3-14-2024

My name is Misti Chmiel and I am currently serving my 30th year in the hearing aid profession. I am a small business owner and sole proprietor in Central Nebraska, as well as a past President of and current Executive Director for the Nebraska Hearing Society.

The NHS wishes to thank the TRC for their patience. After serving 9 years on the Hearing Instrument Specialist's Licensing Board and traveling 3 times a year to Lincoln for meetings I certainly appreciate your commitment. This last rewrite is in the interest of moving the 407 process forward and addressing comments received at the last meeting. To that end we are submitting our final rewrite that addresses what we feel are the 3 major areas of ambiguity.

Changes in Application

First, the subject of tympanometry has been removed completely from the proposal. While training on these tools exists, and we feel our training is sufficient, this is a subject which could potentially muddy the waters of the scope of practice change we are looking to accomplish.

Second, on the subject of tinnitus care, which is a common term, readily available and clearly defined (for example the Tinnitus Care Certificate Program was developed by Dr. Richard Tyler, a professor at the University of Iowa). The NHS had a tinnitus care class with Professor Tyler, in the Spring of 2022. Covid was just ending and 2022 was the last year we had an online seminar only. As stated in our application, tinnitus care was limited to the tinnitus maskers available in many hearing aids today. As a compromise and without limiting ourselves to a specifically designated class, the NHS has instead decided to let the audiologists, who work within the hearing aid manufacturer's audiology departments, work with those tinnitus maskers remotely. This technological ability already exists. Additional scope regarding tinnitus care, as was originally sought, has been removed from our proposal. The only mention of tinnitus care in our proposal is through this remote work done by audiologists.

Finally, the subject of cerumen (wax) removal is what the NHS feels is the most important and greatly needed to provide the services our clients across the state need, increasing access to care, reducing regulatory burdens, and increasing patient safety. We were happy to incorporate suggestions by the NMA and we presented that material, collaboratively written, in September 2023. Additionally, a two year minimum licensed requirement has been added prior to the providing of cerumen removal, and with mandatory increased continuing education included. It has been suggested that we have training before asking for scope expansion-however that has also been viewed negatively as working outside our scope to have training on services not covered by our scope. We hope to eliminate that confusion by safely adding cerumen removal to our scope of practice. We want to be able to legally use the training we receive.

Training and Education

In February 2020, as part of our annual seminar, we had scheduled a three hour wax removal educational course to be given by Dr. Rita Chaiken, who is an Adjunct Professor and a Past President of the Academy of Doctors of Audiology (ADA). That course was due to be an in-person training experience, in which we would observe someone who's scope of practice it is perform cerumen management, but due to the pandemic and limits of gathering, we rescheduled our seminar into an online Zoom event in April. That class was attended by 34 licensed individuals. While we were unable to have an in-person component of the course at that time, those classes readily exist and will be easy to

attend. An outline of Professor Chaiken's cerumen removal class, which included an infection control component, along with contact information for Professor Tyler's tinnitus care class in Iowa have both been submitted.

As mentioned at the last meeting, a knowledge of a patient's medications, particularly blood thinners, is an important aspect of wax removal. We recognize that some patients may not know what their medication name is or what it does, and we do not present to be pharmacists, therefore we plan to designate one hour of our mandatory 12 continuing education hours annually to pharmacology updates and infection control measures. To minimize any possible infection concerns, one-time use disposable units are the preferred choice and non-disposable units must be sterilized as mandated by the manufacturer's of said equipment. As was mentioned previously, our wax removal course included an infection control component, which is evidence that we've been educating ourselves for many years via our annual educational seminars.

Additional States

Additionally, I would like to clarify that Nebraska is not the first state to request a scope expansion since the IHS updated their model act. To date, nine states, Arkansas, Kansas, Mississippi, New Hampshire, North Carolina, Tennessee, Utah, Wisconsin and South Dakota have passed legislation authorizing HIS to perform cerumen removal. South Dakota is the most recent example, authorizing the practice in 2024. Each state's statutes are different, much like our application will differ from the model act. I previously mentioned the 2020 NHS seminar, I would be remiss if I did not add that yes, NE, via the NHS, was the very 1st state to organize continuing education classes via Zoom, but we are not the 1st state to ask for scope expansion since the IHS began work on updating their model act. The statement given at the last TRC meeting, about NE being the very 1st to undergo such a scope of practice expansion, was misleading and I think may have caused undue doubt or concern. Nine additional states use all encompassing terms covering all or any services or testing procedures: Florida, Idaho, Louisiana, Massachusetts, Montana, New Jersey, New York, Ohio and South Carolina.

Additional Feedback and Concerns Addressed

There are other concerns that our applicant group would like to address in this final application revision.

Only adult patients will be treated through this scope of practice change. Thus, the requirement of 18 years of age or older was changed throughout the document to clarify this. This was always our intention, but we hope to clarify any remaining confusion on this topic.

In general, interested parties urged us to "up the education requirements and down the ask (scope change)". We feel that with the specific training we have incorporated, as well as the continuing education requirements we have raised our education requirements to a sufficient level. Additionally, by removing tinnitus care and tympanometry from the proposal we have reasonably lowered our ask.

A list of states which have incorporated new scope terminology was requested and developed from the same list provided by the ADA while working on over the counter (OTC) legislation. That list was completed January 3rd, 2024 and should have been submitted with the list of states currently using the ILE test which covers new scope topics. Due to an unfortunate administrative oversight, it was unintentionally left off, however, that list was sent to the TRC by email as soon as it was discovered it

had not been sent already. We hope you have had time to fully review that list, which shows we are not the first state to request change.

I have attached a historic timeline of the Nebraska Hearing Society, which I hope provides some context regarding our organization as well as changes that have been made in the past.

In a revision, we mentioned dually licensed audiologists within our proposal as an attempt to include them as eligible trainers along with Board Certified HIS. This was met with skepticism so all mention of dually licensed audiologists has been removed entirely.

On the subject of cochlear implants, cochlear implant referral is not the same thing as cochlear implant screening or determining candidacy and is not something included in our proposal, though it was erroneously reported on the ADA national website. An email dated October 13, 2023 received from the Executive Director of the American Cochlear Implant Alliance clearly stated the ADA group was confusing the terms. In their words taken from the email: "We absolutely want to continue to encourage referrals and continuing support by hearing instrument specialists. We value our work with IHS and want to continue working with you. Your members are an important part of the hearing care team."

There were concerns about the scope being too broad in general. We are attempting to narrowly update our scope to better serve patients across the state. Our last scope of practice change was sought and achieved approximately 20 years ago. Now, we are proposing a forward thinking scope that is adaptable to new technologies in the industry.

There was also a question about defining special applications in regards to ear molds and hopefully the changes made will be sufficient and should be self explanatory. Custom made earpieces are available for several common applications; newscasters, motorcycle police, IPOD, hearing protection, etc.

There was a question presented at the last meeting regarding the location limits for referrals. Our response to that is referrals would be to locations as close as possible for the patient or within Nebraska.

Another inconsistency I would like to address is in regards to questions that came up about insurance companies. In 2008 the federal government established the HIS profession with its own taxonomy code and NPI or National Provider Identification numbers for those individuals who sought them out in anticipation of one day insurance companies becoming involved in the world of hearing aids. For example, I've had my NPI number since 2009 and it took a very long time to come to fruition, but nowadays most major insurance companies are starting to include hearing aid benefits for their members. To demonstrate that I am able to contract and work with insurance companies I have brought a few remit copies from 2023 with all the pertinent HIPAA info blacked out. As you can see I am an in-network provider contracted with GEHA, UHC, Aetna, and others. Plans differ of course and individual plan requirements may differ but HIS are generally able to contract with traditional insurance companies as shown.

I also accept insurance plans that deal with third party discount buying groups, like many Medicare Advantage plans do, but it is both types of insurance, not just one. I work with all the Medicaid companies as well and have to accept what each insurance company is willing to pay in the form of fitting fees for services. Typically these are bundled, for example with Medicaid it is one fitting fee for all services rendered in the process of obtaining new hearing aids. It is also true that each individual

office or owner can choose to bundle or un-bundle the services they provide (outside of those insurance plans who dictate charges) just like they can choose to charge an office visit fee or not and most HIS offices don't, while most AuD's offices do.

I believe I have addressed everything and cleared up any remaining misconceptions or ambiguities regarding our proposal. This change in scope will increase access and improve quality of care for many hearing healthcare patients across Nebraska. Hearing Instrument Specialists operate with the best interest of the public in mind and professionally refer out when needed. I thank you for your time and attention today and I welcome any additional questions the committee may have for me.

Respectfully,

Misti Chmiel, BC-HIS
Board Certified Hearing Instrument Specialist
Nebraska Hearing Society Executive Director