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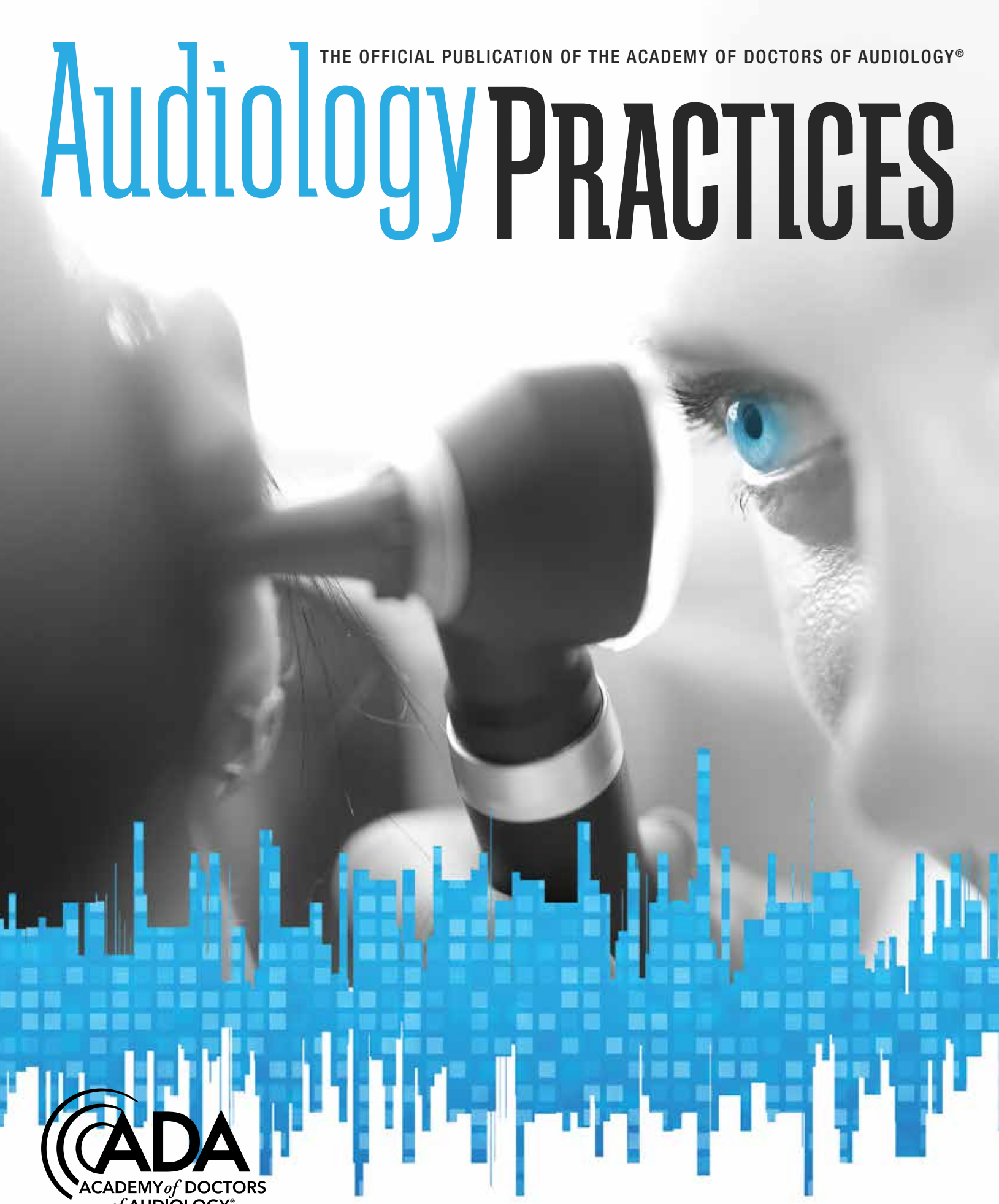
Audiology PRACTICES



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The Power to Practice

VOLUME 13, NUMBER 1 ■ MARCH 2021 | WWW.AUDIOLOGIST.ORG

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Using emotional intelligence to create positive patient financial conversations

Emotion drives human behavior. Especially during times of uncertainty or increased sensitivity, understanding the emotion beneath the words and behavior of patients can help you better address their needs. Here are four steps you can take, utilizing emotional intelligence, to build trust and help patients feel understood during the financial discussion.

Patty Casebolt, Chief Quality Officer, shares some best business practices when it comes to having positive financial conversations.

Step 1. Connect and build rapport

Connecting with patients and building rapport is integral to creating trust. If a patient doesn't trust the staff and providers, they aren't as likely to be open about their financial situation or any other concern they may have. Building rapport involves several key factors including:

Authenticity — be open and honest with patients

Curiosity — have a curious and helpful attitude

Questioning — ask questions to discover patient priorities

Listening — listen to determine deeper, underlying needs

Checking — elicit feedback to confirm understanding

Step 2. Look for emotional cues

The largest part of communication is body language and tone. If you pay attention to more than just what the patients says, you may be more effective in your communication. This is especially important in the current times we are in. Some people are more stressed for a variety of reasons. It is helpful to have a heightened awareness of this and be mindful of slowing down and tuning in to your patient, as well as yourself.

Step 3. Put cost into perspective

Patients may assume they can't afford a product or treatment and make decisions based on that assumption. By educating patients about all of your payment options, you can show them how they may be able to fit hearing care into their budget. It is helpful to compare the monthly payment amount to other common costs the patient is familiar with.

Step 4. Add convenience

Patients may appreciate when a practice has anticipated their needs and is proactive in meeting them. Discussing all of your payment options up front helps patients relax and feel in control. Giving them the opportunity to apply for financing on their smartphone helps maintain privacy, and also expedites the approval process. For patients who are not ready to come into the office, having the ability to apply on your website is an added convenience.

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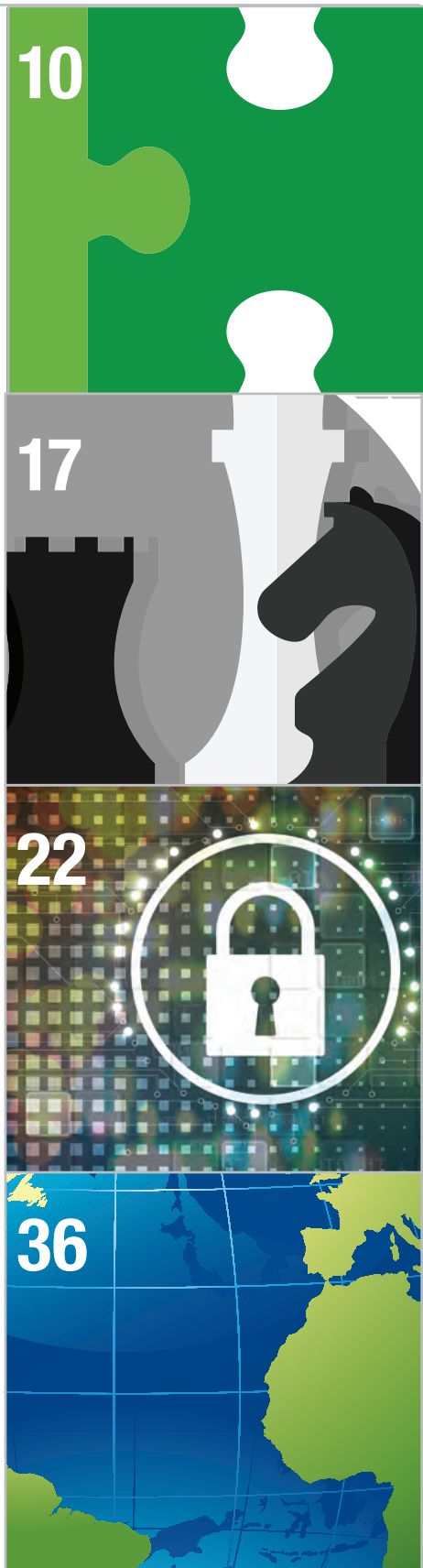

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The Academy of Doctors of Audiology is dedicated to leadership in advancing practitioner excellence, high ethical standards, professional autonomy, and sound business practices in the provision of quality audiological care.

Audiology Practices (USPS 025-476) ISSN (21645248) is published quarterly by the Academy of Doctors of Audiology, 446 East High St., Suite 10, Lexington, KY 40507. Periodicals Postage Paid at Lexington KY and at additional mailing offices. Subscriptions are $25 as part of membership dues. POSTMASTER: Send address changes to *Audiology Practices*, 446 East High St., Suite 10, Lexington, KY 40507.

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Victor Bray, Au.D.

Looking Forward to a Return to Normalcy

I would like to begin by thanking Dr. Debra Abel, ADA's immediate past president, for her outstanding leadership of the Academy during a most difficult year. Entering 2020 with a great plan for a 'normal' year, she was inspiring in helping us to adapt the massive disruption caused by the COVID-19 pandemic. Overcoming the challenges thrown to us, she led a communication reorientation to provide our members valuable guidance for the necessary clinical responses in modified patient care to support private audiology practices. In addition, she helped deliver a successful virtual, international AuDacity 2020 meeting. Thank you, Dr. Abel!

Looking forward, as our massive, national vaccination campaign is underway, one can only hope to a return to normalcy sometime in 2021. As this occurs, ADA would like to return to a focus on our Strategic Plan that incorporates the five pillars of Advocacy, Autonomy, Community, Quality, and Sustainability. While each of these pillars has multiple elements, I would like to take this opportunity to highlight one item in each pillar for the coming year.

Advocacy is focused on passage of the Medicare Audiology Access and Services Act (MAASA), first introduced in the 2019 legislative cycle. ADA, AAA, and ASHA have renewed their cooperation agreement to advance MAASA legislation in the 2021 legislative cycle. This will (a) reclassify audiologists from "supplier" to "practitioner" status in Medicare, (b) support Medicare recipients with direct access to audiology services, and (c) expand coverage for all Medicare-covered diagnostic and therapeutic services that correspond to audiology's scope of practice. Work is already underway in Washington DC to solidify MAASA sponsors and co-sponsors in both the House and Senate. In support of this national work, and necessary state-level work, I would like to welcome Dr. Alicia Spoor as the incoming Chair of the ADA Advocacy Steering Committee.

Under Autonomy, I'd like to highlight our efforts to recruit and support Early Career Professionals (ECPs). ADA offers a variety of resources for ECPs, those individuals who are within seven years post-graduation or new to private practice ownership. The ECP Special Interest Group meets monthly to share knowledge, information, and ideas without fear of scrutiny or condescension which may come from inquiries and discussions through audiology social media outlets and other channels where more seasoned professionals reside. To participate in the ECP, membership in ADA is encouraged, but not required. If you would like to join the ECP group, or recommend someone to the ECP group, contact may be made at info@audiologist.org.

Within the Community pillar, the ADA Mastermind Program supports small-group, peer-to-peer mentoring to facilitate discussions and problem solving. Each Mastermind group consists of 8 – 12 non-competing audiologists (ADA membership required) to operate with complete autonomy in a

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Brian Taylor, Au.D.

Treating Subclinical Hearing Loss is a Business Opportunity

Unsurprisingly, the traditional pure tone audiogram, which has been around for about 100 years, has some significant limitations when it comes to identifying individuals with hearing difficulties. Estimates vary, but it is likely that about 12% of the entire US population, a number that equates to more than 25 million people have self-reported hearing difficulties yet their audiogram is completely within the normal range.

Additionally, two recent studies suggest subclinical Hearing Loss is not a benign condition. Both studies come from researchers at Columbia University, both published in 2020. One study showed an independent association between cognitive ability and subclinical hearing loss, while the second study showed a link between subclinical hearing loss and depressive symptoms. The results of both studies underscore the importance of earlier intervention of middle aged and older adults– even when their hearing thresholds are in the normal range.

Brent Edwards at the National Acoustic Laboratories makes a strong case that individuals with no measured hearing loss and self-reported hearing difficulties, quadrant C in Figure 1 below, are more likely to self-direct their care and buy over-the-counter hearing devices rather than seeking the services of an audiologist.

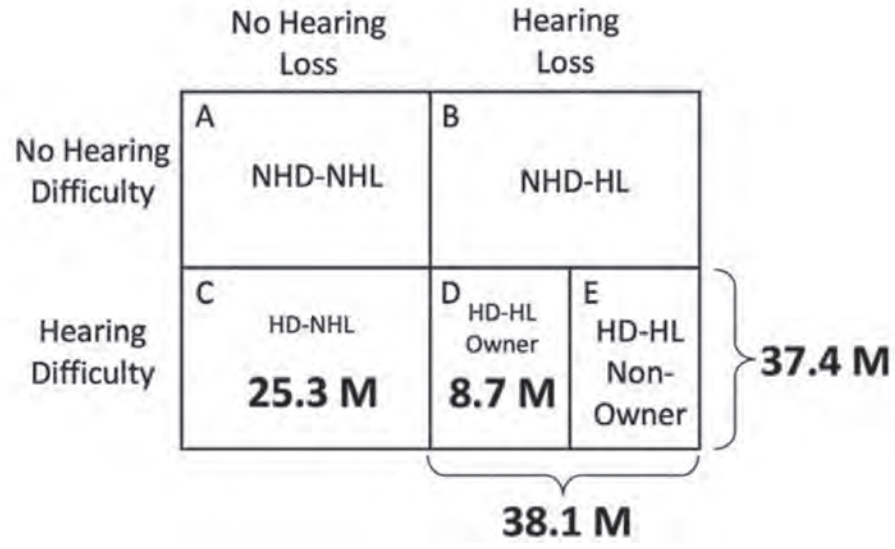

Figure 1. Edwards segmentation quadrants as reported in MarkeTrak 10.

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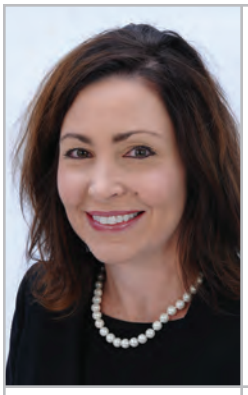
Stephanie Czuhajewski, MPH, CAE, Executive Director



Advocacy Begins at Home: Say I Do to State Dues

The reintroduction of the Medicare Audiologist Access and Services Act (MAASA) will bring forward opportunities to engage members of Congress regarding the importance of audiovestibular health, early intervention, and the important role of audiologists in the delivery of hearing and balance care. MAASA, if enacted, will reclassify audiologists as practitioners within the Medicare system, allow Medicare Part B patients to have direct access to audiology services, and reimburse audiologists for the Medicare-covered services that they are licensed to provide. MAASA will make tremendous improvements to Medicare policies—but it will neither preempt state licensure laws, nor will it compensate for state laws that are poorly constructed.

State Laws Have the Biggest Impact on Day-to-Day Practice

State scope of practice and licensure laws determine whether audiologists can practice at the top of their training, and how, when, where, and in what manner those audiology services are delivered. State advocacy is fundamental for advancement of the profession and state audiology associations should be your go-to resource for monitoring and improving state laws that affect audiologists and practice owners every day.

Telehealth. The COVID-19 pandemic brought telehealth to the forefront for audiologists and their patients. State laws and regulations determine whether it is permissible for audiologists to provide services via telehealth, what services can be provided via telehealth, the requirements for delivering services via telehealth, and Medicaid coverage for telehealth services. During the pandemic, many states implemented emergency or executive orders that have temporarily expanded opportunities for the provision of telehealth services by audiologists and/or have temporarily removed certain requirements in the provision of telehealth services. As some of these executive orders expire, audiologists must be prepared to take a leadership role in shaping permanent state telehealth policies.

Licensure and Scope of Practice. State laws govern occupational licensure requirements and scope of practice for audiologists and other professions. These laws vary substantially across the 50 states and U.S. territories. Many state laws are unclear, employ archaic requirements or limits, and do not adequately reflect a scope of practice that is commensurate with the education, training, and qualifications of audiologists. Licensure and scope of practice are foundational for patient access to care and advancement of audiology as a clinical doctoring profession. State licensure bodies and authorities governing the practice of audiology are not uniformly structured and often oversee multiple professions.

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EVIDENCE MUST TRUMP ORTHODOXY

Even During Uncertain Times

by Terry Mactaggart

The Lancet Commission on dementia prevention, intervention, and care published a report a few months ago that highlights recommendations for policy makers and individuals to help reduce dementia risk worldwide. As many audiologists might recall, The Lancet Commission published a comprehensive, landmark report on this topic just three years ago, but the science in this area has been rapidly changing. In their updated report, published on July 2020, the Commission added three new risk factors: The newly identified factors are 1) traumatic brain injury in mid-life, 2) exposure to air pollution in later life, and 3) excessive alcohol use, defined as more than 14 drinks a week.

Figure 1 includes data from this landmark report. It shows all 12 risks across the life course, and how much the reduction of each factor could potentially reduce the prevalence of dementia, worldwide. In theory, up to 40% of dementia cases could be prevented or delayed by modifying all 12 risk factors—up from the 35% in the 2017 report. Remarkably, hearing loss is the leading modifiable risk factor —a strong argument for hearing testing and intervention to occur at mid-life, not old age, as is primarily the case today.

Of note to audiologists is that the largest modifiable risk factor, contributing 8% to the overall 40% of potentially modifiable risk factors, is hearing loss. A percentage that is down from 9% in the 2017 report. Given that hearing loss is the leading modifiable risk factor in midlife, it makes sense for healthcare professionals to promote the use of hearing protection in high noise areas for everyone, and to encourage routine and periodic hearing screening beginning in middle age, in addition to the use of hearing aids when indicated. Of course, encouraging people to engage in the process of routine hearing screening is not easy. As recent studies suggest, even when an easy to use app-based hearing screening is available, more than 80% of those individuals failing the hearing screening and requesting to be contacted by an audiologist do not initiate further action. Further, of the thousands of individuals who fail an online hearing screening, just over half of them believe they have a hearing loss.

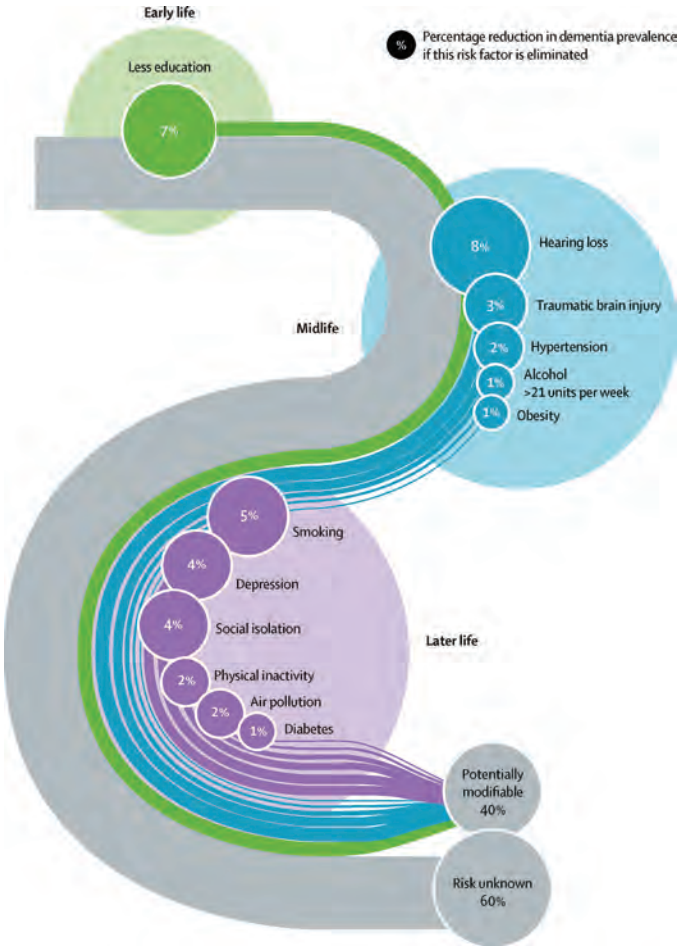
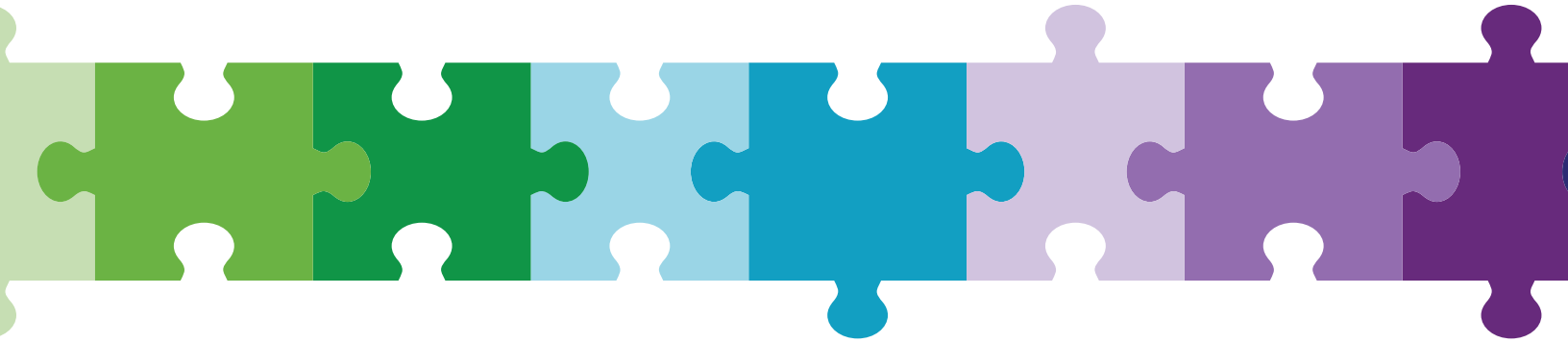


Figure 1. Modifiable risk factors associated with dementia. Source: Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. *Lancet*, 396, 413–446.

The challenge might be even more daunting when in comes to encouragement of hearing aid use. Not only are audiologists plagued by the usual suspects like stigma, inconvenience and complacency – typical behaviors for persons with chronic conditions, but



the evidence that hearing aid use stymies the trajectory of dementia is conflicted as other recent studies suggest. What is more, as researchers Barbara Weinstein and Jan Blustein recently point out in a 2020 article, published in JAMA-Otolaryngology, many marketing claims in the industry surrounding the topic of hearing aid use and dementia are misleading and inaccurate.

If audiologists want to be a paragon of trust and integrity, it's critical that they stick to the science and refrain from erroneous, confusing and deceptive claims, and when patients seek our services we avoid the perception of trying to sell something.

To help us unravel these issues—balancing the needs of persons with hearing loss with the demands of trying to run a business during a once-in-a-century pandemic, let's examine how we can better serve our patients—persons coping with hearing loss and communication challenges during one of the most uncertain moments in our lifetimes.

SERVING THE CONSUMER – A NEW NORTH STAR?

Concerns about coping with the COVID-19 crisis and what may lie beyond have preoccupied our personal and professional lives thus far in 2020. And they will undoubtedly linger for a considerable time.

One silver lining is a growing recognition of the importance of relating to our clientele at a distance —i.e. by relying on the Internet using contemporary communication processes as well as direct-to-consumer hearing detection and treatment technologies.

Responding to these needs can presage a more effective approach to improving and extending care for those currently in the system in addition to providing hearing health knowledge and services to the many millions who have been left out. **There are compelling reasons to set such a goal as our New North Star**!

For more than seven years, I've argued that our scope of hearing health delivery is falling short and the industry as we know it will inevitably be disrupted. The breadth of the hearing problem, the way it traditionally has been managed, coupled with the growth of personalized medicine and consumer electronics has made that a safe bet. Underlying these perceptions has been a quest for a 21st century model that can be applied much more widely, yet remain profitable for practice owners.

The Basic Premise – Given the large number of people who are uninformed or otherwise distracted and are clearly not engaged, **hearing loss has become the largest untreated chronic health issue in our society**. In fact, taking what we now know about the consequences of ignoring or delaying detection and treatment, it's grown to become a serious public health problem. This series of posts enlarge on this foundation by focusing on the consumer and how this deficit should be addressed.

Let's start with "the facts" – The customary numbers are well known. About 48 million Americans (say 15% of the population) report some degree of permanent hearing loss, age being the strongest predictor. Adding 5 million more for Canada brings the total to well over 50 million. At best, slightly more than 20% of these have been treated with hearing devices, of whom at least that same percentage (about 20%) become non-compliant soon after fitting.

Having accumulated well over 160,000 structured hearing data sets from the general public, including those with signs of hearing change within the normal range, we can assert with confidence that these estimates are outdated and understated, likely by at least 50%. Our conservative estimate of those impacted in both countries combined lies between 70-75 million people. And we can anticipate that number will grow, not only as a function of Boomers aging but also because of what is expected to become

a tsunami of younger people joining the cohort because of their "crank up the sound, forever listening-with-buds" life style.

WHY ARE SO MANY PEOPLE LEFT OUT?

There are several well-known reasons—stigma of older age, access to services and acquisition cost of products being the major ones. These are well documented in the literature and summarized in the Academy of Sciences report and the subsequent Congressional Act of 2017 which mandated a new class of over the counter hearing devices.

While wireless wearable devices have become commonplace and miniaturization and performance improvement of hearing instruments continues to occur, promotion by the industry still focuses primarily on older people who become "patients" even though this label plays into an emotional bias held by many against such messaging. Inadvertently perhaps, this leaves behind the tens of millions who are earlier on in their journey yet clearly experiencing hearing change.

Reliance on bricks and mortar clinics as the major distribution source staffed by relatively few professionals compared to the need also weighs in heavily. Participants are often compelled by ownership or financial arrangements with suppliers to perpetuate the existing limited access, high price model.

Family physicians know their patients and are well positioned to perform a key "gatekeeper" role, but they often lack the training and tools as well as the connections and confidence to refer to local dispensers.

If the system was operating effectively, establishing a baseline hearing profile for everyone over 40 and under 12 would be as commonplace as tracking blood pressure. In the majority of medical practices we have worked with, 70% or more of the patient roster should have their hearing tested given age and/or lifestyle and/or co-morbidities.

The hearing industry is also one of the last anywhere to bundle upfront in the price of a device a number of future services rather than allowing the buyer to select and add what he or she believes may be needed. Students of industrial structure would argue that this is very unusual - a function of the market power and scarcity of alternatives the industry has traditionally enjoyed. The net result with few exceptions is the "sticker shock" that consumers typically experience when confronted by pricing.

WHAT IS THE EXPERIENCE OF THOSE USING HEARING INSTRUMENTS?

The simple answer is "mixed" at best. About 25% of those who purchase hearing aids don't use them after a period of trial. Reasons include lack of comfort, frequency and expense of service required, encroachment of background noise and one that is prime – inadequate orientation, training and support. Aided hearing requires the wearer to persevere while experiencing a new way of processing sound. Many find this hard to adapt to and abandon the effort. Basically, the hassle of hearing aid use outweighs the perceived benefit to be gained.

HOW AND WHY IS THE HEARING ENVIRONMENT/ MARKET CHANGING?

There are obvious, now evident signs. Deregulation is a leading indicator as are the growing number of companies reaching out to consumers directly with less expensive devices. An encouraging, if hard to completely isolate factor, is what appears to be a growing awareness among the public about the importance of hearing health.

One explanation is simply to note that we are living in the 21st century rather than the 20th where the Internet, Mobile Me and Medicine 3.0 are increasingly apparent. Consumers are more sophisticated and capable of taking control of their health and wellbeing with new tools that are increasingly being made available. Systems that are perceived to be closed, offering solutions at high prices, are less favoured.

WHAT DO CONSUMERS TYPICALLY WANT FROM A PRODUCT OR SERVICE?

This is a central question, one that as a participant/observer of the industry, I am not confident has ever been adequately addressed. We certainly have a handle on what most audiologists respond to but what about the consuming public at large? While some might argue the point, preoccupation by the industry with product development and selling to its distributor channel has limited gaining a comprehensive and dynamic appreciation of what the ultimate customer expects and is motivated by.

Applying Marketing 101 suggests there are seven factors that make a product famous, nurturing trust, loyalty, and recommendation. These are summarized as:

- **Quality of pitch** – Clear information about what the product or service is and how it is used – its utility.
- **Reliability –** What you see, read or hear about is what you actually get.
- **Convenience in use** – Competent direction leading to trouble free application.
- **Ease of acquisition** – Few, if any, hoops to jump through, no surprises or tricks.
- **Try before you buy** – Ideally a chance to experiment and experience before paying.
- **Post acquisition support** – Particularly important when installing or adjusting to the product or when service is complex.
- **Warranty** – Hassle free recourse if the product or service does not work effectively.

Other lessons from the front lines of audiology often include...

- Don't just talk at customers, teach them!
- Listen and learn as much as you teach...
- Acknowledge shortcomings and mistakes...and move quickly to correct them.

A credible argument can be made that leading suppliers and top practitioners rank quite well when these performance criteria are applied. My personal rating on a 10-point scale lies in the 7.5 to even 8 range. At a guess, that would likely decline by at least two points should the industry as a whole ever be measured. Full disclosure—I tend to be a hard marker.

Recall too that we are referring here primarily to the hearing aid aspect of the industry, rather than the full sweep of hearing health. Our hearing triage indicates that that cohort represents about 30% of those who have tested. In engaging consumers, it is critical to consider the needs of the entire target group and adopt a broader perspective. That is where our new North Star is located!

WHAT DO CONSUMERS NEED (EVEN IF MANY ARE NOT AWARE OF NEEDING TO WANT IT)?

This is where the rubber hits the road if you buy into the Basic Premise—i.e. that excluding so many from the hearing health system represents a growing public health issue; and to fix it requires more than a 20th century brick and mortar solution. That notably is out of tune with the times and will not come close to providing the necessary reach.

Consider what is becoming commonplace in other fields of healthcare and wellness. Recent science combined with virtual means of detection and treatment are available in a growing number of areas. "E-patientry" and the younger doctors supporting it, began to emerge almost ten years ago. MedTech is now one of the hottest categories in the professions as well as the investment community. Hearing health has lagged rather than lead these innovations.

Applying such lessons widely and making a hearing health process of high quality available to millions of people is undoubtedly daunting but not impossible to achieve. Or at least to work aggressively towards.

We take as a given the importance of understanding and becoming proactive about one's hearing status as well as the incidence of hearing change in the general population. It is similar to what we have learned with the COVID dilemma, however. Without adequate testing (and testing 2%-4% of the relevant population is clearly inadequate) we can't make any significant advance in confronting the problem.

As a first step, therefore, providing easily accessible and reliable testing via the Internet using any device, anywhere, at any time is fundamental.

Then comes the equally important question of trustworthy evaluation, recognizing that such classification will be

preliminary but still indicative. It is here that inadequacies are apparent – the traditional 25db threshold for normality across the three frequency speech range of an audiogram does not account for its pattern or the subject's medical history; it also ignores any measure of confidence that a seasoned audiologist would apply. Taken to its extreme (commonly experienced - just try the great majority of tests available on the Internet), it often leads to the promotion of a hearing instrument – what some refer to as "Click Bait". Trolling for low hanging fruit, even with "audiological support" is now de rigeur. The objective almost without exception is to sell yet another device. Critics recognize this as "weaponizing" the test. Using our 10-point scale, this approach would warrant no more than a three.

When properly tested and evaluated, preliminary **hearing triage** becomes possible—i.e. the subject's hearing status can be classified into standard audiological categories. Our data sets indicate that about 80% of the population represent routine cases – they are relatively easy to treat. 20% are complex. A minority—about 30% on average—have or are trending towards what appears to be a permanent Sensorineural problem and should consider a hearing device with appropriate guidance. Another 20% appear to be treatable (Conductive indication) and, if constant, should take action at home and in consultation with their family doctor. The remainder indicate either a Normal pattern and level (the largest category who should keep testing themselves periodically) or Mixed (something is going on, possibly a combination of conditions that can't be separately classified signalling that a full work up is warranted). In every case it is appropriate that the family physician be kept informed given his/her experience with the patient, knowledge of the patient's chart and co-morbidities. Using hearing protection when exposed to loud sound is also paramount.

The key we believe to addressing a very wide audience (not just the obvious segment—older with more advanced sensorineural losses the industry concentrates on) involves providing an attractive and inexpensive **hearing health package** consisting of five components—testing, classification and triaging, pointing towards best next steps given a person's hearing status, making coaching about hearing available including connections when needed to medical and audiological talent, and, if appropriate, providing access to products and services that could be helpful. That combination represents a MedTech solution that avoids bias. It is the closest thing to "personalized medicine" one can achieve for hearing. And are a few steps beyond what has generally been available to date.

The flow chart in Figure 2 illustrates this hearing health pathway. Hearing health tech involves a five-step process designed to educate and empower the consumer about taking control of his/her hearing status.

WHAT DOES THIS WISH LIST FOR CONSUMERS IMPLY FOR THE INDUSTRY?

Strengthening Education, Access and Availability are key ingredients. Also recognizing that while the industry with adaptation can provide important leadership, it will never attain the scale required to confront the problem entirely. Coalitions and partnerships will be required as well as new sources of public and private funding.

Messaging will need to become much more consumer specific. Appealing to a 25-year-old or someone 45 are each different than to a person reaching senior status. Yet all of them may have or be developing hearing issues.

"Protect yourself", "Be the best you can be", "Stay connected to people and things that matter" are themes that generally resonate and could be used much more. But they need additional context – why should a kid in a band care? or a diabetic? or those who are beginning to turn the volume of their TV's up?

This isn't rocket science; seasoned marketers understand what's required. They would argue that the relatively

Figure 2. Hearing health tech is an End-To-End process incorporating effective methodologies, easily understandable guidance and, when requested, reliable advice and solutions.

universal pitch that has worked for decades should be recast. A dose of self-reflection about behaviour often leads to the same conclusion.

The business model will also need to evolve quite sharply. A good start is underway in adopting virtual care. In the future, that will become the primary method to attract, motivate and treat most "patients" (quotations represent my observation and bias – make limited use of that term in reaching out to a much wider demographic; cut back on the "white coat". It's about wellness, not being sick...!).

More reliable methods for testing and evaluation must accompany this development. Software embedded AI and pattern recognition algorithms can detect and classify even early changes within the normal range as well as situations that are obvious. Reports can then be delivered that apply what measure of confidence should be assigned to the results in addition to recommending what best next steps are warranted. Widespread use of such innovations can broaden the base of those tested by a substantial amount. Adding simple speech testing also makes good sense.

The goal of this hearing triage must above all be to inform the subject about his/her status and its importance rather than sell a hearing aid—a premise that will engender trust and greater receptivity to take action. A multiplier effect often results—trusting people leads to others they know who are encouraged to learn more about their hearing function. A reasonable guess suggests that a "happy initial customer" creates an influential ripple to 2.5 others.

A greater range of hearing products and price points needs to be offered if the largest pool of potential clientel (those with mild and moderate hearing loss) is to be attracted. There are a growing number of relatively inexpensive alternatives that will satisfy that clientele, at least for a while. Additional services should be proposed and costed accordingly.

Counselling, an original keystone of audiology, will almost certainly become more significant and sought-after. By tailoring programs well and progressively to match a client's needs, there is little reason to doubt that it will become an important revenue producing service via insurance and/or user pay.

In sum, at least for routine cases, hearing telehealth will become the norm for prospecting, testing, counselling and treatment. That's no longer revolutionary. It's becoming commonplace throughout the spectrum of health and wellness.

What scenarios are possible for responding? Preparing for the future requires agility. Thinking about how strategies might vary with different yet plausible scenarios has eclipsed older methods of strategic planning. There is more than one pathway to consider.

Some argue that because the industry has faced into significant change in the past and held its position, the hearing marketplace will evolve slowly and conservatively. This might be called the "**Small Change—Stay Put"** possibility. Margins will likely be under greater pressure and use of the Net will be an expected adjunct. But the basic model will still be dominant, at least for the current generation of owner-operators.

An alternative future envisages a service model without walls, call that **Virtual Choice**. Application of existing technologies and those on the immediate horizon (AI, AR and VR, for example) will facilitate a learning through fulfillment and follow-up process that is satisfying for many consumers, both urban and rural. Virtual linkages up through full integration with trusted providers (family physicians and pharmacists in particular) will present a value chain that is available for millions more people. And the agile hearing specialist will be able to dovetail more effectively into the health and wellness process becoming a featured aspect of the health hub.

A third could conceivably foresee the entry of new players who rapidly dominate the market. Such a scenario might be dubbed the **"Nuclear Alternative"**. The majority of the FAGMA giants (Facebook, Apple, Google, Microsoft, Amazon, to which we should add Samsung) are staking out turf in the human health/wellness spectrum, areas they predict are key to their future growth. And they already have access to extensive customer bases across the entire demographic and are capable of investing billions in technology, marketing and acquisitions rather than the millions that the hearing industry conceivably has on offer. Another compelling feature is that hearing is considered more than just interesting as the human ear is a pathway to several other health-related measure. Exploiting that avenue is already underway —check out, for example, the latest Apple message when opening their health app.

Such a future could extend the reach of hearing health well beyond what we have or can imagine through steady yet unspectacular evolution. How probable it is remains an open question. If realized, it would imply a significant retreat from the existing model of providing hearing instruments through retail and place much more emphasis on education and counselling.

WHERE TO FROM HERE?

Hearing, like almost every other industry, is being disrupted; the future until further evolution occurs is ambiguous. It's likely safe to conclude that five years from now and certainly by ten it will take on quite a different cast. Four drivers are clear...

1. Hearing health is becoming a big deal! As consumers, we ignore it at our peril. This is recognized increasingly by the medical and public health establishments.
2. The present model is dated and falls well short of achieving anything close to the New North Star objective posed earlier as an aspirational target.
3. In fact, it's a variation of a patient-professional delivery process that is over a century old and beyond it best before date.
4. Significant change relying on 21st century methods is well underway throughout healthcare. Hearing health will not be an exception.

While more brainstorming and much greater experimentation is warranted, three steps appear important in the short term.

- Take as a given the need to expand reach and supplement present practice by adopting virtual technologies.
- Strengthen and leverage counselling and research activities to better understand the mind of the consumer. Present patients and their kin provide an important window into that learning.
- Experiment with, if not fully embrace, the OTC revolution. It has the potential of having a profound impact.

My best sense is that a new business model will emerge quite soon. A broader product and service mix will dictate trade-offs and acumen from a financial perspective. Progressive practices will be more integrated into their communities through use of technologies and partnerships. Undoubtedly some will fail or fade away; others will likely thrive. ■

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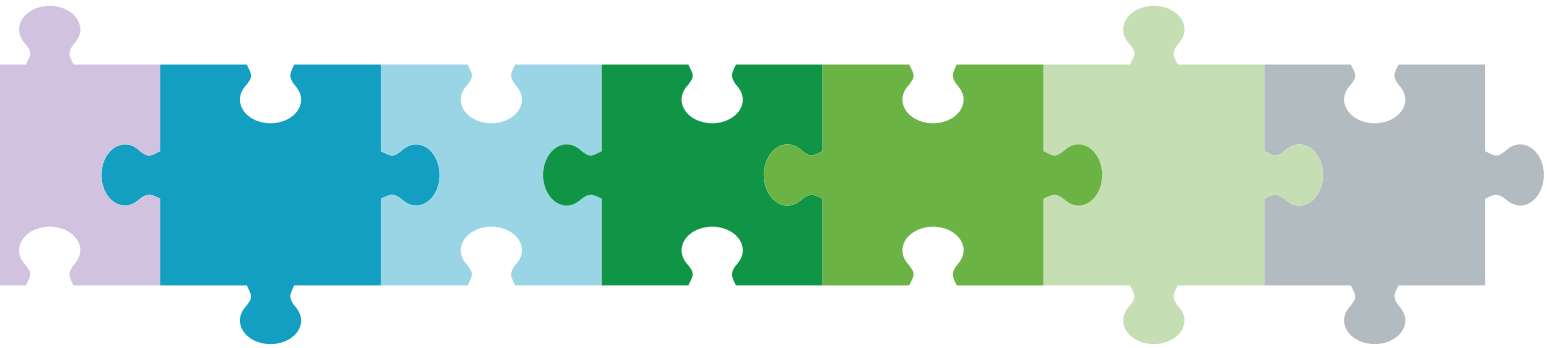

Planning Your Work Instead of Planning to Flail

THE VALUE OF STRATEGIC PLANNING

by Bryan Hanson

Although there is overlap between a strategic plan and a business plan, in most cases, business plans are completed when someone is opening a new business, often a private practice and the originator of a substantial loan requires a formal, written plan. In contrast, a strategic plan is more likely to be competed annually in a clinic, private practice, or other audiology-related business. As a consultant, working in industry as well as with start-up companies, I've been involved in creating and executing dozens of strategic plans. This article summarizes a few practical tips on developing a strategic plan for any clinical audiologist with novice business training.

Like the more elaborate and formal business plan, a strategic plan has two distinct phases: 1.) creating the plan and 2.) executing or working the plan. Since execution can only really happen in the real world, this article is confined to discussing the nuts and bolts of creating the plan. It is surprising to me how many seasoned, reputable audiologists fail to rely on a strategic plan when starting a new program, division, or revenue stream within their existing clinic. A thoughtful, concise, and comprehensive strategic plan, based on a few data-driven assumptions, doesn't have to take days of work. In fact, by following the template outlined in this article, an audiologist can create a plan, with input from other staff, with just a few hours of work spread over a few weeks.

Rather than leave results and outcomes of any new initiative within your clinic up to chance, creating and executing a strategic plan provides direction and focus. It gives you and your team a coherent path into the future. A well-constructed plan allows you to anticipate obstacles and make adjustments to overcome them. Plus, if you work in a corporate system, such as a multi-specialty clinic or medical center, there is a reasonable chance that someone in the C-suite is going to ask you for a strategic plan before they agree to fund any new capital expenditure. It is even more likely that department heads with a corporate structure will ask clinical staff to create, present, and then execute a strategic plan on an annual basis.

What is a strategic plan?

Unlike the formal and often more elaborate business plan, a strategic plan is used to "think through," "whiteboard," or model the details of implementing a new potential revenue stream, program or department within an existing practice. A strategic plan is a systematic way to look into the future using the best available data. It is a blueprint or proposal in which specific action items are purposefully employed over a discrete time frame to achieve a set of goals or objectives. In many cases these goals or objectives have a financial component, (ie. to improve profitability or drive down costs). In other cases, goals and objectives could be tied to quality improvements or other hard-to-define variables.

An effective strategic plan is valuable because it helps plot a course of action to ensure certain goals or objectives are attained within a reasonable timeframe. Additionally, strategic planning is important because it gives staff, other key stakeholders — even customers, clear direction. A coherent plan helps all vested parties see the "big picture" and actively participate in the business.

What do you want or need to accomplish over the next year?

It all starts with a basic question: What does your team want or need to accomplish over the next year? Of course, the response to that question takes many forms, but in most cases the answer to this question is to improve some facet of productivity. That is, improve an existing aspect of your business or add a new wrinkle to the business that generates additional revenue. Some examples of this include adding balance testing, tinnitus management services, or building out a tele-audiology branch of your existing clinic to better meet the needs of older adults in a post-pandemic world. It's really up to you and your team to come up with the most compelling question (and answer) that spurs action around creating a strategic plan. One final consideration about answering this question: You might believe you can ignore or escape having to answer this question, but every business exists on shifting ground. Market forces, shifts in the economy, disruptive technology, and changes to the management of your clinic are some of the most common reasons that warrant a new or revised strategic plan about every year. Rather than wait for the sand to shift under your feet, it is always best to be proactive and anticipate these changes.

The strategic plan you develop is really "the how" of the answer to the original question, what do you want or need to accomplish over the next year? Everyone's strategic plan will be different depending on their unique business needs and goals, but most plans include eight sections. These eight sections are summarized below. Refer to the descriptions of each section as you chart out your own strategic plan. Before reviewing the eight sections, it is vital to do a little pre-work. If you know what your marketplace values from your services, what the competition might be offering that is similar to your offering and the basic demographics of your core customer base, your pre-work is already done. If you don't have any idea about these three key variables, you'll need to do some pre-work prior to creating your strategic plan.

Pre-Work is Essential

Any effective strategic plan starts with quality data. The better the data, the more precise and actionable the plan. The challenge in many cases, however, is that smaller businesses simply do not have the means to capture a lot of data. The lack of perfect data must never be the enemy of decent or good enough data. In many cases, a few simple Google searches, combined with some insights from a few trusted industry experts is probably enough to get what's needed to formulate a data-driven strategic plan. In addition to previous financial statements (e.g., profit & loss statement) that describe how the existing practice has performed in the past, there are a few other items you are likely to need.

- Demographic information of the target audience(s) in your area including median age and income
- Services that might be valued by individuals in your area who have hearing loss or other hearing and/or balance difficulties
- Services your staff has a strong desire or skill level to provide
- Gaps in the marketplace relative to what competitors in your area are offering

Once you have posed the question, found the answer, and done some pre-work, the process of creating a strategic plan can begin. You might want to consider getting your team involved in this process of gathering data as part of your pre-work. Now let's take a look at the eight critical sections of any strategic plan.

Section 1: The Executive Summary

The point of this section is to succinctly outline your plan for the business and its direction. It should be written in a way that enables employees and other interested parties to quickly grasp the concepts, even if they don't understand the industry. If you are writing a strategic plan for people that already keenly know your business, it is possible to skip the executive summary.

Tips for the Executive Summary:

- Complete this section last. You will be able to call out ideas and information highlighted in other sections.
- Don't go into details or give numbers, unless they are big, round, conceptual numbers. Just focus on the big picture.

Section 2: Mission Statement

Your mission statement is your team or practice manifesto. It is what you intend to bring to the world. A mission statement is aspirational and defines what you want your team to be known for, who you are, and why you do what you do. Usually, the mission statement is succinct and direct.

Tips for the Mission Statement:

- Don't overthink it. For many business owners this is the hardest section to write. Just start by writing freely about your own goals and where you want the company to be in five or ten years. Oftentimes, mission statements take a long time to create because there are several players involved in its creation.
- Have a look at mission statements on other company websites to get an idea of how others articulate the essence of their business. Think of the mission statement as the document that drives all your decisions, either within your entire company or your department. A good mission statement reflects your core personal values and those of the people on your team.

Section 3: SWOT Analysis

SWOT analysis is a specialized analytical technique that focuses on looking at Strengths, Weaknesses, Opportunities and Threats within your business, profession, and industry. This is the section that will help you determine the strategies you're going to use to take your business in the direction you want it to go and identify and overcome the barriers that might stand in your way. A SWOT analysis requires good self-awareness and the ability to honestly evaluate your core abilities as a business and how they differ from the competition.

Figure 1. SWOT Analysis

Tips for SWOT Analysis:

- Remember that strengths and weaknesses are internal to your organization and opportunities and threats are external.
- Know the local competitors.
- Use data from business reports, investor's analysist reports to help build a good SWOT. Figure out if your market is growing or shrinking, and what you can expect demand for your product/service to be over the life of your team, department, or division.

- The key to a useful SWOT analysis is to use to take corresponding action. For example, by focusing on the strengths of your staff, you may want to consider adding a new service in a clinical area where there is a high level of expertise and interest among staff.

Section 4: Goals with an Action Plan

Your SWOT analysis should help identify a big idea (or a few big ideas), such as expanding your practice, better meeting the needs of existing customers, and developing new services to meet an unmet need of the market.

In this section you will turn these big ideas into tangible goals to move the practice forward. Just like treatment goals, strategic goals should be measurable and time bound. Your goals represent the desired results that you hope to achieve in your strategic plan. Actions are the activities and steps that must be taken to accomplish the goals.

Tips for writing goals:

- Make sure your goals are SMART: Specific, Measurable, Achievable, Reasonable and Timely.
- First, set your long-term goals. These have a timeframe of a few months or more than a year, depending on the specifics of the situation.
- Then, identify the steps that need to be taken to reach those goals. Drill down until each step can be identified as a short- or medium-term objective. Include these in the strategic plan.
- Don't feel as though you're locked down to the plan or your goals. Things could change over the next several months, and your strategic plan will simply change too. But having a plan in place to start with, even if it isn't the plan you finish with, is vital for your continued success.
- In the goals section, you should also include data on your Key Performance Indicators (KPIs). KPIs are the measurements that tell you where you stand relative to your goals. Tracking KPIs regularly will help you stay on course towards your goals, or let you know where to adjust the plan or tweak your processes.

Section 5: Financial Plan

The financial plan section is the place to outline the hard numbers. In a basic strategic plan, it is okay to keep the financial plan fairly simple. Focus on the expected costs and the projected revenue by doing a simple cost-benefit analysis. As Figure 2 shows, projected revenue should exceed expected costs.

COSTS	BENEFITS
Hire full time audiologist $90,000	Expected monthly revenue after 3 month ramp up: $7500
New equipment $15,000	Breakeven expected in 16 months

Figure 2. Simple cost-benefit analysis

Tips for the Financial Plan:

- Financial projections often include three scenarios: a conservative scenario, a likely scenario, and an aspirational scenario. Remember not to base your expectations on the latter.
- Once you have the financial plan in place, you should track your progress month-to-month against your goals. Using software (such as job management software for professional services businesses) can help you get an accurate picture of how your business is doing and whether you need to move the guideposts.

Section 6: Target Customers and Industry Analysis

In this section, you take an in-depth look at the SWOT analysis and consider the current state of your profession, industry, and market, as well as the people (employees, colleagues, patients, publics).

Tips for the Profession/Industry & Customer analysis:

In this section you look more closely at your competitors' strengths and weaknesses in the market (which represent opportunities and threats that can impact your ability to achieve your goals). Are you trying to tap into a potential market? Protect an existing market from shrinking? Those are two key considerations in this section.

Section 7: Marketing Plan

The marketing plan outlines how you intend to present your company to the local market and what your goals and projections are for increasing your customer base or reaching a higher level of profitability. The marketing plan should consider your products/services, pricing, channels for service and communication delivery (your practice, telehealth, your website etc.), and the messages, promotions, and branding that you will use.

Tips for the marketing plan:

- First, define and outline your USP - Unique Selling Proposition. This is the "it" factor that sets your company, division or department apart from the rest. Your USP should be something that resonates strongly with customers, such as delivering quality, speed, or a unique product.
- Next, think about positioning. How is your product or service positioned? Is it where you want it to be positioned? If not, what must be done to change it? Are you a premier brand or do you target cost-saving customers?
- Think also about your different distribution channels and how the marketing for each channel may differ. For example, if you own a retail store, but you also sell online, how will you market those two different storefronts?
- What kinds of offers and special deals are you going to provide? What marketing collateral do you have and what do you still need to create?
- Outline both your above-the-line (mass advertising) and below-the-line (grassroots, point-of-sale) strategies.

Section 8: Conclusion

Wrap everything up at the end of the strategic plan with a concise conclusion and statement about your team's bright future! Bring in data from the different sections together to focus attention on the important areas for growth and the areas you need to improve or develop.

Executing Your Plan:

Flail not! Start by building a blueprint for success with a strategic plan. Once it is created, however, the plan is essentially useless unless it is executed. Execution of the strategic plan relies on persistence and realism. Effective managers employ clear communication with individuals on the team, organized scheduled team meetings, and consistent dialogue devoted to meeting performance targets and goals.

Don't forget to measure progress using KPIs and feedback from relevant audiences to move incrementally closer to successfully accomplishing your strategic plan within the designated timeframe. ■

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10 TRENDS in Cybersecurity Behavior Across Audiology Private Practice

How Do You Compare?

By Josiah Dykstra, Ph.D., Rohan Mathur, B.A., and Alicia D.D. Spoor, Au.D.

One year ago, an article in Audiology Practices on cybersecurity offered a short checklist for audiologists to self-assess how they were implementing protections in their businesses to safeguard protected health information (PHI)[1]. The article also included three recommended actions to help protect audiology practices: business policies, software updates, and security training. Self-assessment is a valuable tool for individual business owners, but the next step is to understand trends across the profession.

During the summer of 2020, we conducted a survey of ADA members and private practice audiologists' cybersecurity behavior. The 24-item questionnaire was intended to identify trends, gaps, and opportunities that – until now – did not appear in the research literature. We analyzed the responses from 131 participants across 37 states and found that cybersecurity behavior is mixed. Some key themes emerged that can help inform audiologists about positive trends and areas of increased need. The trends can also inform the tech community about how to better tailor products and services for the unique needs of audiology and other medical specialties. In December 2020, a scientific, peer-reviewed paper was published describing details of the findings from this survey.[2]

This article highlights 10 trends in cybersecurity behavior across audiology private practices as revealed by the survey results. Individually, they allow you to compare your own behavior with that of peers and invite you to celebrate success and remediate weakness. In sum they reveal the status quo which may also be measured over time and compared with other medical specialties.

1 **Number of computing devices varies significantly.** The average number of devices used for work-related services varied significantly as evidenced by the standard deviations. Among respondents, the mean number of devices was 6 desktop computers, 2 laptop computers (SD=3), 0 tablets (SD=1), 6 wired telephones (SD=7), and 1 smartphone (SD=2).

2 **Average password exceeds minimum recommendations.** Research shows that longer passwords are more secure. This survey asked "How many characters is your current work email password?" The average answer was 11 characters. The National Institute of Standards and Technology (NIST) recommends a minimum of 8 characters, and HIPAA has no prescribed compliance standard. This survey did not explore password reuse, such as having the same password for both email and social media; this would jeopardize strong email passwords. All users should consider using a password manager to support good password hygiene, such as LastPass or 1Password.

3 **Vast majority have HIPAA-compliant individual logins.** The survey asked whether "Each employee uses their own unique login and password for computers in the office?" A total of 83% said yes (Figure 1). Individual accounts provide authentication and accountability which ensure authorized access to help protect PHI and other sensitive business data. While the survey only explored computer logins, individual logins are necessary for *all* software including hearing aid software and EHR.

4 **Compliance and security are much better for those who spend over $500 per year.** Nearly half (46%) of respondents spent less than $500 on cybersecurity in 2019. Those who spent more than $500 showed higher adoption of cybersecurity in all areas measured, including items with low fixed cost such as an office password policy (Figure 2). Recurring costs may include antivirus subscriptions, cybersecurity awareness training, and annual HIPAA risk assessments. Spending should correlate with the number of providers and computers needing protection, but spending did not correlate to those variables. Practice owners should evaluate whether their security budget appropriately covers safeguards required for PHI and other assessed risks.

5 **Many practice owners perform security functions.** When asked who are the people who perform security-related tasks, such as installing software updates, answers were the practice owner (63%), contracted technical support (50%), employees (27%), and others such as a spouse (12%). In small businesses, it is unsurprising that the owner fulfills many functions including IT. The greatest challenge in cybersecurity, even for those who are computer literate, is maintaining awareness about the steady stream of new threats and their mitigations. Not knowing about a threat is akin to accepting that risk.

6 **Most say "Not enough expertise" prevents better cybersecurity.** Participants were asked "In your opinion, how would you rate your protection against data breaches and hacking?" and "If not Excellent, what limitations are preventing better protection? (Select all that apply)" The most common answer (80%) was not enough expertise, followed by money (24%), and time (22%). Considering how many owners perform some or all of their own cybersecurity, these limitations could have significant consequences and suggest an opportunity for cybersecurity education or outsourcing security tasks.

7 **Less than 1/3 have data encryption on all computers.** Only 33% reported data encryption on all devices. While more and more data are stored in cloud-based EHR/EMR or file storage (such as Google Drive or Microsoft OneDrive), office computers should also have encryption enabled. According to HIPAA, encryption helps protect PHI as a technical safeguard and should be enabled unless you have a reasonable and appropriate equivalent alternative measure. For example, BitLocker is a built-in encryption feature that should be enabled on computers running Windows 10 Professional. Encryption is particularly important on laptops, tablets, and smartphones whose portability makes them susceptible to being lost or stolen.

8 **"Rosy" view of cybersecurity incidents, risk, and preparedness.** Based on answers to the survey, audiologists appear to have an inaccurate perception of the risk and likelihood of cybersecurity incidents. Only 9.2% of respondents reported that they were the victim of a hack or data breach in 2019. Based on comparable data from both small business surveys[3] and physician data[4], the rate of incidents in audiology is likely much higher than observed. The survey also asked "What is the likelihood that your practice will be hacked or be the victim of a data breach in the next 12 months?" While 38% said they didn't know, 55% said not at all likely or slightly likely. Unknown and unacknowledged incidents are a liability to the practice.

9 **Cyber insurance is uncommon.** Similar to life or auto insurance, cyber insurance can be essential in helping cover the expenses related to a data breach, including business disruption, revenue loss, legal fees, and legally mandated notifications. Without insurance, these expenses could easily cost you $100,000 or more depending on the number of PHI records you have. Among practices who spent less than $500 on security in 2019, only 17% of respondents in the survey had cyber insurance. Those spending more than $500 indicated 39% with cyber insurance. Many insurers offer cyber policies or endorsements to package policies, so consider talking to your insurance provider about a quote for cyber insurance.

10 **Risk assessment is the most desired.** Participants were asked to imagine that they had a dedicated $1,000 to spend on a cybersecurity project and select how they would spend it. The top response (44%) was a risk assessment, significantly more than the alternatives which included secure email, training, and backups. This is a reasonable response since it is a necessary prerequisite to determining necessary cybersecurity solutions, and HIPAA requires covered entities to "Conduct an accurate and thorough assessment of the potential risks and vulnerabilities" to PHI. Risk assessments may be done yourself[5] or with the help of a cybersecurity consultant, and should be reviewed at least annually.

Figure 1. Responses across all participants as to whether or not their private practice implements various cybersecurity practices[2]

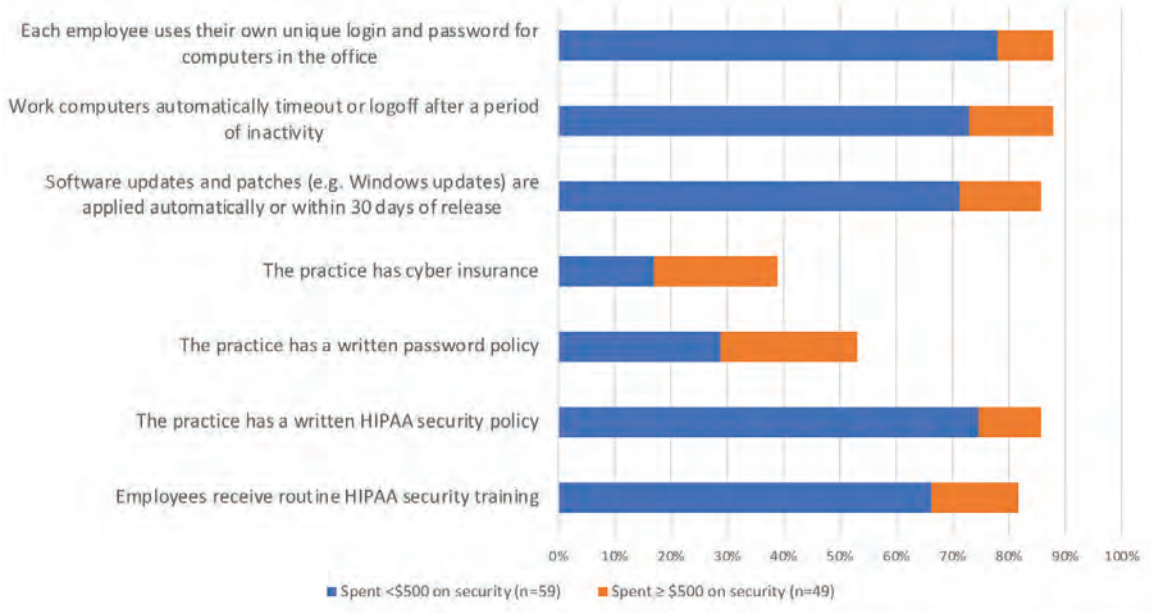

Figure 2. Comparison of seven cybersecurity behaviors grouped by respondents spending more and less than $500 on security in 2019.[2]

Self-reported studies including ours have specific limitations. We feel reasonably confident that the data are accurate given the strong anonymity provided and little fear of reprisal. This study was not intended to be representative of all audiologists or practice settings. Additional research is needed for validation and longitudinal studies could measure change in cybersecurity behavior over time. In a future study we would like to better understand why people make the decisions they do, such as audiologists' mental models about security risks. In psychology, mental models are a cognitive structure constructed by individuals to represent how something works, and a person's intuition about his or her actions and their consequences.

The results of this survey illustrate that cybersecurity is an important and active part of business and patient care for many audiologists. The trends highlighted here are consistent with the struggles and constraints of both a small business and a medical business. As a result, private practice audiology businesses must remain diligent in pursuing the necessary adoption of security and privacy safeguards. We thank ADA and each participant for contributing to this research, and look forward to safe and successful hearing and balance healthcare. ■

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PRESIDENT'S MESSAGE

Continued from page 5

private and confidential environment. ADA staff are available to contact for technical troubleshooting, if needed, but will not participate in the meetings. If you are interested in more information on the Mastermind Program or want to be included in the next group that forms, you may contact info@audiologist.org.

The Audiology Practice Accreditation Program (APAP) lives within the Quality pillar. The purpose of the APAP is to recognize clinics that meet or exceed national standards, exemplifying best clinical and business practices in the delivery of audiologic care. The APAP will measure clinical processes and procedures against a set of peer-reviewed, evidence-based standards. These ADA-accredited practices will demonstrate a commitment to patient-centered care, transparency, and adherence to clinical and ethical guidelines by leading national organizations and institutions. Our current activities include the training of the auditors and incorporation of virtual interactions until we can return to face-to-face operations. Audiology Practice Accreditation is an open-access process for both ADA members and nonmembers. To participate in the APAP process, or to recommend someone as either an auditor or a clinical site to be evaluated, you may contact Stephanie Czuhajewski at sczuhajewski@audiologist.org.

The fifth pillar is Sustainability and I'd like to highlight ADA's vast reimbursement resources. Audiology practices are experiencing changes in service delivery and patient access that are being driven by managed care. ADA members have access to reimbursement expertise through Audiology Resources as a member benefit. A cache of reimbursement and practice management resources are also available on the ADA website at www.audiologist.org. These resources are updated regularly, so check back often. ADA has also established a working group to research and analyze the changing managed care landscape, the implications for audiology practices, and considerations for audiologists. The Working Group is on path to release a comprehensive report later this year which will include important information and recommendations for audiologists, consumers, and policymakers.

The new year of 2021 is underway and I urge you to reach out, connect, communicate, and collaborate with fellow members utilizing the Academy's support systems: the Student Academy of Doctors of Audiology (SADA) for AuD program participants, the ECP Special Interest Group for young professionals, and Mastermind program for the seasoned professionals. As we move together through the transitions of the coming year, I send you best wishes for an end to the pandemic and associated restrictions, for good health to you and your families, and for a successful year for your practices in continuation of the outstanding care you provide to the patients you serve. ■

EDITOR'S MESSAGE

Continued from page 7

He might be right, but the experience of many audiologists would suggest otherwise. It is common to see a handful of patients each month that fit into quadrant C. When we encounter one of these patients, besides telling them in an often off-putting way that their hearing is "normal" and , by the way, here are some strategies you can use to communicate more effectively: face the speaker, stay close, when dining out, ask for an out-of-the-way table or, better yet, a padded booth, and face away from the kitchen or other noisy areas. You all know the schtick.

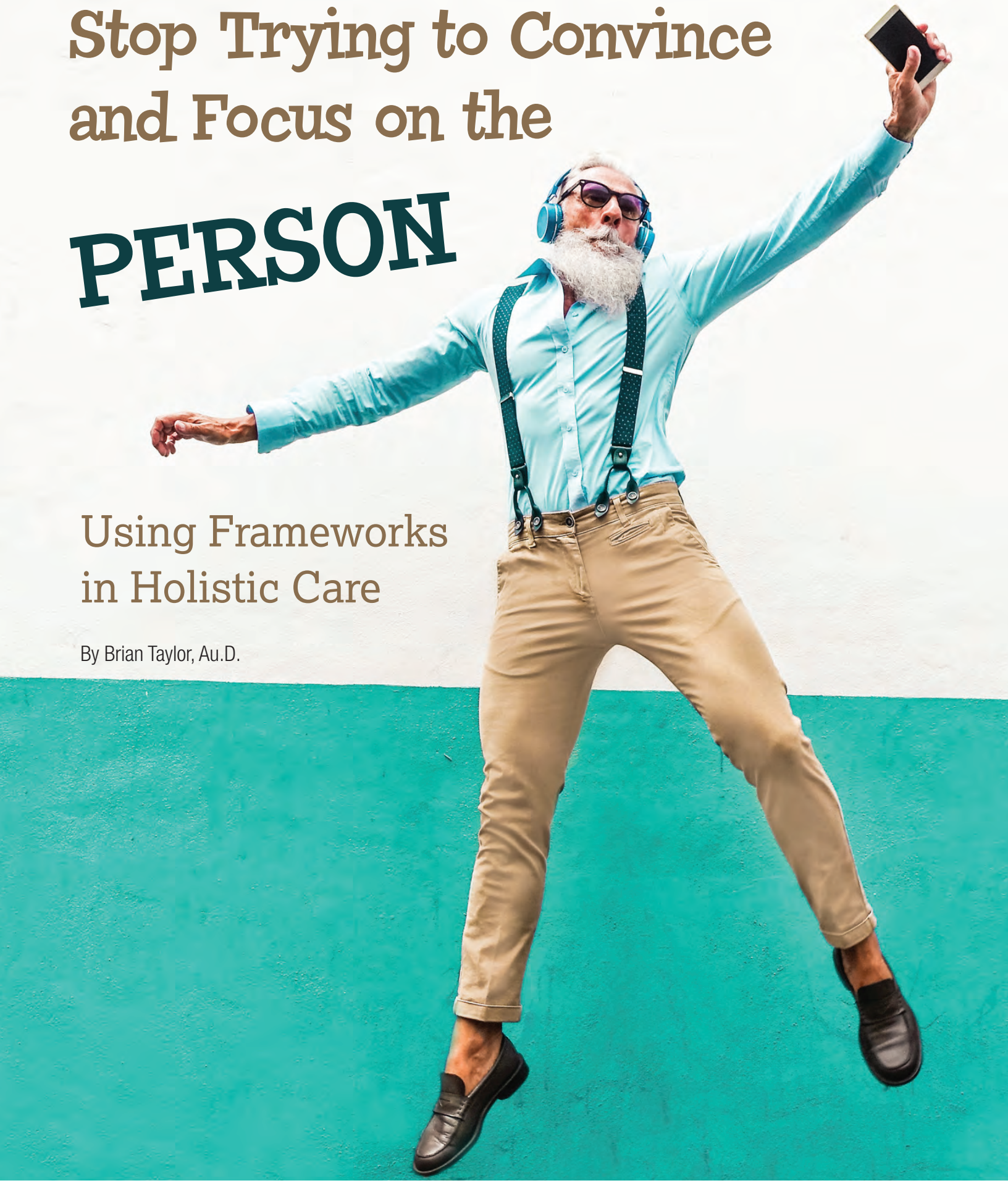
Now, given the convergence of hearing aid and consumer audio technology, audiologists can provide an effective intervention for those with subclinical hearing loss. These so-called hybrid devices offer their users multi-tasking capability: stream music and podcasts, talk on a cell phone hands-free and situational amplification in challenging listening places. Hybrid devices are really hearing aids disguised as earbuds. Before you scoff at the opportunity to recommend people hybrid devices to patients with subclinical hearing loss, there is another study that might convince you.

As part of his landmark OTC study, Humes collected data on several potential study participants with normal hearing. Using the Hearing Handicap Inventory for the Elderly (HHIE) to measure self-reported hearing difficulty, Humes found that individuals with normal hearing had essentially the same degree of self-reported hearing difficulty as measured on the HHIE, and interestingly, the same measured aided benefit as individuals with mild and moderate hearing loss. Based on Humes' 2020 report, published in the July issue of Hearing Review, why not offer adults with subclincal hearing loss a hybrid or mutitasking device that they can wear as a situational amplifier that easily doubles as a device that streams music and podcasts? With the advent of hearing aids disguised as earbuds, entrepreneurial audiologists have a chance to grow their business and address an unmet need. ■

Stop Trying to Convince and Focus on the PERSON

Using Frameworks in Holistic Care

By Brian Taylor, Au.D.



Hearing loss is a multifaceted condition that obliges the audiologist examine the *person* not simply their hearing loss or the type of hearing aids that might be most beneficial. Clearly, the simple act of conducting a hearing test and recommending hearing aids falls far short of effective long-term intervention for many individuals with hearing difficulties. Overcoming the gap between hearing loss prevalence and consistent use of hearing aids requires audiologists to rethink how they interact with persons with hearing loss. To better address the needs of adults with hearing loss, audiologists must be more holistic in their approach to patient care. In many ways, however, technology gets in the way of this humanistic interaction.

The Tyranny of Ever-Improving Technology

For the past 30 years, hearing aids have experienced incremental technology improvements. This means that about every 12 to 24 months hearing aid manufacturers bring a new product or feature to market that, at least on paper, is more sophisticated than the product or feature that preceded it. During the early to mid-1990's multiple channels of wide dynamic range compression, multiple memories and high quality directional microphones revolutionized the performance of hearing aids. In the late 1990s and early 2000s digital signal processing enabled a wide range of noise reduction features to be added to digital hearing devices that contributed to improved performance in background noise. Similar to smartphones and personal computers, audiologists and consumers alike have come to expect hearing aid technology launched today to be incrementally more sophisticated (and beneficial to wearers) than preceding generations. Although these incremental improvements in hearing aid technology are often useful (not to mention fun for audiologists to talk about), they do not always translate into improved patient outcomes.

One recent study illustrates this point. Wu et al (2018) evaluated differences in patient outcome for advanced hearing aids compared to basic hearing aid technology. The researchers compared advanced noise reduction/directional microphone technology (NR/DM) to basic noise reduction/directional microphone (NR/DM) circuitry in both laboratory and real-world listening situations. Fifty-four older adults with mild to moderate, medically uncomplicated hearing loss were fitted with the following four different hearing aid configurations: 1.) Advanced circuitry, NR/DM Features ON, 2.) Advanced circuitry NR/DM Features OFF. 3.) Basic circuitry, NR/DM Features ON, and 4.) Basic circuitry, DNR/DM Features OFF. Each study participant, as well as the researchers, were blinded to the exact configuration they were wearing and each of the four configurations of circuitry was worn by each of the participants for five weeks.

Results show that all 54 participants had better results with NR/DM turned ON for both levels of circuitry. Laboratory results indicated that advanced circuitry outperformed basic technology in speech understanding and localization measures. Interestingly, these differences disappeared in real world measures, as no differences between basic and advanced circuitry were found. These findings suggest that NR/DM strategies are effective in both basic and advanced models, and optimizing audibility by carefully matching and verifying a scientifically validated prescription gain target (a key components of the design of this study) trumps the level of technology found inside the hearing aid.

Further, the results of this study underscore the limitations of incrementally improving hearing aid technology as a panacea for improving all facets of patient outcomes. Yes, hearing aids work, but as this one important study reminds us, hearing aids alone do not solve all of the communication problems of persons with hearing loss: A dedicated audiologist who understands the motivations, values and beliefs of persons with hearing loss is necessary to improve the probability of outcomes for most patients.

The challenge, of course, is that understanding the underlying attitudes, motivations and behaviors of individuals with hearing loss is complicated. The process of behavior change, moving from indifference to action, takes time and effort by both the person with hearing loss and the clinician. Every help seeking individual presents with unique demands that are time-consuming for the audiologist. After all, most audiologists have a limited number of hours to spend with any given patient. Therefore, to be more holistic, to focus on the *person* more than the product, demands that we adopt different behavioral frameworks that allow audiologists to cut through the complexity of hearing loss and its effect on the individual's attitude, motivations and behaviors. There are two frameworks that help audiologists focus on the *person* with hearing difficulties, rather than simply trying to convince that patient to wear hearing aids.

COM-B

The COM-B model, given its simple framework, is a useful way for understanding how to guide behavior change in individuals with hearing loss. The COM-B model, originally created by Mitchie et al (2011), defines capability, opportunity and motivation as the influencing factors that shape a patient's behavior. For persons with hearing loss, when we talk about shaping behavior or behavior change we are usually referring to a patient's ability to accept treatment or to consistent use of hearing aids. The COM-B model, summarized in Figure 1, can be used as a basis for developing interventions and strategies that shape the behavior of persons with hearing loss.

Let's examine the COM-B model through the lens of the person with hearing loss. Capability is defined as the power or ability to do something that contributes to increased motivation that in turn can drive behavior change. In the COM-B model, capability is best described as the psychological and physical factors that affect an individual's ability to consistently wear hearing aids and communicate effectively in day-to-day listening situations. Physical issues include limited cognitive ability, which may preclude a person from remembering to wear their hearing aids every day. Another physical issue that is a capability factor would be dexterity problems that prevent a person from properly inserting hearing aids onto her ears. Psychological reasons that impact consistent hearing aid use and effective communication include a lack of knowledge, confidence, and an external locus of control. Capabilities are factors that need to be addressed by the audiologist through the provision of clear and understandable information and teaching the person with hearing loss to become a more successful communicator. In short, audiologists improve a patient's capabilities through teaching.

Opportunity is defined as the external factors that influence a person's ability to be a consistent hearing aid wearer and effective communicator. These external factors can be divided into environmental factors and social factors. Lack of family support, social stigma and high costs of hearing aids are considered social reasons. In contrast, environmental factors include the inability to access the clinic and online accessibility. Opportunities are factors that can be barriers to successful use of hearing aids and are often addressed through the application of technology that might be novel or engaging. Recent innovations in hearing aids such as smartphone apps that enable individuals to connect with the audiologist remotely or fine-tune their hearing aids, in the context of the COM-B model are tools that create opportunities to become a more consistent or more successful hearing aid

wearer. In short, audiologists improve a patient's opportunities through technological innovations that make the experience of using hearing aids more interactive or engaging.

Let's examine the third component of the COM-B model. Motivation is a person's inclination or willingness to engage in the process of behavior change. Motivation can be divided into two primary types. 1.) Automatic motivations that are impulsive or instinctive. They are often activated quickly by the individual. 2.) Reflective motivation that require evaluation and planning by the individual. With respect to behavior change associated with hearing loss and treatment, both types of motivations are at work.

Automatic motivations related to not wearing hearing aids include embarrassment and stigma associated with using one. Reflective motivations associated with persons with hearing difficulties include the belief that the hearing loss is not bad enough to warrant the use of hearing aids. Reflective motivations also include skepticism that hearing aids will be worth the money, or that it simply not worth the trouble to go through the process of getting a hearing test and acquiring hearing aids. A careful look at the COM-B model in Figure 1 tells us that audiologists can shape a patient's motivation by focusing on opportunities and capabilities.

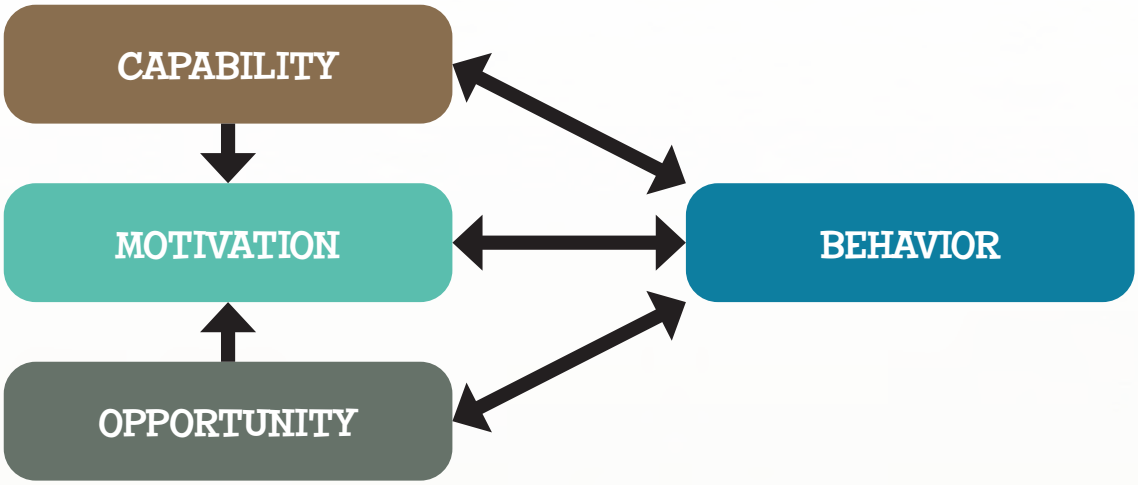


Figure 1. The four components of the COM-B.

The COM-B model is helpful for understanding the factors associated with seeking help, acquiring hearing aids and then wearing them consistently. Through the lens of the COM-B model, audiologists can focus on improving capabilities and providing opportunities that, in turn, motivate the wearer to modify or change a behavior. Rather than giving the proverbial pep talk to patients who are not successful with their devices, a largely ineffective method of external motivation intended to inspire a patient into action, the COM-B model reminds us that when we focus on boosting capabilities through education and training, and creating new opportunities by introducing new tools to the patient, we can influence internal motivation, which in turns drives new behaviors. Table 1 summarizes several of the essential tasks to be completed by the audiologist associated with the four components of the COM-B model. Audiologists can think of opportunity and capability as levers that they can pull to motivate and empower the patient to take action.

Table 1. A summary of key tasks conducted by the audiologist using the COM-B framework.

CAPABILITY	OPPORTUNITY	MOTIVATION	BEHAVIOR
• Provide information that is clear and understandable • Provide training that is useful and targets the need of the individual	• Identify and account for factors that could be barriers to successful treatment • Provide easy to use or engaging tools such as a smartphone app that empower the wearer to think or act in a new way about their condition	• Recognize barriers to success • Collaborate on a plan that accounts for opportunities and focuses on capabilities of the individual	• Empower the patient to take action • Encourage the patient to maintain a sense of control

The four boxes in Table 1, along with the accompanying arrows of the COM-B framework, as shown in Figure 1, remind audiologists that not only can the capability, opportunity and motivation factors affect behavior, but each of these individual factors influence each other. There are numerous examples of how capabilities, opportunities and motivation spur behavior change. When we lower the out of pocket cost of hearing aids, say with a third-party insurance benefit it can influence the motivation of the person with hearing loss to pursue hearing aids. When we provide skills training on hearing aid insertion into the ear or teach the patient how to recognize and better manage a noisy listening situation, we influence capability. When we provide our patients with an interactive smartphone app that makes hearing aid adjustments easy to do without visiting the clinic for an appointment, we are systematically pulling the levers of the COM-B model and influencing behavior change. Improving a patient's capability or opportunity, in turn, motivates the person with hearing loss to wear their devices more regularly.

Think of the capability and opportunity factors of the COM-B model as two sides of an accordion squeezing in on the center factor, motivation. For example, when audiologists engage in the act of teaching a hearing aid wearer to be a better listener in noisy places or demonstrate how to use a new smartphone app that provides better ability to tailor sound quality in a wide range of listening places, those actions can influence both motivation and behavior change.

The 5As

The '5As' model of behavior change counseling is an evidence-based approach appropriate for a broad range of different behaviors and health conditions, including hearing loss. The 5As are: assessing patient level of behavior, beliefs and motivation; advising the patient based upon personal health risks; agreeing with the patient on a realistic set of goals; assisting to anticipate barriers and develop a specific action plan; and arranging follow-up support. The 5As originates from a tobacco cessation guide for physicians developed by the National Cancer Institute. Whitlock et al. (2002) revised the construct to include "Agree" based upon the evident need to include shared decision making in the delivery of patient-centered care. The 5As model, as outlined in Figure 2, contains at its core the patient-driven factor of behavior change. It culminates in an individual action plan for each help seeking patient. This action plan is a document that changes over time and serves as a sort of canvas where new treatment goals are targeted in partnership with the patient and their communication partners. According to Gilligan (2016), the 5As model can be applied to hearing care and audiology by providing services summarized on the next page:

1. AUDIOLOGIST ASSESSES

- Patient Needs and Preferences
- Health Literacy
- Health Beliefs & Behaviors
- Functional Communication Ability
- Hearing Handicap

2. AUDIOLOGIST ADVISES

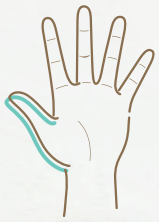
- Educate about hearing loss
- Options for treatment, including non-device treatment options
- Offer the pros and cons of treatment using a patient decision aid
- Provide health-literate information and counseling

3.AUDIOLOGIST AGREES TO

- Engage the patient in shared decision making - work in a partnership with the person with hearing loss
- Explore the patient's story to uncover motivation toward behavior change
- Agree on goals and expectations

4. AUDIOLOGIST ASSISTS IN

- Helping the patient adjust to treatment
- Identify and overcome barriers to treatment
- Foster self-efficacy and independent self-management of hearing loss



5. AUDIOLOGIST ARRANGES TO

- Organize and facilitate follow-up with the patient over time
- Monitor provision of patient centered communication

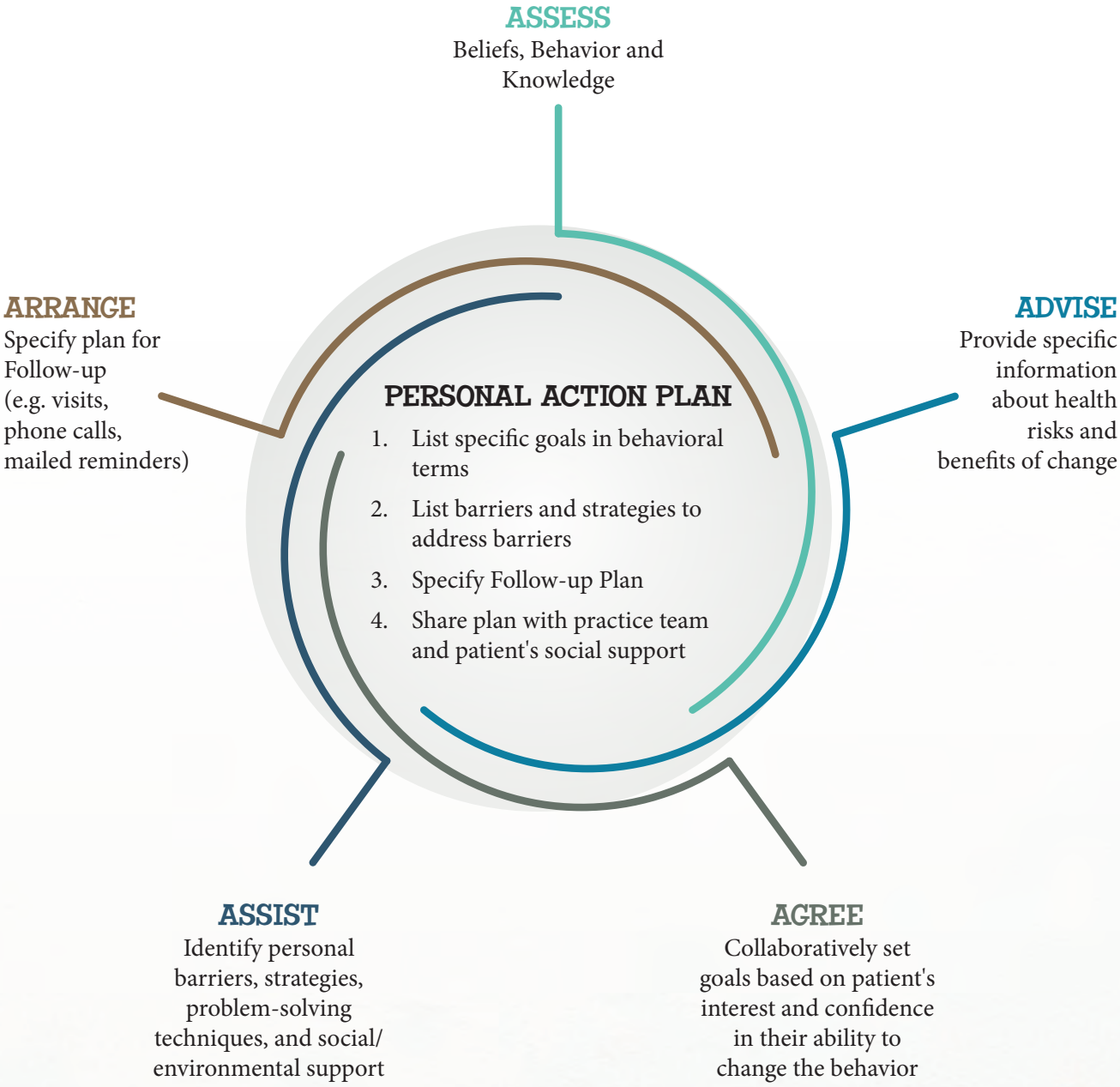


Figure 2- The 5As Self-Management Model

Both the COM-B and 5As model provide audiologists with a systematic approach to the provision of holistic care. By putting either model into clinical practice, an audiologist avoids the common habit of trying to convince help seeking individuals to wear hearing aids and places the focus squarely on the behaviors, attitudes, and motivation of the person. In an age of over-the-counter hearing aids in which persons with hearing loss can opt to self-directed their care, the ability to provide holistic hearing care, using one of these frameworks, can become a competitive advantage. ■

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Humanitarian Audiology HERE & ABROAD

An Interview with Randa Mansour-Shousher, Au.D.

AP Staff Reports

Dr. Mansour-Shousher, thank you for taking time to discuss humanitarian audiology. Can you share some details about what led you to establish HearAide as a nonprofit?

Dr. Mansour-Shousher *My private practice, Northwest Ohio Hearing Clinic, introduced its nonprofit audiology program in 2015, to provide hearing assistance for the growing number of uninsured and under-insured in the Toledo community. Today, HearAide is the only nonprofit hearing center serving Lucas County and Wood County, Ohio. The clinic offers a full suite of diagnostic testing and hearing aid fitting services to individuals who would otherwise go without these services.*

HearAide is structured to provide a long-term no-cost or low-cost care solution that benefits the patient and society. We use a "Circle of Giving" program that requires HearAide patients to volunteer in the community. The service requirement promotes self-sufficiency, builds feelings of self-worth, helps prevent social isolation, and ensures that HearAide patients are invested in their own hearing healthcare. It also makes it easier to distinguish patients who genuinely need financial assistance from those who do not.

In addition to the efforts of HearAide to serve your community in Northwest Ohio, you have also expanded your humanitarian efforts to serve the global community. What prompted your decision to go global?

Dr. Mansour-Shousher *I am a citizen of the world! My parents were Palestinian immigrants. My father first came to the United States with $75 to his name. He worked hard and served in the US army during the Korean War, after which he earned a science degree, while selling carpets door to door in the South. Dad went back home and married mom, who became a refugee in 1948 when her family lost their home and business during the war in Palestine. My parents left Palestine and resettled in Paris, France, where I was born—yes (oui), I am a French girl! After my father completed his medical residency, it was au revoir Paris and hello, Toledo!*

I arrived in the United States at 5 years old, with a heavy French accent and no friends. I was self-conscious, shy, and isolated. I communicated very little. I was lonely. Looking back, I believe this experience influenced my desire to become an audiologist, and in the same way, my immersion in different cultures from an early age, seeded my desire to serve internationally.

Understanding the history and the struggles of our extended family made a lasting impact on me and my siblings. My parents never forgot their homeland or their duty to help their fellow countrymen (and women) obtain education, adequate food and housing, and opportunities for mentoring. My husband, Hussien, had parents with similar values, so we both learned early on that an essential part of a happy, healthy life is being able to be of service to others. While visiting family in Jordan and Palestine each summer, we learned more about the culture and also the great need for hearing healthcare services.

What are some of the biggest differences between serving patients in the Middle East compared with Northwest Ohio?

Dr. Mansour-Shousher *Unlike in the United States, a large percentage of Palestinian and Syrian refugees have hearing loss due to lack of medical care, genetic complications, and war-related trauma. Those with middle ear pathology often go undiagnosed. It is extremely common to encounter large groups of individuals with severe to profound sensorineural hearing loss that has been left unidentified or untreated. The influx of Syrian refugees into Lebanon and Jordan has compounded the need for hearing health services and diluted available resources. It is impossible to address the hearing health needs of the refugees without negatively impacting access to care for Jordanian and Lebanese citizens. In Palestine, the situation is exacerbated by increasing unemployment and physical/geographic restrictions that prevent citizens from seeking care. None of these areas have a universal hearing screening program, let alone any type of hearing screenings in the schools. Hearing aids are a luxury in this part of the world. None of these Middle Eastern countries have ready access to cochlear implants (CIs). Many individuals, even children, are denied care because they cannot produce required documentation of citizenship or a national identification number.*

For example, Mirna and Maya are twin sisters who were born with a severe-to-profound hearing loss that was left untreated. They live with their mother, aunt, uncles, and cousins in a three-room home in a refugee camp in Madaba, Jordan, where I met them for the first time. I felt immediately connected with them and wanted to help. Our team returned the following year and the girls had still not received assistance.

Mirna and Maya were not able to be helped with traditional hearing aids and required cochlear implants. However, the implants aren't available in the refugee camps. Making it even more difficult, the twins were born to a Jordanian mother and a Palestinian father. Because their father is Palestinian, they lacked the necessary identification number required to get medical treatment in the camp.

After we were unsuccessful in obtaining CIs through the Jordanian government system the third year, I came home and took responsibility for their care as a pro bono case. Cochlear Americas graciously donated a complete system including all accessories for implantation. I was able to secure the otologist, anesthesiologist, and audiologist in Jordan who also donated their services. HearAide raised funds to secure the hospitalization costs and rehab cost for pre- and post-implantation. We are still in constant contact with the family and tracking their progress.

Do you have recommended best practices or helpful tips that audiologists should consider when providing humanitarian audiology services abroad?

Dr. Mansour-Shousher *When planning an international humanitarian audiology mission, please consider the following suggestions:*

1. *Partner with local experts for success. Identify and partner with organizations that are familiar with local customs and the political climate. HearAide works with the United Nations Refugee Welfare Association (UNRWA), which is an arm of the United Nations. UNRWA has helped us on the ground during the mission trips to the West Bank/Palestine. Their social workers complete home visits to determine qualifications and maintains a record of individuals in need of audiology services. In many cases, UNRWA can provide patient records, including audiograms if they are available, which can be sent in advance of the trip. This allows us to prioritize those who are eligible and filter out those who may not be helped with hearing aids.*

It is a good idea to follow up with audiologists and/or physicians in the area, and the Ministry of Health. These local clinicians can often help identify individuals who may live in remote areas or who have been overlooked by other organizational partners. It is essential to have people on your mission team who understand the local language, culture and customs.

2. *Organize and replicate (as much as possible) a clinic design that will facilitate success and good patient flow. HearAide has found through experience that stations work very well.*
   - *Registration: At this station, collect identification (names and numbers) to better identify patients and reduce duplication of services. If possible, develop complete patient files with photos as many people may have the same names.*
   - *Triage: At this station, an audiologist should review prior test results and/or check hearing aids, if applicable, and perform otoscopy*
   - *ENT/Medical Clinic: At this station, a medical doctor can assess conditions that require medical intervention and/or assist with cerumen removal to save time with the audiologist. It is a good idea, if possible, to assign a volunteer assistant to work with the physician.*
   - *Screening: Set up OAE and tympanogram stations and perform tests. If possible, use local audiologists and audiology students to assist with testing.*
   - *Testing: At this station, the audiologists will conduct air-conduction and bone-conduction tests. The audiologist and volunteer document the results of the audiogram and bring patients in and out.*
   - *Earmold lab: At this station, the audiologist takes the impressions and volunteers make the earmolds.*
   - *Hearing Aid Fitting: When possible, it is most efficient to set up two fitting stations, equipped with Real Ear or another method of verification. Assign a volunteer to assist, in addition to two audiologists.*
   - *Counseling: At this station, the patient will review an instructional video and receive verbal instructions. HearAide has been lucky to have a speech pathologist as part of the team.*
   - *Art Therapy: At this station, children can draw, paint, and tell their story while they are waiting.*

   The entire process takes about 1.5-2 hours per patient and (if warranted) they leave with hearing aids and supply of batteries.

3. *Remember that people are people and patients are patients. People and patients around the world have more in common than one may realize. The patients that we serve in the Middle East express many of the same emotions as our patients in Ohio. Stigma knows no boundaries. Many patients are self-conscious and either not willing to wear hearing aids or only want to consider CIC-style hearing aids, even though BTE-style hearing aids are often more durable. Some individuals insist on a certain brand of hearing aid, even if they are unfamiliar with the features or specifications. Other individuals have a difficult time accepting the new that they don't qualify for a hearing aid, or that a hearing aid won't help their condition. Finally, patients in the Middle East feel the same joy and get the same Hearing Smile as patients in Ohio when they hear the world for the first time.*

4. *Strive to create a program that is sustainable and offers follow up care. The mission clinic should be equipped to minimally provide hearing screenings, hearing tests, and hearing aids. In some cases, manufacturers are willing to donate or reduce the cost of hearing aids for humanitarian audiology efforts but be prepared to spend a lot of time raising money to purchase hearing aids and batteries. Going back to the same location at regular (yearly) intervals is helpful for continuity. Another way we are working to sustain the HearAide program is by providing a grant to the local university, audiologists, and students to provide clinical space and follow-up services for patients. The grant allowed for the procurement of equipment and a sound booth that will allow for the latest treatment protocols to be followed.*

5. *Get some experience before going it alone. Audiologists who have an interest in humanitarian audiology should join and participate in an international mission trip, before trying to plan one from scratch. HearAide and other missions are always looking for volunteers. It truly takes a village to organize and complete a mission! If you would like to help but are not able to travel, there are opportunities to fundraise and donate to the cause. Missions like HearAide are always raising money for hearing aids, supplies, and equipment needs. With the high CI population, we are also working on providing financial assistance to individuals who need medical surgical care. Keep in mind, there are a lot of audiologists such as myself who are willing to mentor those interested.*

What are the most challenging and rewarding aspects of operating a humanitarian audiology program in Jordan and Palestine?

Dr. Mansour-Shousher *The greatest challenge is educating the community about the need for early identification and intervention for hearing loss, and from there, establishing a newborn universal screening program.*

It has been most rewarding to be able to relate to the culture, to understand the language and the needs of the people and to provide my skills back to my parents' homeland in their honor. HearAide has also grown into an even greater family give back program. During our last trip in September 2019, I was accompanied by my siblings and parents who all took a job in the mission and ran with it. I am also proud that my children, Yasmeen and Marwan, have joined on mission trips and have established their own philanthropic goals. Having a supportive husband, amazing children, and grandchildren has made me the luckiest wife, mother, and audiologist. Knowing the value of helping those who are in need will be carried on is PRICELESS.

Knowing we are helping those who may never have the opportunity, giving them the chance to complete their education, achieve their personal goals, hoping they would have an opportunity to leave the refugee camp and make a difference and give back in their own way. I leave praying what we provided will enhance their future. I want to make an impact in our local and global community and create a legacy. The gift of hearing is truly from my heart. ■

Dr. Randa Mansour-Shousher *is an audiologist with over 30 years of experience. She earned her Bachelor of Science degree from the University of Toledo, her Masters of Science degree from the University of Michigan and her Doctorate of Audiology (Au.D.) from A.T. Still University. Her specialties are tinnitus, vertigo and the latest hearing aid technologies. She is highly-skilled in diagnosing hearing loss, dizziness, tinnitus disorders and developing personalized treatment plans. She may be contacted at* drrmasour@nwohc.com or (419) 383-4012.

If you would like to donate to HearAide, please visit:

https://www.centeraap.org/funds/view-our-funds/hearing-call-fund/ or **www.HearAide.org**

CLOSE to HOME

Finding Your Calling at Your Community Free Clinic

An Interview with Kristin Davis, Au.D.

AP Staff Reports

Dr. Davis, thank you for taking time to share information about your humanitarian service. What process did you go through to volunteer at the Greenville Free Medical Clinic?

Dr. Davis *I finally completed my first volunteer shift at the Greenville Free Medical Clinic (GFMC) in October 2020 after nearly two years of preparing. This is not typical! When I initially approached the clinic, they were very enthusiastic and welcomed the opportunity to add Audiology to the many healthcare services already offered. The staff and volunteers at GFMC have made the process for volunteering seamless and straightforward*

However, as we were building out audiology services from scratch, there were additional hurdles to overcome. By the time I was able to get the necessary equipment in place for Audiology services, and the newly reworked eye and ear room was set up, the COVID-19 pandemic was in full swing, which delayed start up of the new services.

It was worth the wait! My work at GFMC has allowed me to get back to the core of why I chose audiology as a profession—helping others! These patients aren't critical about features or Bluetooth connectivity. They are purely grateful for their healthcare and professionals willing to help. Fortunately, GFMC has remained open following strict masking, temperature checks, and infection control protocols and been a valuable resource for the community.

How should audiologists who are interested in volunteering at a free medical clinic in their community prepare?

Dr. Davis *Based on my experience, I believe that audiologists will be welcomed and highly valued providers in free clinics; however, they should be prepared to build out the program as most clinics will not already offer dedicated audiology services. The great news is that this is right up the alley for private practitioners.*

I found the process to be very collaborative. This was wonderful as I certainly did not have all the answers. We discussed our common goals for community patients. I was able to provide all the technical details of areas to cover to ensure sustainable care for a hearing program such as follow up frequency and necessary hearing aid supplies for maintenance and use. Together, we discussed possible solutions for providing patients access to batteries, supplies, and complimentary follow up hearing aid care.

You were able to contribute a sound booth and audiology equipment to the free clinic. Should audiologists be prepared to donate (or seek donations for) equipment that can be left at the clinic? Can you share a list of equipment that you provided/helped the clinic acquire?

Dr. Davis *Unfortunately, I believe most clinics will not have audiology equipment so that will be a necessary part of the startup process. There is much flexibility in how providing equipment can be approached. Perhaps, you have an older audiometer that your practice can donate, you can solicit your peers for equipment donations, or there are many portable equipment models now which could be used in a private paying practice and then carried as needed to a free medical clinic site. My specific situation is a hybrid of all of the above. I donated an older model audiometer which I already possessed and purchased a small booth for donation. In addition, I utilize a laptop, portable impedance bridge, and portable real ear system from my private practice.*

What services and supplies does the clinic provide using other volunteers or staff?

Dr. Davis *The GFMC has incorporated the hearing clinic into its standard protocols. They handle all intake and screening for financial qualification for services, appointment scheduling, COVID-19 screening, cleaning and infection control, and recordkeeping. This has relieved any extra work on my part. All I have to do is show up and help patients!*

The GFMC has volunteer providers in the areas of general medicine, dentistry, vision, ENT, and pharmacy. In addition, health education classes are available at the GFMC in the areas of diabetes management, women's health, weight management, and smoking cessation. The nursing support staff are wonderful at coordinating referrals and following up to ensure patients are scheduled in as timely a manner as possible.

I am told eye, ear, and dental services are in high demand and many free medical clinics don't have volunteers to provide services in these areas. Speaking with the clinic director recently, she mentioned what a blessing having these ancillary healthcare services is as other comorbidities such as diabetes and high blood pressure are able to be detected and treated when a patient seeks help for their tooth pain, vision difficulty, or hearing loss.

What ongoing challenges do you face related to providing sustainable audiology services?

Dr. Davis *The biggest challenges for a sustainable Audiology clinic are limited resources in labor and in supply of hearing devices, including the supplies necessary to keep devices functioning properly (i.e. batteries, filters). Currently, I am the only hearing services provider; however, I have notified other audiologists through our state organization, the South Carolina Academy of Audiology (SCAA), of the opportunity to volunteer at the GFMC on as little as a one-time basis. I am confident as more audiologists are able to be vaccinated, and as COVID-19 cases begin to trend lower, I will be contacted by more interested in volunteering their time and talent.*

The current plan regarding hearing device supply includes utilizing national established non-profits, if a patient is financially able to pay the application fee. Unfortunately, most are not able to afford application fees. Most patients will need donated devices. I am currently establishing protocols for use of donated devices to ensure we operate within all state regulations. Donations and creative fundraising methods will be utilized for hearing aid battery and maintenance supplies for patients.

Is there a minimum time commitment (either number of days or length of each shift)?

Dr. Davis *There is no minimum time commitment. Since audiology shares space with the vision team, the audiology clinic has specific dedicated times on Mondays 9-5 and Fridays 9-12. I simply coordinate and communicate time I can commit away from my private practice, on a monthly basis. There is no shortage of hearing patients. The nurse practitioner who is the clinical operations manager has been extremely helpful in scheduling hearing patients from the waitlist and managing new hearing referrals. The more volunteers we have the greater number of patients we will be able to serve. The eye and ear room availability would allow us to run hearing clinics a maximum of two days per week if we had the audiology volunteers to fill the clinic time.*

I am also excited about the possibility of offering volunteer opportunities to audiology students and audiology assistants in the future. The general medicine and dentistry programs frequently have medical and dental student volunteers participate in their clinics. The possibility of offering volunteer spots to students is attractive as it helps with the demand for audiology providers while at the same time allows students a chance to experience humanitarian audiology. My hope would be more than a few audiology students would feel the call to implement similar programs in their home communities once they begin their professional careers. Logistically, regulations need to be vetted to allow SC audiologists to serve as temporary supervisors of visiting students from out of state. As more patients are fitted with hearing devices, opportunities for audiology assistants to volunteer on maintenance/device clean and check clinic days will likely become available.

In addition to your volunteer service at the Greenville Free Medical Clinic, you have decided to establish a non-profit, charitable organization. Why did you decide to do that and what was the process?

Dr. Davis *I sort of put the cart before the horse as my first decision was to start a non-profit, Carolina Hearing Foundation. I wanted to serve our community and provide a channel for our private practice patients to give back locally when they choose to donate their older hearing devices. I hadn't figured out the delivery model until I discovered the Greenville Free Medical Clinic and the pieces started to fall into place.*

The timeline for me to fully establish our non-profit has been a long one. There have been periods of time when it has been placed aside due to other priorities. Honestly, I became overwhelmed with the process. In South Carolina, state requirements for starting a charitable organization include creating Articles of Incorporation and By Laws for your entity, to comply with the S.C. Department of Revenue corporate filing requirements. I soon discovered that a federal tax identification number must be established prior to filing with the Department of Revenue in South Carolina.

Having an attorney in the family offered me more flexibility as I was not paying professional attorney fees or working on someone else's timeline. Once I started seeing patients for the GFMC, I recommitted myself to the process, and reached out to other audiologists who had experience with non-profits for advice. I am hopeful to have the non-profit completely established in the next month via a shorter form. From my research, the cost to establish a non-profit organization varies based on attorney fees involved, but costs can be kept lower if the non-profit is established primarily for delivery of donated goods and services and the annual fundraising stays below a certain threshold.

What recommendations do you have for people who are seeking opportunities to participate in humanitarian efforts at the local level?

Dr. Davis *I highly recommend checking The National Association of Free & Charitable Clinics at https://www.nafcclinics.org/ to see if there is a free medical clinic in your area. The Greenville Free Medical Clinic is a member of this organization, and as I have described has made the process of giving back locally, manageable. Perhaps, having your own non-profit organization is deeper than you want to dive. Volunteering your services at a local free clinic does not require you to establish a non-profit. You can simply volunteer and be part of the solution for greater access to hearing healthcare. By providing audiological services, you are able to counsel patients providing access to assistive listening devices through state and federal programs and hearing devices through available national and possibly local non-profit organizations.*

Do you have any recommendations for audiologists who are considering starting a non-profit organization?

Dr. Davis *My best advice is just start! If you feel called to humanitarian audiology, then start and learn as you go. There are many audiologists out there forging this path, who are happy to share their knowledge and provide advice. I also encourage anyone considering starting a non-profit to research any state-specific requirements!* ■

Kristin Davis, Au.D. *is the owner of Davis Audiology in Greenville, South Carolina. She currently serves as the president-elect of the Academy of Doctors of Audiology (ADA). Dr. Davis holds a Doctor of Audiology degree from A.T. Still University.*

Seven Steps to Improved Profitability

BY KIM CAVITT, Au.D.

1 Base all of your pricing based upon your breakeven plus profit rate, per available scheduled hour, per revenue generating provider.

This allows your pricing to reflect YOUR needs and financial goals. Build all of your pricing off of a model were your time and expertise carry a value.

Let's do the math. You charge $30 for cerumen removal. It takes you 30 minutes, on average, to complete the procedure and your breakeven plus profit rate, for that same window of time, is $75. This is less than the average co-payment. In this paradigm, you lose money every time you remove cerumen. In one year, you performed 150 cerumen removal procedures at $4500.

Instead, you charge the patient $75 for the same service. Instead, you received $11250. Not a single patient complained about the price increase because it is still less expensive than the same procedure in a physician's office.

2 Accept that there is a difference between reimbursement and coverage.

Coverage is when a third-party payer pays in whole or in part towards the cost of an item or service. Reimbursement is when you, the provider, get paid by the patient or a third-party source. We need to care more about reimbursement and less about coverage.

Let's do the math. You do implantable device evaluation/management. You evaluate 12 implant candidates a year, you fit 10 new speech processors per year, and you program/reprogram devices for another 60 patients per year, who produce 40 implant service visits a year. You charge patients privately for communication and functional needs assessments/cochlear implant consultations at $200. You charge $200 for cochlear implant speech processor fitting and orientation. You charge $100 for every troubleshooting/service visit. This equates to $8400 in revenue for charging for services that were medically necessary, yet lacked coverage.

3 We need to only participate in managed care and third-party network plans or programs that are financially viable for our practices.

All business is not good business. It is important for audiology practices to be aware of their breakeven plus profit, the time scheduled for each procedure or visit, and the allowable rates from the payer. Do a cost versus benefit analysis of every agreement and determine if the rewards outweigh the risks.

Let's do the math. Your breakeven plus profit is $225 per hour. The third-party network will pay you $500 per ear in a dispensing fee. You must manage each patient for one year post-fitting. On average, you will see patients for one, one-hour hearing aid examination and selection, one, one -hour fitting, and four, 30 minute follow-ups within the first year. You require $900 in coverage to breakeven and make a profit. This makes this program financially viable in this case but, if the you see average patients for more than four follow-ups or your breakeven plus profit exceeds $250 per hour, this same program becomes financially untenable.

4 Stop providing services at no charge.

Every minute of free services you provide is a minute where you are not covering your breakeven plus profit needs. Also, doctoring professionals do not provide free care. Period.

Let's do the math. You provide one free 30 minute service a day, 240 days a year. Let's value that service at $100. You just gave away $24,000 worth of care.

5 Practice to your top of your state license and, if you do not think that is expansive enough, work to change it.

People ask me how audiology can succeed given the threats to the industry. I have an easy, simple answer that has been bearing fruit for years: Practice audiology. Be everything that a patient/consumer cannot receive through disruptive channels. This includes, but is not limited to, cerumen management, communication and functional needs assessments, tinnitus evaluation and management, vestibular evaluation/management, auditory processing evaluation and management, implantable device evaluation/management, pediatric evaluation/management, hearing conservation, and auditory rehabilitation. Most of these services have large, private pay components and can generate revenue and referrals and foster improved relationships and outcomes.

Let's do the math. You perform communication and functional needs assessments on all patients seeking a care plan for treatment. You charge $150 for this one hour visit. This visit is typically private pay. You do 480 communication and functional needs assessments in a year. This would amount to $72,000 in revenue.

Continued on page 55

HAVE YOU HEARD?

AAA, ADA, and ASHA Unite on World Hearing Day to Support Critical Audiology Legislation for Medicare Beneficiaries

Introduced on March 3, 2021 by Representatives Tom Rice (R-SC) and Matt Cartwright (D-PA), with more than 20 bipartisan original co-sponsors, the **Medicare Audiologist Access and Services Act (MAASA) of 2021** will enhance the Medicare benefit by providing critical direct access to both diagnostic and therapeutic services provided by audiologists. The Academy of Doctors of Audiology (ADA), the American Academy of Audiology (AAA), and the American Speech-Language-Hearing Association (ASHA) endorse this legislation as a top priority to ensure expedient and optimal hearing and balance health care for the older adult population in the United States.

The legislation will remove unnecessary barriers to allow Medicare beneficiaries to receive appropriate, timely, and cost-effective audiologic care. This legislation can improve outcomes for beneficiaries by allowing direct access to audiologic services and streamlining Medicare coverage policies so that audiologists can provide the full range of Medicare-covered diagnostic and treatment services that correspond to their scope of practice. The legislation would also reclassify audiologists as practitioners, which is consistent with the way Medicare recognizes other non-physician providers, such as clinical psychologists, clinical social workers, and advanced practice registered nurses. Classification as practitioners under Medicare would enable audiologists to furnish services through telehealth, ensuring continuity of hearing health care in the time of public health emergencies such as COVID-19. The bill garnered significant bipartisan support last Congress with 65 cosponsors.

The introduction of MAASA coincides with annual World Hearing Day. This public awareness event spearheaded by the World Hearing Organization (WHO) includes a global call for action to address hearing loss and ear diseases across the life course. Projecting that 1 in 4 people around the world will suffer from hearing loss by 2050, the WHO has released the first ever World Report on Hearing to call attention to the need for action across nations.

AAA, ADA, and ASHA continue their collaborative efforts to advance a unified approach to expanding access to and coverage of audiology services to the millions of Americans in the Medicare system. A similar bill introduced by Senators Elizabeth Warren (D-MA) and Rand Paul (R-KY) in the last Congress also secured significant bipartisan support.

For more information, visit:

American Academy of Audiology at www.audiology.org

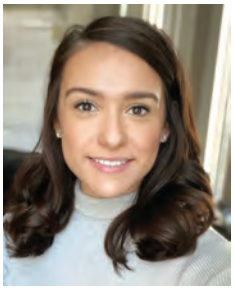
Academy of Doctors of Audiology at www.audiologist.org

American Speech-Language-Hearing Association at www.asha.org

Meet the Student Academy of Doctors of Audiology (SADA) Leaders

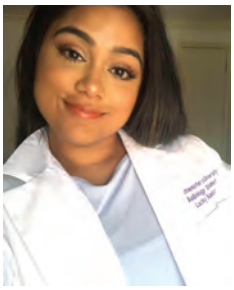
President

Glenn Elms is a 4th year Au.D. student at Salus University. His interests include geriatrics, tinnitus relief, and balance disorders. He currently is an extern at a private practice in Lancaster, PA where he sees adult and pediatric hearing aid fittings, tinnitus evaluations, and newborn hearing screenings. He uses his free time during quarantine to cook more and learn how to knit. He was on the board last year as member relations chair and is excited to serve as president this year.



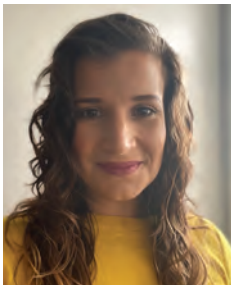
Vice-President

Tamahra Navarrete is a 1st year Au.D. student at A.T. Still University in Mesa, Arizona with an undergraduate degree in Speech and Hearing Sciences from Arizona State University. Her interests include both geriatrics and pediatrics, cochlear implants, intraoperative monitoring, and advocating and raising awareness for underserved communities. In her spare time, Tamahra enjoys hiking, weight training, reading, and spending time with her son Mason and the rest of her family.



Membership Relations Chair

Lucky Nanduri is a first year Au.D. student attending Northwestern University. She is currently exploring her interests in audiology through her classes but hopes to work in a VA hospital after graduating. A fun fact about Lucky is that she enjoys doing makeup.



Fundraising Chair

Heather Wibberley is a second year Au. D student at Towson University in Towson, MD. She is interested in pediatric and geriatric audiology, with a goal of increasing access to hearing health care to individuals in underserved communities. She is excited to be a part of SADA in her efforts to advocate for audiology as a profession and patients we serve. In her spare time, she likes to read, cook, run, and spend time outdoors.

Advocacy Chair

Ce'Nandra Frankin is currently a second year Au.D student at Idaho State University. Ce'Nandra is excited to learn more about how to advocate for the field of audiology. Her clinical interests include cochlear implants, vestibular testing/ treatment and working with special populations such as children and persons that are bilingual. Her hobbies include dancing, cooking, going to the gym and hiking in the mountains.

Education Co-Chair

Cindy Jimenez is a second-year Au.D. student at A.T. Still University in Arizona. After being a student liaison for SADA in Fall 2019, she decided to become more involved with SADA. She enjoys gathering information and sharing it with others. So, she stepped up and decided to run for the education chair. I am proud and honored to share this role with Garrett Findlater. Her goal as an aspiring audiologist is to connect with patients and their loved ones to improve their quality of life. She would love to help people overcome any hearing and balance obstacles that have caused a significant impact on their life. In her free time, she enjoys spending time with her family and going on mini-adventures.

Education Co-Chair

Garrett Findlater is a first year Au. D student at Wayne State University in Detroit, Michigan. He is most interested in electrophysiology and its application in intraoperative monitoring. He is passionate about the education of future audiology students and hopes to enrich the resources available for current Au.D. students during his time as a co-chair. In his leisure time he likes to kayak, cook spicy Thai food and read anything by John Irving.

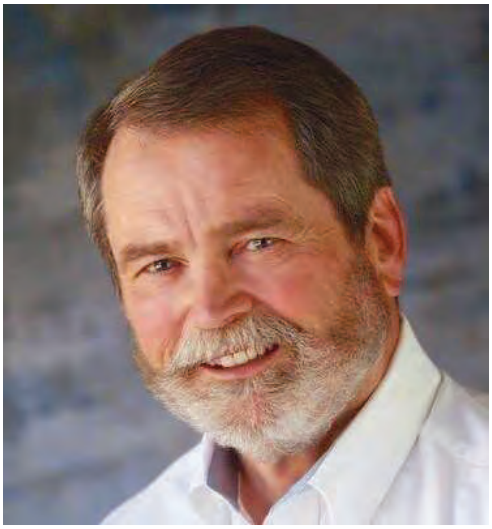
Communication Co-Chair

Kristen Grosso is a current SADA communication Co-chair who is grateful to share this position with Abigail Possinger. Her current role as the Diversity and Inclusion chair of her audiology cohort is what gave her the confidence to take on this position in SADA. She is a first-year student at Wayne State University and is currently gaining experience through clinical rotations at the Henry Ford Hospitals in Michigan. She is entering this field with an interest in private practice, research in vestibular disorders and rehabilitation. When she isn't occupied by school, Kristen enjoys drawing, traveling, and playing the piano.

Communication Co-Chair

Abigail Possinger is the current SADA communications co-chair. She brings experience to the table through her current role as secretary of her audiology cohort and her role as a Pennsylvania Academy of Audiology student ambassador. She is a fourth-year student at Salus University and is currently completing her externship at The Hearing Center at Connecticut ENT Medical and Surgical Specialists, PC. She enjoys working with pediatric patients, the D/deaf community, and a range of hearing assistive technologies. In her spare time, she practices her skills for roller derby and watches her favorite horror movies with her girlfriend and their pets.

Please contact info@audiologist.org to volunteer on a SADA committee.



In Memoriam: Michael K. Thelen, Au.D.

Neenah, Wisconsin - Michael K. Thelen passed away peacefully at home in the presence of his loving family on Friday, January 15. He was born on September 1, 1948 in Menasha and lived in Neenah and spent most of his life in the surrounding cities of the Fox River Valley of Wisconsin.

Michael was passionate about Audiology and was a torchbearer for the Au.D. movement. He was an active and longstanding member of ADA when it was the Academy of Dispensing Audiologists and all the members were able to fit in one room. In 1995 he was one of 200 audiologists to meet in Atlanta for the Au.D. Standards and Equivalency Conference. He completed his Au.D. degree from Arizona School of Health Sciences, AT Still University. He started his own practice, Audiology & Hearing Services Inc. in 1984 and retired from practice in March 2018.

If starting and running his practice and working as a torchbearer for the Au.D. movement wasn't enough to fill his days, he served eight years as the audiologist on the Hearing and Speech Examining Board of the Wisconsin Department of Regulation and Licensing, was president of the Wisconsin Alliance of Hearing Professionals, and was voted Wisconsin's "Audiologist of the Year" in 2004. He was active in the Wisconsin Speech and Hearing Association's audiology network, working tirelessly to promote the profession that he loved and challenging others to higher standards of patient care and practice.

Michael leaves a legacy of advocacy and service not only to his profession but to his patients. He contacted area insurance providers and persuaded them to include insurance coverage for hearing instruments in their plans. This led to other insurance plans around the state adding these benefits to remain competitive.

In his obituary, his family noted, "Michael consistently demonstrated living life to the fullest including learning to fly a plane, sail, earning the Civilian Medal of Gallantry, working with the Special Olympics, and swimming across Lake Winnebago. An avid traveler, Michael was able to see many parts of the world and enjoyed numerous hobbies such as golf, riding his Harleys, and tinkering around his home. In the end, his best and favorite accomplishments were being a husband, dad, and a grandfather. In recent years, his grandchildren were his newest passion and the light of his life."

Michael is survived by Cheryl, his loving wife of 47 years, his children Kimberly (Eric) Phillips, Michele (Ryan) Tuomi, and grandchildren, Tate, Trent, Brooke, and Kyla.

Submitted to ADA by Veronica H. Heide, and Doreen Jensen colleagues and friends of Michael for many years.

▶ Please contact Stephanie Czuhajewski at sczuhajewski@audiologist.org for more information about ADA, ADA membership, and opportunities for advancing your audiology career through involvement with ADA.

INSIGHTS FROM THE OUTSIDE

A New Look at Today's Hearing Healthcare Patients – Active Agers 55+

Insights from the Outside is a group of practicing clinicians — owners from multiple healthcare disciplines including dentistry, audiology, ophthalmology and veterinary medicine. Uniquely created by CareCredit, the group's purpose is to capture and share "best practices" to some of the common challenges all healthcare business owners face, such as attracting new patients, patient barriers to care, care acceptance, patient retention, social media, team training and empowerment, and much more. Recently, the panel reached out to leading experts in various fields such as branding and marketing asking them to share their knowledge as it relates to the hearing healthcare industry. In this article Jeff Weiss, President and CEO of Age of Majority, a marketing agency and consultancy that specializes in Active Aging consumers, shares insights into how businesses can optimize opportunity with these valuable and often overlooked consumers.

There are a lot of myths and stereotypes about who the typical hearing device wearer is, how old they are, what they look like, etc. You've recently completed some research on this topic, can you share some of those findings?

WEISS Absolutely. We began by trying to get a sense of behavior. So, the first thing we asked was how often are you getting your hearing checked. We surveyed men and women from across the country, Active Agers who are 55+, and our results show that 14% of Active Agers have their hearing checked annually and 30% have their hearing checked every few years*. It's probably not surprising that men are more likely to get their hearing checked than women. In fact, they're twice as likely to have their hearing checked every year.

Is the prevalence of men having their hearing checked more often due to the professions they may be in or are there other contributing factors?

WEISS Based on what I've read there isn't a real definitive answer to that question as of yet. A lot of it does appear to be related to occupation or lifestyle. Men tend to be in workplaces where there are much louder noises so that's what they think may be causing the difference.

What other results did your survey reveal?

WEISS Additional findings include that about a quarter of people we surveyed have never had their hearing checked. The reasons cited for this were they "don't think a hearing check-up is needed," and they "don't have the money to pay for hearing care." Of the 14% of Active Agers who get their hearing checked annually — 19% of them have been diagnosed with hearing loss and out of those about a third have gotten a prescription*. As you start going through the numbers — how many people get checked (14%), how many of those people are diagnosed (19%), how many of those people are prescribed (20%)* — you see the bigger picture that very few patients end up with prescribed hearing devices.

I believe the market and the providers would agree with you. Patients who are tested but not treated are actually quite common. For some reason — maybe it's the stigma of wearing hearing aids or maybe because of cost — these patients don't move forward with actually getting the help they need from a device perspective. Have you found that in your research as well?

WEISS Yes, you are absolutely right. Even when you look at the people that have hearing aids, only 44% of those individuals we surveyed, wear them all the time*. That's less than half. When you consider the numbers, I've heard 80% of people who need hearing aids don't get them*, and then you see that the majority of those who do get them, don't wear them regularly, you have to wonder why people aren't wearing them all the time. People in our survey said various things from, "they don't help," and "the batteries aren't that great," to "they're too expensive to wear every day" and "I've lost them". So, there are a lot of reasons patients don't wear hearing devices including stigmas and stereotypes about hearing aid wearers.

Did your research reveal anything more about how patients feel about hearing devices?

WEISS Absolutely, and the good news is that about three quarters of all respondents said the benefits of wearing hearing aids outweighed the negatives and outweighed the stereotypes. The bad news is that about 40% believe wearing hearing aids make you look and feel old. That's just one of those lingering perceptions that continues to exist. As soon as you say "you need a hearing device" it's interpreted to mean because you're old. And that's the kiss of death. It's the biggest stigma that is focused on when it comes to hearing aids. In addition to that 30% of respondents say that hearing devices are ugly.

Overcoming the reasons why people don't want to wear hearing devices has been an issue in the industry for many years. First to get the patient to realize that they need a hearing aid, or something to help their hearing and then once they do purchase, to get them to wear them. Were you able to uncover any insights that may help with that challenge?

WEISS A lot of it falls on the manufacturers. For example, when we asked, how can more people be encouraged to wear recommended hearing devices, 88% of respondents suggested smaller and invisible product design in devices and we are starting see more of those. Better sound quality, that's something that is also already improving a lot. Three quarters say more stylish design and colors to reflect different skin tones. I think that is a big, big opportunity. You know you think about eye wear, which still has some stigma, but if you think about the great job that a lot of these eyewear companies and glass companies do, in

terms of making stylish designs, I'm not sure why that can't happen in the hearing aid industry as well. When it comes to technology, 71% of respondents say better connectivity to devices through Bluetooth would really encourage more people to embrace hearing devices*. Again, we are starting to see more of that as well. At the end the day when you look at how hearing aids are marketed and sold, a lot of it is just functionally. The reality is consumers want to know how this is going to help my lifestyle. That's what providers need to focus on. Yes, hearing aids are going to help you hear better, but what does that mean? It means I can have better relationships with my partner, my family and my friends. Focusing on the lifestyle benefits, that's where the big opportunity is and that's what providers need to communicate to overcome the stigmas that are out there.

Another area that I am sure your research has been exploring is the cost factor. What affect has the recent pandemic specifically and economic conditions in general had on the older consumer's financial situation? Are you finding that they are more cost conscious?

WEISS People who are 55+ account for 40% of all consumer spending*. Now obviously there are people of every age and generation that struggle with finances. But again, one of our myths' is "Don't forget about my senior discount." The reality is that older consumers have more money than anybody else. However, we did ask questions recently in our COVID-19 survey related to financial wellbeing and 25% of Active Agers are very or extremely concerned about their finances*. We did that study back in June of 2020 and while things are changing every day — people are looking at their portfolios if they've got investments, and it's been kind of a roller coaster ride. Some people have been laid off or let go so they have less money coming in. But many Active Agers are still kind of stay the course or not concerned at all.

It's also important to remember Active Agers want to stay as active as they can, and they are willing to spend money on things in order to be active. That's everything from healthier food which can cost more money to home renovations like an in-home gym. In fact, over half of all dollars spent on home renovations are done by Active Agers who are 55+*. So, in general, Active Agers are willing to spend money on their health. We shouldn't assume that they don't have the money or don't want to spend the money — particularly on hearing aids.

Even though many Active Aging consumers have money to spend on their healthcare needs, and some have Medicare or private insurance — many of them still have out-of-pocket costs that are not covered when it comes to hearing healthcare. That's why I think it's important to have different payment options available like the CareCredit healthcare credit card. I think it's also just as important for providers not to stereotype and present payment options to everyone. You never know who might be interested in getting hearing aids but would prefer to pay over time.

How can providers take the data and information provided in your survey results and proactively use it to benefit their practice? Are there a couple of things you would suggest?

WEISS Absolutely. You know we asked some questions in our survey this week — specifically around what can practices do better, and you know the first is to offer more telehealth services. We asked people, what percentage of you have used telehealth and nearly 40% of the respondents are using it now*. So, again if someone has the belief that the active aging population is computer shy or thinks "no I want to see my doctor in person" it's more myth than fact. We are in different times now and a lot of people are using telehealth and loving it. And the people that aren't using it, many of them say that they would consider using it in the future. So, in terms of what providers can do, the first thing that our survey said is to offer more telehealth services, with almost 60% of them saying that is something that they would like to have as an option now*. Not surprisingly with the recent pandemic, better social distancing was important. Over a third of people surveyed mentioned it as a concern when going to the doctor's office. But it's not just about social distancing, people want to understand how the doctors are handling, and how the offices are handling the overall visit. Including wearing masks, what's the doctor going to be wearing. If I am getting blood taken, what is the procedure, etc.

Other insights include offering more weekend and evening appointments. This is really about flexibility but over 30% of people mentioned it*. Obviously, some practices can offer this and other may not be able to. Another answer was insuring on time visits. People don't want to sit around waiting, so on time visits are really important. We also asked what practices can do to better connect with their audiences. Improving electronic communications, like better and more emails was mentioned by over 40% of those surveyed.* The trust level with healthcare practitioners is so fundamental. One way that providers can help foster trust is through communication so I would over communicate over anything else. One last item mentioned in the survey was in home visits and it was also pretty high up on the list. Of course, this harkens back to a long time ago, but I think it's a real opportunity for someone who wants to venture into that space with over 20% of people saying it was something they would like*.

With the recent pandemic and other challenges we are facing today what are the key takeaways that you think providers should take away from your research and its' findings during this time?

WEISS I have four key takeaways, the first is to really focus on mental health, and what you can do to help patients deal with any challenges related to that. You know, physical heath is important, but the pandemic has really put increased emphasis and more anxiety on people when it comes to their mental health, particularly when you think about isolation and things like that, whatever you can do, and that includes hearing aids to help that, would go a long way. The second key takeaway is to forget about the myth that older people are technologically challenged, they can't use their phones, they are not online. Embrace digital — everything from your website and how you communicate with patients online, to how you deliver your services, rather it be through telehealth, or other delivering methods, think digital, because that's how people want to be communicated to and with. Third, get rid of those ageist ideas when it comes to hearing aids. There are generally two reasons why people don't want to wear hearing aids, one is because of the myths and stereotypes. Counter that thinking by focusing on the benefits that come with better hearing. It's all about lifestyle, being able to be active and engage, because that's what people are really looking for. The last key takeaway and the other reason why people are hesitant or don't really want to get hearing aids, is really about the cost associated with them. So being able to offer patients different payment options when it comes to buying hearing aids is important. It's also important to equate the purchase back to lifestyle terms. When you say to a patient, "The cost of your hearing devices is a very small price to pay when you think about the benefits related to your lifestyle. Engaging with the people you love, family and friends, being able to do all of the activities that you want to do — that you'll be able to do so much better if your hearing is corrected" it helps them to connect with the emotional benefits and not just the functionality. ■

*Based on a survey (conducted November 2020) by Age of Majority of more than 600 adults 55+ who are members of Revolution55, Age of Majority's online insight community.

Contact Your Legislators!

Urge them to support the **Medicare Audiologist Access and Services Act** (H.R. 1587)

ADA
ACADEMY of DOCTORS of AUDIOLOGY®

The Medicare Audiologist Access and Services Act of 2021 (H.R. 1587) will remove unnecessary barriers, allowing patients to receive appropriate, timely, and cost-effective audiologic care. This legislation can improve outcomes for beneficiaries by allowing direct access to audiologic services and streamlining Medicare coverage policies so that audiologists can provide the full range of Medicare-covered diagnostic and treatment services that correspond to their scope of practice. The legislation would also reclassify audiologists as practitioners, which is consistent with the way Medicare recognizes other non-physician providers, such as clinical psychologists, clinical social workers, and advanced practice registered nurses.

Support the future of audiology!
Contact Congress today and express your support for H.R. 1587.

Visit chooseaudiology.org/support and contact your congressperson today!

HEADQUARTERS REPORT

Continued from page 9

Interstate Compact. Another state initiative is the Audiology & Speech-Language Pathology Interstate Compact (ASLP-IC). The ASLP-IC is a cooperative agreement among participating states which will facilitate the practice of audiology and speech-language pathology across state lines, by allowing audiologists licensed in participating states to practice in other participating states using their home state license. If the interstate compact is enacted, an audiologist practicing in a member state would be required to adhere to that state's scope of practice. The ASLP-IC is expected to become operational within the next year once it is enacted by 10 states.

The above are but a few examples of areas where state laws intersect with the practice of audiology. ADA encourages you to be actively involved with your state association—and is currently offering financial incentives for members who say "I do" to state membership dues. Visit https://audiologist.org/item/collect-your-ada-reward-for-saying-i-do-to-state-dues for more information! ■

THE SOURCE

Continued from page 45

6 Read your managed care agreement, provider manual, and medical policies for every payer you agreed to participate.

Managed care is a game. It is a game with published rules, which exist in the form of your agreement, administrative guidance, bulletins, and medical policies. We have to learn the rules to compete, and possibly win, the game. Knowledge equals power and power yields increased revenue. This, alone, will allow you to maximize reimbursement and improve cash flow (you will have fewer denials).

Let's do the math. You never realized that your payers allow you to bill them, or the patient, separately for real-ear measurement. You provide this service to 240 patients in a year at a cost of $75 per patient. Half of these patients were insurance cases where they allow $45 for the real-ear measurement. You receive an additional $14400 a year for billing for services you are already providing.

7 Reduce your costs of goods.

No hearing aid cures hearing loss. Every hearing aid still sends sound through a damaged peripheral and central auditory system. No hearing aid or hearing aid manufacturer are markedly better than the other. No hearing aid manufacturer or their representative is worth thousands of extra dollars in gearing aid cost. Negotiate your prices down to their bare bones. Rid yourself of business support, business development funds, rebates, marketing co-ops, and manufacturer "fluff" (gifts, lunches, events). Focus, solely, on getting the lowest price possible for the aids you are most comfortable fitting.

Let's again do the math. You dispense 20 aids. That is 240 aids a year. If you cut your cost by a mere $100 per device, you would add an additional $24000 a year to your bottom line for doing no additional work. ■

Dr. Kim Cavitt *was a clinical audiologist and preceptor at The Ohio State University and Northwestern University for the first ten years of her career. Since 2001, Dr. Cavitt has operated her own Audiology consulting firm, Audiology Resources, Inc. She currently serves on the State of Illinois Speech Pathology and Audiology Licensure Board. She also serves on committees through AAA and ASHA and is an Adjunct Lecturer at Northwestern University.*

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