Approved: February 5, 1996
Date

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Carlos Mayans at 1:30 p.m. on January 30, 1996 in Room 423-S of the State Capitol.

All members were present

Committee staff present: Norman Furse, Revision of Statutes
Bill Wolff, Legislative Research Department
Francie Marshall, Committee Secretary

Conferees appearing before the committee:
James A. Wise, PH.D., President of Kansas Speech Language Hearing Assoc.
Kenneth E. Smith, PH.D., Clinical Audiologist
Dr. John Ferraro
Gwen O'Grady, Audiologist
Harold P. Hesler, Fairway, KS
Dr. Gregory Ator, Asst. Professor of Otolaryngology KU Medical Center
Dr. Ed Schulte
Lila McKee, Audiologist
Ron Hein, Kansas Hearing Aid Association
Day Kaufmann
Dr. Robert E. Woodard
Kevin Howerd Albee
Sherry DuPerier, Kansas Board of Hearing Aid Examiners
Lesa Bray, Department of Health and Environment

Others attending: See Guest List: Attachment 1

HB 2689 - Definition of practice of audiology

Chairperson Mayans opened the hearing on **HB 2689** announcing that due to the number of the conferees, there will be a time limit of three minutes for each party to speak so that there will be enough time for questions and answers.

The following proponents presented testimony supporting **HB 2689:**
Dr. James Wise, President of Kansas Speech Language Hearing Association (Attachment 2),
Dr. Kenneth E. Smith, Clinical Audiologist and President, Academy of Dispensing Audiologists (Attachment 3),
Dr. John Ferraro (Attachment 4),
Gwen O'Grady, certified audiologist (Attachment 5),
Harold P. Hesler, hearing aid user (Attachment 6),
Dr. Gregory Ator, Assistant Professor, Director, Otolaryngology at KU Medical Center (Attachment 7),
Dr. Ed Schulte, Legislative Liaison for the Kansas Speech Language Hearing Association (Attachment 8),
Lila McKee, Licensed Audiologist, Reno County Education Cooperative (Attachment 9),

A question and answer session followed. Questions regarding the continuing educational requirements and the economic impact were addressed. Chairperson Mayans read the Fiscal Note for **HB 2689** prepared by the Division of the Budget (Attachment 10).

The following opponents presented testimony opposing **HB 2689**:
Ron Hein, Legislative Counsel for the Kansas Hearing Aid Association, expressed concern that this issue should be review by an outside body (Attachment 11),
Day Kaufmann, Kansas Hearing Aid Association, presented and read testimony on behalf of Harris Zafar, PH.D. (Attachment 12),
Dr. Robert Woodard, licensed audiologist and licensed hearing aid specialist (Attachment 13),

Kevin Albee, A&D Hearing Aid Center (Attachment 14),
Sherry Duperier, Board of Hearing Aid Examiners (Attachment 15).

The hearing was opened to the opponents for questions by members of the committee.

On questions regarding federal involvement, Mr. Albee stated the FDA is currently reviewing requirements for hearing aids which is reason to delay legislation. Issues regarding the testing and competency level were discussed.

Chairperson Mayans opened the hearing to Lesa Bray, Health and Environment to present her testimony. While not in opposition, she expressed concern for clarification of the bill (Attachment 16). Ms. Bray suggested the changes proposed with **HB 2689** could have some interpretation that might affect the dispensing of hearing aids section of the law and that the language indicates there are two existing statutes covering the same issues. She also said if **HB 2689** passed now, it would be in conflict with the existing Hearing Aid Dispensers Act under article 58, section 74-5808.

The hearing was closed on **HB 2689**.

The meeting was adjourned at 2:45 p.m.

The next meeting is scheduled for January 31, 1996.

House Health & Human Services COMMITTEE GUEST LIST

DATE January 30, 1996

NAME	REPRESENTING
Sherry Duperier	Ks. Board of Hrg. Aid Examiners
Wes DuPerier	Ks. Hearing Aid Assoc.
Kevin Albee	A+D Hearing Aid center
Robert E. Woodard	Ks. Hearing Aid Assoc.
M. Dan Kaufmann	Ks. Hearing Aid Assoc.
Melissa Wangemann	Hein Ebert & Weir
Lila McKee	Educational Audiologists KSHA
Jo Schulte	Kansas Speech and Hearing Assoc.
Jan Weir	" " " "
Barb Deering	Audiologist. St John Hospital
Ken Smith	Kansas Speech & Hearing Assoc.
Lesa Bray	KDHE - Health Occ. Cred.
Joseph F. Kroll	KDHE
Rich Guthrie	Health Midwest
Terry Leatherman	KCCI
John Ferraro	KSHA / Univ. of Kansas - KUMC
Gregory A. Ator MD	Otolaryngology / Otology / KUMC
Gwen O'Grady	KSHA / KUMC
Jim Langford	DOB

H&H.S. Comm.
1-30-96
Attn #1

TESTIMONY OF

JAMES A. WISE, PH.D., PRESIDENT

KANSAS SPEECH LANGUAGE HEARING ASSOC.

ON HOUSE BILL #2689

BEFORE THE HOUSE COMMITTEE ON

HEALTH AND HUMAN SERVICES

CONCERNING ELIMINATION OF

DUAL LICENSURE

FOR AUDIOLOGISTS

FEBRUARY, 1996

Good Afternoon, Mr. Chairman and Committee Members:

I am Dr. James A. Wise, President of the Kansas Speech Language Hearing Association and president of Associated Audiologists, an audiology private practice in Olathe, Kansas. In addition, I am also the chairman of the Kansas Commission for the Deaf and Hard of Hearing. KSHA is the state affiliation of the American Speech Language Hearing Association which is the professional, scientific and accrediting association for almost 1000 speech language pathologists and audiologists in Kansas. Approximately half of our memberships provide services in educational settings such as elementary, secondary and private schools and state-operated programs. The other half render services in health care settings including private practice and hospitals. KSHA appreciates the opportunity to testify before the committee and we applaud your efforts to fully understand the importance this licensure issue from House Bill 2689 has on consumers and audiologists.

In order to provide a frame of reference, let me begin by describing our current licensure status and the unique differences between Audiologists and Hearing Instrument specialists.

Currently, audiologists are required to have two separate licenses in the state of Kansas if they want to practice and dispense hearing aids. Audiology licensure is issued by the Kansas Department of Health and Environment which provides a comprehensive mechanism already in place. The licensing board advises Secretary O'Connell on appropriate consumer protection and other relevant rules and regulations governing our profession such as continuing education and credentialing. If an audiologist wishes to dispense hearing aids, an additional license is required through the Board of Hearing Aid Examiners. This license is obtained only after passing a written and rather subjective practical examination.

In order to further put this in perspective, let me describe the relevant differences between our profession in terms of requirements and academic training. This is summarized in your handout.

Our profession places the highest premium on educational and clinical preparation for entering into Audiology. The qualifications necessary to practice are exhaustive as it focuses on the most remarkable and complex sense of hearing.

Audiologists must have a minimum of a master's degree in audiology. As part of their degree, they must complete 350 clock hours of supervised observation and evaluation in treatment of children and adults with a variety of hearing disorders which includes the selection and use of amplification and assistive devices. Following graduation, all audiology applicants are

required to complete at least nine months of supervised, on-the-job experience with direct-client contact including assessment, diagnosis, evaluation, screening, amplification, and treatment related to management of individuals who exhibit communication disabilities related to hearing.

In contrast, hearing aid dealers are only required to have a high school diploma and to be eighteen years of age and free of any communicable disease before taking the licensing examination.

To require audiologists to obtain a license for which only a high school diploma is necessary when they already have a minimum of a master's degree and nine months post-graduate training in hearing disorders and their treatment is incomprehensible.

While these distinctions are important, at the heart of the matter is ensuring consumer protection. Audiologists currently have a mechanism in place that assures consumer protection through an advisory board, credentialing staff and being bound by a code of ethics. Certainly this board will competently modify any additional changes needed in the rules and regulations to even enhance existing consumer protection if needed. Consumer protection is alive and well in the KDHE Audiology licensure law.

In addition to the above rationale, duplicate licensure is punitive to the audiologist and eventually to the consumer which is passed on through increased costs of service.

Mr. Chairman, the majority of audiologists in the state of Kansas feel this change is a sensible, economical decision consistent with contemporary practice and good government. We urge your support of Bill 2689.

Thank you for the opportunity to address this Committee.

Sincerely,

James A. Wise, Ph.D., C.C.C.-A
Associated Audiologists, Inc.
13025 S. Mur-Len, Suite 220
Olathe, KS 66062

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Olathe, KS 66062

KSHA

KANSAS SPEECH-LANGUAGE-HEARING ASSOCIATION

KSHA LICENSURE

COMPARATIVE STANDARDS FOR LICENSURE UNDER THE KANSAS BOARD OF HEARING AID EXAMINERS (KBHAE) AND THE KANSAS BOARD OF SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY (KBSLPA)

FACTOR	HEARING AID DISPENSER (NON-AUDIOLOGIST)	DISPENSING AUDIOLOGIST
■ Academic Training	None specified.	1. General Education - Bachelors degree; Professional Education - Masters or Ph.D. degree from accredited institution offering graduate program in speech-language pathology and/or audiology. 2. Submit evidence of 60 semester hours of academic credit from accredited college or university constituting a well-integrated program; 30 of these 60 hours must be in courses acceptable toward a graduate degree by the institution in which these courses are taken.
■ Practicum Requirement	Nonmandatory training permits may be obtained allowing applicant to dispense hearing aids under direct supervision and immediate observation of the licensed dispenser; no specific requirements are designated for these training experiences.	1. Submit evidence of the completion of 350 clock hours of directly supervised practicum with cases representative of a wide spectrum of ages and communication disorders; the experience must be within the accredited academic institution or one of its cooperating programs. 2. Professional standards require 150 of the 350 hours to be completed at the graduate level.

FACTOR	HEARING AID DISPENSER (NON-AUDIOLOGIST)	DISPENSING AUDIOLOGIST
■ Practicum Requirement (Cont'd.)		3. At least 50 hours must be completed in the identification and evaluation of hearing impairment; in addition, at least 50 hours must be included in the habilitation or rehabilitation of hearing impaired. 4. Submit evidence of 350 supervised clock hours (250 at graduate level) which include at least 180 hours in the evaluation and treatment of hearing disorders in children and adults and the selection and use of amplification and assistive devices for children and adults.
■ Experience Requirement	Present satisfactory evidence to the board that the applicant maintains a satisfactory relationship with and responsibility to a holder of a dealer's license.	Submit evidence of no less than 9 months of full-time paid clinical experience in the area for which the license is required; this clinical experience must be obtained under the supervision of individuals licensed or qualified in the appropriate area.
■ Examination Requirement	Satisfactory completion of an examination administered under the direction of the KBHAE.	Pass a national examination that is standardized, valid and reliable.
■ Continuing Education Requirement	Submit proof annually of completion of 10 hours of continuing education.	Submit proof during each two year renewal period of 30 hours of continuing education.
■ Other	Must be at least 18 years of age.	

KSHA

KANSAS SPEECH-LANGUAGE-HEARING ASSOCIATION

KANSAS SPEECH-LANGUAGE-HEARING ASSOCIATION

History

The Kansas Speech-Language-Hearing Association was formed in 1952 in Wichita, Kansas, with 34 speech pathologists and audiologists present. In 1953, a constitution, patterned after the constitution of the American Speech-Language-Hearing Association, and by-laws were adopted and the Kansas Speech-Language-Hearing Association was formally organized. Today, there are close to 900 members in the Association.

Mission

The mission of the Kansas Speech-Language-Hearing Association is to promote the interests of and provide the highest quality services for professionals in audiology, speech -language pathology, and speech and hearing science and to advocate for people with communication disabilities.

Professionals Who Diagnose & Treat Communication Disorders

Audiologists are the professionals who diagnose and treat hearing disorders. They provide counseling and rehabilitation services to people who have hearing loss. Services include dispensing hearing aids and other assistive listening devices.

Speech-language pathologists are the professionals who diagnose and treat speech, language, and related disorders. The teach people coping strategies and provide treatment to eliminate or minimize speech, language, and related problems.

Audiologists and speech-language pathologists hold at least a master's degree. Four universities in the state of Kansas offer degrees in speech-pathology and/or audiology - Fort Hays State University, Kansas State University, University of Kansas, and Wichita State University. They are certified by the American Speech-Language-Hearing Association. Additionally, Kansas along with 42 other states regulate the practice of audiologists and/or speech-language pathologists through licensure or another process. Over 50% of the nation's speech-language pathologists work in schools, private practice, hospitals, clinics, nursing homes, and other health care settings.

KSHA

KANSAS SPEECH-LANGUAGE-HEARING ASSOCIATION

SCOPE OF PRACTICE FOR AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

Audiologists and speech-language pathologists hold either the master's or doctoral degree, the Certificate of Clinical Competence of the American Speech-Language-Hearing Association, and state license where applicable. These professionals identify, assess, and provide treatment for individuals of all ages with communication disorders. They manage and supervise programs and services related to human communication and its disorders. Audiologists and speech-language pathologists counsel individuals with disorders of communication, their families, caregivers and other service providers relative to the disability present and its management. They provide consultation and make referrals. Facilitating the development and maintenance of human communication is the common goal of audiologists and speech-language pathologists.

The practice of audiology includes:

- facilitating the conservation of auditory system function; developing and implementing environmental and occupational hearing conservation programs;
- screening, identifying, assessing and interpreting, diagnosing, preventing, and rehabilitating peripheral and central auditory system dysfunctions;
- providing and interpreting behavioral and (electro) physiological measurements of auditory and vestibular functions;
- selecting, fitting and dispensing of amplification, assistive listening and alerting devices and other systems (e.g., implantable devices) and providing training in their use;
- providing and rehabilitation and related counseling services to hearing impaired individuals and their families; and
- screening of speech-language and other factors affecting communication function for the purposes of an audiologic evaluation and/or initial identification of individuals with other communication disorders.

The practice of speech-language pathology includes:

- screening, identifying, assessing and interpreting, diagnosing, rehabilitating, and preventing disorders of speech (e.g.. articulation, fluency, voice) and language (ASHA, 1983, 1989);
- screening, identifying, assessing and interpreting, diagnosing, and rehabilitating disorders of oral-pharyngeal function (e.g., dysphagia) and related disorders;
- screening, identifying, assessing and interpreting, diagnosing, and rehabilitating cognitive/communication disorders;
- assessing, selecting and developing augmentative and alternative communication systems and providing training in their use;
- providing aural rehabilitation and related counseling services to hearing impaired individuals and their families;
- enhancing speech-language proficiency and communication effectiveness (e.g., accent reduction); and
- screening of hearing and other factors for the purpose of speech-language evaluation and/or the initial identification of individuals with other communication disorders.

KSHA

KANSAS SPEECH-LANGUAGE-HEARING ASSOCIATION

WHY AUDIOLOGY AND SPEECH-LANGUAGE SERVICES SHOULD BE INCLUDED IN HEALTH CARE REFORM IN KANSAS

■ Who is Affected by Communication Disorders?

Of the nearly 42 million people in the United States who have a speech, language, hearing, or related disorder, 248,000 live in the state of Kansas. Communication impairments are the most common disabilities in the United States, affecting nearly one of every six Americans. These disorders span the spectrum of all ethnic and economic backgrounds affecting the youngest of children, with more than one percent of all newborn babies having a moderate or severe hearing loss, to adults, with approximately 23 million Americans over age 18 having a speech, language, or hearing impairment. It also is estimated that more than 1/3 of Americans age 65 or older have some form of hearing loss and nearly 40% of people in nursing homes have a speech or language impairment.

■ Speech-Language Pathology and Audiology Services Should be Included in Health Care Reform as a Basic Service

For those individuals affected by speech, language, hearing, or related disorders, treatment is a basic health care need. Early identification, treatment, and rehabilitation of a communication disorder will ensure that everyone, regardless of age, race, or economic status, has an equal opportunity to obtain an education, pursue employment, and to function independently as contributing members of society.

■ Rehabilitation for Communication Disorders is Cost-Effective

Early identification and treatment of speech, language, hearing, and related disorders are cost-effective approaches to reduce reliance on government assistance or support programs at the federal and state levels. People with communication disorders struggle every day to overcome barriers to learning and employment. They struggle to express what most of us take for granted, even a simple conversation with a loved one. For them, treatment is no luxury. All Kansans deserve access to basic health care services, including rehabilitative services provided by audiologists and speech-language pathologists.

■ Audiologists and Speech-Language Pathologists are Providing Help

As a direct result of the aging of the American population, it is estimated that the number of people with hearing and speech disorders will increase from now until the year 2050 at a rate faster than total U.S. population growth. During this period, there will be an increased need for qualified audiologists and speech-language pathologists. These professionals will assist people with communication disorders by providing speech, hearing, and language services, including the dispensing of hearing aids and their assistive and augmentative technology.

TESTIMONY OF

KENNETH E. SMITH, PH.D., CLINICAL AUDIOLOGIST
PRESIDENT, ACADEMY OF DISPENSING AUDIOLOGISTS

ON HOUSE BILL #2689

BEFORE THE HOUSE COMMITTEE ON

HEALTH AND HUMAN SERVICES

CONCERNING ELIMINATION OF

DUAL LICENSURE

FOR AUDIOLOGISTS

January, 1996

H+HS Comm
1-30-96
attm#3

Good afternoon, Mr. Chairman:

I am Dr. Ken Smith, President of both Hearing Associates (a private Audiology practice in Shawnee Mission and Kansas City, Kansas) and the Academy of Dispensing Audiologists (a national organization of almost 900 audiologists dedicated to the promotion of excellence in patient care).

In my 20 years of private practice, I have witnessed significant expansion in the scope of practice of Audiologists, to the benefit of the consumer. This expansion has been accompanied by rigorous academic training and practicuum experiences for students, development of codes of ethics and behavior that guide and limit the professional behavior of the Audiologist, continuing education as technology and methodology have exploded and recognition of the Audiologist as a significant player in responsible, cost effective hearing care for consumers.

At this point in history, university trained, licensed Audiologists provide hearing services to infants, children, adults and seniors in a wide variety of settings, ranging from hospital operating rooms to the schools.

We carefully evaluate hearing sensitivity, word recognition, the ability to process speech, the ability of the brain to receive sound and the status of the mechanical parts of the ear. We assist the physician in the diagnosis of medical hearing problems, monitor the effects of certain types of surgical procedures on hearing and make sure that school children are receiving proper benefit from their hearing aids and Assistive Listening Devices. We are active in the prevention of hearing impairment resulting from industrial, military, vocational or recreational noise exposure, and author or support most of the significant research in human hearing.

Our evaluations are carried out under controlled conditions, using a wide variety of sophisticated equipment and methodology based on university and institutional research, and standards. Our continuing education process is designed to keep us abreast of our ever-increasing body of knowledge about new technologies and methods for patient care.

Beyond the numbers and the test data, we are specialists in counseling and evaluating of the communication needs and motivation of the patient with hearing impairment, the role of the family in the rehabilitation process and the specification of communication assistive devices designed to minimize the effects of the hearing loss.

For more than 15 years, Audiologists have been trained for and actively involved in the delivery of hearing aids and assistive listening technology to our patients. This evolution in our scope of practice is a direct result of our training, practicuum experiences, and the logic involved with the consumer being able to receive complete, convenient, professional services from the Audiologist, a single source. The Audiologist, like the Dentist and

Optometrist, completes a professional evaluation and delivers the tools of rehabilitation designed to make a significant improvement in the quality of the patient's life.

In short, hearing aid and assistive listening technology are an integral part of our scope of practice, an essential part of the professional practice for which we are trained, something we already do as Audiologists. House Bill #2689 seeks to eliminate the duplication of regulation through licensure, and to recognize that which is already a part of our scope practice. I urge you to act favorably on this bill and appreciate your listening to my description of the Audiologist's scope of practice.

January 30, 1996

TO: House Committee on Health and Human Services

RE: House Bill No. 2689 - Issues Related to Academic and Clinical Preparation of Audiologists

My name is Dr. John Ferraro. Since 1983, I have held the positions of Professor and Chairman, Hearing and Speech Department, University of Kansas Medical Center, and Co-Director, University of Kansas Intercampus Program in Communicative Disorders. I am writing to urge you to pass House Bill No. 2689, and to provide you with information on the academic and clinical training of Audiologists relative to the area of hearing aids.

Students enrolled in our program at KU take coursework, do research and participate in clinical education leading to the Master of Arts and Doctor of Philosophy degrees in Audiology and Speech-Language Pathology. Our program is accredited by the American Speech-Language-Hearing Association (ASHA), which currently recognizes the Master's degree as the entry level degree for clinical practice in both Audiology and Speech-Language Pathology. Two years ago, ASHA adopted resolutions mandating that by the year 2002, the doctorate will be the entry degree for clinical practice in Audiology. ASHA also is the professional body responsible for granting the Certificate of Clinical Competence to our clinical practitioners. Any student who wishes to become a certified Audiologist or Speech-Language Pathologist must graduate from an ASHA-accredited, university program such as ours.

Certification guidelines in Audiology call for specific coursework in a variety of areas, including hearing aids, and at least 350 hours of supervised clinical practicum, the majority of which must be taken at the graduate level. Students enter our graduate program in Audiology with a baccalaureate degree. Their final two years of undergraduate study includes coursework related to basic and applied aspects of communication, and communication disorders - all of which are applicable to the area of hearing aids. Criteria for acceptance into our graduate program include a minimum undergraduate Grade Point Average of 3.0 (on a 4.0 scale), strong performance on the Graduate Record Examination, and letters of recommendation from undergraduate instructors. The average undergraduate GPA for the students accepted into our Audiology graduate program at KU last year was 3.5.

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The Master's program in Audiology at KU, and most other universities, is a two-year program. During this time, students spend at least 100 class hours in courses specifically related to hearing aids, in addition to several hours of clinical practicum. This coursework is both technical and applied, and clinical experiences include the evaluation, dispensing and fitting of hearing aids for patients seen in our clinics, and participation in follow-up, rehabilitation programs for these patients. Our students' knowledge and competency in these areas is routinely assessed via both written and practical examinations. A minimum grade point average of 3.0 is required to remain in the program.

After receiving their Master's degree, students must pass a national examination, and complete a Clinical Fellowship Year to become eligible for ASHA certification and Kansas licensure. The national examination has several questions related to hearing aids, and virtually all of our students gain additional clinical experience with hearing aids during their Fellowship year.

In summary, the academic and clinical experiences that students attain in the area of hearing aids while completing the Master's degree and the other criteria necessary for certification and licensure as an Audiologist, are quite extensive to say the least.

Finally, since the provision of hearing aid-related services is essential to both our academic and clinical programs at the KU Medical Center, all of our clinical faculty must currently maintain licensure to practice as Audiologists, and also to dispense hearing aids. The University, in turn, is obligated to pay the licensure fees for these faculty. Passage of House Bill No. 2689 would eliminate the need for the dispensing license. This would result in substantial financial savings for our program, which is especially important in these times of budgetary restraint.

Thank you for your attention to this important issue.

John A. Ferraro, Ph.D.
Carolyn Doughty-Margaret Kemp Professor and Chairman
Hearing and Speech Department
University of Kansas Medical Center
Co-Director
University of Kansas Intercampus Program in Communicative Disorders.

TESTIMONY

My name is Gwen O'Grady. I am a certified audiologist with a license to practice audiology in the state of Kansas. I was recruited to the University of Kansas Medical Center in 1994 to run the University hearing aid program and to teach a course on amplification/ hearing aid fitting. This issue is both a personal and professional issue to me.

I have been practicing audiology since 1981 and obtained my first hearing aid dispensing license in 1983. My husband works for the state of Missouri and I work for the state of Kansas on State Line Road (on the Kansas side). When we decided to accept these positions we also decided if we were to make such a huge change in our lives that it would only be beneficial if it also improved the quality of our family life. That prompted us to find living quarters that reduced our commute and increased our family time together. To accomplish that, we found a home in Missouri that was less than a ten mile commute for each of us.

After checking with both the Kansas and Missouri hearing aid boards I was assured in June of 1994 that all I would need to do was obtain a Missouri hearing aid license and reciprocity to Kansas was just a matter of paper work--NO PROBLEM!!!!

Unfortunately, while Missouri was considering my request for reciprocity from California, Kansas and Missouri discontinued their reciprocity agreement. This occurred the week my husband and I signed papers to purchase our home and could not back out of the deal without significant financial loss. I immediately called the Kansas hearing aid board and requested the information to apply for a Kansas hearing aid license and was informed that I could not sit for the hearing aid dispenser's exam because I lived in Missouri. I verbally requested that Kansas consider a request for reciprocity from

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California where I had been licensed for the past five years. This request was denied. I expressed my concern to the contact person on the hearing aid board and was told there was nothing they could do to help me. In all my years of being a licensed audiologist and hearing aid dispenser there has never been a consumer complaint against the services I have provided. All I wanted to do was continue working in the field in which I am trained and love doing.

Can you imagine the horror of moving over 2000 miles, buying a new house and starting a new job and two weeks into the job having to call the entire department together and tell them that I'm sorry but I can't fulfill the terms of my contract? The Kansas Board of Hearing Aid Dispensers had made my life a nightmare. I understand that the Hearing Aid Dispensing Board is considering a change to this procedure and residency requirement however it is too late to make a difference in my situation.

I do teach the introductory course on amplification. My course content includes all of the require guidelines from our national organization. Since I have taken the hearing aid dispensing license test in two states, I also make the final in the course be the practical test required to dispense hearing aids. No student passes my class without passing this practical exam. I include all of the issues pertinent to hearing aid dispensing: FDA requirements regarding consumer protection, sterile techniques, otoscopic exam prior to and after the impression, and appropriate hearing aid prescriptions. In the packets that have been passed out, I have included all of the academic and clinical requirements for a Masters degree in Audiology, the guidelines in training graduate students in amplification and a course syllabus for introduction to amplification. I hope this material will assist you with your decision.

The American Speech-Language-Hearing Association (ASHA) is the scientific and professional organization for speech-language pathologists and audiologists. ASHA determines the standards for certification, grants certification and membership, conducts accreditation for university graduate programs, and develops and defines the scope of practice, preferred practice patterns, position statements, practice guidelines, and ethical standards for practice. In order to qualify for certification through ASHA, audiologists must complete a graduate degree, obtain a minimum of 350 supervised hours of clinical contact, pass a national examination, and complete a professional clinical fellowship (full time for nine months) supervised by a certified audiologist.

The foundation of graduate study in Audiology is a well rounded undergraduate curriculum. Prerequisite areas include work in mathematics, physics, biologic sciences, human development, and psychology. In addition to the basic education, it is required that candidates for consideration in Speech and Hearing Sciences complete courses in pathology of the auditory system, normal auditory and speech-language development, speech perception deficits, speech language disorders associated with congenital and acquired hearing impairment, audiologic evaluation procedures and audiologic rehabilitative procedures. Successful candidates with a B(3.0) average are eligible to apply to the graduate school, but are not guaranteed admittance. Once accepted to the graduate program, further study of hearing and hearing (re) habilitation is undertaken. For a complete course of the study outline refer to the attachment.

In addition to all of the course work required, candidates for a graduate degree in Audiology, are required to enroll in one to three credit hours of supervised clinical practicum per semester. This practicum at all sites except the public schools includes hearing aid fitting. In the public

schools, the students often work directly with hearing impaired children and verify the benefit gained from amplification. The minimal accepted patient contact hours is 350, however most of the students receive 450-500 hours of supervised patient contact prior to the start of the clinical fellowship (36 hours per week supervised for 9 months). For a complete outline of the required clinical experience, please refer to the attached document.

Historically, audiologists were not, by professional standards, allowed to dispense hearing aids. The standard for training in hearing aids (beyond classroom lecture) at the undergraduate and the graduate level was to prescribe appropriate amplification devices and refer the patient to a hearing aid dispenser for the hearing aid fitting. The patient then returned to the audiologist for verification that the instrument was performing as expected. Training at that time was performed by professors who were not currently nor had ever dispensed hearing aids. It was felt (by ASHA) unethical to sell hearing aids for a profit. In the late 1970's, this stand was overturned by the federal courts. This change in the scope of audiology had a profound and lasting effect on the training programs in audiology. As recently as 1993, the standards of training were once again upgraded. It is now required that all programs be accredited by the Educational Standards Board of ASHA.

The current program outlined and attached should speak for itself in the terms of depth, scope and intensity. The standards required go far beyond the minimal required to dispense hearing aids. Currently students receive a thorough background and substantial supervised patient contact. There should be no question that the rigorous program outlined is adequate to train a Master level clinician to practice in the art and science of hearing aid dispensing.

REQUIRED COURSES FOR A GRADUATE DEGREE IN AUDIOLOGY:

COURSE	CONTENT
Diagnostic Audiology	Audiometric testing and middle ear analysis. Audiometric calibration. Analysis of audiograms.
Psychoacoustics and Theories of hearing	Responses elicited by common stimuli. Sensory scales and noise phenomena. Speech perception.
Anatomy and Physiology of Hearing and Vestibular system	Advanced study of anatomical and physiological properties of human hearing and vestibular mechanisms.
Electroacoustics and Instrumentation	Study of the generation, control, and measurement of simple and complex sounds essential to audiology.
Hearing aids	Study of the components, function fitting and performance characteristics of hearing aids. Applications in rehabilitative audiology. Practical aspects hearing aid fittings, electroacoustic analysis, real ear measurements and earmold impressions.
Hearing Disorders	A study of the disorders of the auditory system including anatomical, physiological, perceptual and audiological manifestations of pathologies affecting hearing.
Auditory Evoked Potentials	Theoretical bases, techniques and clinical applications for auditory evoked potentials

Hearing Conservation	A study of industrial, educational and military hearing conservation programs
Hearing aids II	Advanced study in fitting hearing aids special circuits and practical aspects of hearing aid dispensing
Rehabilitative Audiology	Principals and methods of communication assessment and intervention with hearing impaired children and adults to minimize the effects of hearing impairments. Study of latest technology in amplification, school amplification devices and cochlear implants
Pediatric Audiology	Normal and pathologic development of the auditory system. Audiometric testing, auditory and communication aspects in habilitation of the hearing impaired child
Vestibular Systems and Disorders	Study of the anatomy and physiology of the normal peripheral and central vestibular system. Clinical assessment of vestibular disorders and vestibular rehabilitation
Seminars in Audiology	Critical evaluation of current topics in hearing science, audiology and hearing aid fitting

Effective for Applications for Certification
Postmarked January 1, 1993, and Thereafter

OUTLINE OF THE *NEW* STANDARDS FOR THE CERTIFICATES OF CLINICAL COMPETENCE

I: DEGREE: Applicants for either certificate must hold a master's or doctoral degree. Effective 1/1/94, all graduate coursework and clinical practicum required in the professional area for which the Certificate is sought must have been initiated and completed at an institution whose program was accredited by the ESB in the area for which the Certificate is sought.

II: ACADEMIC COURSEWORK: 75 semester credit hours (s.c.h.).

A: BASIC SCIENCE COURSEWORK: 27 s.c.h..

- 6 s.c.h. in biological/physical sciences and mathematics.
- 6 s.c.h. in behavioral and/or social sciences.
- 15 s.c.h. in basic human communication processes to include the anatomic and physiologic bases, the physical and psychophysical bases, and the linguistic and psycholinguistic aspects.

B: PROFESSIONAL COURSEWORK: 36 s.c.h., 30 in courses for which graduate credit was received and 21 in the professional area for which the Certificate is sought.

CCC-SLP

- 30 s.c.h. in speech-language pathology.
  - — 6 in speech disorders[1].
  - — 6 in language disorders[1].
- 6 s.c.h. in audiology.
  - — 3 in hearing disorders and hearing evaluation[1].
  - — 3 in habilitative/rehabilitative procedures[1].

CCC-A

- 30 s.c.h. in audiology.
  - — 6 in hearing disorders and hearing evaluation[1].
  - — 6 in habilitative/rehabilitative procedures[1].
- 6 s.c.h. in speech-language pathology, not associated with hearing impairment.
  - — 3 in speech disorders[1].
  - — 3 in language disorders[1].

III. SUPERVISED CLINICAL OBSERVATION AND CLINICAL PRACTICUM: 375 clock hours (c.h.).

A: CLINICAL OBSERVATION: 25 c.h., prior to beginning initial clinical practicum.

B: CLINICAL PRACTICUM: 350 c.h. total.

- 250 c.h. at graduate level in the area in which the Certificate is sought.
- 50 c.h. in each of three types of clinical settings.

CCC-SLP

- 20 c.h. in each of the following 8 categories:
  1. Evaluation: Speech[2] disorders in children
  2. Evaluation: Speech[2] disorders in adults
  3. Evaluation: Language disorders in children
  4. Evaluation: Language disorders in adults
  5. Treatment: Speech[2] disorders in children
  6. Treatment: Speech[2] disorders in adults
  7. Treatment: Language disorders in children
  8. Treatment: Language disorders in adults
- Up to 20 c.h. in the major professional area may be in related disorders.
- 35 c.h. in audiology
  - — 15 in evaluation/screening
  - — 15 in habilitation/rehabilitation

CCC-A

- 40 c.h. in the first 2 categories listed below; 20 c.h. in the fifth category:
  1. Evaluation: Hearing in children
  2. Evaluation: Hearing in adults
  3. Selection and Use: Amplification and assistive devices for children.*
  4. Selection and Use: Amplification and assistive devices for adults.*
  5. Treatment[3]: Hearing disorders in children and adults.

*At least 80 hours must be completed in categories 3 and 4 with minimum of 10 hours in each of these categories.

- Up to 20 c.h. in the major professional area may be in related disorders.
- 35 c.h. in speech-language pathology unrelated to hearing impairment
  - — 15 in evaluation/screening
  - — 15 in treatment

IV: NATIONAL EXAMINATIONS IN SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

V: THE CLINICAL FELLOWSHIP

[1]Academic credit for clinical practicum may *not* be used to satisfy these minimum requirements. However, a maximum of 6 s.c.h. for practicum may be applied to the 36 s.c.h. minimum professional coursework.

[2]"Speech" disorders include disorders of articulation, voice, and fluency.

[3]"Treatment" for hearing disorders refers to clinical management and counseling, including auditory training, speech reading, and speech and language services for those with hearing impairment.

6-7

Guidelines for Graduate Education in Amplification

Committee on Amplification for the Hearing Impaired
American Speech-Language-Hearing Association

The revised Guidelines for Graduate Education in Amplification were prepared by the Committee on Amplification for the Hearing Impaired and adopted by the ASHA Legislative Council (LC 16–90) in November 1990. Members of the committee responsible for the revised Guidelines include Thomas S. Rees, chair; G. Jean Boggess; Evelyn Cherow, ex officio; Alice E. Holmes; Barbara J. Moore-Brown; Polly E. Patrick; and Valenta G. Ward-Gravely. Teris K. Schery, 1988–1990 vice president for clinical affairs, was monitoring vice president.

Prerequisite Areas

Persons providing professional audiologic services in amplification should demonstrate knowledge of the following prerequisite areas through academic content and practical application:

I. General science areas, including acoustics, anatomy and physiology of the hearing and speech mechanisms, basic electronics, psychophysical methods, instrumentation, computer technology and applications, and calibration.

II. Pathology of the auditory system, including disorders of the peripheral and central auditory systems and treatment modes for auditory disorders.

III. Normal auditory and speech-language development.

IV. Speech perception deficits and speech-language disorders associated with congenital and acquired hearing impairment.

V. Audiological evaluation procedures, including complete pure tone, speech recognition, acoustic immittance, electrophysiological measures, site of lesion tests, case management, counseling, referral procedures, and report writing.

VI. General audiologic rehabilitative procedures, including determination of rehabilitative needs, interviewing and counseling, in-service training strategies, and long-term remediation strategies for individuals regardless of age or degree of hearing impairment.

Specific Competency Areas in Amplification

These areas are directly related to amplification and are suggested for inclusion in a model curriculum for graduate level courses and practicum in amplification. They are considered the minimum requirements for providing an adequate base of knowledge in amplification. Persons providing audiologic services in amplification should demonstrate knowledge of and skills in:

I. Physical and electroacoustic characteristics of hearing aids and other assistive amplification devices, including the following:

A. Physical characteristics of hearing aids, including types, components, batteries, volume and tone controls, limiting circuitry, and digital signal processing technology.

B. Past and current national and international terminology and specification standards.

C. Measurement methods for electroacoustic characteristics in compliance with existing ANSI standards, using both coupler and manikin systems.

D. Methods for assessment of real ear performance of hearing aids using ear canal probe-tube microphone systems.

E. Effects of acoustic and electroacoustic modification on real ear response.

II. Earmold and in-the-ear hearing aid acoustics, materials, types, tubing, impression techniques, and modifications.

III. Room acoustics, including the effects of noise, reverberation, and distance on speech intelligibility, environmental modifications, and interaction with amplification devices.

IV. Principles and methods of evaluation, including

A. Determination of need for and characteristics of appropriate amplification using case history, self-assessment inventories, profiles and questionnaires, and audiological assessment data.

Reference this material as follows:

American Speech-Language-Hearing Association (1991). Guidelines for graduate education in amplification. *Asha*, 33, (Suppl. 5), 35–36.

5-8

B. Effects of acoustic and electroacoustic modification on user performance with hearing aids.

C. Selection procedures and protocols, such as traditional and contemporary evaluations, prescriptive fittings, real ear measurements, and programmable hearing aids.

D. Rationale for selection of various hearing aid characteristics and types of fittings, such as monaural/binaural, CROS variations, directional microphones, compression, and circuitry that attempts to suppress background noise.

E. Appropriate alternatives to traditional hearing aids, including vibrotactile aids, cochlear implants, and implantable hearing aids.

F. Procedural modifications for special populations, such as pediatric, geriatric, developmentally disabled, and physically disabled.

V. Rehabilitative procedures, including

A. The hearing aid orientation process.

B. Counseling with and on behalf of hearing-impaired individuals about hearing aids, hearing loss and its effects on speech perception, and speech-language development.

C. Assessment and rehabilitation techniques for communication problems of the hearing aid user.

D. Rehabilitative procedures appropriate for special populations.

VI. Assistive listening and alerting devices, including types of systems, rationale for use, and evaluation procedures for selection and monitoring of these systems.

VII. Procedures and equipment for maintenance, troubleshooting, and repair of hearing aids, earmolds, and assistive listening devices.

VIII. Amplification delivery systems, including models for dispensing, interprofessional and interagency relationships, professional certification and licensure, program accreditation, state and federal legislation, and regulations pertaining to the manufacture and sale of hearing aids and related equipment.

IX. Business management and marketing strategies.

X. Professional aspects of hearing aid services, including autonomy, record keeping and documentation, principles of quality assurance, risk management, professional liability, equipment and facilities selection, financing, and reimbursement systems.

HEARING AND SPEECH DEPARTMENT

AUD819 - PRINCIPLES OF AMPLIFICATION
SPRING SEMESTER, 1996
(3 CREDIT HOURS)

TIME: Wednesday - 1:30 - 4:20

PLACE: H.C. Miller Building, room 3005

INSTRUCTOR: Gwen O'Grady, MSPA, CCC/A
phone: 588-5730, email: gogrady@kumc.edu

OFFICE HOURS: Wednesday 8:30-11:30 or by appointment

COURSE DESCRIPTION: Study of the components, function, fitting and performance characteristics of hearing aids; applications of amplification in rehabilitative audiology.

COURSE OBJECTIVE: The purpose of the course is to enable the student to acquire knowledge and understanding of the principles and rationales involved in hearing aid fitting.

CLASS FORMAT: lecture, discussion and labs

GRADING POLICY: Grades will be based on:

Examinations:	50%
Project:	25%
Quizes:	15%
Labs	10%

GRADING SCALE:

90-100%	A
80-89%	B
70-79%	C
60-69%	D
59% or less	F

REQUIRED TEXT BOOKS: Probe Microphone Measurements : Mueller, Hawkins, Northern

Strategies for Selecting and Verifying Hearing Aid Fittings: Valente

RECOMMENDED TEXT BOOK: Handbook of Clinical Audiology: Katz

Additional required readings will be assigned.

TENTATIVE SCHEDULE FOR LECTURE/LAB:

1-17-96: Hearing aid candidacy/ Types of hearing aids
Lab: Earmold impressions
Readings for next week: 1993 Carhart Lecture(8pgs)
Audrey Lowe(1pg)
Mueller Ch 1(19pgs)

Katz Ch 43(657-677--20pgs)
handout: an easy method for calculating the AI (3pgs)
Earmold impressions (2pgs) EMI, Griffing
Handout: 3 types of SNHL (4pgs)
Assignment: get an email acct. Send me an email :gogrady@kumc.edu by 1-31-96.
turn in 3 perfect earmold impressions by 2-14-96

1-24-96: Components of hearing aids: Current and historical
Electroacoustical characteristics of hearing aids
Lab: Fonix 6500/earmold and hearing aid modifications
Readings for next week: Netscape URL:http//vega.unive.it/contrib/audies/hear.html
by 2-7-96.
Electoacoustic analysis handout: Sweetow and Madory (2pgs)
Class H, 2pgs
Output limiting: applied principles (3 1/2 pgs)
Earmold modifications: Westones (1pg)
Earmold modifications: Westones (1pg)
handout: amplifiers (1/3 pg)
handout: glossary
Unitron: How a hearing aid works (3 pgs)
Katz Ch 43 (677-691--14pgs)
Assignment: Fonix workbook pg 4-13

1-31-96: Electroacoustic characteristics cont
Coupling effects
Student Presentation.
Lab:Fonix 6500/ modifications cont.
Readings for next week: Valente ch 4 (23 pgs)
handout: effect of coupling (1pg)
Katz Ch43 (691-718--26pgs)
Assignment: Fonix workbook pg 14-23 Read through all the workbook for tolerances etc.

2-7-96: Hearing aid evaluations: current and classic
Student Presentation
Lab: UCL/MCL/LGOB
Readings for next week: Valente Ch 6 (25 pgs)
Katz ch 44 (10 pgs)
3M sound advice
Preves: Some Issues in current HA technology (4pgs)
Assignment : Fonix workbook pg 23-33

2-14-96: Hearing aid orientation and rehabilitation
Solving amplification problems
Student Presentation
Readings for next week: Katz Ch 48 (12 pgs)
Reiter: Psychology of the hearing impaired (29pgs--please read for pleasure and understanding-- no test questions but crucial for clinicians working with the hearing impaired!)
Starkey: Practical methods (reference)
Martin: Nuts and Bolts: solving hearing aid problems (2pgs)
Gitles: Succesful Rehab: Whose responsibility? (2pgs) PartII: (2pgs)
Gitles: Communication Interaction (2 pgs)

2-21-96: Test: one hour
Prescriptive formulae
Lab: compare / contrast formulae for specific hearing losses
Readings for next week: Mueller ch 2, 3 (44 pgs)
Revit, pg19-21
IHAFF (3PGS)
Phonak: A guide to practical applications of pre selections formulae

2-28-96: Real Ear Measurements (REM)
Student Presentation
Lab: REM/ ear impressions/ modifications
Readings for next week: Mueller ch 4, 5 (45 pgs)
Valente ch 5 (17 pgs)

3-6-96: REM
Student Presentation
Lab: REM/ ear impressions/modifications
Readings for next week: Mueller: ch 6, 7 (45 pgs)
Berger: But clients often use less gain than prescribed (2 pgs)
Assignment: real ear work sheet

3-13-96: REM
Student Presentation
Student Presentation
Lab: REM/ear impressions/modifications

3-20-96: Test

3-27-96: Special Circuits
Student Presentation
Readings for next week: Mueller ch 9, 10 (42 pgs)
handout: Classifying automatic signal processors (2pgs)

4-3-96: Special Circuits
Student Presentation
Readings for next week: Fitting strategies for 3M (2pgs)
handout: Acoustic advantages of deep canal fittings
Teder: compression in the time domain (5pgs)
Killion: The K-amp (22pgs)

4-10-96: Programmable Hearing Aids
Readings for next week: Valente Ch 14 (36 pgs)

4-17-96: Programmable Hearing Aids
Readings for next week: Mueller ch 8 (22 pgs)
Phonak: fitting young children with programmable hearing aids
Seewald: The DSL method for kids(5 pgs)
Seewald: 20 questions (5 pgs)

4-24-96: Special Considerations: elderly and children
Lab: DSL program
Readings for next week: Structure of a hearing aid sale--take with a grain of salt...
Missed Opportunities
Stach: 20 ?'s (5pgs)
Mims: fitting decisions (2pgs)

5-1-96: Wrap up loose ends
Handout take home final
-you will be assigned a patient with a hearing loss
-you must decide if the patient is a candidate for a hearing aid(s)
-you must demonstrate how you follow all FDA regulations
-you must select the instrument and document why it is the most appropriate instrument for this patient
-you must select the appropriate coupling system (if indicated)
-you must demonstrate how you verify benefit from amplification
-you must plan an appropriate rehabilitation program/schedule

5-8-96: In class practical final
-demonstrate the proper technique for ear mold impressions
-demonstrate the ability to make an adequate earmold impression
-perform real ear measurement
-dicuss how the real ear measurements effect the hearing aid prescription
-demonstrate electroacoustic measures and determine if a hearing aid is functioning according to manufacture's specifications
-when presented with typical patient "complaint" you must determine an appropriate acoustic or electroacoustic modification to solve the problem

ANY STUDENT IN THIS COURSE WHO HAS A DISABILITY THAT PREVENTS THE FULLEST EXPRESSION OF ABILITIES SHOULD CONTACT THE INSTRUCTOR PERSONALLY TO MAKE INDIVIDUAL ARRANGEMENTS.

ANY STUDENT WHO DOES NOT UNDERSTAND AND/ OR ACCEPT THE CONTENTS AND TERMS OF THIS SYLLABUS MUST NOTIFY THE INSTRUCTOR VERBALLY AND IN WRITING WITHIN ONE WEEK AFTER RECEIVING THIS SYLLABUS.

HAROLD P. HESLER
5327 CANTERBURY ROAD
SHAWNEE MISSION, KS 66205
JANUARY 28, 1996

HEARING AID TESTIMONY

H & H S Comm
1-30-96
Attm. #6

Harold P. Hesler
5327 Canterbury Road
Shawnee Mission, KS 66205
January 28, 1996

HEARING AID TESTIMONY

My name is Harold Hesler, a resident of Fairway, Kansas, testifying as a hearing aid user. My reference to notes will conserve your time. I am 84 years old and have been using a hearing aid in my right ear since October 1993, and in my left ear since mid January 1996.

My hearing problems probably have developed from exposure to damaging noise from farm equipment operation in the days before air conditioned cabs; from working as a mechanical engineer in heavy machinery fabrication shops, steel mills and power plants; from serving as an aircraft gunnery student and instructor in WW II; and as an aircraft pilot.

I began noticing a difficulty in understanding normal conversation in my late 70's. When I started to investigate the possible need for a hearing aid, I was confused by a seeming lack of unbiased comparative information. I expressed my concern to my daughter, who holds a graduate degree in nursing, at the time, and was managing a clinic in Illinois. Doctors at the clinic recommended that I seek the help of an audiologist who would hold at least a Masters' Degree in Audiology from a qualified university and a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association. My personal physician concurred with this recommendation and this simplified my search for help.

I found a competent audiologist with the recommended qualifications, who through a series of tests, determined the extent of my problems, specified and handled the purchase of the aid that best suited my individual need. He also fit, adjusted and serviced my hearing aid so that it has been a valued accessory that I wear continuously.

The single hearing aid had two noticeable disadvantages. In conversations at a table or while traveling, it was difficult to understand persons seated on my left and it was difficult to locate the direction of the source of a sound. This can be especially valuable driving in traffic and after discussions with my audiologist, I have purchased an aid for my left ear. Although I have used it less than a month, I already notice its value and I wear it continually.

I believe I received good advice to take my hearing problem to an audiologist. His suggestions and advice have proved accurate and beneficial and I have been well pleased with the equipment and professional service he has provided.

Now with respect to any controversy over state licensure requirements, it is my opinion, based on my experience, that the recommendations of a properly certified audiologist should bear the most weight in making your decision.

I would be happy to answer any questions you might have.

The University of Kansas Medical Center

School of Medicine
Department of Otolaryngology

January 30, 1996

Testimony Before the House Committee on Health and Human Services

Good Afternoon, Mr. Chairman & members.

My name is Gregory A. Ator. I am a physician and an assistant professor of Otolaryngology at the University of Kansas Medical Center. My field of practice is Otology - Neurotology or that specialty of medicine dealing with disorders of hearing. This is a subspecialty of the branch of medicine known as otolaryngology or ENT as it is more commonly known. My role at the university includes education, research, and clinical care. I also have multiple interactions with audiology students as they complete qualifications towards the Master's Degree in Audiology. I work with the students in my clinical practice as well as serving on selected student's Master's thesis committees. I also collaborate with faculty members of the Hearing and Speech Department at the University in educational as well research endeavors.

I am here today to speak in favor of House Bill 2689 addressing the duplication of licenses required by the audiologist interested in fitting hearing aids.

I support this bill for several reasons, most of which arise as a result of my close working relationship with the audiology profession.

My work frequently requires knowledge of the exact hearing ability of patients and for this I rely almost exclusively on my audiology colleagues. Indeed, most otolaryngologist rely on the services of an in-house audiologist for the determination of hearing levels. No hearing aid dealers are employed in this capacity. The most obvious reason for this is the difference in level of training. Audiology has an extensive multi-year graduate level training, classroom as well as supervised hands on observation, in the pursuit of knowledge of hearing and hearing disorders.

As we have heard in prior testimony the training requirements of each group differ. It is clear that the audiologist is better trained in all aspects of hearing assessment and treatment not just those related to hearing aid dispensing. Hearing aids are also a small part of the medical practice of hearing disease treatment which I, with the help of the audiology profession, am engaged in. Other issues apart from hearing aid dispensing are frequently intellectually and technically more demanding of the audiologist. Thus although hearing aid dispensing is common to audiology and hearing aid dealers there the similarity ends.

From the above it is clear that the licensing of audiologist in the area of dispensing hearing aids should be simplified as laid out in the proposed legislation.

My personal experience as a university faculty member dealing with the daily clinical problems of the hearing impaired and my experience as a practicing physician who is frequently sought out for medico-legal questions regarding hearing matters confirms my confidence in the audiology profession.

Thank you for your attention and I will be pleased to address questions or comments.

Sincerely,

Gregory Ator

Gregory A. Ator, M.D., F.A.C.S.
Assisant Professor
Director, Otology Division

H+HS Comm.
1-30-96
attm # 1

3901 Rainbow Blvd., Kansas City, Kansas 66160-7380 • (913) 588-6700

TESTIMONY OF

ED SCHULTE, PH.D., MEMBER-AT-LARGE

KANSAS SPEECH- LANGUAGE- HEARING ASSOCIATION

FOR

THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES

REGARDING HOUSE BILL #2689

REVISION OF SPEECH PATHOLOGY AND AUDIOLOGY LICENSURE

TO INCLUDE DISPENSING OF HEARING AIDS

(ELIMINATION OF DUAL LICENSURE FOR AUDIOLOGISTS)

JANUARY 30TH, 1996

H+HS Comm.
1-30-96
attm# 8

January 30, 1996

Testimony to Health and Human Services Committee
Representative Carlos Mayans, Chair
Kansas State House

Mr. Chairman and Committee Members,

My name is Dr. Ed Schulte. I am the Member-at-Large serving as Legislative Liaison for the Kansas Speech Language Hearing Association. I work at CMS Therapies, a division of Horizon/CMS Healthcare providing contract therapy to hospitals and nursing homes across the State of Kansas. My testimony is as an elected representative of KSHA, a Speech Pathologist with 18 years of experience, and by the way, as an individual who has personally experienced a moderate-to- severe hearing loss in both ears, which was recently repaired surgically .

In summarizing the testimony of my colleagues, I would like to reiterate the most critical reasons for the committee to recommend support of House Bill 2689, as well as address any negative issues that would be associated with passage of this bill. I will address the impact on Hearing Aid Dealers who may oppose this legislation, clarify the impact on the consumer, and identify the key reasons we need your support for this bill:

1. Impact on the Hearing Aid Dealers Association-
KSHA does anticipate there will be a small monetary impact on Hearing Aid Dealers licensure. With audiologists no longer paying fees for the additional license, the cost of licensure fees for dealers may need to increase. We believe, however, that any increased cost of a hearing aid dealers license, also reflects the much lower monetary investment in the training of a dealer, as compared to the educational and training costs of a masters or doctorate degree in audiology. We believe this is a fair cost to pay for being able to practice at a lower level of training, and invite any dealer who wishes, to apply for the fine training programs available in the state. A second area of economic impact exists. KSHA does believe that in some instances, informed consumers may choose to utilize the services of a certified audiologist as opposed to a Hearing Aid Dealer. Dealers in some locations may be impacted by this consumer choice, while reputable dealers in other locations or other areas of the state should be relatively unaffected. It is important to note, however, that we believe the number of dispensing audiologists will remain relatively constant with current levels, and that there are sufficient

numbers of consumers needing amplification to support quality oriented dispensers of both training levels. We are not, and have no intent to pursue this bill with the purpose of prohibiting Licensed Hearing Aid Dealers from pursuing their current livelihood.

2. Impact on Consumers-

With passage of HB #2689, consumer protection should be improved. There is no loss in quality by allowing audiologists to dispense hearing aids while adhering to the higher standards imposed by the audiology training standard. (Refer to previous testimony regarding comparative training levels and licensure standards.) Also, with clear differences in training reflected by different licensure, consumers would be better able to match their needs, to the professional training level of the provider. Informed choice by consumers ***is*** a consumers best protection. Secondly, current ethical and professional practice standards under the current Speech Pathology and Audiology licensure act, provide sufficient protections to prevent consumer harm, or to deliver an appropriate consequence in the event that harm occurs. We do not believe we will see roadside sweet corn and hearing aid stands spring up in audiologists front yards (even if they are ear specialists), but that dispensing will continue to be the work of well trained, professionally competent individuals. KSHA also suggests that consumer costs should show a net decrease. Audiologists fees would no longer need to reflect the costs associated with maintaining the redundant hearing aid dealers license. And, as indicated by Dr. Ferraro, our state funded training institutions would realize considerable savings by not having to allocate departmental budgets (i.e. state tax funds) to pay staff fees for the second license.

3. The Legislative Issue-

The members of KSHA understand how difficult it must be for legislators to address scope of practice issues. In most instances this requires mediation between at least two professional groups wanting to either restrict or prohibit the actions of the other legislatively. The elected official faces the ordeal of working with two sets of constituents, each with their representative viewpoint as to why the other should ***not*** be allowed to engage in the target activity. Support for HB #2689 falls outside of this usual scenario. KSHA and the dispensing audiologists we represent do not wish to prohibit the ability of properly trained members of the Hearing Aid Dealers Association to fit hearing aids. Rather, that as the higher trained and already regulated professional, licensed audiologists be allowed to dispense under a license structure which is more appropriate, which already exists, and which is required in order to perform all the other duties of their practice. I reiterate, while HB #2689 may not prove popular with the dealers

membership, it does not limit their ability to continue to function as independent business persons in their own right, with a license structure appropriate to their level of training. It is not, however, the same level of training, nor should it be the same license structure for the two groups. Finally, reduction of costly, unnecessary, and duplicative regulation is good government. While a small action, support of HB #2689 is evidence that even a small step in the right direction, is a positive action. In the current governmental climate, we can use all the small positive steps our legislature can demonstrate.

In closing, we bring before you a bill that we acknowledge will not make everyone happy. But it is the right thing in regard to its impact on consumers, its impact on taxpayers, and its impact on the Audiology professionals who were well trained at this state's colleges and universities. We ask your support of HB# 2689 which allows for the dispensing of hearing aids by licensed audiologists under their current licensure act.

Thank you for your attention.

January 30, 1996

Testimony to Health and Human Services Committee
Representative Carlos Mayans, Chair
State House

Representatives and Senators,

Thank you for allowing me to address your committee today. I am speaking for Kansas' educational audiologists in support of HB 2689.

As an educational audiologist it is imperative that I be competent in all facets of identification audiometry including, the evaluation of hearing, evaluation of the need for and selection of hearing aids, FM systems, cochlear implants, vibrotactile devices and other hearing assistance technology. This includes making ear mold impressions and modifications. Additionally my employment setting requires that I be skilled in explaining all findings and the educational and legal implications of each to parents, teachers, physicians, and other professionals, ensuring that each child's learning environment, including amplification systems and classroom acoustics, and educational service program is appropriate in meeting his or her needs.

I have provided a copy of the "Minimum Competencices for Educational Audiologists" document approved by the Executive Board of the Educational Audiology Association in June, 1994. Items 1.A. through 1.H. detail the skills required as a educational audiologist which are relevant to our discussions today.

I have been employed as an educational audiologist since 1977. During those years I have been able to utilize daily the information learned during my graduate studies and practicum experiences at Wichita State University. Additionally, I have participated in a host of continuing education activities over the past 19 years in order to keep current as advances, particularly in the area of hearing aid technology, have been made.

H+HS Comm
1-30-96
Attm #9

In 1989, I was employed on a part-time basis as an audiologist for the Hutchinson Clinic, P.A., in Hutchinson, Kansas. For the next five years I continued to be employed by the Reno County Education Cooperative as an educational audiologist and by the Hutchinson Clinic as a clinical audiologist. My duties at the Clinic consisted of conducting comprehensive audiologic evaluations primarily for the purpose of evaluating the need for and selection of hearing aids and fitting and dispensing the same. I found the transition from educational audiologist to clinical audiologist to be quite smooth. My background, including formal education, experience as an educational audiologist, and continuing education activities had prepared me well for my role as clinical audiologist. In 1995, I was asked to join the staff at the Hutchinson Clinic on a full-time basis but declined the offer as I preferred my role as an educational audiologist.

The Bill before you is important to all Kansans with hearing impairment because when passed it will clarify for the consumer the credentials and qualifications of an audiologist from those of an individual without the formal education and practical experiences provided by graduate education programs in audiology. As my earlier testimony attests, the training, testing, and continuing education required to hold a Kansas audiology license has prepared me well to fit and dispense hearing aids. Therefore, it is important to eliminate the need for duplicated credentials and to be able to serve the consumer's audiological needs under one license.

I appreciate being allowed to address your committee today. I hope you will vote to support HB 2698. Thank you.

Respectfully Submitted,

Lila McKee

Lila McKee, M.A., CCC-A
Licensed Audiologist
Reno County Education Cooperative - USD# 610
Hutchinson, Ks.

Minimum Competencies for Educational Audiologists

Approved June 1994 by the Executive Board of the Educational Audiology Association

I. The educational audiologist should demonstrate competency for providing services to individuals birth through 21 years of age and their families in the following areas:

- A. Identification audiometry, including pure tone audiometric screening, immittance measures, and newborn screening criteria.
- B. Threshold audiometric evaluation for pure-tone air and bone conduction, speech reception and word recognition testing, immittance measurements, otoscopy, special tests including interpretation of electrophysiological measures, differential diagnosis of auditory disorders, and diagnosis of central auditory processing disorders.
- C. Medical and educational referral and follow-up procedures and criteria.
- D. Audiological assessment of individuals using procedures appropriate to their receptive and expressive language skills, cognitive abilities, and behavioral functioning.
- E. Evaluation of the need for and selection of hearing aids, FM systems, cochlear implants, vibrotactile devices, and other hearing assistance technology. This includes making earmold impressions and modifications.
- F. Structure of the learning environment, including classroom acoustics and implications for learning.
- G. General child development and behavior management.
- H. Written and verbal interpretation of auditory assessment results and implications appropriate for the intended audience, such as parents, teachers, physicians, and other professionals.
- I. IFSP/IEP planning process and procedures:
  1. Interpretation of auditory assessment results and their implications on psychosocial, communicative, cognitive, physical, academic, and vocational development.
  2. Educational options for individuals who are deaf or hard of hearing, including appropriate intensity of services and vocational and work-study programming, as part of a multidisciplinary team process.
  3. Legal issues and procedures, especially the legal rights of and due process for students, parents, teachers, administrators, and school boards, including the implications of the Americans with Disabilities Act, the Individuals with Disabilities Education Act, and Section 504 of the Vocational Rehabilitation Act of 1973.
- J. Consultation and collaboration with classroom teachers and other professionals regarding the relationship of hearing and hearing loss to the development of academic and psychosocial skills:
  1. Ensure support for enhancing the development of auditory functioning and communication skills.
  2. Recommend appropriate modifications of instructional curricula and academic methods, materials, and facilities.
- K. Participation in team management of communication treatment for individuals who are deaf or hard of hearing or who have difficulties processing speech/language through the auditory system. These procedures should integrate the following:
  1. Orientation to, and the use and maintenance of, appropriate amplification instrumentation and other hearing assistance technologies.
  2. Auditory skills development.
  3. Speech skills development, including phonology, voice, and rhythm.
  4. Visual communication, including speechreading and manual communication.
  5. Language development (expressive and receptive oral, signed, and/or written language).
  6. Selection and use of appropriate instructional materials and media.
  7. Structure of learning environments, including acoustic modifications.
  8. Case management/care coordination with family, school, medical, and community services.
  9. Facilitation of transitions between levels, schools, programs, agencies, etc.
- L. Knowledge of communication systems and language used by individuals who are deaf and hard of hearing.
- M. Counseling for the family and individual who is deaf or hard of hearing, including emotional support, information about hearing loss and its implications, and interaction strategies to maximize communication and pyschosocial development.
- N. Selection and maintenance of audiological equipment.
- O. Maintenance of records, including screening, referral, follow-up, assessment, IFSP/IEP planning, and services.
- P. Implementation of a hearing conservation program.
- Q. Awareness of cerumen management concerns and techniques.
- R. Implementation of inservice training for staff and support personnel.
- S. Training and supervision of paraprofessionals.
- T. Sensitivity to family systems, diversity, and cultures, including Deaf culture.
- U. Knowledge of school systems, multidisciplinary teams, and community and professional resources.
- V. Effective interpersonal and communication skills.

II. The educational audiologist should have an internship/practicum in a school setting under the supervision of an educational audiologist. A preferred internship would be a full-time experience lasting approximately six weeks.

STATE OF KANSAS

DIVISION OF THE BUDGET
Room 152-E
State Capitol Building
Topeka, Kansas 66612-1504
(913) 296-2436
FAX (913) 296-0231

Bill Graves
Governor

Gloria M. Timmer
Director

January 29, 1996

The Honorable Carlos Mayans, Chairperson
House Committee on Health and Human Services
Statehouse, Room 426-S
Topeka, Kansas 66612

Dear Representative Mayans:

SUBJECT: Fiscal Note for HB 2689 by House Committee on Health and Human Services

In accordance with KSA 75-3715a, the following fiscal note concerning HB 2689 is respectfully submitted to your committee.

HB 2689 would bring the dispensing of hearing aids or other assistive listening devices under the legal definition of the practice of audiology. Under current law, these activities are specifically excluded from the definition of the practice of audiology. Audiologists in the State of Kansas must meet certain training and education requirements and be licensed to practice by the Secretary of Health and Environment. The bill would allow audiologists licensed by the Department of Health and Environment to dispense hearing aids without a license from the Board of Examiners for Hearing Aids.

Estimated State Fiscal Impact				
	FY 1996 SGF	FY 1996 All Funds	FY 1997 SGF	FY 1997 All Funds
Revenue	--	--	($1,456)	($7,278)
Expenditure	--	--	--	--
FTE Pos.	--	--	--	--

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The passage of HB 2689 would have a minimal effect on revenues to the State General Fund, but likely would reduce revenues to the Board of Examiners for Hearing Aids by a substantial amount. It is estimated that 43.0 percent of the licensees of the Board of Examiners for Hearing Aids are licensed audiologists. The current revenue estimate for the Hearing Aid Board Fee Fund for FY 1997 is based on total receipts of $16,925. Of that amount, 20.0 percent or $3,385, would be deposited in the State General Fund and $13,540 would be available for expenditure by the Board. If all audiologists would decide not to maintain licensure from the Board and assuming that group generates 43.0 percent of the fee revenue, then total receipts would be reduced by $7,278 to $9,647. The State General Fund would receive $1,456 less and the Board would have $5,822 less available to fund operating expenses for FY 1997 and each year thereafter. The Department of Health and Environment indicates that passage of HB 2689 would have no impact on its operations.

Sincerely,

Gloria M. Timmer

Gloria M. Timmer
Director of the Budget

cc: Sherry DuPerier, Hearing Aid Board
Sandy McAdam, KDHE

2689.FN

HEIN, EBERT AND WEIR, CHTD.
ATTORNEYS AT LAW
5845 S.W. 29th Street, Topeka, KS 66614-2462
Telephone: (913) 273-1441
Telefax: (913) 273-9243

Ronald R. Hein
William F. Ebert
Stephen P. Weir
Melissa A. Wangemann

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
TESTIMONY RE: HB 2689
Presented by Ronald R. Hein
on behalf of
KANSAS HEARING AID ASSOCIATION
January 30, 1995

Mr. Chairman, Members of the Committee:

My name is Ron Hein, and I am legislative counsel for the Kansas Hearing Aid Association.

As introduced, HB 2689 would expand the scope of practice for audiologists. The Kansas Hearing Aid Association (KHAA) strongly opposes HB 2689.

Later you will hear testimony setting out many of the specific reasons why the KHAA opposes this legislation based on the merits of the legislation itself. I wish to focus on two broader policy issues raised by this legislation.

First of all, a hearing was held yesterday before this Committee concerning the issue of credentialing. This is another attempt by a health care provider regulated by the state to expand its scope of practice by coming directly to the Legislature. As indicated yesterday, there is an effort underway to examine a process for referring such scope of practice changes to another body that can review the details of the proposal prior to it being brought directly to the legislature. The proposal with regards to the mental health area was to use the umbrella organization of the Behavioral Sciences Regulatory Board to hear such appeals and make recommendations to the legislature. Another proposal would refer health care providers to another separate body which would be advisory to the legislature. Both of those alternatives recognize the difficulty of scope of practice issues being dealt with by a legislative committee which is limited on time, which is not vested with the expertise in the area, and which does not utilize a hearing process that permits either cross examination or a dialogue for attempting to reconcile these issues.

The legislature should encourage collaborative efforts that call upon the regulated groups to sit at the same table and try to work out their differences. The Kansas Hearing Aid Association recognizes the need for government to be streamlined, yet also recognizes the need for consumers to be protected against incompetent hearing aid dispensers. With those goals in mind, the KHAA proposed to the Kansas Speech Language and Hearing Association (KSHA) that the audiologists and the hearing aid dispensers attempt to merge the functions of their regulating bodies. The audiologists are currently regulated by the Department of Health and Environment, and utilize an advisory committee to make recommendations to the Secretary. The hearing aid dispensers have their own

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independent board, the Kansas Board of Hearing Aid Examiners. After some meetings of an ad hoc group on behalf of both KSHA and KHAA, KSHA unilaterally terminated the discussions, without any indication of why the discussions were terminated.

The KHAA made another overture to begin discussions with the KSHA, had one "venting" meeting of representatives from both boards, and then had what KHAA believed was a very successful meeting. This second meeting was between the entire KHAA board and a significant number of the KSHA board. At that time, KHAA submitted a proposal to KSHA which would have recognized some of the concerns raised by KSHA, and an additional pledge to meet with KSHA throughout the 1996 interim with a goal towards presenting a collaborative proposal to the 1997 Legislature. It was hopeful that this collaborative proposal would include consolidation of the functions for these two groups who deal with the hearing impaired, with a view toward eliminating duplication of regulatory authority, eliminating duplication of licenses, consolidation of state functions, insuring consumer protection, and eliminating differing regulatory interpretations by the governing bodies.

KSHA indicated at that meeting that they would respond to the KHAA proposal prior to introducing this bill. However, the next notice that KHAA received about the matter was the introduction of this bill. Subsequent to the introduction of this bill, KSHA sent a letter to the KHAA indicating a desire to continue communication. However, that is like trying to negotiate a peace settlement without a cease fire.

Just a few short years ago, the KHAA supported the licensure legislation for audiologists, based primarily upon the assurance by the audiologists that they would not seek to pass legislation such as HB 2689.

KHAA strongly urges the Committee to reject HB 2689. We would request that the audiologists and their umbrella organization, KSHA meet with the KHAA and participate in good faith discussions to reconcile their respective concerns on this legislation and on the future regulatory structure for these two groups. The KHAA strongly believes that an agreement can be reached which will permit both professions to operate in a competitive environment with good solid consumer protection.

Thank you very much for permitting me to testify, and I will be happy to yield to questions.

JANUARY 17, 1990

M. Day Kaufmann
Kansas Hearing Aid Association, Inc.
1919 W. 10th Street
Suite #21
Topeka, KS 66604

Dear Day:

In an effort to insure understanding and further the working relationship between the KHAA and the KSHA, we would like to satisfy any concerns regarding the intentions of the proposed speech pathology and audiology licensure bill by clarifying a few points. The proposed bill to license speech pathologists and audiologists is an effort to legally define these two professions in the state of Kansas and to restrict the use of the titles to individuals who have met certain defined levels of professional education. It is an attempt to provide the consumers of speech pathology and audiology services with a means of identifying licensed providers and a means of recourse in the event of inappropriate service delivery. It further will ensure that providers of speech pathology and audiology services remain current in the professions by requiring continuing education. These concerns are not currently being met.

The proposed credential is not intended to replace or supercede the current credential of any other groups operating within the scope of a Kansas license. For example: We do not anticipate, nor do we intend for the current state law requiring a license to fit or dispense hearing aids to be affected. The proposed bill will not exempt dispensing audiologists from the current hearing aid fitters license. In order to be identified as an audiologist and also to fit or dispense hearing aids a practitioner will need to hold two valid licenses. The acquisition of a license in audiology will not give the licensee the right to dispense hearing intruments.

We appreciate your support for our licensing effort.

Sincerely,

Thomas F. Gray, Ph.D.
KSHA Licensure Committee

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Audiology & Hearing Aid Services Inc.

8020 E. Central, Suite 100, Wichita, KS 67206 Telephone 316-634-1100 Fax 316-634-2928

January 29, 1996

To: The Members of the Committee Holding hearings on House Bill #2689
From: Haris Zafar, Ph.D., F.A.A.A. Haris Zafar

Thank you very much for allowing me to share some thoughts on the important issue of hearing aid dispensing by audiologists in the State of Kansas.

I have lived in Wichita for the last 15 years, I have a Master of Business Administration and a Ph.D. in Audiology from Wichita State University. I have served on the faculty at Kansas Newman College and was Assistant Professor and Program Director for Health Care Administration at Wichita State University until the fall of 1993. I am presently owner and President of Audiology and Hearing Aid Services, Inc. in Wichita.

The central issue to be considered in matters of licensure such as this must always be the welfare of the citizens of Kansas. Many times with all the turmoil surrounding such issues the best interest of the citizens and consumers is sometime neglected.

The Kansas Board of Hearing Aid Examiners has been the caretaker for determining proficiency and expertise of hearing aid dispensers in the State of Kansas. I feel they have done an excellent job and with the introduction of recent legislation, will do an even better job at assuring that we have competent individuals dispensing hearing aids in Kansas.

On the issue of the including hearing aid dispensing under the scope of practice for individuals holding a Kansas Audiology license, I feel that since Kansas has a separate audiology license from the credentials granted for audiology by the American Speech and Hearing Association (ASHA), we no longer strictly operate under the ASHA guidelines in place for audiology. If that is the case then more information is needed to determine the competence of students in audiology program across our state concerning the theoretical and clinical training they are receiving currently. Once that information is available then a determination may be made if present audiology program training levels are adequate or not, and if any changes need to be made in the curriculums to serve the best interest of the citizens of Kansas. The State Board of Hearing Aid Examiners already assures competency for dispensing hearing aids in our state through a written examination, practical demonstration of skills and required continuing education. I feel that everyone should be made to adhere to these requirements.

I am attaching a copy of a letter written by James Jerger Ph.D. from Baylor University published in the January/February issue of Audiology Today, the official Journal of the American Academy of Audiology. This letter concerns the Doctor of Audiology (AuD) program at Baylor University. The letter only touches the surface regarding problems which are encountered when emphasis shifts to clinical audiology in university audiology programs.

Again, thank you very much for allowing me to share some thoughts with you.

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LETTERS TO THE EDITOR

Editor's Note: **I received several telephone calls requesting explanation of our last cover photograph (*AT*, 7:6) of a tuning fork in a glass of water. By no means are we suggesting the use of tuning forks to mix drinks, or study underwater propagation of sound. In fact, the photograph represents a classic laboratory demonstration, used in every high school biology class, that the source of sound is vibration. Apparently, some of you skipped that class? Plunged into a glass of water, a vibrating tuning fork makes a splash. If the professor brings the students close enough to the exhibit, the demonstration will be remembered by a number of surprised wet faces!**
–Jerry Northern, Editor

THE FUTURE OF THE AuD

There are no simple solutions to complex problems. Upgrading our profession to the doctoral level is just such a complex issue. In addition to the problems associated with the initiation of new AuD training programs, there are the closely related problems of upgrading undergraduate preparation for doctoral study, recruiting the present major training programs to the concept, dealing with existing master's degree programs, and treating fairly and honorably people already working at the master's level.

At Baylor we have found that adequate preparation at the undergraduate level is critical to success in the kind of quality program we want to offer, and that current applicants seldom have the necessary preparation in the natural and physical sciences. Accordingly we have changed the admission requirements to include better undergraduate preparation in biology, physics and chemistry. The immediate effect of this change will be to put the program on hold until applicants from the undergraduate speech and hearing programs are better prepared, or until alternative sources for applicants have been developed (see box, pg. 13).

The problem of undergraduate preparation is, of course, intimately related to the present academic structure. In retrospect, it was naive to believe that significant change could be achieved by simply starting up new programs without regard for the impact of the existing bachelor's, master's and doctoral degree programs. Until a plan has been developed across the entire education structure, for an orderly transition to the AuD degree as the standard of preparation for clinical audiology, there is little likelihood of significant curricular change at the undergraduate level.

Finally, dealing fairly and honorably with master's level persons now working in the field is an enormously complex issue requiring the wisdom of Solomon, the patience of Job, and the empathy of Mother Theresa. Persons who advocate simplistic solutions like "entitlement" are part of the problem, not part of the solution.

I believe that the only effective avenue for dealing with these interlocking problems in a positive way is to convene a summit meeting of persons truly representative of the many different segments of the profession, in order to develop a coordinated plan for orderly change in all of the different dimensions of educational and professional activity central to the upgrading of the profession. Such coordination is, I believe, essential to successful future progress. It is vital, moreover, that all segments of the profession be represented at such a summit. For too long the AuD movement has been dominated by a relatively small group of individuals who have placed forward motion above common sense. It is time for the profession, as a whole, to take charge of its destiny.
–James Jerger, Houston, TX

dealing fairly and honorably with master's level persons... is an enormously complex issue requiring the wisdom of Solomon, the patience of Job, and the empathy of Mother Theresa.

AuD? EARN IT!

I just read the President's Message to the membership (*AT*, 7:5) and the AuD Fact Sheet. Either I misunderstand the third option or I am horrified by it! If I understand it, it says that an applicant may be awarded some kind of retroactive doctorate by application to the AFA. By what authority does the AFA give degrees? Thousands of us went through a legitimate doctoral education program to earn our degrees. If one wants to be called "doctor", then one must go to a degree-granting institution and earn it. Life experiences and continuing education do not qualify as doctoral level education. I fear that our colleagues in related disciplines will think that the AuD is not legitimate; let us not delegitimize even further. You want a doctorate? Go to school and earn it!
–Sanford Gerber, Spokane, WA

DEBATE DEBACLE

I believe that the supporters of entitlement have lost sight of our initial charge for the AuD degree! The AAA originally endorsed the doctorate degree for graduate students who were entering the work force from inadequate academic training programs. Somehow that goal has been suffocated by individuals who care to use the designate, Doctor, at any cost. While entitlement may be in your personal best interest, is it in the best interests of our profession? If you are truly sincere, gather your colleagues in a constructive effort to close down academic programs that consistently produce inferior graduates!

It's foolish to assume that you will gain something for nothing. If the degree designate is truly what you aspire, then take the initiatives that are presently available or those that are being currently developed for your benefit. But please, don't make a mockery out of the professional degree for personal gain.
–John Jacobson, Norfolk, VA

CONTINUED DEBATE IS COUNTERPRODUCTIVE

There is general consensus that the current system for education and training does not adequately prepare audiologists to deliver services. The only defendable reason for upgrading degree requirements for the practice of audiology is to address this problem. All discussions about the AuD should focus on "the public we serve", without consideration of tangential issues such as professional prestige or the edge in marketing services.

I predict that by the early 2000s, there will be three groups of practicing audiologists: (1) a relatively small group of young audiologists with one graduate degree ... an AuD ... earned from one of a handful of regionally accredited universities; (2) another medium-sized group of experienced audiologists who elected to earn an AuD, conveniently and inexpensively,

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Testimony presented by Dr. Robert E. Woodard, Ph.D.
To: House Committee on Health and Human Services
RE: House Bill 2689
Date: January 30, 1996

My name is Dr. Robert E. Woodard. I am both a licensed hearing aid specialist and a licensed audiologist. My education is in the field of Communicative Disorders and Sciences. I have a Bachelor's in Speech Pathology from Oklahoma State University, a Master's in Audiology from the University of Tulsa, and a Ph.D. in Communicative Disorders and Sciences, with an emphasis in Audiology, from Wichita State University. My work experience has included clinical audiology, research audiology, and hearing aid dispensing.

I am opposed to HB2689. I am concerned that audiologists in the state of Kansas to come out from under the hearing aid licensure law. My biggest concern is the limited training that audiology students typically receive in the practice of fitting and dispensing hearing aids. I have spoken with other audiologists that share the same concern. When I earned my Master's degree in 1979, I had taken one three hour course in hearing aids. This was strictly an academic course--there was no practicum. When I was working on my doctorate at Wichita State University, the Master's students were required to take a one three hour course taught during a four week summer session--again with no hearing aid practicum. I spoke with an audiologist who graduated from the University of Kansas just last May (1995). He too had been required to take a single three hour course in hearing aids. With so many advances in hearing aid technology in recent years, it does not appear that the university training programs have kept pace.

In 1977 when I interviewed for admission to the doctoral program at Wichita State University, I had a long heart-to-heart conversation with the late Dr. Roger N. Kasten. It was his belief that audiology had grown so diverse (clinical, educational, research, industrial and hearing conservation, aural rehabilitation, etc.) that no one could be trained to be an expert in all aspects. In other words, a person would have to specialize in his/her area of audiology. His point is very poignant in 1996. Just because a person has a degree in audiology does not make him/her an expert in hearing aid fitting and dispensing.

The audiologists want the public to believe that by virtue of the audiologist's education, he or she is eminently more qualified to fit and dispense hearing aids than is the traditional hearing aid dispenser. They seem to be implying that education in and of itself creates a competent and ethical professional. Therefore, they should not have to

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demonstrate knowledge, skill, or competency in the fitting and dispensing of hearing aids, i.e., they should not have to sit for the state examination administered by the Kansas Board of Hearing Aid Examiners.

Let me give you a hypothetical example. A licensed audiologist works in a public school setting for over 20 years. They move to another city and can only find employment in a medical setting which includes diagnostic audiology and hearing aid fitting; areas of the profession they have not been involved in for over 20 years. Their license to practice audiology clearly does not make them competent to be either a diagnostician or to be fitting and dispensing hearing aids. This is the fallacy with the proposal by the audiologists.

The traditional hearing aid dispenser and audiologist represent two separate professions. Granted, there are similarities between the two. Both can test hearing for hearing loss. However, the traditional hearing dispenser is a business person. The traditional audiologist is a clinician. There is a great deal more involved in the fitting and dispensing of hearing aids than just testing hearing. There is product knowledge, service and repair, customer relations, business management, etc.--areas not typically taught in audiology training programs. If the audiologists are as concerned about consumer protection as they claim that they are, then why not leave hearing aid dispensing to the experts who have the experience--the traditional hearing aid dispenser.

It should be noted that prior to the early 1980s, it was UNETHICAL for audiologists to dispense hearing aids FOR PROFIT as dictated by the American Speech-Language Hearing Association's Code of Ethics. However, ASHA reversed it's position and the UNETHICAL became ethical overnight. It became ethical for audiologists to dispense hearing aids in a world where the traditional hearing aid dispenser had been fitting and dispensing hearing aids, and caring and servicing the hearing impaired, for over 40 years. The audiologists have been trying to become the sole entry point into the hearing healthcare system. By doing so, they would relegate the traditional hearing aid specialist to an incidental role of just hearing aid dispensing--no testing and fitting, just dispensing. The catch is that they could only dispense if referrals were made to them by an audiologist. If the audiologists are also dispensing hearing aids, the traditional dispenser would be eliminated from the scenario completely.

After a decade of effort, the process was put into a different level with different priorities. A national challenge was

initiated to secure the audiologist as the sole entry point into the hearing healthcare system. While it has taken some time to come to the forefront, earlier efforts have been attempted. In early 1993, Vocational Rehabilitation of the SRS changed their funding policies to match those of Medicaid. The KSHA audiologists complained to Voc. Rehab. that the fees were too low for audiologists to afford dispensing through the agency. Voc Rehab stated that their guidelines were changed in the interest of quality assurance. The audiologists used this as an opportunity to introduce discriminatory policy changes through Voc Rehab. The audiologists convinced Voc Rehab to establish a policy under which only audiologist would be allowed to administer hearing tests for Voc Rehab even though both the audiologist and the traditional hearing aid dispenser were licensed by the same state board and deemed qualified by the State of Kansas to administer hearing tests. After intervention by the Kansas Hearing Aid Association and the Kansas Board of Hearing Aid Examiners, SRS/Voc Rehab withdrew their proposal and implemented the same federal medical referral criteria that are followed nationwide as an answer to the quality assurance plan.

The audiologists have argued that it is unfair for them to be required to carry both a license in audiology and a license to dispense hearing aids. They claim it would 'level the playing field' if they were required to carry only one license. I worked in the insurance profession for a short period of time. My license to sell life insurance and health insurance did not allow me to also sell property and casualty insurance. I was an insurance agent, but that did not give me the right or competency to sell products for which I was not trained.

I think that it is clear that it would be a disservice to the citizens of Kansas to allow audiologists to dispense hearing aids without having to demonstrate competency. As a rule, audiology students are inadequately trained to be granted the 'carte blanche' authority to dispense hearing aids. Textbook training does not provide the graduating student the necessary people and practical skills necessary to insure knowledgeable and competent dispensing professional. I do not support HB2689 and ask that you vote against it.

Kevin Howerd Albe
Master Degree From K.S.U. in Audiology
Bachelor Degree From K.S.U. in Speech/Language Pathology
Audiology, License #25
Dispenser and Fitter of Hearing Aids, License #929

My audiology training was conducted at Kansas State University, and my experiences highlighted the strong anti hearing aid fitters feelings and biases prevalent within the Speech Pathologist and Audiologist communities.

Dr. Harry Rainbolt was my adviser. I explained that my father was a Hearing Aid Dispenser and he wanted me to join him in his practice.

Dr. Rainbolt advised me not to make my plan public, as other members of the staff had very negative feelings toward Hearing Aid Dispensers and they would make it very hard for me to get my Masters Degree.

Another staff member, an instructor and the Clinical Director during my studies, had a very low opinion of Hearing Aid Dispensers. She would express this opinion during class, at clinician meetings, as well as at social settings. She stated that Hearing Aid Fitters were as a group unethical and that they were unqualified to perform hearing test and/or fit hearing aids.

This professor was aware of my plans. I had taken three classes from her and, in addition, she had been my clinical supervisor for two semesters. I graduated with a Bachelor's of Science Magna Cum Laude. However, this same person refused to provide me with a good recommendation for graduate school unless I took a remedial spelling and grammar course which she administered. Considering my academic achievement I don't know if my

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poor spelling or / relationship with Hearir Aid Dispensers was the true cause of this demand.

Students were bombarded with this anti Hearing Aid Fitters sentiment. A graduate student at K.S.U., expressed her belief that Hearing Aid Dispensers were irresponsible and unethical. She stated that the master's degree was "proof of ethics". She told me on more than one occasion that Hearing Aid Dispensers were in the business to make a quick buck.

All professions have ethical problems. Be assured that education does not guarantee ethics, and be assured that as a group hearing aid dispensers are not unethical.

These experiences clearly express the basic biases that are instilled into Audiologists and Speech/Language Pathologists while in the educational environment. These biases cause distrust between the field of audiology and traditional Hearing Aid Dispensers. These feelings and biases are not based on fact.

Education programs and examinations at the graduate level do not necessarily insure competence in the area of hearing aid dispensing. To gain my licenses as an Audiologist and a Hearing Aid Fitter, I was required to take three tests. The Comprehensive examination at K.S.U. to earn the Master's Degree in audiology, the National Teachers Examination (N.T.E. / required for the Audiology License from the state of Kansas) and the Kansas Hearing Aid exam.

The comprehensive exam at K.S.U. was a very thorough test of the graduate subject matter. The exam was primarily written, and it did contain some questions on the fitting of hearing aids.

The oral portion of the exam was to explore areas of weakness revealed, and expanded upon other areas not necessarily contained within the written portion of the exam. There was no practical component on this exam to prove my competence.

The N.T.E. was a standardized multiple choice written exam. It covered broad areas of audiology concentrating on areas of current research, academic interest, and areas of testing and aural rehabilitation. The test had a great emphasis on the historical developments of audiology, i.e. the Kemp echo, but little of true clinical importance. The area of least emphasis was aural rehabilitation and testing. To my recollection there were no questions involving the fitting or modification of hearing aids. There was no practical component to ensure competence in the area of hearing aid fitting.

The Hearing Aid Fitters exam covered all areas of testing and hearing aid fitting. The written portion contained areas of anatomy, FDA fitting and referral guidelines, pure tone and speech testing, fitting, trouble shooting, follow-up, etc.

There were four practical examinations given. These exams were earmold impression taking, operation and understanding of an audiometer, performing an actual hearing test including masking on an audiometric simulator, and speech and masking oral exam. This oral portion of the exam was focused on the hardest component of testing, that being masking, and the most important when considering the appropriateness of amplification and the need for referral. The oral examination thoroughly examined speech testing results and the ability to mask.

The most important evaluation for a Hearing Aid Fitter,

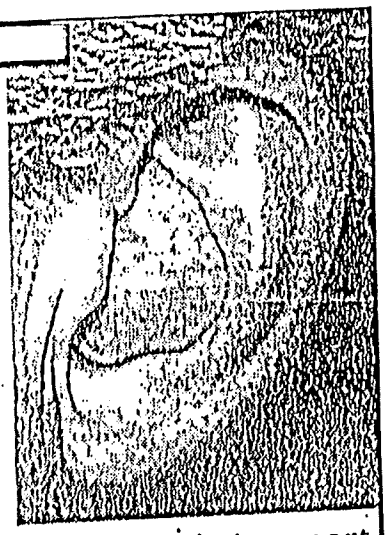
whether or not the person is an Audiologist, s clinical competence. Of the three exams the N.T.E. is the one with the least meaning toward clinical competence. Its focus was primarily research and academic. Yet it is the test that will qualify the audiologist to dispense. The most thorough test of clinical competence was the Hearing Aid Fitters exam. It provided a very clear evaluation of all areas of testing and fitting of hearing aids and shows weaknesses that need correction. In fact, I failed the ear mold portion of this test the first time I took it. This was after completing a Master's degree with the standard clinical practicum.

Current education and testing required to become a licensed audiologist does not ensure competence in the area of hearing aid fitting. There is a strong need for there to be a practical examination of clinical competence and this exists under the current structure of the licensure laws.

The jurisdiction for hearing aid fitting must remain clear. The consumer is not better served or protected if this jurisdiction is divided among multiple boards. A consolidation of the Audiology Board and the Board of Hearing Aid Examiners may be desirable; a single Board to License both Audiologists and Hearing Aid Fitters. Barring such a consolidation a single Board must maintain control over licensing of hearing aid dispensing for simplicity, consistency and consumer protection.

5: HOUSE COMMITTEE / HEALTH & HC. VAN SERV. / HB 2079

How to buy hearing aids



The key to success with hearing aids is not the brand or style you buy – it's the provider you choose.

Complete evaluation, thorough testing, expert counseling (especially in helping you set realistic expectations), and personal follow-up after purchase are necessary when buying hearing aids. Without these services, it's unlikely the products you purchase will be ideal for you.

Our practice is staffed by board-certified physicians and audiologists, not hearing aid sales people. We provide complete hearing care and hearing aid fittings at a reasonable cost.

We won't push you into buying hearing aids. We *will* thoroughly diagnose your hearing, discuss your needs and lifestyle, and offer you a range of choices for improving your ability to hear and communicate. We'll also inform you of all costs ahead of time. You'll find working with us comfortable, professional, and very worthwhile.

We'd like to learn about *your* hearing needs. Call us today!

VISA

CIATES, P.A.

Comprehensive Hearing Care

EXAMPLE OF NEGATIVE ADVERTISING USED BY AUDIOLOGISTS IN KANSAS. THIS IS THE ARROGANCE DEMONSTRATED AND CONVEYED TO THE PUBLIC.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Food and Drug Administration
Center for Devices and
Radiological Health
2098 Gaither Road
Rockville MD 20850

AUG 12 1994

SEP 12 195

Frederick Spahr, Ph.D.
Executive Director
American Speech-Language-Hearing Association
10801 Rockville Pike
Rockville, Maryland 20852

Dear Dr. Spahr:

The Food and Drug Administration (FDA) has recently received a number of complaints concerning the content of newspaper advertisements run by audiologists. These advertisements have appeared in various newspapers in a number of states over the past year. These advertisements attribute to FDA, statements such as:

> "... the average hearing aid dealer is not always qualified to do all the tests and evaluations central to a person's hearing."
>
> "[FDA] found that fewer than 50% of the people who bought hearing aid were adequately tested and evaluated."
>
> "[FDA] advises you to consult an audiologist...before purchasing a hearing aid."
>
> "... success with hearing aids is 13 times greater when they are provided by an audiologist."

FDA has specifically investigated the reference to "13 times greater" and has been unable to identify any source for this statistic within FDA.

Given the number and the geographic distribution of these advertisements it appears that many audiologists may believe that these or similar statements have been made by FDA. FDA wishes to convey to the audiologic community that FDA does not endorse any of the above statements and does not recommend audiologists over other hearing aid dispensers.

Questions concerning this letter may be addressed to the undersigned at (301) 594-4639 or Promotion and Advertising Policy Staff (HFZ-300), Office of Compliance at the letterhead address.

Sincerely yours,

Jan Davis

Jan Davis, M.P.H.
Consumer Safety Officer
Promotion and Advertising
Policy Staff
Office of Compliance
Center for Devices and
Radiological Health

1A-6

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Food and Drug Administra
Center for Devices and
Radiological Health
2098 Gaither Road
Rockville MD 20850

AUG 12 1994

Ms. Robin Holm
International Hearing Society
20361 Middlebelt Road
Livonia, Michigan 48152

Dear Ms. Holm:

Thank you for your letter dated March 23. The Food and Drug Administration (FDA) shares your concerns regarding the use of statements attributed to FDA that have appeared in audiology advertisements over the past year. FDA has sent a letter to the American Academy of Audiology, the Academy of dispensing Audiologists, and to the American Speech-Language-Hearing Association informing them that these statements were not made by FDA and that the advertisements misrepresent FDA's position.

FDA's regulatory authority in the area of hearing impairment is limited to hearing aid devices. FDA has no jurisdiction over the practice of audiology. In addition to the Federal Trade Commission, we suggest that reports concerning false statements in audiology advertisements also be sent to the state departments of consumer protection and to the state agencies which regulate the practice of audiology.

Questions concerning this letter may be addressed to the undersigned at (301) 594-4639 or Promotion and Advertising Policy Staff (HFZ-300), Office of Compliance at the letterhead address.

Sincerely yours,

Jan Davis

Jan Davis, M.P.H.
Consumer Safety Officer
Promotion and Advertising
Policy Staff
Office of Compliance
Center for Devices and
Radiological Health

14-7

KANSAS BOARD OF HEARING AID EXAMINERS

Box 252
Wichita, Kansas 67201-0252
316-263-0774

Testimony Before the
House Health & Human Services Committee

Presented by:

Sherry DuPerier, M.S., CCC-A
Co-Executive Office of the
Kansas Board of Hearing Aid Examiners

January 30,1996

H+HS Comm
1-30-96
attmt 1 5

My name is Sherry DuPerier and I am the Co-executive Officer of the Kansas Board of Hearing Aid Examiners, a position I have held for 2 years. Prior to that time I served as Chair of the Board for over 4 years. I am a hearing aid dispenser and an audiologist. I obtained my masters degree in Communicative Disorders from the University of Texas at Dallas.

I speak on behalf of the Board of Hearing Aid Examiners - the board responsible for regulating the fitting and dispensing of hearing aids in Kansas.

It is the unanimous opinion of the Board that regulatory control for the fitting and dispensing of hearing ads should remain solely with the Board of Hearing Aid Examiners. Our reasons include the need for consistent consumer protection, demonstrated competency, and fair and equal treatment for all dispensers.

Demonstrated competency is a clear requirement to insure adequate consumer protection. When Kansas Speech and Hearing Association representatives and Kansas Hearing Aid Association representatives began meeting to discuss the possible consolidation of duties both parties agreed that testing was critical. However the current bill has no mention of any form of testing or proof of competency. The Board's position has never wavered.

Most graduating audiologists will tell you that hearing aid hours are minimal - and moreover the hours related to the practical aspects of dispensing are even more deficient. Many have stated they have too much research, theory and textbook training. They indicate a lack of real world and practical information and experience.

The current activity regarding the status of dispensing in Kansas is not the first. It is well known that ASHA, The American Speech Language and Hearing Association, is attempting to add dispensing to the audiology scope of practice in all states. In an effort to obtain gatekeeper status, audiologists in Kansas attempted to restrict the traditional hearing aid dispensers scope of practice by proposing policy changes to Vocational Rehabilitation Services. The proposal would have allowed only an audiologist to test hearing for rehabilitation services. Since all hearing aid dispensers are legally qualified to test hearing, this restriction was discriminatory. When explained to the governing agencies, SRS withdrew the proposal. It is the belief of many traditional hearing aid dispensers that the single gatekeeper concept is the ultimate goal of audiology. Previous actions and todays scope of practice change are interim steps in reaching that goal.

Audiologists have tried since 1977 to tilt the playing field by asking the FDA to make audiology the entry point for hearing aids. They have stated in FDA hearings that they are the only ones qualified to test hearing. The AAO (American Academy of Otolaryngology) has just completed testimony for the third time stating the hearing aid dispensers and audiologists are both qualified to test hearing.

Such precedent setting policy requests as Vocational Rehabilitation and ASHA testimony where misleading information has been conveyed are reasons for the concern by both traditional hearing aid dispensers and many dispensing audiologists about the passage of House Bill 2689. From the time that audiology licensure became an issue, the Board of Hearing Aid Examiners has been misrepresented in correspondence. Original proposals failed to mention the existence of a hearing aid licensing board or the resolution of the consumer complaints at issue. Our mandated continuing education was not mentioned and the proposal failed to mention the Federal age and medical referral requirements that regulate all licensed hearing aid dispensers.

More confusion is found in minutes from the Kansas Department of Health and Environment minutes. It is clear from two reports that not even the members of the Audiology Advisory Board knew who was proposing the consolidation or who that person represented. The minutes state that they thought Jim Wise was a member of the Board of Hearing Aid Examiners and that our Board requested the consolidation. This seemed to them to be a self serving plan by the Board of Hearing Aid Examiners and was ultimately rejected. It was in reality Jim Wise representing KSHA that initiated the merger discussion, not a member of our board. The entire issue was fraught with miscommunication.

On January 16th of this year an information alert regarding hearing aid licensure was sent to KSHA members. The memo included the following "This board (the Board of Hearing Aid Examiners) is controlled by the hearing aid dealers. Currently audiologists represent approximately 50% of the licensed members, but have little or no representation on this board."

The hearing aid board is made up of five persons - three dispensing members and 2 non dispensing lay members. The board employs a co-executive officer to handle daily activities. The position of chair has been held by an audiologist for six years. Currently both the chair and the co-executive officer are audiologists.

Eighty-five percent of KSHA members are speech pathologists and have little or no reason to understand the hearing aid board. This misleading information unfairly convinced them that their association has a problem and a reason to fight for licensure change.

In addition the information alert states "since the passage of our law some five years ago, the state of health care and audiology state and federal regulations have changed dramatically. The current licensure status makes it difficult for audiologists to adapt to these changing times, and there is confusion among consumers in differentiating audiologists from hearing aid dealers."

As an audiologist, and a licensed hearing aid dispenser, I am unaware of these dramatic changes. Certainly health care has changed - and will continue to change and the audiology community will change, but current licensing programs have no bearing on the subject. The comment that current licensure status makes it difficult to adapt is unfounded. The confusion among consumers between audiologists and hearing aid dispensers has nothing to do with licensure or insurance - it is an identity problem.

Couple misleading information with the sense of urgency regarding this bill and our concern is clear. It bears repeating that we have looked at consolidation if necessary criteria are met but it has been felt by many that we have not been given an adequate opportunity, nor an adequate assembly.

The issue is clearly not a $50 license fee as has been stated since dispensing in many instances accounts for a significant percentage of the audiologists income. Nor is the issue mere convenience. A common argument relates two licenses and therefore increased continuing education hours. Most would argue that if a person plans to practice in an audiological setting offering a wide variety of audiological services, one of which is hearing aid dispensing, that person would need increased and diversified continuing education.

It is the Board's responsibility to provide consumer protection. Allowing various professional associations to provide dispenser licensing will create inconsistencies. We for these reasons contend that no benefit will come from this change.

We are not academicians with a theoretical view of hearing aids. Nor are we clinicians practicing in the diversified field of audiology. We are hearing aid dispensers and some of us happen to be audiologists. We are asking that any one, whether an audiologist or a hearing aid dispenser, demonstrate their competence. The intent of the proposed change will eliminate any such requirement and will grant all audiologists, whether a graduate of the future, today, or 10 years ago, the automatic right to fit and dispense hearing aids in the state of Kansas.

Two agencies governing the same profession is not economically efficient, is a duplication of services, and cannot insure equivalent rules. Division of enforcement responsibilities between two separate boards licensing hearing aid dispensers is ill-conceived, and not in the best interest of the consumers of Kansas. Every person in the state of Kansas who dispenses hearing aids should be subject to the state licensing examination, and the administration and implementation should be by the single agency responsible for that examination. I ask you to vote against House Bill 2689.

THE STATE OF KANSAS

KANSAS BOARD OF HEARING AID EXAMINERS

Box 252
Wichita, Kansas 67201-0252
316-263-0774

Ms. Pat Casper
Health Occupational Credentialing
900 S. West Jackson
Topeka, Ks. 66612-1290

November 3, 1989

Dear Ms. Casper:

The Kansas Board of Hearing Aid Examiners has recently been made aware of a request for credentialing/licensure being made by the Kansas Speech, Language and Hearing Association. After reviewing the proposal, we feel that the information presented has some serious flaws and omissions. We feel that these points are of extreme importance and ask that you consider our concerns as you meet with the Kansas Speech, Language and Hearing Association on November 13.

Of significant importance is the repeated omission of the Kansas Board of Hearing Aid Examiner's existence. The hearing impaired of Kansas have been served by this board since 1968. The Hearing Aid Licensing Act addresses a multitude of areas regarding ethics, legality and practical knowledge in the testing of hearing and fitting and dispensing of hearing aids.

Several examples of infractions are mentioned in the proposal---and those that relate to hearing aids have been resolved by this board. However, as stated earlier, our existence is ignored. In addition, the proposal cites an inability to mandate continuing education. Again, the licensing board has requirements for annual educational credits which have not been acknowledged.

Another point of grave misrepresentation is the omission of FDA age and medical referral criteria. All hearing aid dispensers nationwide are governed by these criteria. In addition the FDA has made strong recommendations regarding the need for hearing aid dispensers, medical waivers and accessibility for the consumer. Pertinent excerpts from this publication are enclosed.

15-6

We urge you to consider our concerns on this matter. The addition of the licensing in question will create a duplication of services as related to testing of hearing and fitting and dispensing of hearing aids. This will in turn create additional costs and considerable confusion to the consumer. If you have any questions concerning our comments, please contact any of us at 316-263-0774. We will look forward to the outcome of the upcoming hearing.

Sincerely,

KANSAS BOARD OF HEARING AID EXAMINERS

Woodrow R. Rice
Chairman

Charles Gillum, Sr.
Vice Chairman

Sherry DuPerier, M.S., CCC-A

Audiology Happenings...

By: Molly Pottorf, Audiology Chair

On January 7, 1995, the Audiology Committee, as well as members of the Licensure Committee met in Emporia, Kansas. Legislative issues, including SRS regulations, scope of practice pertaining to hearing aid dispensing, and legislative audiology representation, and Kansas Hearing Screening Guidelines were the two hot topics of the day. Subcommittees met concurrently in the morning for discussion, and then gathered as a whole in the afternoon.

Legislative Issues: A letter of support was drafted for the proposed Voc. Rehab. regulation recommending that an audiologist shall provide an audiological exam to screen for medical problems prior to the dispensing of hearing aids led to the drafting of a letter of support. The letter, as well as individually written letters by all audiologists in attendance, were to be sent to SRS. Hearing aid dealers are strongly opposing such regulation contending that there is an insufficient number of audiologists to provide the services across the state. The committee agreed to conduct a telephone survey to determine the extent to which services are available across the state.

It was determined that the proposed merging of the KDHE Speech and Audiology Licensure Advisory Board and the Hearing Aid Examiners Governing Board be tabled because it would not be consistent with our long range goals. It was determined that we would not take any action until after the new FDA regulations are published this Spring. To insure the committee accurately represents the wishes of the profession, a question regarding scope of practice was included as part of the telephone survey.

At this point in time, it is vital to have audiology representation on KSHA's Legislative Committee. Jim Wise will continue to be the audiology representative on the legislative board.

Kansas Hearing Screening Guidelines: The writing committee has worked hard to complete the revisions to the Kansas Hearing Screening Guidelines. Approximately 35 pages were rewritten for Level 4, as well as another 25 pages which were edited in some fashion. Because of the number of pages involved, KSBE is currently determining if the document will need to be reprinted in sections (thus prioritizing the revisions) or if all the revisions can be reprinted at one time. As of this writing, a response is still pending. Regardless, the work is basically done. Copies of the rewrites may be requested by contacting Basil Kessler at KSBE. Approval of the Guidelines will be sought at the Spring Symposium. Comments prior to the Symposium are welcome. (See article Kansas Hearing Screening Guidelines article).

The Long Range Goal of the KSHA Audiology Committee was established: The practice of audiology by recognized as the primary hearing health care profession in the state. To accomplish this goal, three goals were suggested: 1) Promote the practice of audiology so that audiologists are recognized as the primary hearing health care professional (public awareness, marketing, legislative involvement, etc.). 2) Coordinate efforts to provide continuing education opportunities to audiologists for certification and professional growth, and to allow for exchange of professional dialogue (convention, symposium, *Connection* articles, etc.), and 3) Identify and coordinate issues pertaining to the practice of audiology (Kansas Hearing Screening Guidelines, reimbursement issues, universal screening, etc.).

Kansas Hearing Screening Guidelines: Thanks to the contributions of 14 Kansas audiologists, the Kansas Hearing Screening Guidelines are nearing completion. By mid-February, all of the revisions should be in the hands of KSBE. A total of 60 pages have been edited or completely rewritten. The major changes of the Guidelines are summarized below. Approval of the Guidelines will be sought at the Spring Symposium. Comments are welcome prior to the Symposium and should be addressed to Beth Karlsen (Levels 1, 2, and 3) or Molly Pottorf (Level 4). **Copies of the rewrites may be requested by contacting Basil Lessler at KSBE.**

Level 1 and 2 (sweep and threshold screening otoscopy) are basically unchanged.

Level 3 (tympanometry and play audiometry).

1. Suggested course outline remains at 6 hours, however, the workshop can be expanded to 8 hours at the discretion of the instructor. It was felt that the experience and competencies of the workshop participants would dictate the length of the workshop.
2. Tympanometry is required as part of the hearing screening protocol for all children who have not entered Kindergarten. We ran into difficulty trying to explain this since educators use grade level while health department personnel use age level. Hence, we stated the need for tympanometry, thus: "Children age 2 1/2 through age 5 (but not in kindergarten) should be screened using pure tone screening, tympanometry and otoscopy". Both age and grade level occurs frequently throughout the document.
3. Play audiometry was included in the section with tympanometry because of the probability of having to include a "play" component when first attempting to obtain pure tone screening results, typically around the age of 2 1/2 years. Since tympanometry is required for this age group, it seemed logical to build the play audiometry section into Level 3.

Level 4 Infant/Toddler Screening was significantly revised.

(Continued on page 4.)

* TO DATE (1/29/96) NO FDA REGS. HAVE BEEN ISSUED

15-7

ASHA —

Analyzed all state licensure laws for recognition and regulation of support personnel to assist consensus panel on support personnel in audiology deliberations.

- Represents the profession at such meetings of state government representatives as the National Conference of State Legislatures, Council of State Governments, and Council on Licensure, Enforcement, and Regulation.

State Legislative Activity and Audiologists: An Update

- On or after July 1, 1996, audiologists may dispense hearing aids in the state of Connecticut without a second hearing aid dealers license **IF** they have completed at least 6 semester hours of coursework regarding the selection and fitting of hearing aids and 80 hours of supervised clinical experience with children and adults in the selection of hearing aids at an institution of higher education in a program accredited by ASHA or its successor.

Although this makes Connecticut the 20th state to allow audiologists to dispense without a hearing aid dealers license, the language may require audiology students to take an additional course not currently required by ASHA. It also may mean that colleges and universities in Connecticut may have to alter their curriculum to give students the courses necessary for licensure. If applicants for licensure do not have the requisite number of courses in order to dispense hearing aids, they will be required to take the written examination for the hearing aid dispensing license.

- Earlier this year, Colorado and Louisiana enacted legislation exempting audiologists from hearing aid dispensing licensure. The states granting total exemption are Alabama, Alaska, Arkansas, Colorado, Connecticut, Florida, Georgia, Indiana, Louisiana, Maryland, Massachusetts, New York, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Utah, and West Virginia.

- Four states enacted legislation exempting audiologists from some of the requirements for hearing aid dealers licensure. Arizona's new law exempts audiologists from fees and second license while still requiring audiologists to take the written and practical exam. Missouri and Illinois joined Pennsylvania in exempting audiologists from either the practical or written exam. Oregon, along with California, Iowa, Kentucky, Mississippi, and Montana, exempts audiologists from the on-the-job training from hearing aid licensure. New Mexico exempts audiologists from both the examination and the on-the-job training and Minnesota exempts audiologists from some fees.

- The New Jersey Legislature is still considering a bill (Senate Bill 845) that would provide direct insurance reimbursement for audiology and speech-language pathology services. The bill, originally introduced in 1994, received two successful hearings and is awaiting a full vote in the Assembly. The bill still has a chance for passing this year as the New Jersey Legislature is not scheduled to adjourn until January 10, 1996.

- The Kansas Audiology Committee continues to focus their efforts on audiology licensure restructuring in order to permit hearing aid dispensing under the audiology license. The Committee is attempting to work with the KBHAE in the spirit of improving delivery services to the consumer. A joint meeting is planned to ascertain the specific fears and concerns of each group while also identifying the benefits to the professionals and consumers.

State and Federal Advocacy Training Modules Available From ASHA

The ASHA Ad Hoc Committee on Public Policy Advocacy, in consultation with the ASHA Governmental Affairs Department, has completed its state and federal advocacy training modules. These modules are now available **at no cost to ASHA members** and are designed to help members effectively lobby their legislators on both the state and federal level. Included with the modules are reference materials, evaluation forms, and plain paper overheads that can be copied onto transparency film for use in presentations. To obtain a copy, contact: Andrew Williams, ASHA, 10801 Rockville Pike, Rockville, MD 20852.

ASHA Nominates Members to Serve on HCFA's Clinical Practice Expert Panels

The Health Care Financing Administration (HCFA) has engaged Abt Associates, Inc., to develop service-

Representive Carlos Mayans and Committee
State Capitol
Topeka, KS

Dear Representive Mayans and Committee:

My name is Ed Clausen and I am a Kansas licensed Audiologist who is also licensed by the Kansas Board of Hearing Aid Examiners. It is my opinion that to assume a degree in Audiology automatically qualifies someone as being competent in the fitting and dispensing of Hearing Aids is incorrect.

A degree in Audiology encompasses many different areas, including multiple methods of evaluation, anatomy & physiology, Speech-Language Pathology, hearing disorders and rehabilitation to name a few. Hearing Aids are only a part of the overall education obtained. Amplification makes up a small part of the required clinical practicum hours, as does the number of questions pertaining to Hearing Aids on the National Examination.

As in any profession, hands-on experience provides valuable information and anyone entering the practice of dispensing Hearing Aids needs to understand what will be expected of them. This experience and knowledge should not be assumed.

In closing I feel that it is not in the consumers best interest to have two separate bodies that govern the dispensing and fitting of hearing aids. The public would be better served by one unified body.

Thank you very much for your time.

Sincerely,
Ed Clausen

Ed Clausen
KS Licensed Audiologist #01249
KS BD of H.A.E. #976

15-9

KANSAS BOARD OF HEARING AID EXAMINERS

Box 252
Wichita, Kansas 67201-0252
316-263-0774

Representative Carlos Mayans and
Members of the Health and Human
Services Committee

Dear Representative Mayans & Committee:

I write to you as Chair and Co-Executive officer of the Kansas Board of Hearing Aid Examiners, a Kansas licensed audiologist, and a Kansas licensed hearing aid specialist. In December of 1995, I wrote Governor Graves about the issue that is now at hand. I would like to inform you of this activity that we feel will impact state government.

Both the Kansas Board of Hearing Aid Examiners and the Kansas Department of Health and Environment regulate parties that are negotiating possible statutory changes. The audiologists are regulated by KDHE. Hearing aid dispensers are regulated by the Board of Hearing Aid Examiners. The proposal would expand the audiologists' scope of practice to include hearing aid dispensing, an activity that is currently regulated by the Board of Hearing Aid Examiners. The changes would result in the duplication of services, increased governmental spending, and possibly conflicting regulations. We feel that everyone should be subject to the same law and two agencies overseeing the same action is unwise. We feel that it would lead to inconsistencies and contradictory rulings. The enforcement responsibilities should not be separated.

First and foremost is the Board's obligation to protect the Kansas consumer by insuring that licensees are adequately trained and tested and that they abide by the laws, rules and regulations for hearing aid dispensers. In the amendment that has been submitted changing the audiologist's scope of practice, it would put testing and regulation of one activity, hearing aid dispensing, under two separate agencies. It is also our obligation as a governmental body to oversee all aspects of hearing aid dispensing to insure that the fee fund agency is operated as efficiently as possible. We believe in government accountability and efficiency. We feel that the change is not cost effective or economically sound.

15-10

During original licensure discussion for audiology in 1990, the Kansas Speech and Hearing Association stated their purpose in licensure was to make sure that unqualified persons were not practicing audiology or speech pathology - their intent had nothing to do with hearing aid dispensing. In correspondence with the Kansas Hearing Aid Association, the audiology committee stated that "the proposed bill will not exempt dispensing audiologists from current hearing aid fitters license. In order to be identified as an audiologist and also to fit hearing aids a practitioner will need to hold two valid licenses".

The audiologists have also failed to adequately convey pertinent information about the Board of Hearing Aid Examiners. In one piece of correspondence they state that "the Board is controlled by hearing aid dealers" and follow with "audiologists represent 50% of the licensed members, but have little or no representation on the board." At this time there are 230 hearing aid licensees of which 99 or 43% also hold an audiology license. At this time, of the three dispensing members of the board, the chair is an audiologist. In addition, please note that the co-executive officer and former board member/chair is also an audiologist.

As both the chairman of the hearing aid licensure board and a licensed audiologist, I feel that separating the enforcement and licensing responsibilities of hearing aid dispensing is not in the best interest of the consumers of Kansas. I ask that the committee deny the request for this change in the scope of practice.

Sincerely,

KANSAS BOARD OF HEARING AID EXAMINERS

Seara Weir

Seara Weir, M.A.
Chair/Co-Executive Officer

State of Kansas

Bill Graves Governor

Department of Health and Environment

James J. O'Connell, Secretary

Testimony presented to

Committee on Health and Human Services

by

The Kansas Department of Health and Environment

House Bill 2689

Mr. Chairman, on behalf of the Kansas Department of Health and Environment, thank you for the opportunity to provide testimony on House Bill 2689 which amends the licensure of audiologists in Kansas. The amendments offered in this bill would permit fitting and dispensing hearing aids or other assistive listening devices under an audiologist's license. Current educational standards for becoming a candidate for audiology licensure provide the education and training necessary for the fitting and dispensing of hearing aids.

A candidate must have completed at least a Master's Degree in audiology. Audiology is defined as..."the application of principles, methods and procedures related to hearing and the disorders of hearing and to related language and speech disorders. Disorders include any and all conditions, whether of organic or nonorganic origin, peripheral or central, that impede the normal process of human communication including, but not limited to, disorders of auditory sensitivity, acuity function or processing." Additional testing standards and clinical practicum experience must be met prior to applying for a license in audiology in Kansas. The licensed audiologist may also supervise an audiology assistant (recorded under the audiologist's license) who meets minimum qualifications according to established rules and regulations.

KDHE has some question that this bill could be interpreted to require licensure as an audiologist in order to dispense hearing aids. If the committee is favorably disposed to support the bill, it may wish to consider an amendment which would clarify its intent, such as: "Nothing in this act shall be construed as requiring licensure as an audiologist to dispense hearing aids or other assisted hearing devices."

As this bill can be incorporated with little impact to the current licensure program, the department does not oppose these changes. However, it should be noted that the current hearing aid act requires licensure by that board unless the individual is licensed under the healing arts act. Therefore, if this bill passes, a conflict would exist between the two statutes.

Testimony presented by:

Lesa Bray, Director
Health Occupations Credentialing
Bureau of Adult and Child Care
January 30, 1996

H+HS Comm
1-30-96
Attm #16

Health Occupations Credentialing, Mills Building 400B
109 SW 9th Street, Topeka KS 66612-2218

Telephone: (913) 296-0056
FAX: (913) 296-7025