

American Speech-Language-Hearing Association
**Testimony for the Subcommittee on Labor, Health and Human Services, Education and
Related Agencies Committee on Appropriations**
United States Senate
U.S. Department of Health & Human Services
May 11, 2022

Chair Murray and Ranking Member Blunt: The American Speech-Language-Hearing Association (ASHA) thanks you for the opportunity to submit testimony on the Fiscal Year (FY) 2023 Labor, Health and Human Services, Education and Related Agencies appropriations bill. My name is Judy Rich, EdD, CCC-SLP, BCS-CL, ASHA's President for 2022.

As the Subcommittee begins its work on this critical legislation, I offer ASHA's support for the following programmatic funding requests for the U.S. Department of Health & Human Services:

- \$16,000,000 for the Centers for Disease Control and Prevention (CDC) and \$19,522,758 for the Health Resources and Services Administration (HRSA) for the Early Hearing Detection and Intervention programs within the Department of Health and Human Services.
- \$514,885,000 for the National Institute on Deafness and Other Communications Disorders (NIDCD) at the National Institutes of Health (NIH), while ensuring that NIDCD receives an equitable funding share from any increases to NIH funding in FY 2023.
- \$126,470,000 for the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) at the Administration for Community Living (ACL) within the Department of Health and Human Services.

Early Hearing Detection and Intervention Act

The Early Hearing Detection and Intervention (EHDI) Act is one of the nation's most important public health programs, offering early hearing screening and intervention to all newborns, infants, and young children in every state and territory. EHDI authorizes HRSA to fund state-based programs that facilitate screening, ensure timely audiological diagnostic evaluations, and connect families with crucial early intervention services designed to meet the unique language and communication needs of deaf and hard of hearing newborns, infants, and young children. EHDI authorizes the CDC to provide technical assistance on data collection, management, and research to these state-based programs.

Since Congress first authorized EHDI in 2000, it has been instrumental in increasing newborn hearing screening rates from 46% to 98% in 2019. Before EHDI, the average age for identifying hearing loss was two to three years of age—past the critical period when language acquisition has already begun.¹ Research shows that early intervention for hearing loss is imperative for children to develop age-appropriate communication, psychosocial, educational, and language skills. Early detection of hearing loss can dramatically improve a child's chances to succeed professionally, academically, and socially. Furthermore, early detection and intervention of hearing loss has proven to be cost-effective.^{2,3}

Funding EHDI at sufficient levels is critical to ensure all newborns are screened for hearing loss and receive follow-up services. Hearing loss is a serious health condition that impacts more than 34 million Americans, and two to three out of every 1,000 children in the United States are

born with a detectable level of hearing loss in one or both ears.⁴ **Underfunding EHDI may leave thousands of children with undiagnosed hearing loss and deprive children who are deaf or hard of hearing from receiving follow-up services** that improve language skills and development. When hearing loss is detected late, the critical time for stimulating auditory pathways to hearing centers of the brain is lost.

Children with hearing loss also face significant barriers in accessing hearing health care services. Variables including socioeconomic factors, geographic location, medical infrastructure, and access to social support contribute to delays in diagnosis and treatment of hearing loss. These disparities impact members of racial and ethnic minority communities at a higher rate. According to a 2017 study, African American infants are 92% more likely to experience *loss to follow-up* than infants from other ethnic groups.⁵ Rural Hispanic children whose caregivers have low English fluency encounter greater difficulty accessing these health care services.⁶ According to CDC data, American Indian and Alaskan Native children enroll in early intervention services at a rate 26.4% less than their White counterparts.⁷ The CDC must continue its work to improve surveillance, ensure access to timely identification of congenital and acquired hearing loss, and enhance the connection to follow-up services, particularly among racial and ethnic minority populations.

It's unfortunate that FY 2022 authorized and appropriated funding levels that are insufficient to enable state EHDI programs to meet current program requirements and ensure children have access to timely hearing screening, diagnosis, and follow-up services. Past EHDI legislation has expanded the program's scope, while resources have stagnated. Expanding the scope of the program without a corresponding increase in resources has placed an unsustainable strain on the program. Additional program objectives passed into law by Congress, including continued follow-up beyond 6-months of age, and comprehensive supports for families of children who are deaf or hard of hearing, remain a challenge for under resourced EHDI programs.

ASHA urges the Subcommittee to provide identified levels of funding for newborn hearing screening authorized by the Early Hearing Detection and Intervention Act to ensure that all children with hearing loss receive timely screening, diagnosis, and intervention services.

National Institute on Deafness and Other Communication Disorders, and the National Institute on Disabilities, Independent Living and Rehabilitation Research

ASHA applauds the Subcommittee's continued efforts to increase funding for health care research. ASHA strongly supports continued increases in funding for the National Institute on Deafness and Other Communications Disorders (NIDCD) at the National Institutes of Health (NIH), and the National Institute on Disabilities, Independent Living and Rehabilitation Research (NIDILRR) at the Administration for Community Living (ACL).

NIDCD investments are needed to ensure groundbreaking research on communication sciences as rehabilitation continues to evolve and expand. Approximately 46 million Americans have a communication disorder.⁸ These disorders impact the economy through costs related to lost productivity, special education services, rehabilitation needs, health care expenditures, and lost revenue. NIDILRR funding increases would allow the Institute to support the wide range of applied research and expand into new areas of emerging science to support individuals with disabilities.

ASHA urges the Subcommittee to provide identified levels of funding for NIDCD and NIDILRR to ensure this research continues and evolves to address the needs of individuals with communication disorders.

Conclusion

Thank you for the opportunity to provide this testimony for the record. ASHA appreciates the Subcommittee's past investments in these important health programs and urges continued support at the recommended funding levels. These investments are crucial to ensuring audiologists and speech-language pathologists can meet the hearing, balance, speech, language, swallowing, and cognition-related needs of their patients, clients, and students.

If you or your staff have any questions, please contact Josh Krantz, ASHA's director of federal affairs for health care, at jkrantz@asha.org.

¹ Centers for Disease Control and Prevention. (2003). *Morbidity and Mortality Weekly Report. Infants Tested for Hearing Loss—United States, 1999-2001*. <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5241a1.htm>.

² Tordrup, D., Smith, R., Kamenov, K., Bertram, M., Green, N., Chadha, S., et al. (2022). *Global return on investment and cost-effectiveness of WHO's HEAR interventions for hearing loss: a modelling study*. *The Lancet: Global Health*. [https://doi.org/10.1016/S2214-109X\(21\)00447-2](https://doi.org/10.1016/S2214-109X(21)00447-2).

³ Grosse, S., Mason, C., Gaffney, M., Thomson, V., White, K. (2018). *What Contribution Did Economic Evidence Make to the Adoption of Universal Newborn Hearing Screening Policies in the United States?* *International Journal of Neonatal Screening*. <https://doi.org/10.3390/ijns4030025>.

⁴ National Institute on Deafness and Other Communication Disorders (NIDCD). (2017). *Researchers help uncover a root cause of childhood deafness in the inner ear using animal model*. <https://www.nidcd.nih.gov/news/2017/childhood-deafness-research>.

⁵ Bush, M. L., Kaufman, M. R., & McNulty, B. N. (2017). Disparities in access to pediatric hearing health care. *Current opinion in otolaryngology & head and neck surgery*, 25(5), 359–364. <https://doi.org/10.1097/MOO.0000000000000388>.

⁶ Ibid.

⁷ Centers for Disease Control and Prevention (CDC). (2020). *Hearing Loss in Children*. <https://www.cdc.gov/ncbddd/hearingloss/2018-data/15-screening-demographics.html>.

⁸ National Institute on Deafness and Other Communication Disorders (NIDCD). (2019). *Mission*. <https://www.nidcd.nih.gov/about/mission>.