au.D.
Leslie Gilbert, Au.D.
Logan Fraser, Au.D.

Audiology Associates INCORPORATED
aaiaudiology.com

Jennifer Kincaid, Ph.D.
Jessica Kreidler, Au.D.
Meredith Kruzits, Au.D.
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.

Melissa J. Segev, Au.D.
Briana Bruno Holtan, Au.D.
Mikayla Abrams, Au.D.
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Corinne Waterman, Au.D.

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.
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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,

Maryland License #01241

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

Alaska Hearing & Tinnitus Center
1005 E Dimond Blvd
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Anchorage, Alaska 99515
Phone: 9075224357
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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,

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.

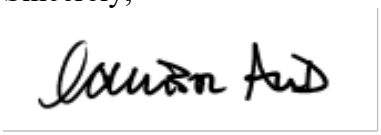
This bill modernizes the language needed to accurately reflect our rigorous didactic and clinical training. It allows audiologists to be on par with other non-physician, clinical doctors in the Maryland

(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

Designer 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,

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

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/

(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

[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

[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
MD License: #00145

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.

Audiology Associates INCORPORATED
aaiaudiology.com

Jennifer Kincaid, Ph.D.
Jessica Kreidler, Au.D.
Meredith Kruzits, Au.D.
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,

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.

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.
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Niki Razeghi, Au.D.
Candace G. Robinson, Au.D.
Corinne Waterman, Au.D.

Thank you for your support of SB 795 legislation.

Sincerely,

Melissa J. Segev

Melissa Segev, Au.D.
Doctor of Audiology
Maryland License #01149

Dentist- Audiology Provider Support Letter SB 795.
Uploaded by: PRESIDENT Kincaid
Position: FAV

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 dentist at Seneca Smiles, a general dental practice in the D.C./Maryland/Virginia metropolitan area. My daily patient population includes adults in their 90s to kids as young as one year old who I see for their dental healthcare needs. I am writing in support of HB 464 which would modernize the definition of audiology.

Audiologists play a vital role in my ability to provide comprehensive healthcare. 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 who I also refer my patients to, including optometry and podiatry. I rely on Audiologists to evaluate, diagnose, manage, and treat my patients' hearing and balance disorders.

Dental colleagues as well as my patients with hearing loss often times struggle to find access to care because of the sheer ambiguity between them and their otology or ENT counterparts.

This valuable piece of legislation would modernize audiologic healthcare in Maryland. When passed, my patients will benefit with better access and affordability for their hearing and vestibular healthcare, and also assist me in serving patients who I can best serve.

Thank you for your support of SB 795 legislation.

Sincerely,

Dr. Pedro Lam

Pedro Lam, DDS

Owner of Seneca Smiles Dental Clinic

ENT- Audiology Support Letter SB 795.pdf
Uploaded by: PRESIDENT Kincaid
Position: FAV

Alan E Oshinsky M.D. PA
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February 23, 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. Alan Oshinsky. I am a board certified and licensed otolaryngologist (ENT physician) in Maryland and Chief of the Division of Otolaryngology, Head and Neck Surgery at Mercy Medical Center, Baltimore, Maryland. I have been in active, private, and academic full-time practice for over 37 years in Baltimore City with satellite offices in the surrounding Baltimore metropolitan area. I evaluate and treat patients of all ages with a strong emphasis in geriatrics. Hearing health is vital to all patients but, especially so in seniors. Medical literature in the past five to seven years has unequivocally confirmed a strong association between hearing loss and reduced quality of life in this population. I am writing to affirm my very strong support of HB 464. This bill will modernize the definition of audiology and improve access for all Marylanders.

Audiologists play a vital role in my ability to provide comprehensive ear, nose, and throat healthcare. Licensed audiologists in Maryland are required to earn a clinical doctorate degree (Au.D.) and their robust curriculum requires significant didactic and clinical training in the specialty of audiology and vestibular healthcare. Their degree and scope of education frequently exceeds that of other allied health providers including physician's assistants, nurse practitioners and optometrists. I heavily rely on Audiologists to evaluate, diagnose, manage, and treat my patients with hearing and balance disorders.

This valuable piece of legislation would modernize the scope of practice of audiologic healthcare in Maryland. When passed, my patients will benefit with better access and affordability for their hearing and vestibular healthcare as well as assist me in serving patients who I can best serve.

Thank you for your support of HB 464 legislation.

Sincerely,

Alan E. Oshinsky, MD, PA

Chief Division of Otolaryngology, Head and Neck Surgery

Mercy Medical Center

NP- Audiology Provider Support Letter SB 795.pdf
Uploaded by: PRESIDENT Kincaid
Position: FAV

February 27, 2024

Chair Pamela Beidle
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 am a licensed nurse practitioner at Johns Hopkins Hospital as an acute care clinician located in Baltimore, Maryland. My daily patient population includes patients 15-95 who I see for their complex acute care healthcare needs. I am writing in support of HB 464 which would modernize the definition of audiology.

Audiologists play a vital role in my ability to provide comprehensive patient healthcare. 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 who I also refer my patients to, including optometry and podiatry. I rely on Audiologists to evaluate, diagnose, manage, and treat my patients' hearing and balance disorders.

A significant patient population that I care for head and neck patients with significant complex needs. Audiologists are central to the complex care needs for their expertise.

This valuable piece of legislation would modernize audiologic healthcare in Maryland. When passed, my patients will benefit with better access and affordability for their hearing and vestibular healthcare, and also assist me in serving patients who I can best serve. Thank you for your support of SB 795 legislation.

Sincerely,

Jessica Peters, DNP,MSN, RN, ACNP-BC, CNE

Assistant Professor, Johns Hopkins University School of Nursing

Acute Care Nurse Practitioner, Johns Hopkins Hospital

Patient- Audiology Support Letters SB 795.pdf
Uploaded by: PRESIDENT Kincaid
Position: FAV

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 constituent, I ask you to support SB 795, which would give Doctors of Audiology in the state of Maryland full access to treat my hearing and balance needs. This would make healthcare more accessible, especially as I get older. Also, healthcare is becoming more expensive. Being able to have a doctor evaluate, diagnose, manage, and treat my hearing loss and dizziness disorders quickly and less costly means a great deal to me.

Earlier this year I had COVID. While I did not have a severe case I noticed that approximately 12 days in I had sudden hearing loss in my right ear. My audiologist did an exam and identified hearing loss and swelling. I was in need of steroids immediately to address the issue as there is a small window of time to reduce the swelling before it caused permanent hearing loss. Though my audiologist could diagnose me and knew the treatment she was unable to prescribe the medication. In turn I needed to seek emergency care with the general practitioner in order for her to review the results from the audiologist and then prescribe the medication.

I appreciate your help and ask that you please support HB 795. Having my doctors and healthcare providers be more affordable, having quick appointment times, and full access to further healthcare would make my life easier and delay complications that might arise.

Thank you for your support of SB 795 legislation.

Cindy McCarthy

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 constituent, I ask you to support SB 795, which would give Doctors of Audiology in the state of Maryland full access to treat my hearing and balance needs. This would make healthcare more accessible, especially as I get older. Also, healthcare is becoming more expensive. Being able to have a doctor evaluate, diagnose, manage, and treat my hearing loss and dizziness disorders quickly and less costly means a great deal to me.

I recently found out that I had hearing loss in one ear. I visited Dr. Melissa Segev for ringing and dizziness, but because she was unable to order additional testing or prescribe steroids, I lost valuable time in my treatment. Because of the additional time that it took to schedule a separate visit with an ENT, who then prescribed steroids, my hearing loss was deemed permanent. Getting treatment quickly is critical to positive patient outcomes. Had Dr. Segev been able to immediately treat me, I may have had a different outcome. Allowing audiologists to deliver the full range of evaluation, diagnosis, and treatment will provide better patient outcomes.

I appreciate your help and ask that you please support HB 795. Having my doctors and healthcare providers be more affordable, having quick appointment times, and full access to further healthcare would make my life easier and delay complications that might arise.

Thank you for your support of SB 795 legislation.

Sincerely,

Katie Schieltz

Katie Schieltz

Audiology Associates

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 constituent, I ask you to support SB 795, which would give Doctors of Audiology in the state of Maryland full access to treat my hearing and balance needs. This would make healthcare more accessible, especially as I get older. Also, healthcare is becoming more expensive. Being able to have a doctor evaluate, diagnose, manage, and treat my hearing loss and dizziness disorders quickly and less costly means a great deal to me.

I am a Patient Care Coordinator for an Audiologist and this bill would allow me to get any pertinent information on our patients and treat them here accordingly without referring to another doctor for numerous testing etc. This is that time consuming for our patients and the patients often are delayed by days even weeks in dealing with several offices for their hearing healthcare. I had a patient that had to go to the ENT and she waited several weeks as there were no appointments available sooner with an ENT that took her insurance and this was only to order imaging. This could have been avoided if all her care could have been done immediately here.

I appreciate your help and ask that you please support HB 795. Having my doctors and healthcare providers be more affordable, having quick appointment times, and full access to further healthcare would make my life easier and delay complications that might arise.

Thank you for your support of SB 795 legislation.

Sincerely,

Angela Strouse

Staff- Audiology Support Letter SB 795.pdf
Uploaded by: PRESIDENT Kincaid
Position: FAV

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 the Practice Manager for a Audiology Group in MD, this has been the most rewarding job of my 30 plus year career in the medical field. In my role I oversee 11 locations and the support staff for all these locations, however I did start out as a support staff in one of our individual locations.

We see people of all ages and do all hearing testing needed, plus we do vestibular/balance assessments, tinnitus assessments, ABR testing, ECochG, CI evaluations and follow-ups and cerumen removal.

I am also the daughter of a significantly hearing-impaired parent and I personally know how much impaired hearing can affect not just the patient but everyone in their lives.

The above 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.

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.

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.

Audiologists need to be able to order radiological testing and lab work for patients to not prolong obtaining a medical diagnosis. We currently must refer patients back to their PCP or ENT and send them our recommendations and hope that they read the report and follow through on our recommendations to help the patient.

Healthcare has modernized and Maryland needs to keep pace.

Thank you for your support of SB 795 legislation.

Sincerely,

Christina Fike

DG Written Testimony_SB0795.pdf
Uploaded by: Senator Gile
Position: FAV

DAWN D. GILE
Legislative District 33
Anne Arundel County

Finance Committee

Chair

Anne Arundel County
Senate Delegation

Miller Senate Office Building
11 Bladen Street, Suite 3 East
Annapolis, Maryland 21401
410-841-3568 · 301-858-3568
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THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

Testimony in Support of SB0795 - Health Occupations - Practice Audiology - Definition

Madame Chair, Madame Vice Chair, and Fellow Members of the Senate Finance Committee:

First, I want to thank you for your support last year when we gave the Audiologists authority to "prescribe and order hearing aids" as required by the Food and Drug Administration's (FDA) final rule. That common-sense proposal was not without a fight.

In last year's bill, the words "diagnose, manage, and treat" auditory and vestibular (balance) conditions in the ear, were included in the bill as-introduced. Due to objections from the same individuals who are in opposition this year, and in the spirit of compromise, those words were struck to pass last year's bill, notwithstanding the strong evidence we will present this year, to prove those words belong in statute.

Why am I asking for those words, and other essential health care provisions that directly relate to the training and competency of Audiologists, to be inserted in the Practice of Audiology Statute?

The answer begins with the fact that it's been 20+ years since the basic Audiology Statute was written and the science of audiology - and the technologies related to audiology, have changed. We want to do two things – first, ***modernize*** the Audiology Statute to reflect those medical technological advances that benefit patients, and secondly, ***harmonize*** the Audiology Statute with other similar Health Occupation Statutes in Maryland and in other states. I have appended those statutes and regulatory references to my testimony.

In the normal concern of ***perceived*** scope battles that this committee hears – you should ask yourself, "Why should a profession, which is capable of providing audiologic medical services to the fullest capabilities of their education and training, be prohibited from doing so?"

Our goal here is to provide the most affordable and skilled health care with timely access to our constituents. I want to emphasize the '*affordable and skilled'* and *timely access* aspects as you listen to the testimony.

During my sponsor panel, you will hear directly why patients need the Audiologists to *order* certain procedures --- *not* perform --- but order those procedures. You will hear about the misdiagnosis of a tumor by an ear, nose, and throat (ENT) physician that was suspected by the Audiologist and could have been confirmed and treated years earlier, if the Doctor of Audiology could have ordered imaging.

You will also hear from an Audiologist about how her patients are being told they must wait five weeks to see an ENT, when they need immediate care. The opposition will profess that they would take the patient earlier, if called; but they *were* called. And if you put yourself in this patient's shoes, being told to wait five weeks because you are in a heavily populated area, or the specialized surgeon only comes to the county office once a month, is not only frustrating, but it also jeopardizes your timely access to health care.

In addition, the ever-increasing physician shortage affects patient affordability and clearly impacts timely accessibility.

Appended to my testimony is a detailed and extensive document that supports and justifies every word in this bill and supports the *modernization* of the Audiology Statute and unarguably *harmonizes* the Statute with other health care occupational Statutes in Maryland.

Specifically, the words "diagnose, manage, and treat" are used in the Optometry, Podiatry, Chiropractor, and Dentistry Statues and are cited in the appendix. Are the opponents here challenging the legislatively-approved words in those statutes? I have not seen any other proposed legislation to that affect. If they are not actively trying to limit *those* doctors' services, why are they opposed to these words being used for Doctors of Audiology, who in many cases have as much or more training as their clinical doctoring counterparts?

More specifically to the bill, health care screenings are part of the Academy of Doctors of Audiology (ADA) licensure requirements and referenced in my appendix with other sources.

Removal of a foreign body or cerumen, (which is the fancy medical term for earwax) from the external ear is absolutely supported by the medical training of these licensed Audiologists, but it is being restricted in their practice by the proposed MSO amendments. Why *can't* a Doctor of Audiology safely and efficiently clean earwax from a patient's ears? Sometimes we just need to use common-sense.

The ordering of cultures and blood work, as cited in the appendix, is part of the American Speech Language and Hearing Association's (ASHA) Council of Academic Accreditation (CAA) treatment standards required in a Doctor of Audiology program. The proposed MSO amendments strike "for which Audiologists are trained to "ORDER" bloodwork." It's a denial of the right to practice to the full scope of their licensure and to the detriment of our constituents.

As part of a medical team, especially with bone-anchored hearing aids and cochlear implants (both have a surgical internal and external component), radiographic imaging is required **prior** to the surgical procedure. The MSO amendment would *increase* cost to the patients by requiring **more** appointments with the ENT surgeon. This amendment would require the patient to have at least one additional visit to the ENT surgeon to simply obtain a paper referral to the radiology center.

This also results in the patients being billed for an additional office visit from the ENT surgeon, rather than allowing the Audiologist to directly provide the imaging referral at the original diagnostic appointment. All of this is required **before** the surgeon will schedule surgery. This is a common, but unnecessary, barrier in the audiology profession, affecting the patient's affordability and timely access to health care.

Fellow Members of the Committee, I appreciate your attention to this important bill to *modernize* the Audiology Statute and to *harmonize* it with other Maryland Health Occupation statutes and other states with similar Statutes that are cited in my appendix.

Per the Fiscal Note, this bill would not require additional state resources. I therefore respectfully request a favorable report on SB 795.

HB 464 SB 795 Appendix.pdf
Uploaded by: Senator Gile
Position: FAV

HB 464 / SB 795 Appendix

Practice of Audiology Legislation- Rebuttal to Opposition

Possible and Actual MSO (ear, nose, and throat,ENT)/MedChi (medical doctors,MD) concerns are noted in **black.**
Documented Rebuttals from Maryland Academy of Audiology (MAA) are in **red.**

Expanding scope (not modernizing):

- Audiology scope of practice definition is outdated with the technology in the profession, and with the clinical doctor required for the professional. Other clinical doctors (optometry, dentists, podiatry, and chiropractors) have updated their practice acts with modern terminology and language.
- **Evaluate**
  - "Evaluation" is already in the practice definition, including testing. HO 2-101 (2) (q) (1).
- **Diagnose**
  - The specific reference to 'assessment/diagnosis/evaluation' related to clinical training and the percentage of time a [student] must have, is already recognized for Audiologists in COMAR 10.41.03.03 B.(4)(a).
  - Audiologists are evaluating hearing acuity and diagnosing hearing loss, if applicable, via a Comprehensive Audiologic Evaluation. Physicians, per the Board of Examiners Spring Newsletter, 2016, cannot test hearing. There is no (technical component) TC/PC (professional component) split for CPT 92557 (Comprehensive Audiologic Evaluation). Therefore, the physicians are relying on the audiologists for this information.
    - Source: https://www.aapc.com/codes/coding-newsletters/my-otolaryngology-coding-alert/reader-question-92557-does-not-apply-to-audio-techs-107381-article
    - https://www.aapc.com/blog/52001-when-to-apply-modifiers-26-and-tc/
  - Didactic training to "diagnose" is required as part of the American Speech-Language Hearing Association's (ASHA) CAA accreditation of Doctor of Audiology educational programs.
    - Source: https://caa.asha.org/reporting/standards/2023-standards-revisions/
  - "Diagnosis" required as part of American Academy of Audiology's (AAA) ACAE accreditation of Doctor of Audiology educational programs.
    - Source: https://acaeaccred.org/about-us/
  - "Diagnose" is used in the U.S Dept. of Veterans Affairs (VA) scope of practice.
    - Source: Email: vhaaspsprogramoffice@va.gov
      Web Address: https://www.rehab.va.gov/PROSTHETICS/audiology/index.asp
      Description:
      "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).

- "Diagnosis" is used in the Academy of Doctors of Audiology (ADA) model licensure for audiology.
  - Source: https://www.audiologist.org/about-us/academy-documents/model-licensure-statute
- "Diagnosis" is used in the American Academy of Audiology (AAA) model licensure for audiology.
  - Source: https://www.audiology.org/practice-guideline/scope-of-practice/
- "Diagnosis" is used in the American Speech-Language-Hearing (ASHA) model licensure for audiology.
  - Source: https://www.asha.org/policy/sp2018-00353/
- Audiology language mirrors the other clinical doctoring (non-physician) professions in Maryland, including:
  - OPTOMETRY.
    - Source: https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gho&section=11-101&enactments=false
  - PODIATRY.
    - Source: https://health.maryland.gov/mbpme/Pages/hoa.aspx
  - CHIROPRACTORS.
    - Source: https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gho&section=3-101&enactments=false
  - DENTISTRY.
    - Source: https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=b3f60a68-496f-4b3f-9316-586e646f0947&config=014EJAA2ZmE1OTU3OC0xMGRjLTRlNTctOTQ3Zi0wMDE2MWFhYzAwN2MKAFBvZENhdGFsb2e9wg3LFiffInanDd3V39aA&pddocfullpath=%2Fshared%2Fdocument%2Fstatutes-legislation%2Furn%3AcontentItem%3A661B-JPP3-CGX8-04J8-00008-00&pdcontentcomponentid=234188&pdteaserkey=sr6&pditab=allpods&ecomp=8s65kkk&earg=sr6&prid=c5914f41-7642-43e5-897e-a8281f49518f
  - Licensed Professional Counselor can both diagnose and treat.
    - Source: H.O. 17-6B-01(o),(y); https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=28aa737d-eb2e-46c7-bdcc-075953abaea5&config=014EJAA2ZmE1OTU3OC0xMGRjLTRlNTctOTQ3Zi0wMDE2MWFhYzAwN2MKAFBvZENhdGFsb2e9wg3LFiffInanDd3V39aA&pddocfullpath=%2Fshared%2Fdocument%2Fstatutes-legislation%2Furn%3AcontentItem%3A63SM-VX91-DYB7-W41R-00008-00&pdcontentcomponentid=234188&pdteaserkey=sr49&pditab=allpods&ecomp=bs65kkk&earg=sr49&prid=ad25de66-8c10-4312-8d9e-a412a034d052
- The word "diagnose" mirrors the language of Audiology Scope of Practice in other states:
  - Colorado
    - Source: https://drive.google.com/file/d/0B-K5DhxXxJZbRFlEdVhVVE54TmM/view?resourcekey=0-NYAcD8U00QTeW_gOnWc70Q
  - South Carolina
    - Source: https://www.scstatehouse.gov/code/t40c067.php

        - New Hampshire
            - Source: http://www.gencourt.state.nh.us/rsa/html/XXX/326-F/326-F-1.htm
        - Utah
            - Source: https://le.utah.gov/xcode/Title58/Chapter41/C58-41_1800010118000101.pdf
        - Alabama
            - Source: http://abespa.alabama.gov/PDF/rules/Rules&Regulations2021.pdf
        - South Dakota
            - Source: https://sdlegislature.gov/Statutes/Codified_Laws/2060798
        - Vermont
            - Source: https://legislature.vermont.gov/statutes/fullchapter/26/067
- **Manage**
    - "Prevent or modify", a form of management, is already in the practice definition. HO S2-101 (2) (q) (1).
    - "Manage" is required as part of ASHA's CAA accreditation of Doctor of Audiology educational programs.
        - Source: https://caa.asha.org/reporting/standards/2023-standards-revisions/
    - "Manage" is required as part of AAA's ACAE accreditation of Doctor of Audiology educational programs.
        - Source: https://acaeaccred.org/about-us/
    - "Management" is used in the Academy of Doctors of Audiology (ADA) model licensure for audiology.
        - Source: https://www.audiologist.org/about-us/academy-documents/model-licensure-statute
    - "Managing" is used in the American Academy of Audiology (AAA) model licensure for audiology.
        - Source: https://www.audiology.org/practice-guideline/scope-of-practice/
    - "Management" is used in the American Speech-Language-Hearing (ASHA) model licensure for audiology.
        - Source: https://www.asha.org/policy/sp2018-00353/
    - Audiology language mirrors the other clinical doctoring professions in Maryland, including:
        - OPTOMETRY.
            - Source: https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gho&section=11-101&enactments=false
    - "Management" mirrors the language of Audiology Scope of Practice in other states:
        - Alabama
            - Source: http://abespa.alabama.gov/PDF/rules/Rules&Regulations2021.pdf
        - Illinois
            - Source: https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1325&ChapterID=24
- **Treat**
    - "Treat" is required as part of ASHA's CAA accreditation of Doctor of Audiology educational programs.
        - Source: https://caa.asha.org/reporting/standards/2023-standards-revisions/

- "Treat" is required as part of AAA's ACAE accreditation of Doctor of Audiology educational programs.
  - Source: https://acaeaccred.org/about-us/
- Hearing aid dispensing, selling, and fitting has been a part of the audiology scope of practice for years (Source: HO 2-101 (q) (2)), and implies treatment of hearing loss using air conduction hearing aids.
- "Treatment" is used in the VA scope of practice.
  - Source: Email: vhaaspsprogramoffice@va.gov
    Web Address: https://www.rehab.va.gov/PROSTHETICS/audiology/index.asp
    Description:
    "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).
- "Treatment" is used in the Academy of Doctors of Audiology (ADA) model licensure for audiology.
  - Source: https://www.audiologist.org/about-us/academy-documents/model-licensure-statute
- "Treatment" is used in the American Academy of Audiology (AAA) model licensure for audiology.
  - Source: https://www.audiology.org/practice-guideline/scope-of-practice/
- "Treatment" is used in the American Speech-Language-Hearing (ASHA) model licensure for audiology.
  - Source: https://www.asha.org/policy/sp2018-00353/
- 2023 legislation (HB 401/SB 449) codified audiologists' ability to prescribe, order prescription hearing aids, with the Food and Drug Administration's (FDA) new category of prescription hearing aids. "Prescribe, order" are a form of treatment.
  - Source: https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/hb0401?ys=2023RS
- Osseo-Integrated Devices (defined in the language) and Cochlear Implants have a sound processor (defined in the language) that need to be prescribed, ordered, dispensed, and externally fit, similar to prescription hearing aids. These surgical systems are required when air conduction hearing aids are not beneficial for specific hearing loss.
  - The legislation clearly defines that audiologists are not performing surgery for Osseo-Integrated Devices, Cochlear Implants, or other reasons.
- Audiology language mirrors the other clinical doctoring (non-physician) professions in Maryland, including:
  - OPTOMETRY.
    - Source: https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gho&section=11-101&enactments=false
  - PODIATRY.
    - Source: https://health.maryland.gov/mbpme/Pages/hoa.aspx
  - CHIROPRACTORS.
    - Source: https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gho&section=3-101&enactments=false

        - DENTISTRY.
            - Source: https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=b3f60a68-496f-4b3f-9316-586e646f0947&config=014EJAA2ZmE1OTU3OC0xMGRjLTRlNTctOTQ3Zi0wMDE2MWFhYzAwN2MKAFBvZENhdGFsb2e9wg3LFiffInanDd3V39aA&pddocfullpath=%2Fshared%2Fdocument%2Fstatutes-legislation%2Furn%3AcontentItem%3A661B-JPP3-CGX8-04J8-00008-00&pdcontentcomponentid=234188&pdteaserkey=sr6&pditab=allpods&ecomp=8s65kkk&earg=sr6&prid=c5914f41-7642-43e5-897e-a8281f49518f
    - Treat mirrors the language of Audiology Scope of Practice in other states:
        - Florida
            - Source: http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0468/Sections/0468.1125.html
        - Maine
            - Source: http://www.mainelegislature.org/legis/statutes/32/title32sec17101.html
        - Colorado
            - Source: https://drive.google.com/file/d/0B-K5DhxXxJZbRFlEdVhVVE54TmM/view?resourcekey=0-NYAcD8U00QTeW_gOnWc70Q
        - Alabama
            - Source: http://abespa.alabama.gov/PDF/rules/Rules&Regulations2021.pdf
        - Utah
            - Source: https://le.utah.gov/xcode/Title58/Chapter41/C58-41_1800010118000101.pdf
- **Evaluate, Diagnose, Manage, and Treat are in physician's definition of medicine.**
    - The physician's definition is :"Practice of Medicine: diagnosis, healing, treatment, or surgery."
        - Source: https://dhs.maryland.gov/documents/Licensing-and-Monitoring/Maryland%20Law%20Articles/RCC/HEALTH%20OCCUPATIONS%20Title%2014%20Physicians.pdf
- **Evaluate, Diagnose, Manage, and Treat are in physician's definition of medicine. When these terms are used in other health occupations they are limited or qualified by a requirement for a higher level of education and training within that specialty. (ENT reply received 01/23/2024)**
    - The only education and training higher than a clinical doctorate degree is a physician's training- Medical Doctor (MD) or Osteopathic Medicine (DO).
    - These words are in other provider's Scope of Practice Statutes that have less didactic and clinical training than Audiologists.
    - Direct-entry midwives are providers who are not yet nurses have the following terminology:
        - Evaluating, laboratory tests, monitoring, suturing, obtain and administer medication.
            - Source: HO 8-6C-02; https://law.justia.com/codes/maryland/2021/health-occupations/title-8/subtitle-6c/section-8-6c-02/

- Psychologists:
  - Doctor of Psychology (PsyD) degree is required and have the following terminology:
    - Diagnosis, Treatment
      - Source: https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gho&section=18-101&enactments=false
- Certified social worker-clinical:
  - Master's degree in social work and 12 additional credit hours, 2 years of experience with 3000 hours is required and have the following terminology:
    - Diagnosis, Treatment
      - Source: https://health.maryland.gov/bswe/Pages/regulation.aspx
- Occupational Therapists:
  - Master's degree in occupational therapy is required and have the following terminology:
    - Treat
      - Source: Occupational Therapists – TREAT – H.O. 10-101(l); https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=52e50e92-63a3-4fbd-8209-6218aae854a2&config=014EJAA2ZmE1OTU3OC0xMGRjLTRlNTctOTQ3Zi0wMDE2MWFhYzAwN2MKAFBvZENhdGFsb2e9wg3LFiffln
- Physical Therapists:
  - Doctor of Physical Therapy (DPT) degree is required and have the following terminology:
    - Treatment programs
      - Source: https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gho&section=13-101&enactments=false
- Clinical alcohol and drug counseling
  - Master's degree is required in Maryland and have the following terminology:
    - Diagnosis, Treatment
      - Source: https://docs.google.com/document/d/15IiJmiIU0gEsrfTdS3BBDUguf7j5AhNYyIxUQ_qGOR8/edit
- Clinical marriage and family therapy
  - Master's degree is required and have the following terminology:
    - Diagnosis, Treatment
      - Source: https://docs.google.com/document/d/15IiJmiIU0gEsrfTdS3BBDUguf7j5AhNYyIxUQ_qGOR8/edit
- Clinical professional art therapy
  - Master's degree is required and have the following terminology:
    - Diagnosis, Treatment
      - Source: https://docs.google.com/document/d/15IiJmiIU0gEsrfTdS3BBDUguf7j5AhNYyIxUQ_qGOR8/edit

- Clinical professional counseling
  - Master's degree and have the following terminology:
    - Diagnosis, Treatment
      - Source: https://docs.google.com/document/d/15IiJmiIU0gEsrfTdS3BBDUguf7j5AhNYyIxUQ_qGOR8/edit

- **Auditory**
  - "Hearing" is already in the practice definition, including testing.
    - Source: HO S2-101 (2) (q) (1).
  - The definition of auditory is of, relating to, or experiences through hearing.
    - Source: https://www.merriam-webster.com/dictionary/auditory
  - Auditory is a more accurate terminology for hearing, tinnitus, auditory processing, etc.
  - Auditory is required as part of ASHA's CAA accreditation of Doctor of Audiology educational programs.
    - Source: https://caa.asha.org/reporting/standards/2023-standards-revisions/
  - Auditory is required as part of AAA's ACAE accreditation of Doctor of Audiology educational programs.
    - Source: https://acaeaccred.org/about-us/
  - Auditory is used in the Academy of Doctors of Audiology (ADA) model licensure for audiology.
    - Source: https://www.audiologist.org/about-us/academy-documents/model-licensure-statute
  - Auditory is used in the American Academy of Audiology (AAA) model licensure for audiology.
    - Source: https://www.audiology.org/practice-guideline/scope-of-practice/
  - Auditory is used in the American Speech-Language-Hearing (ASHA) model licensure for audiology.
    - Source: https://www.asha.org/policy/sp2018-00353/
- **Vestibular**
  - "Vestibular" is already in the practice definition, including testing.
    - Source: HO S2-101 (2) (q) (1).
- **Human Ear**
  - Auditory and vestibular system are located in the human ear. Auditory consists of the external, middle, and inner ear. The vestibular system is located in the inner ear.
    - Source: https://www.nidcd.nih.gov/health/how-do-we-hear
  - "Ear" knowledge is required as part of AAA's ACAE accreditation of Doctor of Audiology educational programs.
    - Source: https://acaeaccred.org/about-us/
  - Audiology language mirrors the other clinical doctoring professions in Maryland, including:
    - OPTOMETRY.
      Optometry/human eye.
      - Source: https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gho&section=11-101&enactments=false
    - PODIATRY.
      Podiatry/human foot or ankle.
      - Source: https://health.maryland.gov/mbpme/Pages/hoa.aspx

- CHIROPRACTORS.
  Chiropractic/human body.
  - Source: https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gho&section=3-101&enactments=false
- DENTISTRY.
  Dentistry/human mouth.
  - Source: https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=b3f60a68-496f-4b3f-9316-586e646f0947&config=014EJAA2ZmE1OTU3OC0xMGRjLTRlNTctOTQ3Zi0wMDE2MWFhYzAwN2MKAFBvZENhdGFsb2e9wg3LFiffInanDd3V39aA&pddocfullpath=%2Fshared%2Fdocument%2Fstatutes-legislation%2Furn%3AcontentItem%3A661B-JPP3-CGX8-04J8-00008-00&pdcontentcomponentid=234188&pdteaserkey=sr6&pditab=allpods&ecomp=8s65kkk&earg=sr6&prid=c5914f41-7642-43e5-897e-a8281f49518f

- **Conducting Health Screenings**
  - Screenings of many varieties are in public places (e.g., blood pressure screening at Walmart). Allowing a clinical doctor to complete a health screening does not introduce any more harm than a screening that an individual completes themselves.
  - Screenings (related to the then Medicare PQRI system, PQRS system, and current MIPS requirements) were determined to not be a scope of practice issue, as it does not require diagnosis.
    - Source: https://health.maryland.gov/boardsahs/Pages/minutes.aspx
  - Health screenings may aid in triage of patients and, with an appropriate referral, should not reference a specific insurance requirement (e.g., Medicare MIPS) that may change names in the future
  - "Screening tools for functional assessment" are required as part of ASHA's CAA accreditation of Doctor of Audiology educational programs.
    - Source: https://caa.asha.org/reporting/standards/2023-standards-revisions/
  - "Hearing screenings" is used in the Academy of Doctors of Audiology (ADA) model licensure for audiology.
    - Source: https://www.audiologist.org/about-us/academy-documents/model-licensure-statute
  - "Screening" topic is used in the American Academy of Audiology (AAA) model licensure for audiology.
    - Source: https://www.audiology.org/practice-guideline/scope-of-practice/
  - Used in the American Speech-Language-Hearing (ASHA) licensure.
    - Source: https://www.asha.org/policy/sp2018-00353/

- **Removal of a foreign body from the external auditory canal**
  - Audiologists are currently licensed to remove cerumen. Often, when cerumen is removed and examined, foreign objects can be identified, including parts of a Q-tip, a hearing aid wax filter, or insects.
  - When a foreign object is visualized during otoscopy, patients may be directed to an Urgent Care center for removal (not an ENT surgeon). These Urgent Care providers may have **less** training on cerumen removal compared to an audiologist.

- **Removal of cerumen from the external auditory canal**
  - "Cerumen Management" is already a part of the audiology regulations. Simply needs to be codified.
    - Source: Title 10 Subtitle 41 Chapter 07
      - https://health.maryland.gov/boardsahs/Pages/regulations.aspx
  - "Remove cerumen" is required as part of ASHA's CAA accreditation of Doctor of Audiology educational programs.
    - Source: https://caa.asha.org/reporting/standards/2023-standards-revisions/
  - "Remove cerumen" is used in the American Academy of Audiology (AAA) model licensure for audiology.
    - Source: https://www.audiology.org/practice-guideline/scope-of-practice/
  - "Cerumen management" is used in the American Speech-Language-Hearing (ASHA) model licensure for audiology.
    - Source: https://www.asha.org/policy/sp2018-00353/

- **Ordering of cultures and labwork**
  - "Medical and surgical interventions" for treatment is required as part of ASHA's CAA accreditation of Doctor of Audiology educational programs.
    - Source: https://caa.asha.org/reporting/standards/2023-standards-revisions/
  - "Prescribe, perform and interpret clinical, laboratory, and other diagnostic procedures and tests…" is required as part of AAA's ACAE accreditation of Doctor of Audiology educational programs.
    - Source: https://acaeaccred.org/about-us/
  - "Laboratory tests" is used in the American Academy of Audiology (AAA) model licensure for audiology.
    - Source: https://www.audiology.org/practice-guideline/scope-of-practice/
  - Britian's audiologist can order some lab tests - The development of next generation sequencing techniques, with many genes being tested in parallel as part of a 'panel test', has allowed expansion of the available testing for deafness to over a hundred genes. Previously, the service availability of a panel test for deafness was limited, expensive for individual clinicians to fund and there was a long wait for results. The introduction of the National Genomic Test Directory in England has standardized the criteria for the deafness panel test, which went live in April 2021, clarified which clinicians can request the test (including audiologists) and is funded centrally by NHS England.
  - Other non-physicians are recognized professions that can order lab test:
    - Licensed Acupuncturists (at least 5 states allow this).
    - Doctors of Chiropractic are allowed to order and interpret labs in all but 2 states.
    - Registered Dieticians (RD) can order labs just as long as they work in clinic or hospital & used to monitor effectiveness of dietary plans, and of course Pharmacists.
    - Direct-Entry Midwives.

- **Ordering and performing of in-office nonradiographic scanning or imaging of the external auditory canal**
  - Ear scanning/imaging using nonradiographic equipment is the newest technology for taking an impression of the external auditory canal. Current systems use a single use, disposable membrane and/or cameras to take a 3D image of the ear.
    - Source: https://natus.com/sensory/otoscan/#info

- Ear imaging/scanning using nonradiographic equipment is not new technology; it initially started in the early 2000s with the Navy to obtain hearing protection.
  - Source: https://www.audiologyonline.com/articles/otoscan-3d-ear-scanning-future-24421
- This equipment is generally considered safer than taking physical impressions of the ears (one of the most invasive things an audiologist administers with patients).
  - Source: https://www.entandaudiologynews.com/development/spotlight-on-innovation/post/leaving-an-impression-otoscan-ear-scanning-solution#:~:text=Yes%2C%20two%20of%20the%20most,completed%20in%202%2D3%20minutes
- Dentistry has nonradiographic imaging equipment: intraoral scanner.
  - Source:
    - https://www.meetdandy.com/go-digital/?utm_medium=paidsearch&utm_source=google&utm_campaign=demo&utm_content=17678123183_140123091762&utm_term=630774824788&id=9007880-e-g-c--&_bk=best%20dental%20scanners&_bm=e&_bn=g&gclid=Cj0KCQiA2KitBhCIARIsAPPMEhLNQIIYYq0WQVSVKtp9iVXp3HD2JVTkSJr9gStj2ZJ-MCHqtE2AjyUaAn92EALw_wcB
    - https://www.go3dpro.com/aoralscan-3-intraoral-scanner.html?gad_source=1&gclid=Cj0KCQiA2KitBhCIARIsAPPMEhLfQZ-9gaIjxMeXc_IepJBY8mn6XlBB9vxfyLYvm-LpY9jeBq9-pqQaAuvfEALw_wcB
    - https://www.3shape.com/en-us/digital-dentistry/intraoral-scanners
- Optometry has nonradiographic imaging equipment: retinal imaging.
  - Sources:
    - https://us.medical.canon/products/eye-care/
    - https://www.optos.com/products/

- **Ordering of radiographic imaging**
  - Language clearly excludes the performance of radiographic imaging.
  - Radiologist interprets the imaging.
  - Audiologists can review results and triage patients, if necessary.
    - Can prevent surgical subspecialty providers (e.g., ENTs) from seeing patients who do not need surgery, therefore allowing them to focus on their scope of practice ("Practice of Medicine: diagnosis, healing, treatment, or surgery.)
      - Sources: HO 14-101 (o) (1) https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gho&section=14-101&enactments=false
      - Language does not allow audiologists to heal or complete surgery.
  - Audiologist in Britian can order imaging. They have master's degrees in Audiology.
    - Source: https://www.baaudiology.org/app/uploads/2020/04/Guidance-on-Referral-for-MRI-by-Audiologists.pdf
  - Chiropractors order x-rays in all 50 states and some advanced imaging.
    - Source: https://www.radiologytoday.net/archive/rt0810p20.shtml#:~:text=Chiropractors%20in%20all%2050%20states,coverage%20is%20a%20separate%20matter

No need for audiologists to change their definition.

- The current language needs to be modernized to current terminology, reflecting didactic and clinical training. All providers should be working to their highest scope of practice. Audiologists

are trained didactically and clinically to evaluate, diagnose, manage, and treat auditory and vestibular disorders, helping physicians see individuals who are most needed.

- Shortage of MD/ENTs.
  - Private audiology practices have logged a 5-week waiting period for patients to be seen by an ENT, when necessary. Even when an audiology practice calls an ENT office for sudden hearing loss (which can require trans-tympanic membrane medication treatment) the efforts do not yield an appointment in less than 1 week.
- A MHCC 2023-2026 report states: More than 1.7 million Marylanders reside in primary care and mental health professional shortage areas.
  - Source: https://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/2023/plr_strategic_rpt_2023.pdf
- An NIH study rated Maryland as a 'C' in the physician demand in 2017, with severe shortage estimated in the future.
  - Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7006215/
- The AMA reports a physician shortfall of at least 37,000, and as many as 100,000, over the next decade.
  - Source: https://www.ama-assn.org/press-center/press-releases/ama-president-sounds-alarm-national-physician-shortage#:~:text=It's%20no%20wonder%20why%20the,100%2C000%E2%80%94%20over%20the%20next%20decade
- Maryland specific shortages:
  - Gene Ransom was quoted in Baltimore Banner calling the primary care physician shortage the most acute shortage of healthcare providers statewide.
    - Source: https://www.thebaltimorebanner.com/community/public-health/maryland-doctors-hard-to-find-TGPPWBIXYFCVBIXYA75ASGMWBY/
  - The Maryland Health Care Commission notes there are only 80 primary care physicians for every 10,000 residents.
    - Source: https://mhcc.maryland.gov/transparency/PhysicianProfile.html
  - MedChi (2007) reports physician shortages.
    - Source: https://www.medchi.org/Portals/18/files/Law%20&%20Advocacy/Initiatives%20Page/Workforce%20Study%20Executive%20Summary.pdf?ver=2009-09-02-040000-000
- There is also a shortage of ENTs in Maryland.
  - Source: https://www.enttoday.org/article/some-studies-predict-a-shortage-of-otolaryngologists-do-the-numbers-support-them/?singlepage=1&theme=print-friendly
- AAO-HNS also reports shortages of ENTs:
  - "We identified cohorts of 8573 otolaryngologists, 1148 NPs, and 895 PAs. There were significantly higher population-controlled densities of otolaryngologists and APPs in urban counties as compared with rural counties. The majority of otolaryngologists (92.1%) and APPs (83.3%) were in urban counties. However, the proportion of APPs (16.7%) in rural counties was significantly higher than the proportion of otolaryngologists (7.9%) in rural counties ($P < .01$). A significant majority of rural counties (72.2%) had zero identified providers, and a greater proportion of rural counties (5.0%) were served exclusively by APPs as compared with urban counties (3.2%)."
    - Source: https://journals.sagepub.com/doi/10.1177/01945998211040408
- Expedite care is needed for patients. The wait time to see an ENT, or other specialist, for other triage care is extraordinary and can be detrimental to timely health care access and outcomes.

Same scope at physicians:

- “”Practice medicine” means to engage, with or without compensation, in medical diagnosis, healing, treatment, or surgery.
    - Source: https://www.medchi.org/Portals/18/files/Law%20&%20Advocacy/Initiatives%20Page/120413Practice_of_Medicine.pdf?ver=2016-06-24-092029-000
    - HO S14-101 (o) (1) (i), (ii), (iii), (iv).
    - Healing and surgery are **NOT** in the audiology practice language. In fact, surgery is explicitly listed as not within the scope.

Is this about Incomes (not outcomes)?

- Physicians would lose an office visit (E&M code).
    - Visits to a primary provider can yield a diagnosis and treatment plan. Less money is billed to the insurance companies, there is less out-of-pocket costs to the patients in co-pays, co-insurance, deductibles, and non-covered services.

Not recognized for diagnosis, treatment

- Audiologists are already recognized by insurances, including Medicare as diagnostics providers, under Section 1861(ll)(3) of the Social Security Act (the Act).
    - Source: https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
- Many third-party payers recognize audiologists as both diagnosticians and treatment providers as the CPT and HCPCS (billing) codes are eligible for coverage/reimbursement.

Other states do not allow this scope.

- See all the above states that allow for diagnose, manage, and treat.
- Veterans Administration Scope of Practice includes “prevention, diagnosis, and treatment…including hearing loss, balance…”
    - Source: https://www.rehab.va.gov/audiology/#:~:text=Audiologists%20are%20licensed%20healthcare%20professionals,loss%2C%20balance%20impairment%20and%20tinnitus

Patient safety issues

- Zapala (2010) study from Mayo Clinic Florida summarized:
  “Of study patients evaluated for hearing problems in the one-year period of this study, the majority (95%) ultimately required audiological services, and in most of these cases, audiological services were the only hearing health-care services that were needed. Audiologist treatment plans did not differ substantially from otolaryngologist plans for the same condition; there was no convincing evidence that audiologists missed significant symptoms of otologic disease; and there was strong evidence that audiologists referred to otolaryngology when appropriate.”
    - Source: https://pubmed.ncbi.nlm.nih.gov/20701834/
- Audiologists in Maryland and around the US have identified results that require additional treatment, often including radiographic imaging. However, audiologists cannot refer for the radiographic imaging and have been sued (the Maryland claim was denied) for not ordering imaging results, as the ENT providers did not feel the results required imaging.

Audiologists are not trained to diagnose, manage, and treat.

- Besides the above-noted educational standards which clearly demonstrate that audiologists are trained to diagnose, manage, and treat, two AuD programs are in Maryland. They are both accredited programs.
    - Towson Curriculum:
        - Diagnostic Courses
            - ACSD 603- Anatomy and Physiology of the peripheral auditory and vestibular systems
            - ACSD 604- Neuroanatomy and Physiology of the central auditory and vestibular systems
            - ACSD 621- Auditory Diagnostics
            - ACSD 723- Auditory Diagnostics II
            - ACSD 743- Electrophysiologic evaluation of the peripheral auditory system
            - ACSD 744- Electrophysiologic Evaluation of the Central Auditory Nervous System
            - ACSD 843- Vestibular Assessment and Rehabilitation
            - ACSD 844- Tinnitus
            - ACSD 845- Vestibular Diagnostics and Treatment Lab
        - Manage/Treat Courses
            - ACSD 622- Auditory Diagnostics Laboratory
            - ACSD 645- Communication and Aging
            - ACSD 690- Audiology Clinic on Campus
            - ACSD 705- Counseling in Audiology
            - ACSD 745- Audiology Clinic on Campus
            - ACSD 746- Audiology Clinic on Campus
            - ACSD 747- Audiology Clinic off Campus
            - ACSD 748- Audiology Clinic of Campus
            - ACSD 753- Pediatrics and Educational Audiology
            - ACSD 751- Hearing Conservation
        - Medical
            - ACSD 606 Pharmacology in Audiology
            - ACSD 607 Genetics in Audiology
            - ACSD 723- Medical Audiology
            - ACSD 853- Cochlear Implants
        - Source: https://catalog.towson.edu/graduate/course-descriptions/acsd/
    - UMD Curriculum:
        - Diagnostic courses
            - HESP 606- Basic Hearing Measurements: interpretation of routine audiometric tests.
            - HESP 649A and 649B- Clinical Practice in Audiology: diagnosis and treatment of hearing disorders.
            - HESP 706- Advanced Clinical Audiology: interpretation of test results.
        - Manage/Treat courses
            - HESP 615- Counseling in Communication Disorders
            - HESP 635- Rehabilitative Audiology
            - HESP 645- Pediatric Audiology: treatment of hearing-impaired children.
            - HESP 649A and 649B- Clinical Practice in Audiology: diagnosis and treatment of hearing disorders.
            - HESP 730- Vestibular-ocular Function and Assessment: rehabilitative issues.

- Medical:
    - HESP 632- Medical Audiology: auditory pathologies, assessment and management
    - HESP 710- Industrial and Environmental Noise Problems: Medico-legal aspects of noise-induced hearing loss.
    - HESP 712- Cochlear Implants and Other Implantable Technologies: medical/surgical aspects.
- Source: https://hesp.umd.edu/undergraduate/program-highlights-doctoral-program-clinical-audiology-(caud)

2 - SB 795 - Audiology Bd - Support - revised - FI

Uploaded by: State of Maryland (MD)

Position: FAV

Maryland
DEPARTMENT OF HEALTH
Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

Board of Examiners for Audiologists,
Hearing Aid Dispensers, Speech-Language
Pathologists & Music Therapists
4201 Patterson Avenue
Baltimore, Maryland 21215

2024 SESSION
POSITION
PAPER

BILL NO: SB 795
COMMITTEE: Finance
POSITION: Support

TITLE: Health Occupations – Practice Audiology – Definition

BILL ANALYSIS: SB 795 proposes to alter the definition of "practice audiology" for the purposes of certain provisions of law governing the licensure and regulation of Audiologists.

POSITION AND RATIONALE: The Board of Examiners for Audiologists, Hearing Aid Dispensers, Speech-Language Pathologists and Music Therapists (the "Board") is in full support of SB 795.

The Board supports SB 795 for several reasons. The key reason being is that audiologists are the primary providers for their patients and are the best healthcare professionals for the diagnosis, evaluation, management, and treatment of hearing and vestibular conditions. Audiologists are the most knowledgeable in caring for their patients with hearing and vestibular conditions. Therefore, audiologists should have total autonomy in how best to serve their patients. No other medical or healthcare professional has the knowledge that audiologists possess, to treat the above referenced conditions.

The State Board of Examiners for Audiologists, Hearing Aid Dispensers, Speech-Language Pathologists and Music Therapists, respectfully requests a favorable report on SB 795.

Thank you for your consideration. If you should require anything further, please contact Keena Stephenson, Executive Director, at keena.stephenson1@maryland.gov, or 443.832.0597.

The opinion of the Board expressed in this document does not necessarily reflect that of the Department of Health or the Administration.

ASHA Comments MD SB795 Audiology SOP.pdf
Uploaded by: Tim Boyd
Position: FAV

ASHA
American
Speech-Language-Hearing
Association

February 26, 2024

The Honorable Pamela Beidle, Chair
The Honorable Katherine Klausmeier, Vice-Chair
Finance Committee
Room 3
East Miller Senate Building
Annapolis, Maryland 21401

RE: ASHA Support for SB 795

Dear Chair Beidle, Vice-Chair Klausmeier, and Members of the Committee:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write in support of SB 795, which makes vital updates to the scope of practice for audiologists in Maryland that will improve access to skilled services desperately needed in the state.

ASHA is the national professional, scientific, and credentialing association for 228,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology assistants; and students. Over 4,200 ASHA members reside in Maryland, including 365 audiologists.[1]

Working with osseointegrated devices, performing cochlear implant fittings, and conducting screenings of mental health and cognitive impairment are firmly established within the practice of audiology. We appreciate that this legislation also recognizes that audiologists possess the education, training, and skills to evaluate the need for and treatment of conditions associated with cerumen management and removing foreign bodies from the ear canal.

In supporting this legislation, ASHA affirms that ordering cultures, bloodwork testing, and radiologic imaging are modern components of audiology practice. We recognize that the Board of Examiners for Audiologists may need to enact regulations to implement provisions in SB 795 affecting these areas, which it is authorized to do under §2–205. ASHA supports such regulation and will work with audiologists in the state to ensure the Board issues appropriate guidance on cultures, bloodwork, and imaging as they directly relate to diagnosing, managing, and treating auditory or vestibular conditions.

Thank you for your continued support of audiologists and the audiology profession. We appreciate your consideration of ASHA's position on SB 795. If you or your staff have any questions, please contact Tim Boyd, ASHA's director of state health care and education affairs, at tboyd@asha.org.

Sincerely,

Tena L. McNamara, AuD, CCC-A/SLP
2024 ASHA President

[1] American Speech-Language-Hearing Association. (2023). *Maryland* [Quick Facts]. https://www.asha.org/siteassets/advocacy/state-fliers/maryland-state-flyer.pdf.

MSO Testimony 2024 - UNFAVORABLE - Senate Bill 795

Uploaded by: Barbara Brocato

Position: UNF

MARYLAND SOCIETY OF OTOLARYNGOLOGISTS

SUBJECT: **Senate Bill 795– Health Occupations – Practice Audiology – Definition**
COMMITTEE: Senate Finance Committee
The Honorable Pam Beidle, Chair
DATE: Tuesday, February 27, 2024
POSITION: UNFAVORABLE

The Maryland Society of Otolaryngologists (MSO) represents more than 300 physicians who live and practice in Maryland. Otolaryngologists are physicians who diagnose and treat the ear, nose, throat, and related structures of the head and neck; most commonly referred to as ear, nose, and throat specialists (ENTs).

Senate Bill 795 would expand the scope of services and procedures an audiologist can provide in Maryland, and involve medical diagnosis, management and treatment which audiologists are not trained to provide. Disorders and conditions of the ear, while seemingly simple can often be complex and multi-factorial.

Areas of concern include:

- **The proposed definition for the "practice of audiology" through the use of the phrase "use any means known in the science of audiology".**
  - This language is broad, undefined and does not speak to validated and acceptable standards of care. This would undermine the Board's authority to discipline or question the appropriateness of a practice methodology.
- **"Evaluate, diagnose, manage [and] treat" are among the roles being added to the "practice of audiology".**
  - This terminology traditionally references the practice of medicine. When these terms are used in other health occupations they are limited or qualified by a requirement for a higher level of education and training within that specialty.

Our foremost commitment is to deliver the best patient care and use best practices. We often work side by side with our Audiologists colleagues and together face the challenging conditions and disorders our patients present.

These bills need thoughtful discussion and deliberation by all stakeholders that cannot be accomplished in the weeks remaining of the 2024 Session.

For these reasons we ask you to vote UNFAVORABLE on Senate Bill 795.

Attachments:

- **Appendix 1: Letters of Opposition from Audiologists**
- **Appendix 2: Affidavits of availability to treat patients**
- **Appendix 3: Map of State showing distribution of otolaryngology practices**
- **Appendix 4: Language shared with Proponents to eliminate areas of concern**

For further information please contact: Mark Dettelbach M.D. madmd1964@yahoo.com

TESTIMONY APPENDICES:

- **Appendix 1: Letters of Opposition from Audiologists**
- **Appendix 2: Affidavits of availability to treat patients**
- **Appendix 3: Map of State showing distribution of otolaryngology practices**
- **Appendix 4: Language shared with Proponents to eliminate areas of concern**

LETTERS FROM ACTIVELY PRACTICING

AUDIOLOGISTS
IN
OPPOSITION

TO
SENATE BILL 795
HOUSE BILL 464

THE CENTERS FOR ADVANCED
ENT CARE
ENT ASSOCIATES AT GBMC

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DEPARTMENT OF AUDIOLOGY

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MELINA A. BLASI, Au.D., CCC-A, FAAA
LISA A. PETERS, AuD., CCC-A, FAAA
SHARON PRIEBE, Au.D, FAAA
LARRY TAYLOR, Au.D,. CCC-A, FAAA
DEVRA BRACE, Au.D., CCC-A, FAAA

February 22, 2024

The Honorable Pam Beidle, Chair
Senate Finance Committee
3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

RE: Senate Bill 795 - Health Occupations – Practice Audiology – Definition - OPPOSE

Dear Chair Beidle,

I the undersigned express reservations about House Bill 464 and the scope and breadth of expanded services enumerated in the bill.

As an actively practicing audiologist, I am concerned about the following:

Article 25 (IV) The ordering of cultures and bloodwork testing.

Article 26 (V) The ordering and performing of in-office nonradiographic scanning or imaging of the external auditory canal.

Article 29 (VI) The ordering of radiographic imaging.

I am the Director of Audiology at a busy ENT practice and have been practicing for over 30 years. As an audiologist, I have not had any training or classes on microbiology or radiology. I would not feel comfortable ordering any cultures or bloodwork testing, nor would I feel comfortable ordering any radiographic imaging. I am also not trained to make a medical diagnosis of a disorder or condition of the ear.

Ultimately, we feel this bill and exploration of expanding the scope of practice needs further study and discussion among all stakeholders. We are glad to participate in these discussions.

Respectfully submitted:

Kimbelry Bank, Au.D., CCC-A (Maryland license number #659)

February 21, 2024

The Honorable Pam Beidle, Chair
Senate Finance Committee
3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

RE: Senate Bill 795 - Opposed - Health Occupations – Practice Audiology – Definition

Dear Chair Beidle,

I the undersigned express reservations about Senate Bill 795 and the scope and breadth of expanded services enumerated in the bill.

As an actively practicing audiologist, I am concerned about the following:

Article 25 (IV) The ordering of cultures and bloodwork testing.

Article 26 (V) The ordering and performing of in-office nonradiographic scanning or imaging of the external auditory canal.

Article 29 (VI) The ordering of radiographic imaging.

I am the Director of Audiology at a busy ENT clinic and have been practicing here for the past 16 years. As an audiologist, I have not had any training or classes on microbiology or radiology. I would not feel comfortable ordering any cultures or bloodwork testing, nor would I feel comfortable ordering any radiographic imaging. I am also not trained to make a medical diagnosis of a disorder or condition of the ear. I represent 9 other audiologists at my practice who feel the same way.

Ultimately, I feel this bill and exploration of expanding the scope of practice needs further study and discussion among all stakeholders. I am glad to participate in these discussions.

Respectfully submitted:

Lisa Gebert, Au.D., CCC-A (MD license #01141)

February 27, 2024

The Honorable Joseline Pena-Melnyk, Chair
House Health and Government Operations Committee
241 House Office Building
6 Bladen Street
Annapolis, MD 21401

RE: House Bill 464 - Health Occupations – Practice Audiology – Definition - OPPOSE

Dear Chair Pena-Melnyk,

We the undersigned express reservations about House Bill 464 and the scope and breadth of expanded services enumerated in the bill.

As actively practicing audiologists, we are concerned about the following:

Certain wording of the bill such as: "use any means known in the science of audiology" are very broad, and undefined. Potentially leading to wide interpretation and variability of practices within audiology. Additionally expanding the role of audiologists into the utilization of radiographic studies, laboratory testing, and the prescribing of medications falls under the role of our physician colleagues.

Ultimately, we feel this bill and exploration of expanding the scope of practice needs further study and discussion among all stakeholders. We are glad to participate in these discussions.

Respectfully submitted:

Cara Mahoney, Au.D.
Cara Mahoney, Au.D.

SIGNED AFFIDAVITS FROM OTOLARYNGOLOGISTS STATING THEIR ABILITY TO ACCEPT AND ACCOMMODATE PATIENT REFERRALS ON AN URGENT BASIS

To the Maryland Legislature:

On behalf of our practice, I promise through this affidavit that our group of practitioners accepts patient referrals on an urgent basis and can bring these patients in within a business day of the request. If there is a problem encountered with scheduling, I offer services to facilitate accommodation.

Annette Pham, MD, FACS
The Centers for Advanced ENT Care,
Metro ENT & Facial Plastic Surgery division

Practitioners in our office
Annette Pham, MD, FACS
Andrew Y. Lee, MD

To the Maryland Legislature:

On behalf of our practice, I promise through this affidavit that our group of practitioners accepts patient referrals on an urgent basis and can bring these patients in within a business day of the request. If there is a problem encountered with scheduling, I offer services to facilitate accommodation. Our offices also offer same day audiologic services.

Name/Signature: Marc Dubin, MD 2/18/24

Practice/Division Name : Ear Nose and Throat Associates

Practitioners in our office
Dario Kunar, MD
Brian Kaplan, MD
Marc Dubin, mD
Aaron Wood, MD
Sam Hahn, MD
Doug Reh, MD
Brian Brooke, PA
Kim Harris, PA

To the Maryland Legislature:

On behalf of our practice, I promise through this affidavit that our group of practitioners accepts patient referrals on an urgent basis and can bring these patients in within a business day of the request. If there is a problem encountered with scheduling, I offer services to facilitate accommodation. We also offer same day audio testing

Name/Signature

Mark Dettelbach MD 

Practice/Division Name

CAdENT Feldman ENT

Practitioners in our office

Seth Oringher MD

Chris Mesick MD

Phil Schoenfeld MD

Jack Williams MD

Natalie Earl MD

Jerome Schwartz MD

Jessica Shen MD

Nora Malaisrie MD

Kira Ogoshi PA

Adam Hartheimer PA

To the Maryland Legislature:

On behalf of our practice, I promise through this affidavit that our group of practitioners accepts patient referrals on an urgent basis and can bring these patients in within a business day of the request. If there is a problem encountered with scheduling, I offer services to facilitate accommodation. Our offices also offer same day audiologic services.

Michael Siegel, MD

Name/Signature

Siegel, Bosworth + Sorensen, Division I

Practice/Division Name

Michael Siegel, MD
John Bosworth, Jr, MD
Pete Sorensen, MD
Eleni Ioannidis, PA-C
Ava Shahdaddian PA-C
Alyssa Lloret, PA-C.

Practitioners in our office

To the Maryland Legislature:

On behalf of our practice, I promise through this affidavit that our group of practitioners accepts patient referrals on an urgent basis and can bring these patients in within a business day of the request. If there is a problem encountered with scheduling, I offer services to facilitate accommodation. Our offices also offer same day audiologic services.

Name/Signature
SCOTT LONDON, president Chesapeake Ear Nose + Throat

Practice/Division Name

Practitioners in our office

Scott London, MD
Dan Santos, MD
Tan Nguyen, MD
Praveen Dugal, MD
Mark Schreyer, MD
Yerseng Lumeyer, MD
Kevin Connolly, MD
Asiya Omarar, PA
Suzanne Kim, PA
Pipa Patel, PA

Laura Toll, AuD
Erin Young, AuD
Julia Vissagio, AuD
Jael Schoenfeld, AuD
Alex Andre, AuD
Jordan Erickson, AuD

To the Maryland Legislature:

On behalf of our practice, I promise through this affidavit that our group of practitioners accepts patient referrals on an urgent basis and can bring these patients in within a business day of the request. If there is a problem encountered with scheduling, I offer services to facilitate accommodation. Our offices also offer same day audiologic services.

Name/Signature

Nicholas Mehta
Cynthia Chrosniak
Kealan Hobelmann

Practice/Division Name

Chrosniak, Mehta + Hobelmann

Practitioners in our office

Nicholas Mehta

Cynthia Chrosniak

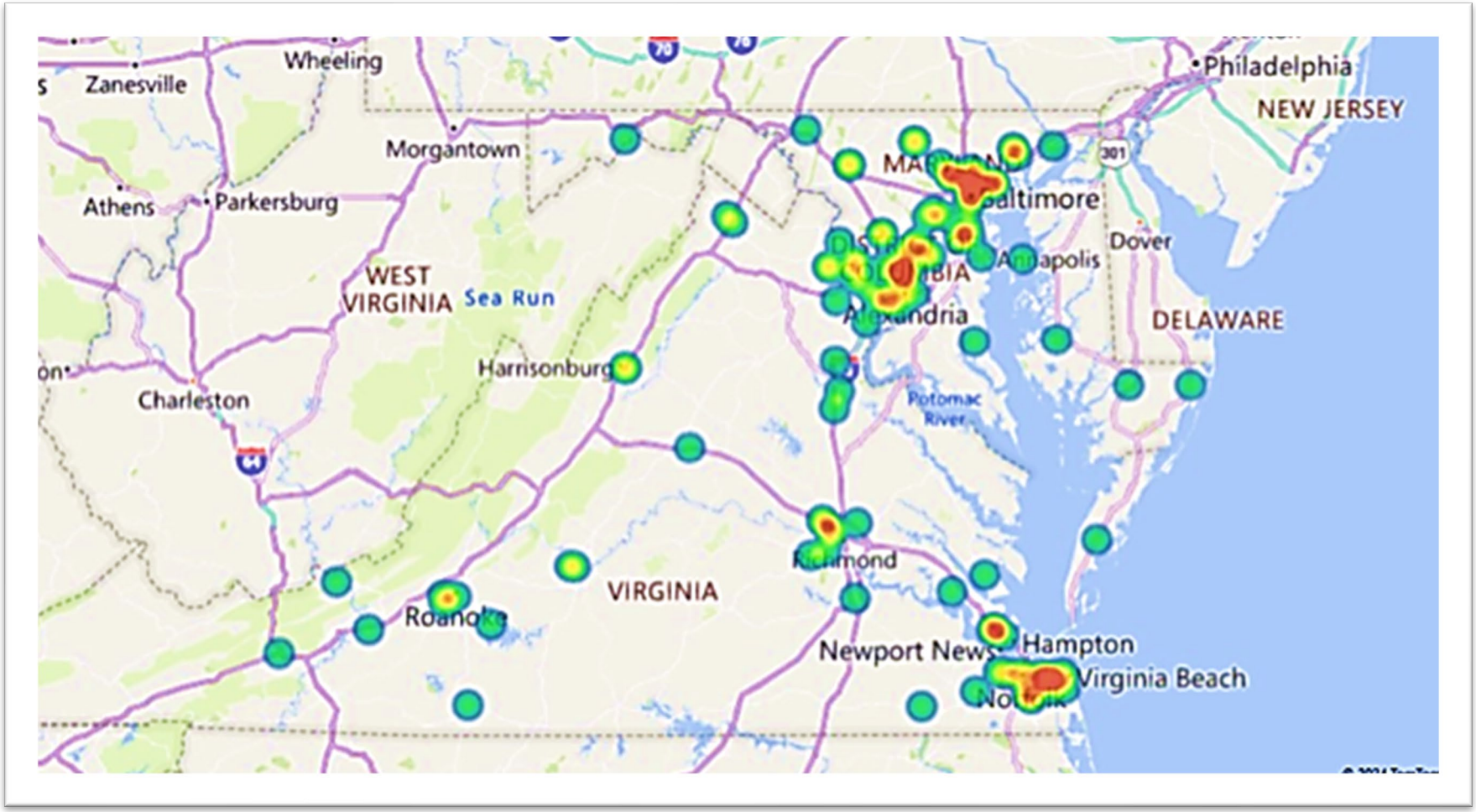
Kealan Hobelmann

Appendix 3:

Map of Practice Settings

Map showing distribution of Otolaryngology Practices across the State of Maryland and surrounding region.

Red shows highest concentrations of practices



Appendix 4:

Language shared with Proponents to eliminate areas of concern

MSO Proposed Amendments

SENATE BILL 795

J2 4lr1744
CF HB 464

By: **Senators Gile, Beidle, Ellis, Hershey, Klausmeier, Lewis Young, Mautz, Ready, and A. Washington**
Introduced and read first time: February 1, 2024
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Occupations – Practice Audiology – Definition

FOR the purpose of altering the definition of "practice audiology" for the purposes of certain provisions of law governing the licensure and regulation of audiologists; and generally relating to the practice of audiology.

BY repealing and reenacting, without amendments,
Article – Health Occupations
Section 2–101(a)
Annotated Code of Maryland
(2021 Replacement Volume and 2023 Supplement)
BY repealing and reenacting, with amendments,
Article – Health Occupations
Section 2–101(q)
Annotated Code of Maryland
(2021 Replacement Volume and 2023 Supplement)

BY adding to
Article – Health Occupations
Section 2–101(r–1)
Annotated Code of Maryland
(2021 Replacement Volume and 2023 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health Occupations

2–101.

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

sb0795

(a) In this title the following words have the meanings indicated.

(q) **(1)** "Practice audiology" means to**[**:

(1) Apply the principles, methods, and procedures of measurement, prediction, evaluation, testing, counseling, consultation, and instruction that relate to the development and disorders of hearing, vestibular functions, and related language and speech disorders, to prevent or modify the disorders or assist individuals in hearing and auditory and related skills for communication; and**]** ~~USE ANY MEANS KNOWN IN THE SCIENCE OF AUDIOLOGY TO:~~

(I) NONMEDICALLY EVALUATE, AND TRIAGE ~~DIAGNOSE, AND TREAT~~ AUDITORY OR VESTIBULAR CONDITIONS IN THE HUMAN EAR;

[(2)**]** **(II)** Prescribe, order, sell, dispense, or fit hearing aids to an individual for the correction or relief of a condition for which hearing aids are worn**;**

(III) PRESCRIBE, ORDER, SELL, DISPENSE, OR EXTERNALLY FIT A SOUND PROCESSOR TO AN OSSEO–INTEGRATED DEVICE FOR THE CORRECTION OR RELIEF OF A CONDITION FOR WHICH OSSEO–INTEGRATED DEVICES ARE WORN; AND

(IV) PRESCRIBE, ORDER, SELL, DISPENSE, OR EXTERNALLY FIT A SOUND PROCESSOR TO A COCHLEAR IMPLANT FOR THE CORRECTION OR RELIEF OF A CONDITION FOR WHICH COCHLEAR IMPLANTS ARE WORN.

(2) "PRACTICE AUDIOLOGY" INCLUDES:

(I) THE CONDUCTING OF HEALTH SCREENINGS CONSISTENT WITH AUDIOLOGY TRAINING AS REQUIRED BY THE BOARD FOR LICENSURE;

(II) THE REMOVAL OF A SUPERFICIAL FOREIGN BODY FROM THE EXTERNAL AUDITORY CANAL WHICH IS NOT IMPACTED TO THE POINT IT REQUIRES ANESTHESIA OR MICRO INSTRUMENTATION TO REMOVE;

(III) THE REMOVAL OF SUPERFICIAL CERUMEN FROM THE EXTERNAL AUDITORY CANAL WHICH IS NOT IMPACTED TO THE POINT IT REQUIRES ANESTHESIA OR MICRO INSTRUMENTATION TO REMOVE;

~~(IV) THE ORDERING OF CULTURES AND BLOODWORK TESTING;~~

(V) THE ORDERING AND PERFORMING OF IN–OFFICE, NONINVASIVE, NONRADIOGRAPHIC SCANNING OR IMAGING OF THE EXTERNAL AUDITORY CANAL; AND

~~(VI) THE ORDERING OF RADIOGRAPHIC IMAGING.~~

(V) REFERRING PERSONS WITH AUDITORY AND VESTIBULAR DYSFUNCTION OR ABNORMALITIES ONLY TO A PHYSICIAN, OR THAT PHYSICIAN'S PHYSICIAN ASSISTANT OR NURSE PRACTITIONER, FOR MEDICAL EVALUATION, INCLUDING BUT NOT LIMITED TO CULTURES, BLOODWORK, RADIOGRAPHIC IMAGING, MRI, MICROSCOPY AND MICRO INSTRUMENTATION WHEN INDICATED BASED ON AUDIOLOGIC AND VESTIBULAR TEST RESULTS.

MSO Proposed Amendments

(VI) PRIOR TO THE PROVISION OF SERVICES NOTED ABOVE IN PARAGRAPH 2, THE INDIVIDUAL AUDIOLOGIST MUST IDENTIFY TO THE BOARD WHICH SERVICES THEY INTEND TO PROVIDE AND DEMONSTRATE PROOF OF TRAINING.

(3) "PRACTICE AUDIOLOGY" DOES NOT INCLUDE:

(I) SURGERY OR INVASIVE TECHNIQUES SUCH AS USING AN INSTRUMENT, INCLUDING A LASER, A SCALPEL, A NEEDLE, CAUTERY, A CRYOPROBE, OR A SUTURE, IN WHICH HUMAN TISSUE IS CUT, BURNED, VAPORIZED, REMOVED, OR OTHERWISE PERMANENTLY ALTERED BY MECHANICAL MEANS, LASER, IONIZING RADIATION, ULTRASOUND, OR OTHER MEANS;

(II) OSSEO–INTEGRATED DEVICE SURGERY;

(III) COCHLEAR IMPLANT SURGERY; OR

(IV) THE PREPARATION, OPERATION, OR PERFORMANCE OF RADIOGRAPHIC IMAGING.

(R–1) "SOUND PROCESSOR" MEANS A NONSURGICAL, EXTERNAL UNIT THAT ATTACHES TO AN INTERNAL OSSEO–INTEGRATED DEVICE OR COCHLEAR IMPLANT.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2024.

AAOHNS MD SB 795 Testimony - Final.pdf
Uploaded by: James Denneny
Position: UNF

AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY®

To: Members of the Maryland Senate Finance Committee

From: James Denneny, III, MD, Executive Vice President/CEO, American Academy of Otolaryngology-Head and Neck Surgery

Date: February 26, 2024

Re: Opposition to Senate Bill 795

On behalf of the American Academy of Otolaryngology-Head and Neck Surgery, the nation's largest medical organization representing physician specialists dedicated to the care of patients with disorders of the ears, nose, throat and related structures of the head and neck and leaders of the hearing healthcare team, we oppose Senate Bill (SB) 795 as introduced and offer the following testimony.

With eight years of formal education, a minimum five-year residency, and at least 15,000 hours of clinical training, otolaryngologist-head and neck surgeons are the most qualified providers to diagnose and treat ear, nose, and throat conditions - and are trained to lead a care team.

Expansion of the "scope of practice" related to the diagnosis and treatment of medical conditions should be based on didactic and clinical training followed by rigorous assessment of competence, licensure and privileging related to specific areas of expertise, not legislated in response to the wants of "conflicted" trade associations. SB 795 is an extreme example of expanding scope of practice for all audiologists, whether they trained last year or forty years ago, without requisite education and clinical training. We have become accustomed to the introduction of legislation proposing unreasonable and potentially dangerous expansion of audiology "scope of practice" in other states over the last two decades. To our knowledge, however, no other such legislation has made a similar outrageous and perilous leap to include provisions in audiology's "scope of practice" reserved nationwide for clinicians who are licensed to practice medicine.

In describing what it means to "practice audiology" the bill grants audiologists the ability to "order, evaluate, diagnose, manage, or treat any auditory or vestibular condition in the human ear."

Audiologists are not trained in the diagnosis and treatment of medical disease either didactically or clinically and are therefore not equipped to address the spectrum of medical problems, and inherent interactions, which present in many types of hearing and balance problems. In short, audiologists do not have the prescribing rights necessary to fulfill their requested expansions listed in this bill. This distinction is extremely important in diagnosing and treating hearing and balance disorders, as

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many of these are linked to serious medical conditions that also require their own separate diagnosis and management.

The wording of this proposed legislation would allow audiologists to first make medical diagnoses and then manage and treat any disorder of the human ear. The language describing management and treatment implies the ability for audiologists to order non-auditory and non-vestibular testing, write prescriptions and perform surgeries, none of which they have been trained to accomplish or licensed to perform.

There is a vast difference between performing or reviewing auditory and vestibular testing, and interpretating these tests, and making a correct medical diagnosis. An accurate medical diagnosis is a critical first step to subsequently prescribing the most appropriate treatment, which often includes many more options than the straightforward placement of the hearing aid or implantable hearing device or performing balance therapy. A specialty-trained physician, **not an audiologist,** must be the one to make the shared decision in consultation with the patient, as to most appropriate treatment, whether it be pharmaceutical intervention, implantable hearing device(s), other otologic surgery, or observation, based on a complete history and assessment of all risks and benefits for that patient.

Specifically, this bill allows audiologists to:

"*Use any means known in the science of audiology to: evaluate, diagnose, manage, and treat auditory or vestibular conditions in the human ear*."

"Any means known" should not imply requisite training or competence. One's knowledge of something's existence does not mean they have the expertise to safely evaluate, diagnose, manage, and effectively diagnose conditions in that area.

"iii) prescribe, order, sell, dispense, or externally fit a sound processor to an osseo–integrated device for the correction or relief of a condition for which osseo–integrated devices are worn; and (iv) prescribe, order, sell, dispense, or externally fit a sound processor to a cochlear implant for the correction or relief of a condition for which cochlear implants are worn."

The two conditions delineated regarding implantable hearing devices and necessary sound processors do not fall within the sole purview of an audiologist, as these provisions imply. All processors for each device should be fit in conjunction with the implanting surgeon or the physician managing the patient.

"*I) The conducting of health screenings*"

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We see no justification for this clause. Audiologists do not have training or experience in conducting "Health Screenings" unrelated to hearing or balance. This clause could be interpreted to include screening for almost anything (i.e. cardiac, cancer, reproductive, infectious disease, etc.).

"*(II) The removal of a foreign body from the external auditory canal*; (III) *The removal of cerumen from the external auditory canal*"

While audiologists and other members of the hearing healthcare team are capable of removing simple foreign bodies and non-impacted cerumen, they are not trained or qualified to utilize magnification, micro instrumentation and anesthesia if necessary. The bill should be amended to recognize that limitation.

"*(IV) The ordering of cultures and bloodwork testing"*

This provision is a function currently limited to medical practitioners' scope of practice and in no circumstance should the ordering of cultures and bloodwork testing be a part of an audiologist's practice. The ordering clinician must be familiar with possible treatments for the medical problems necessitating the testing and the ability to treat them. As proposed, this provision could be construed as a means for audiologists to obtain backdoor entry into prescribing rights!

"*(vi) The ordering of radiographic imaging*"

Similar to the above clause regarding cultures and blood testing, the ordering of radiographic studies must be limited to medical clinicians who can appropriately choose the correct imaging strategy and act on the results.

In summary, audiology training does not include the necessary didactic and clinical training during their four years of education or post-training competency validation to justify these medical privileges they are requesting or be deemed equivalent to an otolaryngologist-head and neck surgeon, after their nine to eleven years of training. Audiologists have not been granted prescribing or surgical rights in any of the fifty states. Enacting the legislation, as introduced, in Maryland would be detrimental to patient safety, granting such privileges to audiologists without adequate training to appropriately perform them. This bill attempts to expand access without full consideration of the potentially devastating clinical outcomes.

We urge the members of the Finance Committee to defeat this unprecedented attempt to provide the requested medical privileges to audiologists under their current training paradigm.

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AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY®

Sincerely,

James C Denneny III

James C. Denneny, III, MD
EVP/CEO

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