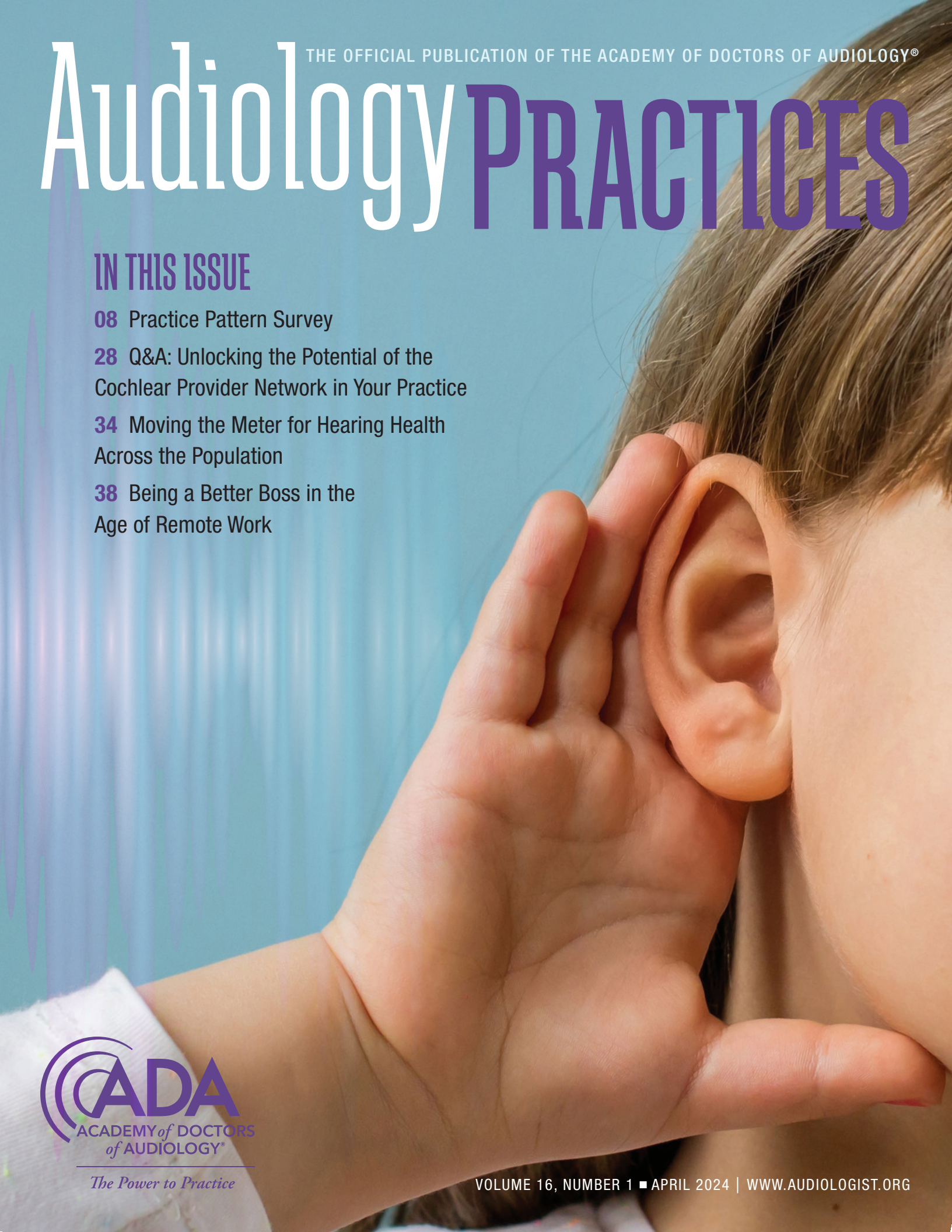
THE OFFICIAL PUBLICATION OF THE ACADEMY OF DOCTORS OF AUDIOLOGY®

Audiology PRACTICES

IN THIS ISSUE



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Jason Leyendecker, Au.D.

Fostering Communication and Collaboration to Achieve Common Goals

Former presidential speech writer, James Humes once wrote, "The art of communication is the language of leadership." I want to thank you for electing me as your president. It is an honor to serve the Academy of Doctors of Audiology (ADA) community. It has been 4 months now into my journey as president and it is proving to be a busy year.

It's ironic that our profession is a doctoring profession dedicated to improving communication, yet this is probably the area of improvement our profession needs the most. I'm not talking press releases and the valuable communications to our members; I'm talking one-on-one conversations to really understand what one person is thinking and saying. In a world where we consume so much information through social media, it is easy to have a one-sided view of any problem we see in our profession. We become very passionate about that view and will push hard to see that view go forward. All while putting opposing views in a box claiming they are not going to be effective for moving our needle.

I'm reminded about a book from one of my favorite authors, Patrick Lencioni who discusses teamwork in Five Dysfunctions of a Team. For a profession to move forward we need to continue to work on our teamwork skills. The five dysfunctions include, lack of trust, fear of conflict, lack of commitment, avoidance of accountability, and inattention to results. As an organization, we must create trust with our colleagues in other organizations, our manufacturing partners and our neighboring professions. The more we communicate with these organizations and build trust we can start working on things together. Conflict seems to be easy to create in our profession. Just look at any of the audiology Facebook pages. That said, constructive conflict leads to growth. It leads to being able to be open, honest, and respectful with people while discussing difficult challenges.

Commitment doesn't seem to be a problem within our organization; however, we could always use more committed people to ease the burden of those who have been helping the most within our organization. We can always use more committed audiologists ready to help when things get tough. Avoidance of accountability comes from not trusting each other and believing in the common objectives. If we do not create goals to commit to, we will always fall to the level of our weakest link. If we do not have accountability, we will not have the change necessary to move the needle. Lastly, our results must be measurable. ADA has a fantastic group of motivated individuals who want to move the needle, but we aren't always sure what that looks like. As practice owners we all have our key performance indicators that we track within our clinics, so we know we are effective in all aspects of our business. Why not create measurable indicators for change within our profession? Setting these measurable goals, we can ensure everyone knows what the finish line looks like and we can all take ownership of that!

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Brian Taylor, Au.D.

A More Nuanced View of the Hearing Care Market Has Finally Arrived

One positive development in 2024, that should continue to advance over the next few years, is how we view the market for hearing care services. Due to new research and fresh perspectives, we now have a much more nuanced view of the market for hearing care.

To fully appreciate our progress in better understanding the various market segments and how they might be of value to hearing care professionals, it helps to examine how market segmentation has evolved over the past decade.

Let's go back ten short years. It was the 2014 annual AAA meeting in Orlando, Florida (the final year of the legendary Trivia Bowl) and I was fortunate enough to be part of a panel hosted by Karl Strom and CareCredit. During that event, I discussed the slide shown in Figure 1. The consensus opinion is this little pyramid was first created by the late Bob Oliveira, CEO of Hearing Components in the 1990s. This much traveled pyramid still serves as a good, albeit crude way of understanding the untapped market for hearing devices.

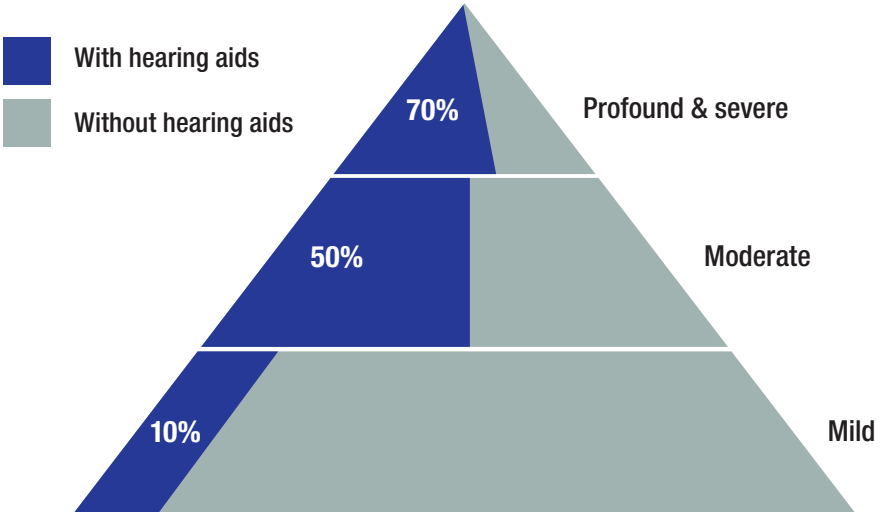

Figure 1. Estimated hearing aid uptake rates (blue section of triangle) as a function of degree of hearing loss.

For the unversed, what is illustrated in Figure 1 is an estimate of the number of hearing aid owners, striated by degree of hearing loss. Unsurprisingly, people with mild hearing loss by far have the lowest rates of hearing aid use. Considering Bob Oliveira was talking about this challenge thirty years

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Stephanie Czuhajewski, MPH, CAE, Executive Director

Advancing the Medicare Audiology Access Improvement Act: The Crucial Role of State Audiology Associations

The Medicare Audiology Access Improvement Act (MAAIA), H.R. 6445/S.2377, represents a monumental step forward in healthcare policy—streamlining access to audiological services for Medicare beneficiaries and appropriately recognizing audiologists as clinical doctoring professionals. While the legislation itself is a federal initiative, state audiology associations play an instrumental role in its advancement. State associations can leverage their unique position to advocate for change, educate stakeholders, and mobilize support at both the local and national levels.

State audiology associations are teeming with highly influential stakeholders (voters and donors) for federal legislators and are, therefore, at the forefront of advocacy efforts to promote the Medicare Audiology Access Improvement Act. I recently had the opportunity to provide a legislative briefing for the Oregon Academy of Audiology (OAA) on the status of MAAIA and the important position that Senator Ron Wyden (D-OR) has as Chair of the U.S. Senate Committee on Finance. In that role, Senator Wyden literally sets the agenda for Medicare policy considerations for the entire Senate. OAA leaders and members are working actively to engage and inform Senator Wyden and his in-state team about the importance of implementing MAAIA to improve the health and quality of life for seniors in Oregon and across the nation. ADA is grateful for these efforts, which will undoubtedly go a long way to advance the bill in this Congress.

Steps that State Associations Can Take to Advance the Medicare Audiology Access Improvement Act

1. Write a letter supporting MAAIA on your state association letterhead and email it to health policy staff (ADA can draft the letter and provide you with the contacts to whom it should be sent)
2. Organize a group of audiologists to attend in-state events where your members of Congress are speaking (oftentimes local chambers of commerce and other community-based organizations will host opportunities for business owners and/or citizens to meet with legislators).
3. Contact state consumer advocacy groups, in-state university audiology training programs, and organizations serving older adults, and ask for their support for MAAIA. The bigger the in-state coalition supporting the bill, the more likely members of Congress will co-sponsor it.
4. Ask your state association audiologist members to encourage their patients to contact their legislators' local and federal offices and ask for their support for MAAIA. Each legislator has a website with their local and D.C. office contact information.

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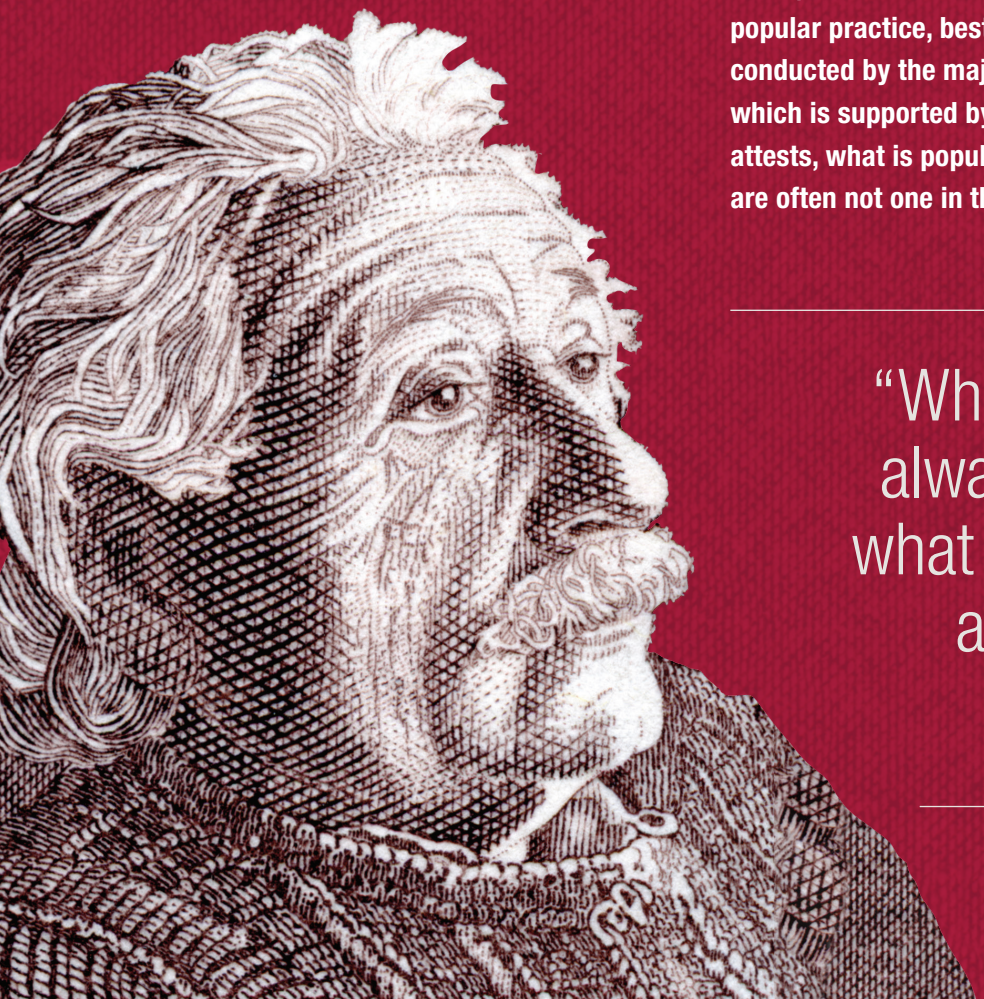
PRACTICE PATTERN SURVEY

What is **Popular Practice in 2024** and How Does It Compare to Current Standards?

Brian Taylor, Au.D. and
Kevin Liebe, Au.D.

Spend some time at Facebook's Audiology Happy Hour and you will see no shortage of hot takes on how or why various clinical tests or procedures should be conducted. Online forums might be a great place to share thoughts, ideas, and opinions on a variety of topics related to the practice of audiology, but how often do these views reflect best-practices?

Ideally, there should not be a noticeable difference between popular practice, best defined as the tests and procedures conducted by the majority of audiologists, and best-practice, which is supported by scientific principles. As the Einstein quote attests, what is popular and what is right (supported by science) are often not one in the same.



"What is right is not always popular and what is popular is not always right."

—Albert Einstein

Through a combination of innovative technological breakthroughs and emerging research that comes from well-designed studies, clinicians can refine their approach to the identification and treatment of hearing loss. However, many new ideas and approaches, even when supported by research don't always displace the inertia of popular practice: What we learned in school and in our early training may no longer be the "gold standard" of care, but many stay mired in their tried-and-true way of doing things, despite new evidence that doesn't support it.

As Doctors of Audiology, it is incumbent upon all of us to stay abreast of emerging evidence that could modify or even change the way we deliver care. But, considering the busyness of our daily lives, it is often difficult to break old habits and add a new wrinkle to our assessment protocol or workflow that might have better efficacy. Fortunately, we can rely on published standards and guidelines to direct us.

There is no shortage of clinical audiology guidelines that can be applied to the hearing aid selection and fitting process, although many of them are probably outdated. Since 1990, numerous hearing aid selection and fitting guidelines have been published including the Vanderbilt Report (1991), the Independent Hearing Aid Fitting Forum (1997), AAA's Adult Fitting Guidelines (2005) and others. More recently, the Audiology Practice Standards Organization (APSO) created a series of practice standards that can be implemented clinically to best achieve high quality patient outcomes. Regardless of the specific set of guidelines, there are several important reasons, according to Valente (2006), that necessitate following current guidelines:

- Promote uniformity of care
- Decrease variability of outcomes
- Promote better fitting practices
- Elevate the clinical care to our patients as well as elevate our profession
- Provide greater patient satisfaction
- Reduce the hearing aid return rate

Both standards and guidelines* are typically created by a panel of experts with decades of collective experience who create the standards after considerable vetting and debate. Once the panel agrees upon the standards or guidelines, they are published, or like in the case of the APSO standards, archived on a website. Given that the APSO adult hearing aid selection and fitting standard has had a chance to percolate for a few years (reviewed by Mueller et al, 2021), three years post-publication of the APSO standard for fitting adults with hearing aids seems like a good time to gauge if that standard has changed practice patterns.

Rationale and Methods

With an eye toward what might be considered best-practice, the aim of this survey was to assess what is popular practice in 2024. Further, the purpose of this survey was to obtain additional insights on how the APSO standards for fitting hearing aids on adults might be used by workaday clinicians who are juggling many responsibilities throughout their week. Toward that end, a 30-question survey was created in August 2023. The electronic survey was emailed on two separate occasions in October and November 2023 to a segment of the Hearing Healthcare Technology Matters (HHTM) database, comprised of 5,859 US-based audiologists. Of those receiving the emailed survey, 1824 opened the email and the entire survey was completed by 186 audiologists. Figure 1 shows the various clinical settings reported by these 186 respondents with the plurality of them working in a private practice setting.

**See Coverstone (2019) for a description of the differences between standards, guidelines and best practices.*

Figure 1. Clinical settings reported by the respondents.

In addition to their clinical settings, the respondents were asked about their years of clinical experience. Figure 2 summarizes the self-reported years of experience for the respondents. The mean years of clinical experience was 14.2 years.

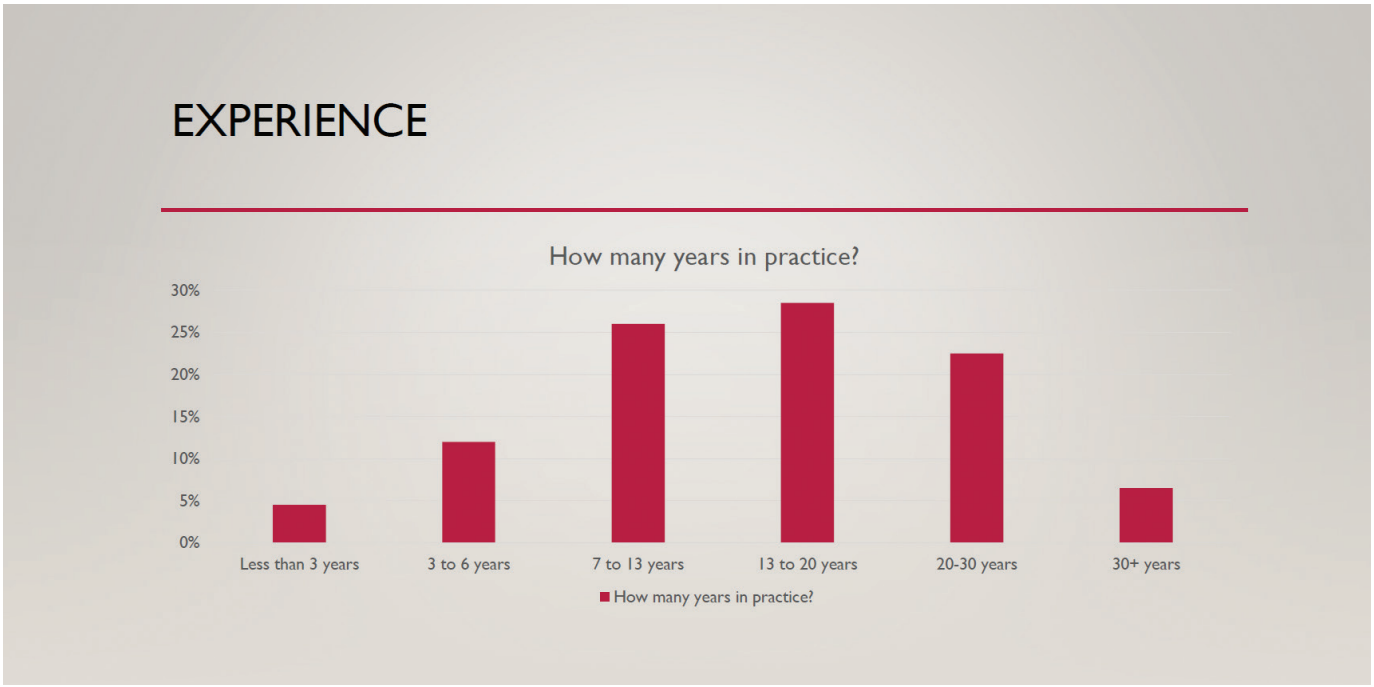


Figure 2. The self-reported clinical experience of the respondents.

Section 1: Clinical Procedures

The first half of the survey was devoted to specific clinical procedures conducted in the clinic on adult hearing aid prospects and candidates. The questions were sequenced in a manner similar to how adult patients would be assessed in the clinic, beginning with a communication needs assessment and ending with verification and validation procedures. The recently published APSO guidelines for fitting hearing aids on adults and geriatric patients (S2.1) served as a framework for the design of the questions. That is, survey questions were created that corresponded with several elements of the S2.1 standard. Additionally, other best-practice guidelines were used as a basis of comparison.

The Top-2 Box responses were used to determine what is "popular practice." Specifically, the Top-2 Box responses "always" and "routinely" were summed to determine what is "popular practice."

Pre-fitting Communication Needs Assessment

As APSO S2.1 asserts, "a needs assessment is conducted in determining candidacy and in making individualized amplification recommendations. A needs assessment includes audiologic, physical, communication, listening, self-assessment, and other pertinent factors affecting patient outcomes." Figure 3 shows the results for the question, how often do you complete a standardized needs assessment for a new patient. According to the survey, 69% of respondents routinely conduct a needs assessment using a standardized approach.

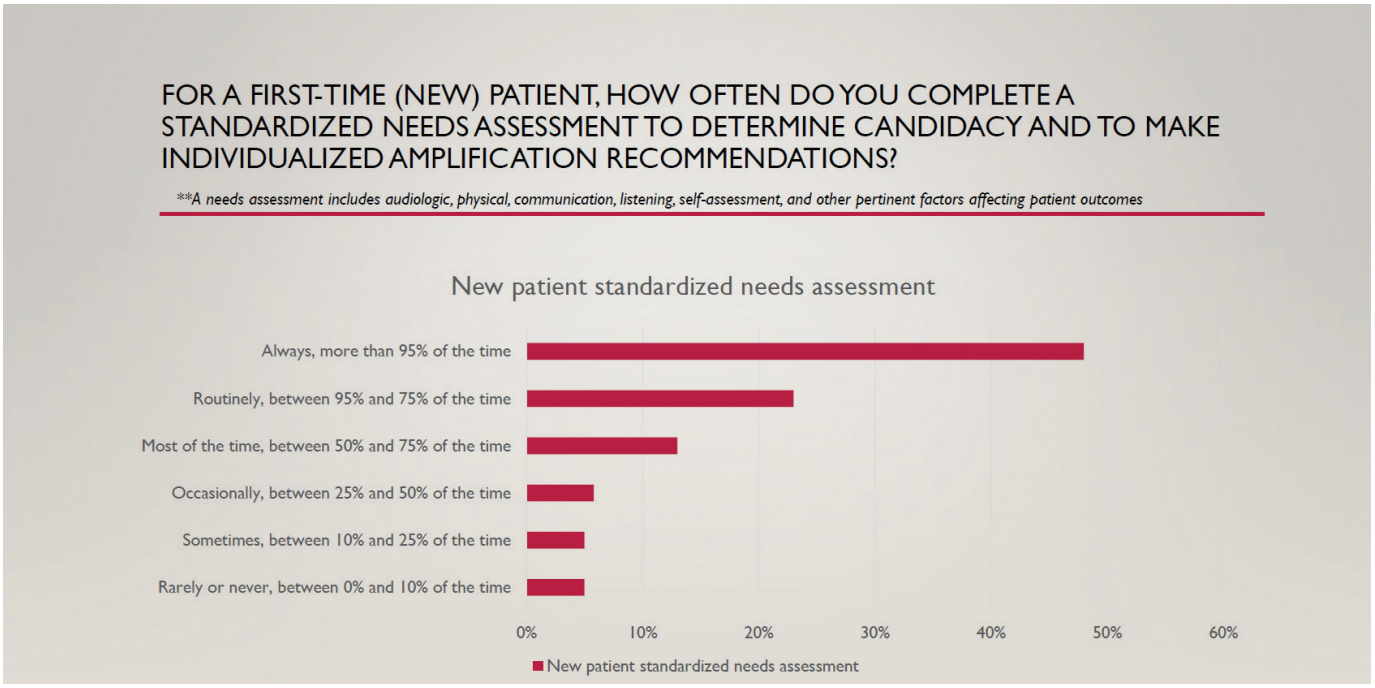


Figure 3. How often is a standardized communication needs assessment conducted.

Although the APSO standard is confined to "what" tests are recommended, additional information in this survey was gathered to understand "how" certain tests are conducted in the clinic. Figure 4 shows the various types of standardized communication needs assessments that are conducted in the clinic. By far, the Client-Oriented Scale of Improvement (COSI) is the most popular needs assessment used by respondents.

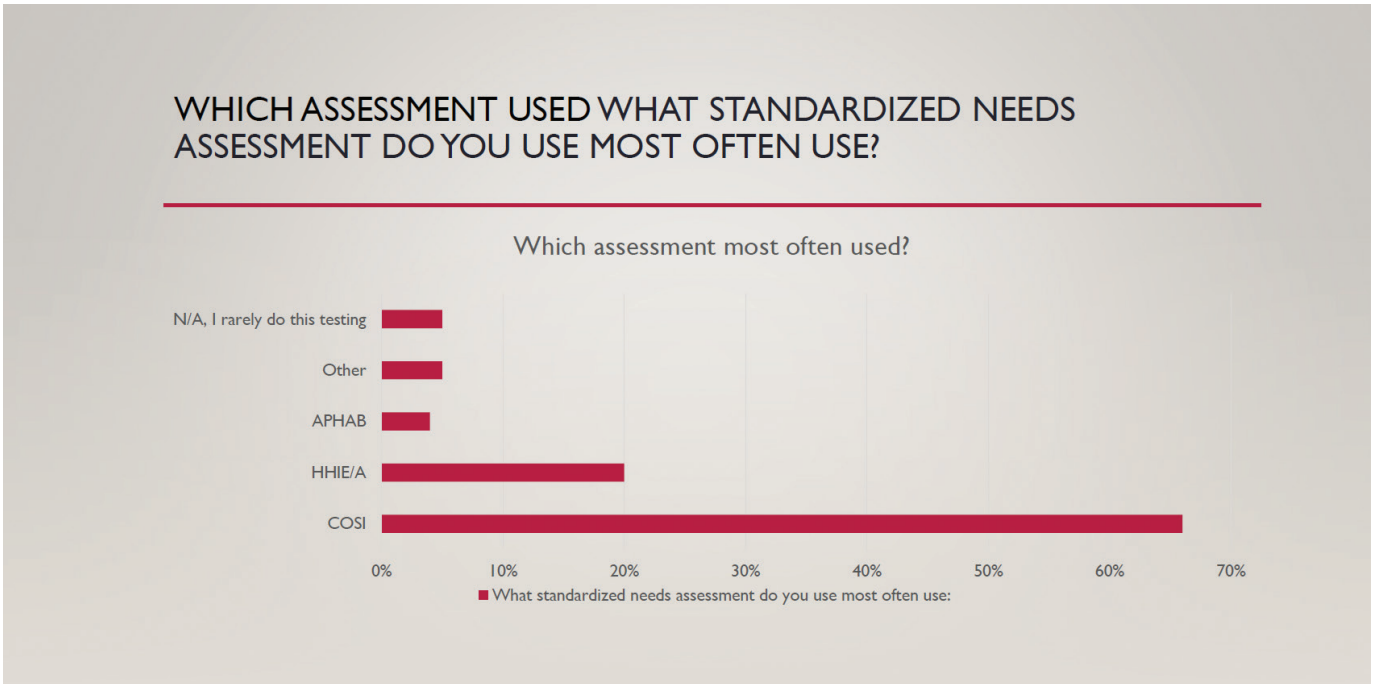


Figure 4. The most commonly used standardized needs assessment tools.

Pre-fitting Word Recognition in Quiet Testing

Although the APSO S2.1 standard makes no reference to conducting word recognition in quiet (WRQ) testing, APSO S3.1 Comprehensive Diagnostic Hearing Evaluation for Adult Patients says, a measure of speech recognition ability is obtained using recorded stimuli at a presentation level that is expected to approximate the patient's maximum performance. Additionally, there are specific guidelines outlining exactly how WRQ testing should be conducted. These guidelines, summarized by Mueller and Hornsby (2020) include the following:

- A presentation level that ensures audibility. The "2k + xSL" approach, outlined by Guthrie & Mackersie (2009), is the current standard approach to presentation level.
- Use of the recorded NU-6 "ordered by difficulty" 50-word list and conclude testing if the patient passes the screening guidelines.

The use of a recorded NU-6 ordered by difficulty word list has been part of standard WRQ testing for decades while the accepted standard practice for presentation level was published more recently in 2009. Further, the entire updated procedure that reflects current standards for WRQ testing has been published in its entirety twice: Hornsby and Mueller (2013) and Mueller and Hornsby (2020).

The survey asked a series of questions to ascertain if clinicians routinely conduct WRQ testing using these standards. According to the survey, 98% of respondents routinely conduct WRQ testing. However, the methods in which they conduct WRQ testing varies.

As Figure 5 shows, just under half (48%) of respondents indicated that they never use monitored live voice (MLV). In contrast, popular practice (52% of respondents either routinely or part of the time) is to rely on MLV. Use of MLV, according to the standards outlined by Mueller N Hornsby (2020), render WRQ testing invalid.

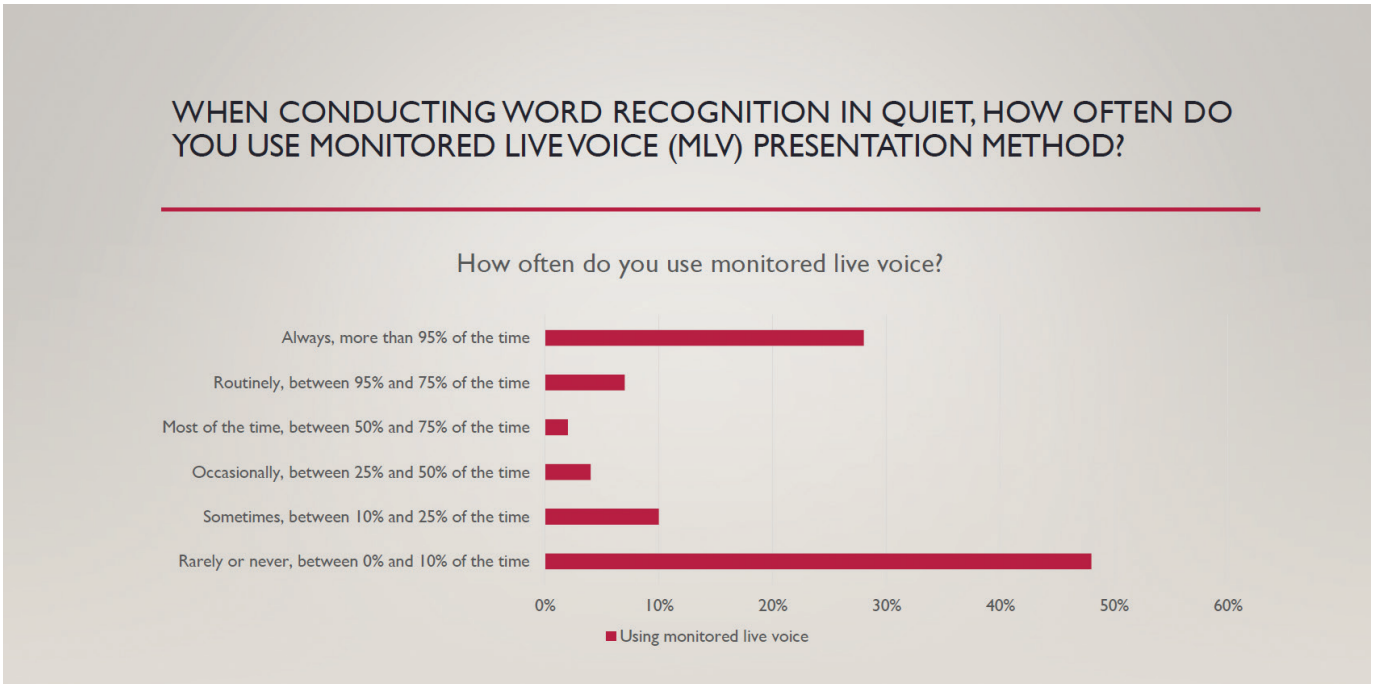


Figure 5. Percentage of respondents using monitored live voice (MLV).

As previously mentioned, the word list used to complete WRQ testing is an essential component of valid completion of this assessment. Both the W-22 and NU-6 have enjoyed widespread clinical use. However, because the NU-6 recording is "ordered by difficulty" it can be used in a validated way to shorten WRQ testing if the patient passes the screening guidelines. It is quite surprising, as depicted in Figure 6, that the W-22 is much more popular than the NU-6 and by a massive 69% to 30%.

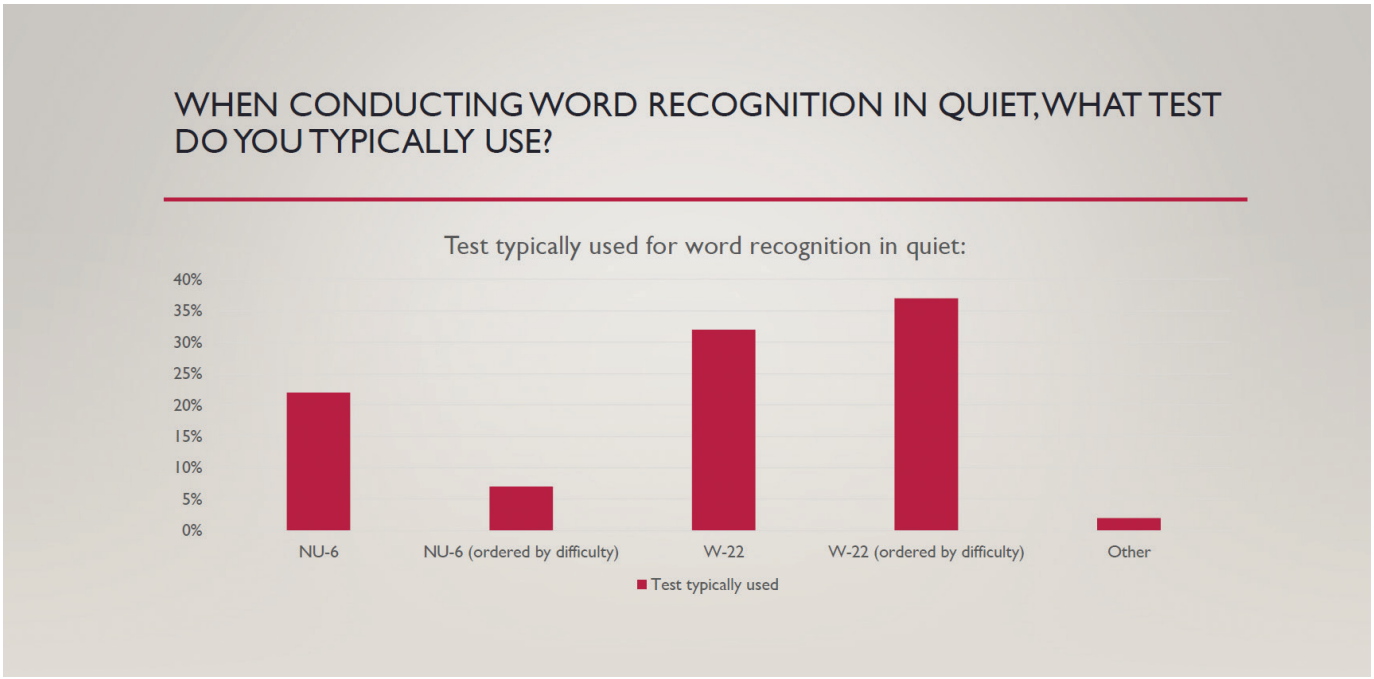


Figure 6. The type of word tests used by respondents.

As also previously mentioned, the presentation level for administering WRQ testing was established by Guthrie and Mackersie in 2009. In a nutshell, their approach uses the sensation level above the 2000 Hz threshold of the patient to establish the presentation level. Further, in their "2k + xSL" approach, when it is not feasible to conduct the test at this presentation level, the clinician should conduct WRQ testing at a "level just below the patient's uncomfortable loudness level (LDL)." According to Hornby and Mueller (2013), this approach replaces the antiquated "SRT + 30 or 40 dB SL" or "MCL" approaches. Unfortunately, according to the survey, those antiquated approaches are still the most popular, as shown in Figure 7. Results indicate that about one-third of respondents use the current standard approach outlined by Guthrie and Mackersie (2009) when conducting WRQ testing.

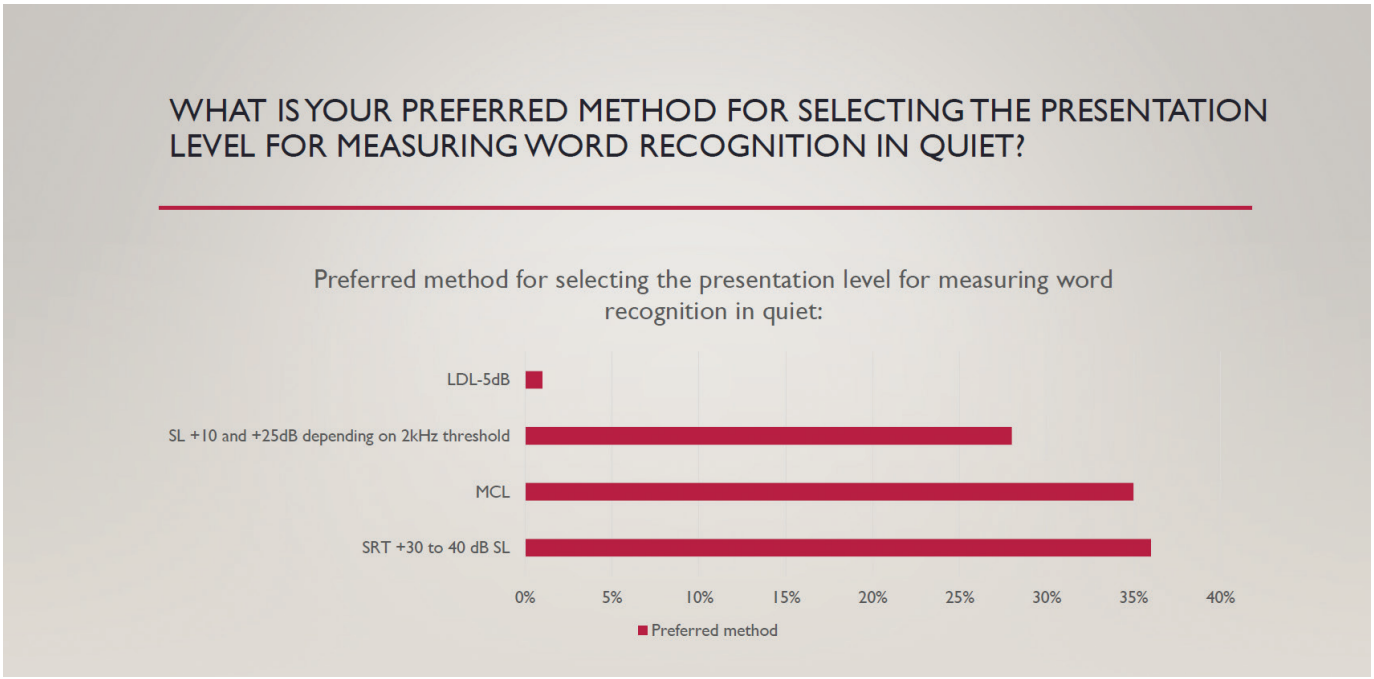


Figure 7. Presentation levels used to conduct WRQ testing.

Pre-fitting Speech in Noise and LDL Testing

As outlined in APSO standard S2.1, pre-fitting testing includes assessment of speech recognition in noise, unless clinically inappropriate, and frequency-specific loudness discomfort levels. As shown in Figure 8, approximately one-third of respondents reported that they routinely conducted speech in noise testing prior to selecting and fitting hearing aids. The most popular speech in test was the Quick SIN with 78% of respondents who routinely conduct speech in noise testing reporting they use that test. The other 12% who routinely conducted speech in noise testing used a smattering of other speech in noise tests including the AZBio, HINT and Words in Noise (WIN) test.

In accordance with the APSO standards that call for speech-in-noise testing to be part of the pre-fitting assessment, a recent award-winning peer reviewed article (Fitzgerald, et al, 2023) called for the Quick SIN to replace WRQ testing as part of the routine diagnostic hearing assessment. Based on their analysis of 5808 individuals undergoing Quick SIN testing, the predictive power of their model suggested that the Quick SIN can replace WRQ in most instances. They provided guidelines as to when performance in quiet is likely to be excellent and does not need to be measured. As the authors propose, switching practice patterns from WRQ testing to the Quick SIN as the default speech test would enable routine audiometric assessments to be more sensitive to patient concerns, and would benefit both clinicians and patients by completing speech testing quicker.

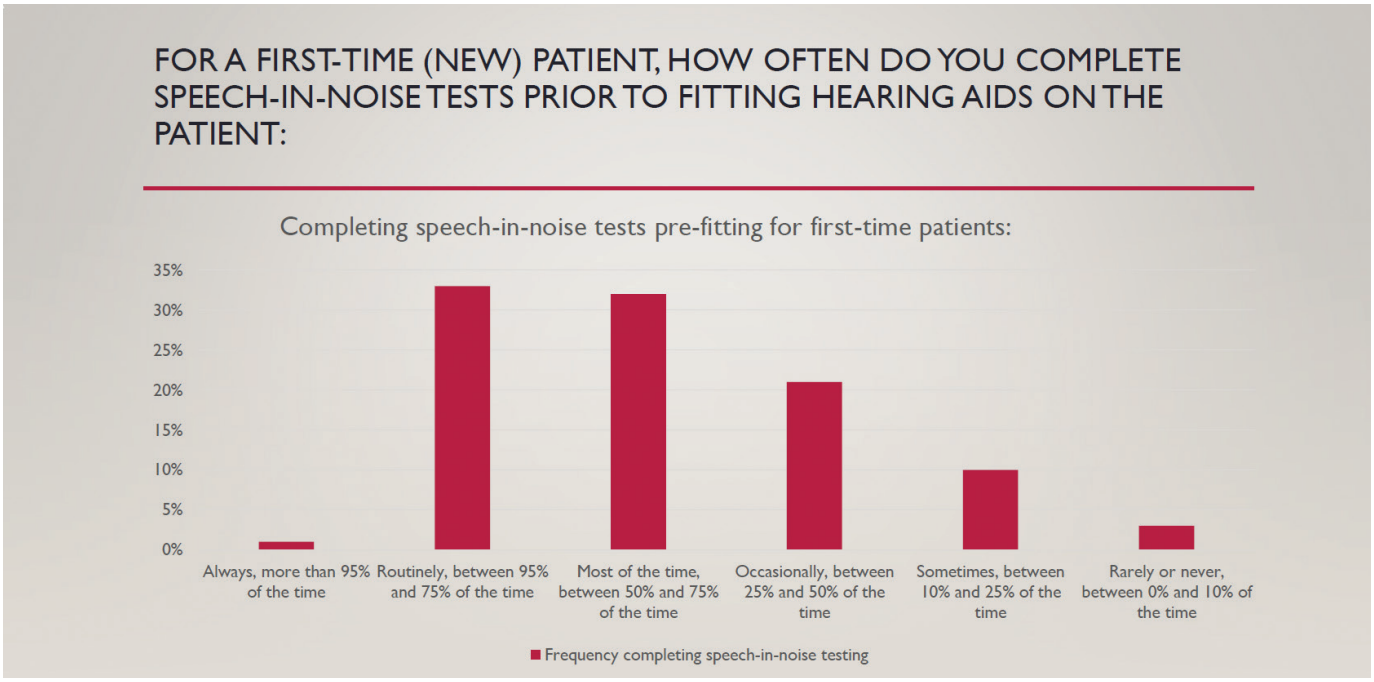


Figure 8. Percentage of respondents conducting speech in noise testing.

Unaided loudness discomfort level (LDL) testing is also a part of the S2.1 APSO standard. Even though it is part of the standard, it is not a popular practice as less than 25% of respondents (Figure 9) conduct it routinely. Not completing pre-fitting LDL testing implies that the audiologist is relying on either the manufacturer to determine the maximum power output (MPO) of the hearing aid or to use a predicted value that is based on the patient's threshold. According to data on MPO settings of all six major manufacturer's devices (Mueller, et al 2021), both these approaches usually lead to MPO settings that are well-below the patient's measured LDL. In some cases, according to their analysis, low MPOs will make the wearer's signal to noise ratio worse (when speech is above the noise) and consequently have a negative effect on speech understanding. These findings clearly support the need to conduct frequency-specific LDLs and use these values to program the hearing aids correctly, a practice that less than 25% of respondents conduct routinely.

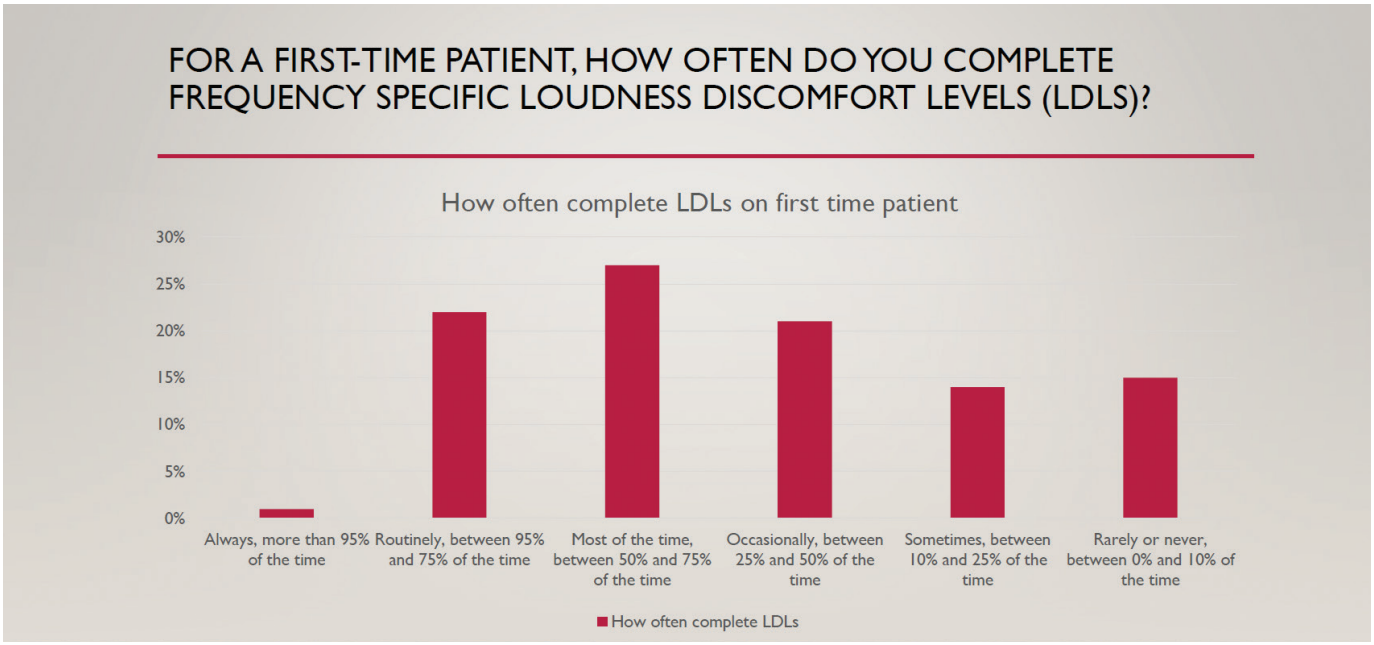


Figure 9. Percentage of respondents conducting unaided LDL testing.

Electroacoustic and Verification Measures

The APSO S2.1 standard calls for an assessment of initial product quality using standard electroacoustic measures to verify either manufacturer or published specifications. Figure 10 illustrates the percentage of respondents that routinely conduct this electroacoustic measurement standard. It shows that about 5% of respondents routinely conduct this measure. This suggests that clinicians trust the manufacturer's quality control process so much that most do not cross-check published specifications with their own set of test box measures.

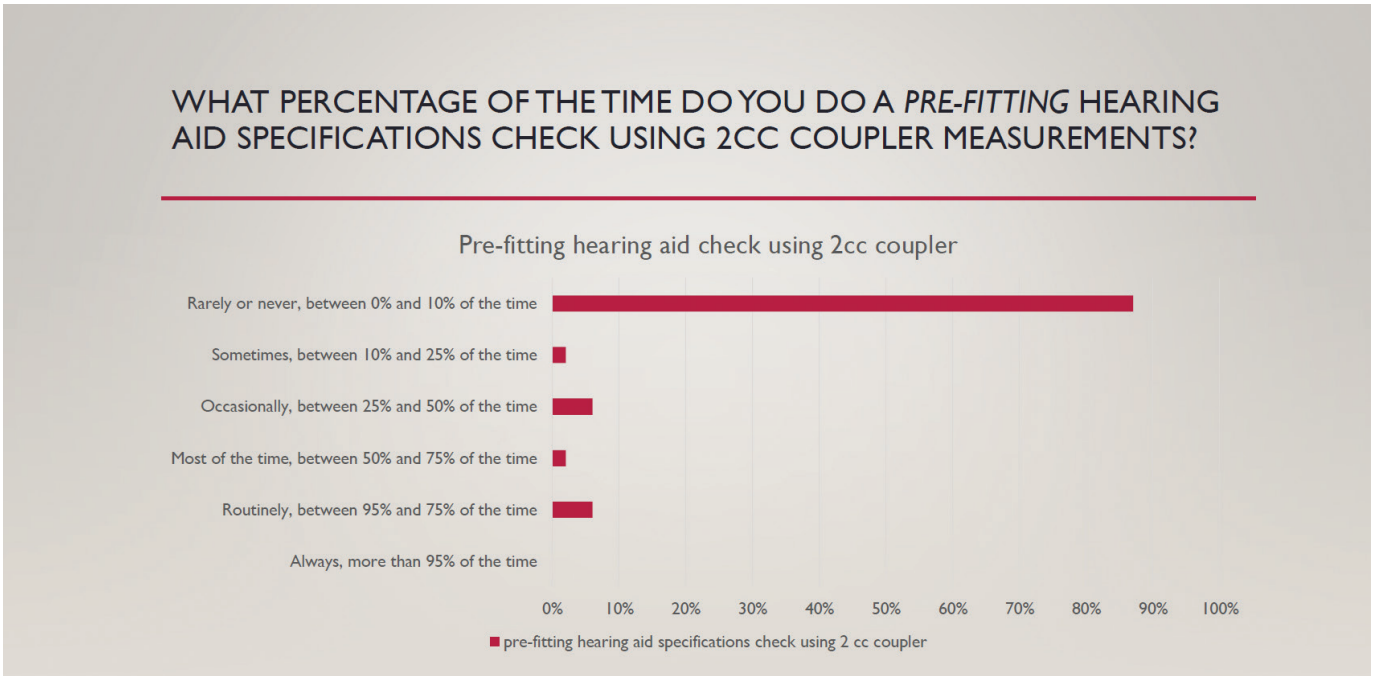


Figure 10. Percentage of respondents conducting electroacoustic measures in a test box.

Another essential component of fitting hearing aids is verifying that a prescriptive target has been matched. For decades, real ear measures (REM) have been the established method of verification. The APSO S2.1 standard calls for hearing aids to be fitted so that various input levels of speech result in verified ear canal output that meets the frequency-specific targets provided by a validated prescriptive method. The survey asked several questions to gauge whether any parts of this standard are popular practice. Figure 11 indicates that approximately 60% of respondents routinely conduct REM. On the other hand, 40% rely on a variety of less effective methods for verifying hearing aid performance in the ear.

Approximately 60% of respondents routinely conduct REM. On the other hand, 40% rely on a variety of less effective methods for verifying hearing aid performance in the ear.

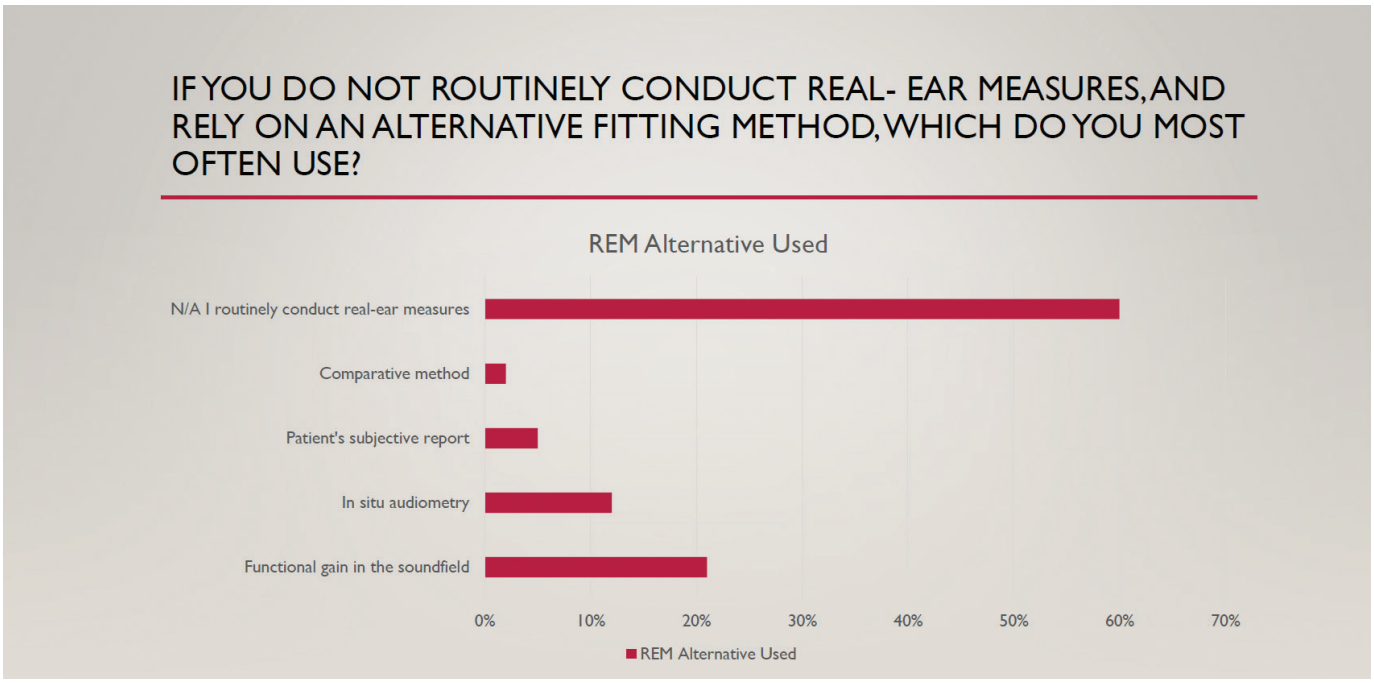


Figure 11. Percentage of respondents conducting real ear measures versus other methods

Figure 12 illustrates some of the reasons for conducting REM. As per the APSO standard, a *validated* prescriptive target, typically either the NAL-NL2 or DSL v5.0, and not a manufacturer's version of those targets or their proprietary target, would be matched. As noted in Figure 12, 44% of respondents following the ASPO standard, match a validated prescriptive target. Respondents were also queried about the input signal they use when conducting REM. It is well established that a calibrated "speech-like" input signal should be used. According to the responses, about 90% of those routinely conducting REM use a calibrated "speech-like" signal with less than 5% reporting they use an uncalibrated live voice to conduct REM.

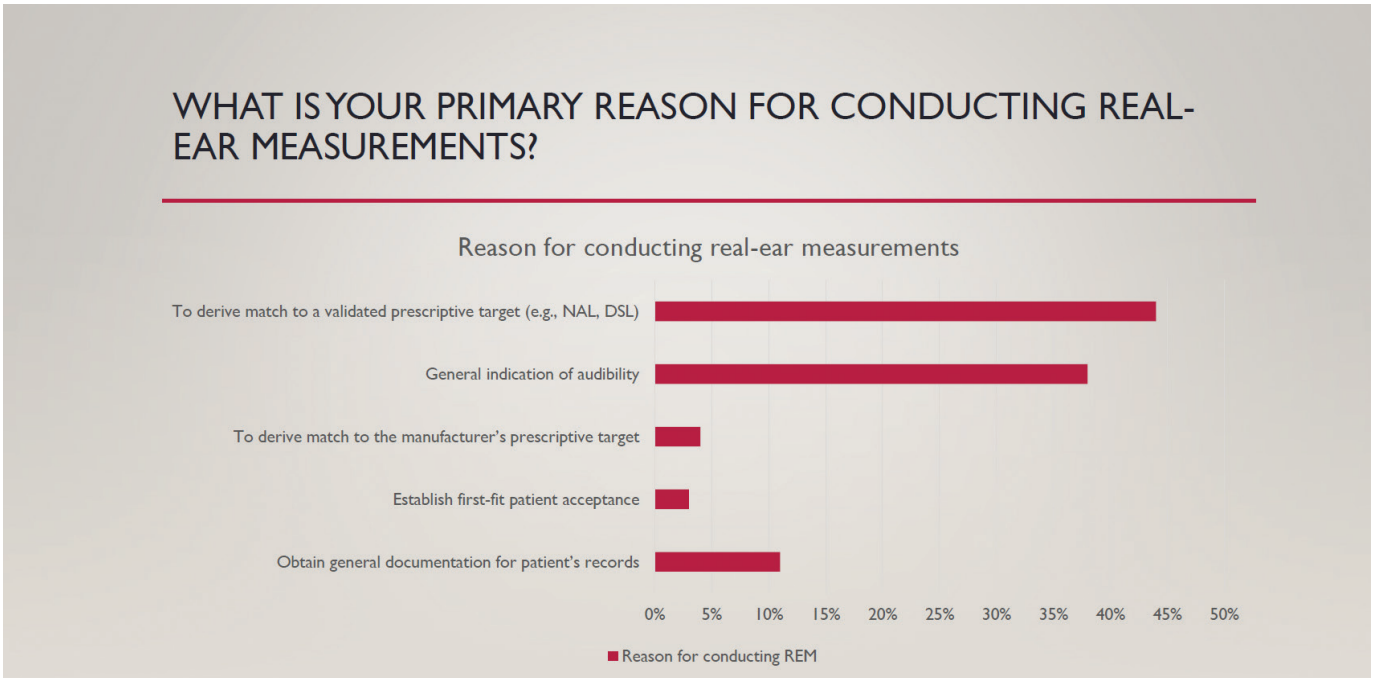


Figure 12. Reported reasons for conducting real ear measures.

Although not part of the APSO standard, autoREM measures have become widely available from most REM manufacturers. Recall that autoREM allows the REM system and hearing aid fitting software to "talk" to each other, making the verification process more time-efficient. According to the results in Figure 13, about one-third of respondents routinely use autoREM, while another third rarely or never use it.

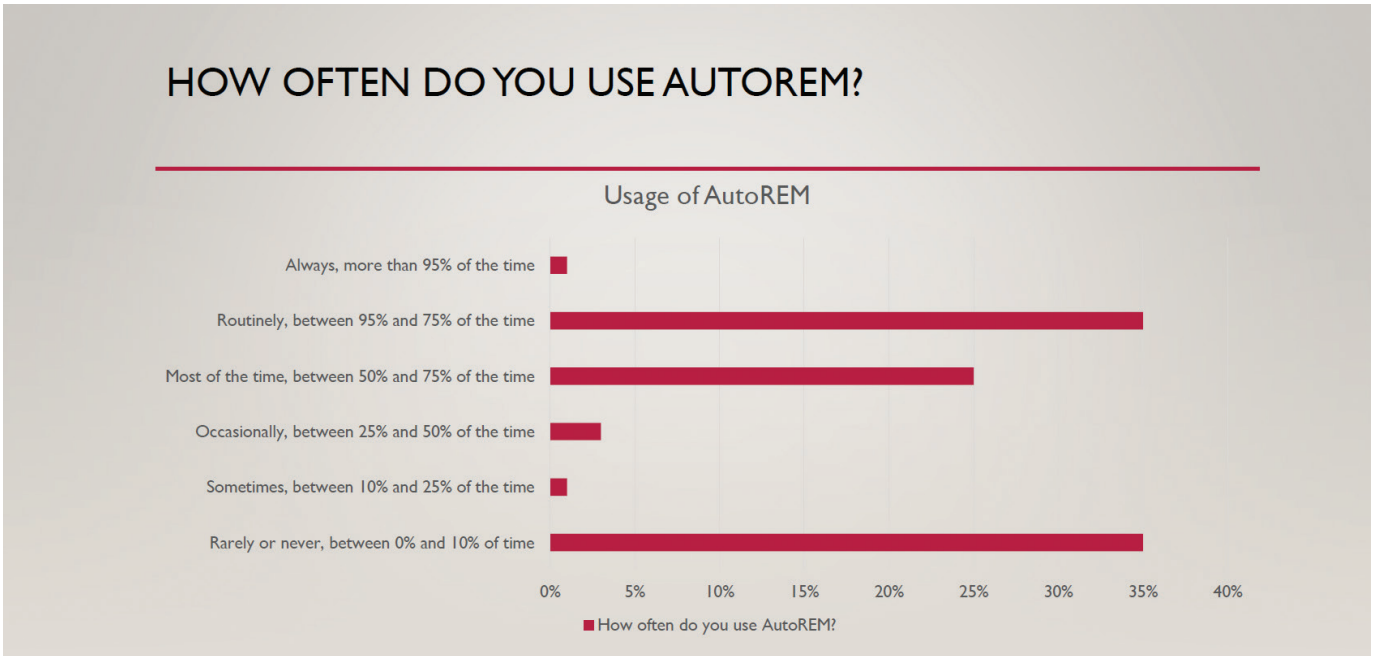


Figure 13. Percentage of respondents using autoREM.

A final APSO standard related to hearing aid verification states that the frequency-specific maximum power output is adjusted to optimize the patient's residual dynamic range and ensure that the output does not exceed the patient's loudness discomfort levels. This is a two-step process involving measuring the patient's unaided LDL and converting that LDL value (in dB HL) to dB SPL, and then using REM to verify that the maximum power output (MPO) of the hearing aid is just below the LDL. The REM term for this is the Real Ear Aided Response for an 85 dB SPL input (REAR85). Recall from Figure 9 that approximately 25% of respondents conduct unaided LDL measures, which is an essential part of the REAR85 measure. Figure 14 shows that just under 25% of respondents routinely conduct REAR85 measures, while an almost equal number rarely or never conduct the REAR85. Thus, measuring the REAR85, an essential part of ensuring the MPO is just under the wearer's LDL is not a popular practice.

Measuring the REAR85, an essential part of ensuring the MPO is just under the wearer's LDL is not a popular practice.

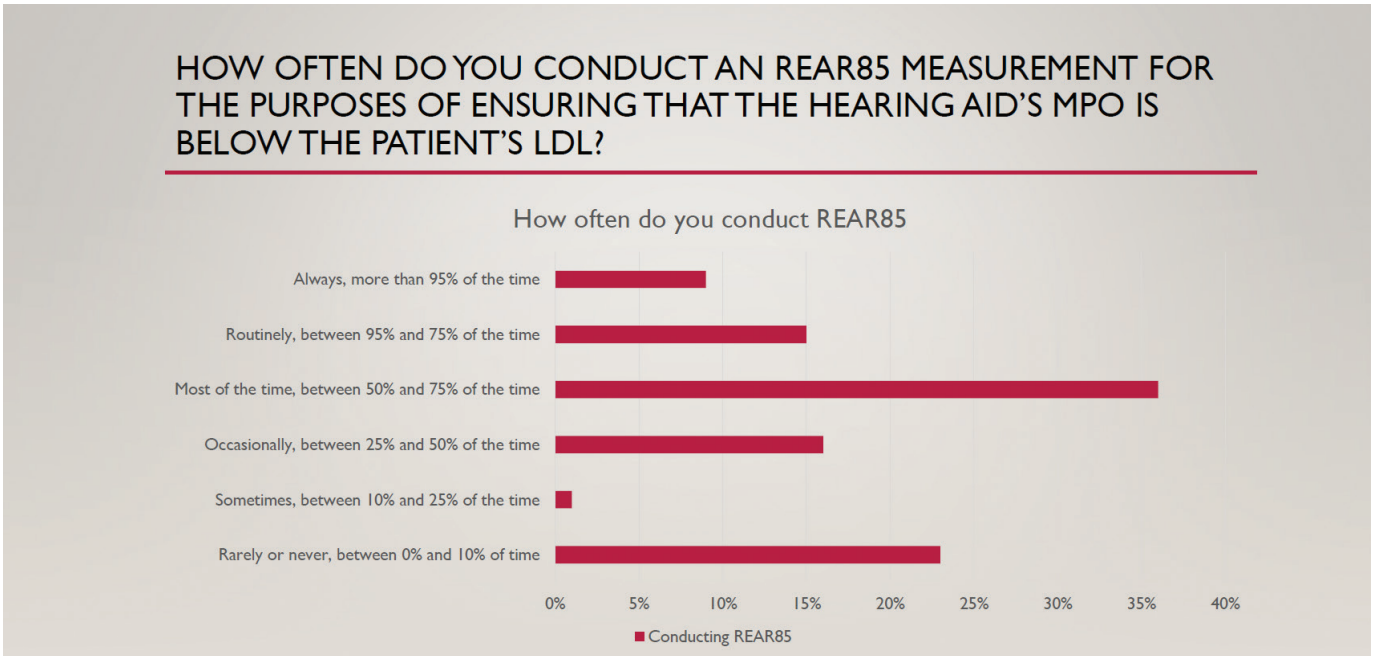


Figure 14. Percentage of respondents who conduct REAR85 measures.

The APSO S2.1 standard calls for the measurement of hearing aid outcomes using a validated self-assessment measure. Results of the survey show that about 65% of respondents routinely measure outcomes with a validated self-assessment, as depicted in Figure 15. Figure 16 shows the self-assessments that are most commonly used in the clinic, with the COSI being the most popular. Figure 16 also indicates that 35% of respondents report that they rarely or never measure outcomes.

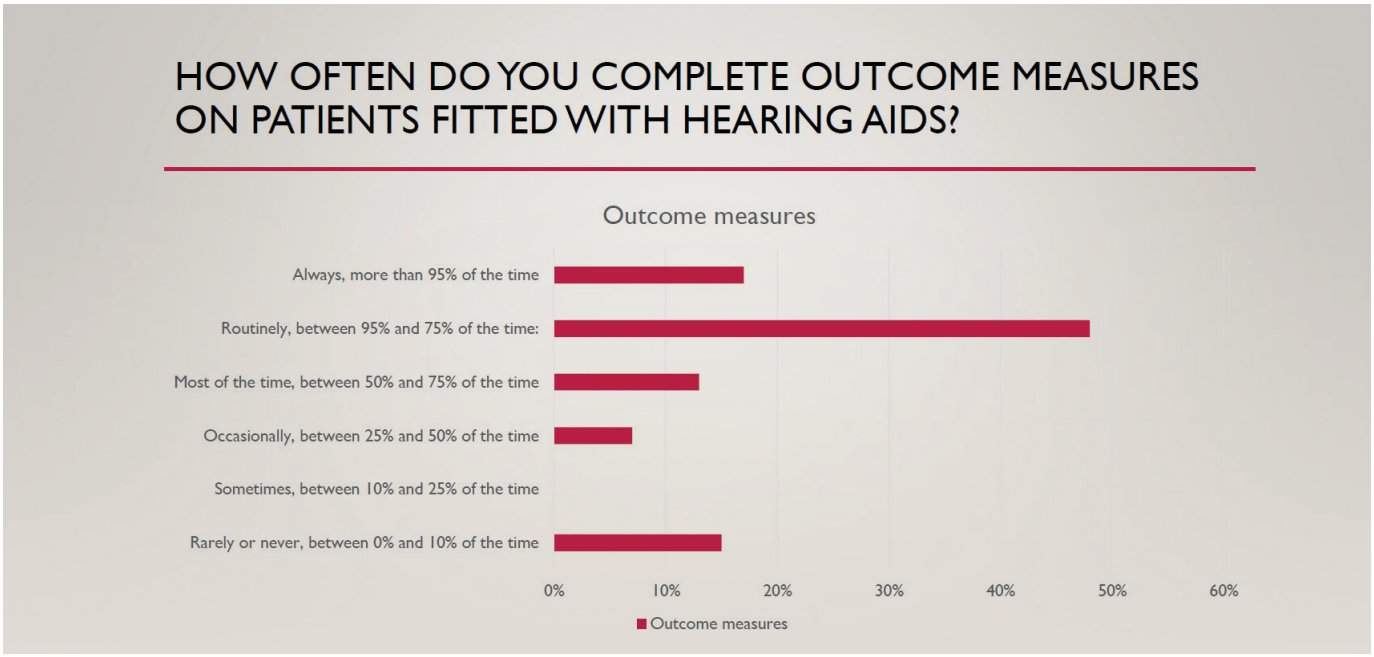


Figure 15. Percentage of respondents who measure outcomes with a validated self-report.

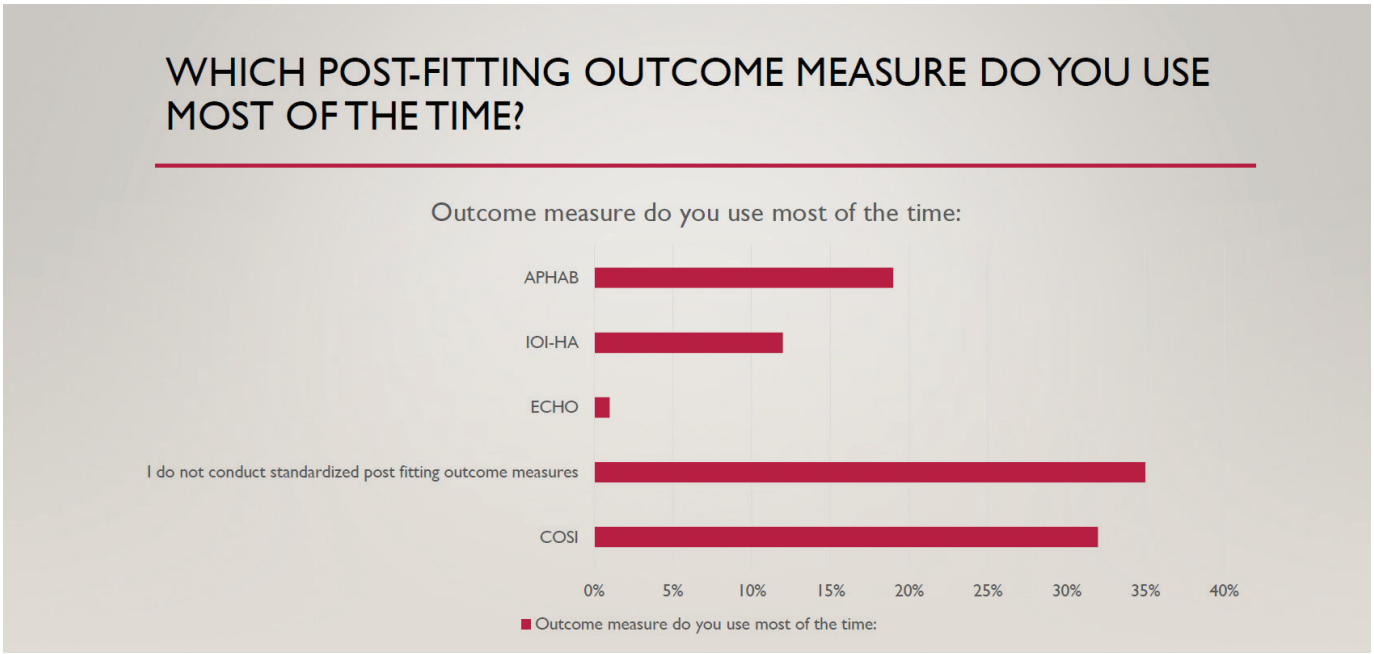


Figure 16. The most popular outcome measures used in the clinic.

Are Custom Earmolds Becoming a Lost Art?

Over the past twenty years, receiver in the canal (RIC) hearing aids have become extremely popular. Along with the RIC style, an instant fit eartip is often recommended. There are several advantages associated with these instant fit eartips, including comfort, concealment, and convenience. There are, however, some disadvantages associated with the use of instant fit eartips, the chief one being the unpredictable nature of slit leak vents that often negate the effectiveness of noise reduction algorithms for low and mid frequency inputs (Balling et al, 2019). Figure 17 illustrates that only 11% of respondents fit custom earmolds/eartips "most of the time" or routinely, suggesting that customization of the ear coupling system is far from a popular practice.

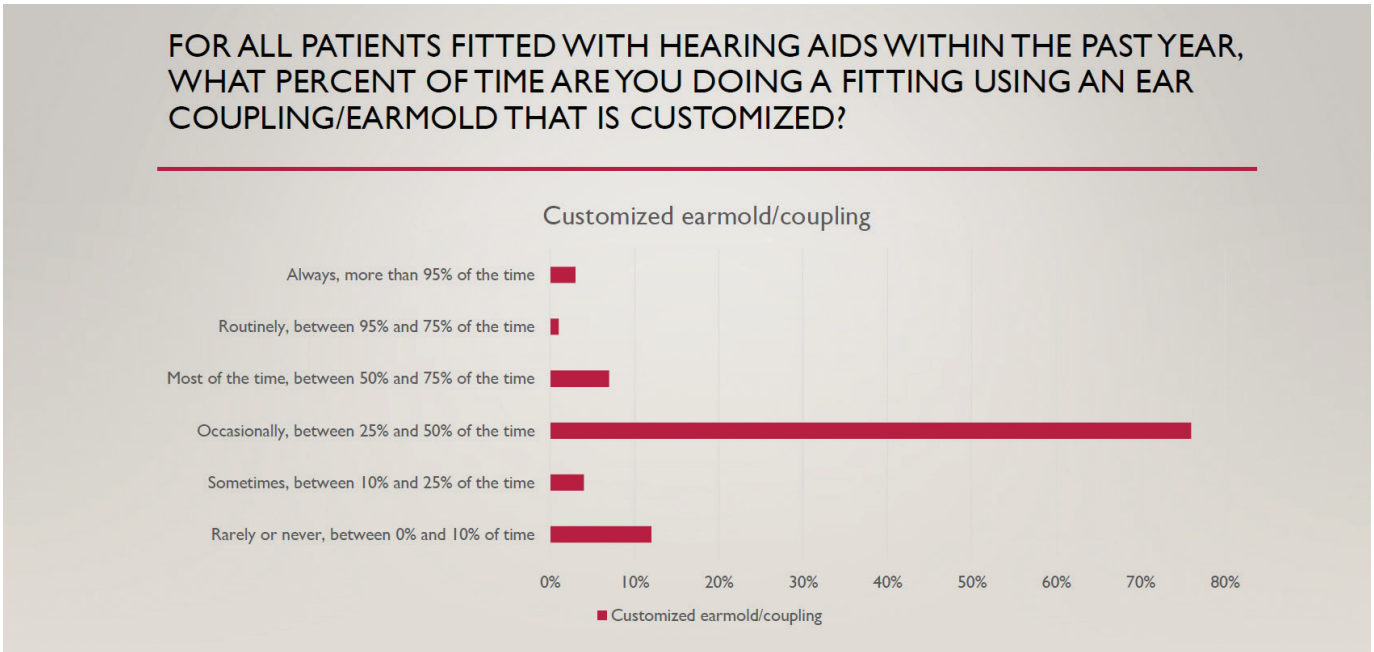


Figure 17. How often are custom earmolds or eartips a part of the fitting.

Section 2: Practice Management and Workflow

Part 2 examines various components of managing an audiology practice. With the onset of COVID-19 four years ago, audiologists were forced to rely on remote care services such as tele-audiology. With the pandemic behind us, it seems like a good time to also see if any of these new technologies have found their way into popular clinical use.

Patient Acquisition

Over the past decade, third-party administrators have become an increasingly larger part of the patient-clinician equation. Although the prevalence of third-party administrators varies a lot by region, most audiologists conduct at least a part of their business with third-party administrative involvement. Figure 18 shows a break down of how much business audiologist conduct with third-party administrators. There is an almost even split between audiologists who report that all or most of their business is private pay versus those who report that all or most of their business comes from third-party payers. Note that nearly one-quarter of respondents report that all of their business continues to originate from private pay sources.

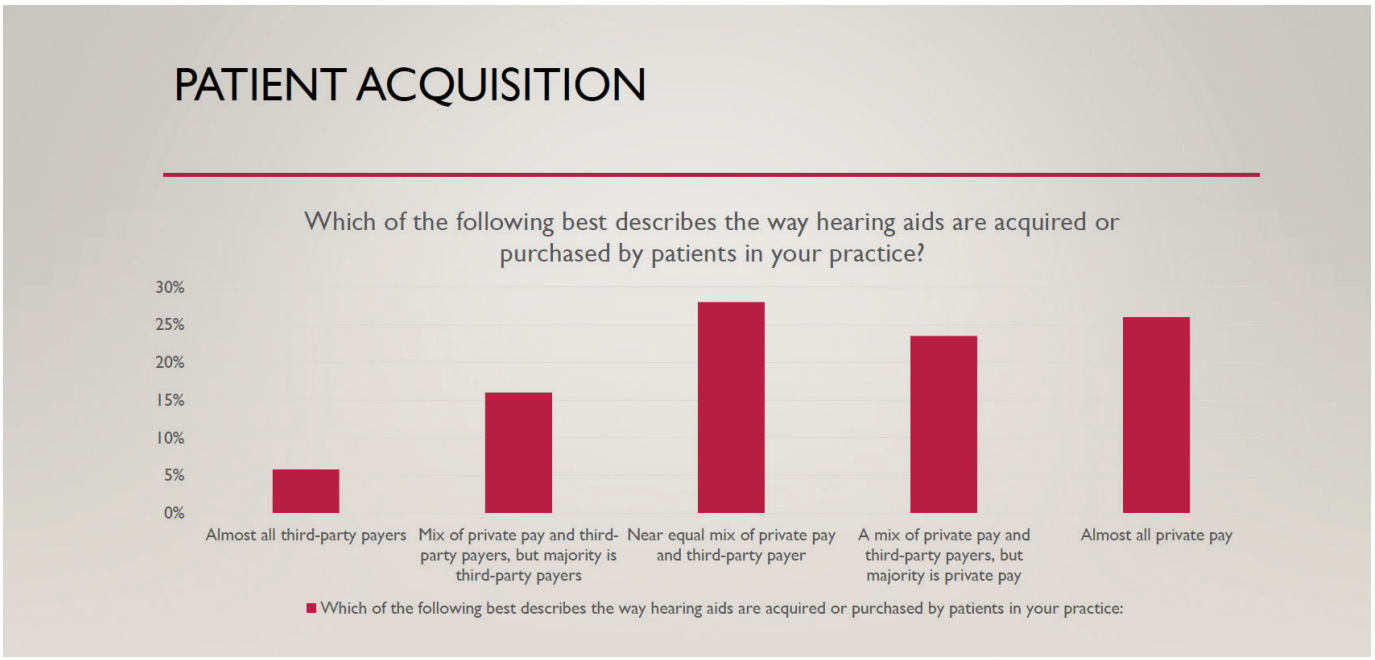


Figure 18. A break down of patient acquisition sources as reported by respondents.

Time Spent with Patients

Since a primary focus of this survey was common procedures used to fit hearing aids on adults, two questions pertaining to how time was spent with patients were asked. Figure 19 shows the average length of time devoted to fitting hearing aids on a new patient, with 56% of respondents stating the average appointment length was one hour and an equal number (~20%) stating the average length was either under one hour or 90 minutes. Follow-up care is another important component of managing a thriving audiology practice.

To better gauge the amount of time spent conducting follow up care, the respondents were also asked how many appointments, on average, were provided patients post-fitting. The results are illustrated in Figure 20. These results show a nearly even split between two, three and four or more follow-up visits. A previous survey from 12 years ago (Ramachandran et al 2012) indicated that about one-third of wearers fitted with hearing aids during the 1-year tracking period needed four or more follow-up visits. The results in Figure 20 are consistent with this finding, suggesting that recent approaches to improving efficiency such as tele-care and the use of audiology assistants haven't changed the number of follow up visits in an appreciable way.

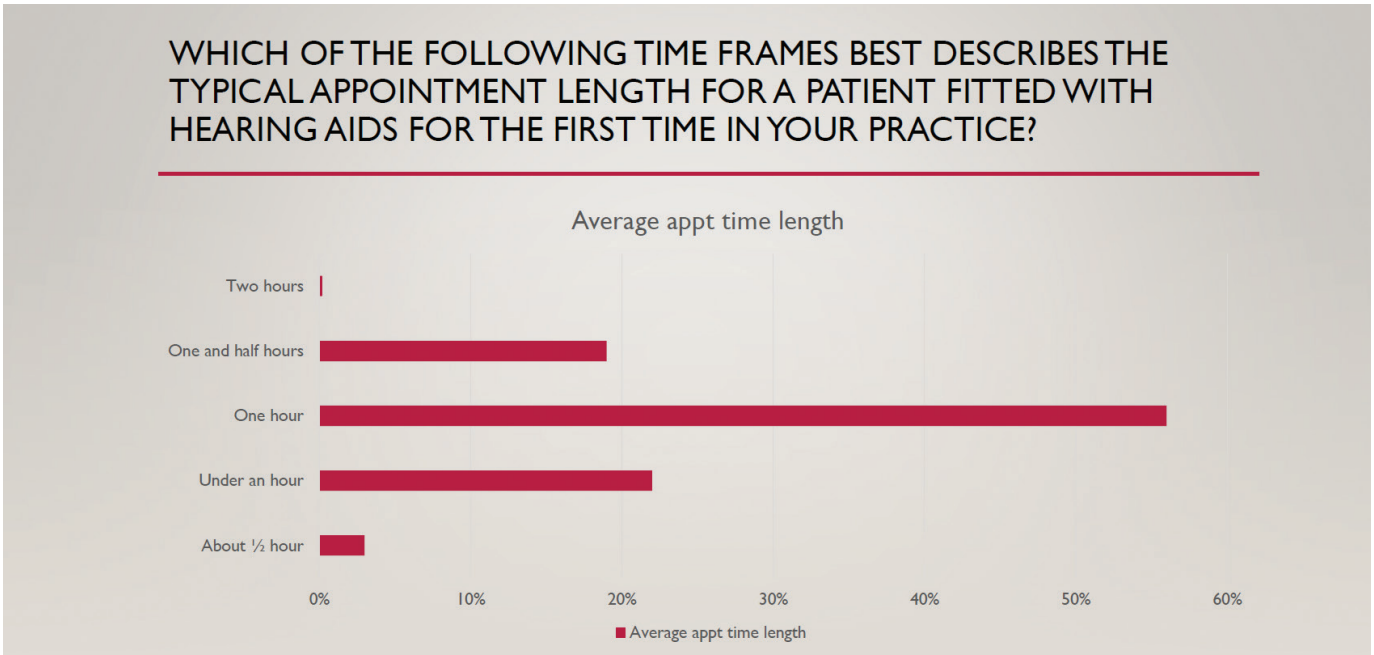


Figure 19. The length of time to conduct a hearing aid fitting as reported by respondents.

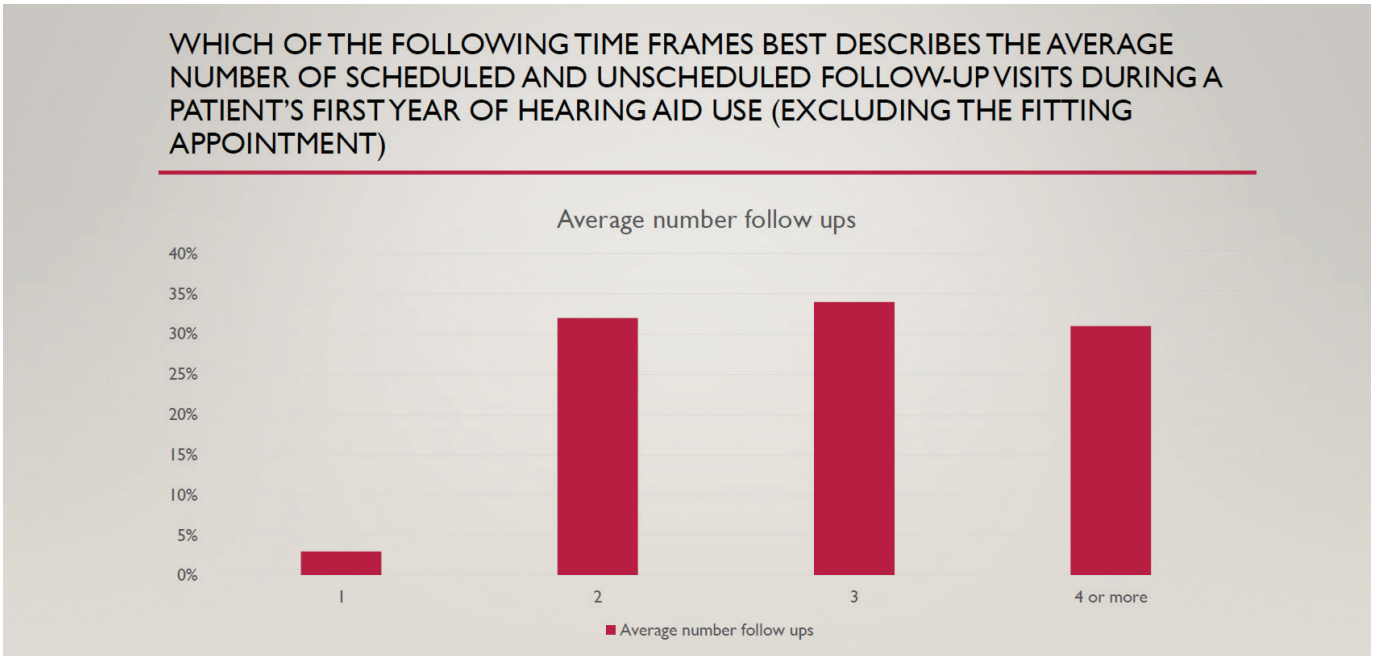


Figure 20. The average number of follow up visits for post-fitting care.

Use of Audiology Assistants and Telecare

For the past several years both audiology assistants (technicians) and remote telecare options (tele-audiology) have been widely available to audiologists who want to utilize them to improve their clinical efficiency. Given the relatively large number of post-fitting follow up visits (almost 75% of respondents reported three or more), it seems that the use of both telecare and audiology assistants would be popular. Results shown in Figure 21 and 22, however, suggest otherwise. Figure 21 shows that 98% of all

or most follow up care is delivered in person rather than via telecare. Another recent trend is the use of audiology assistants who can be employed to perform many routine tasks and free up time for audiologists to see new patients. Several states now offer licensing or certification for audiology assistants. As Figure 22 illustrates, most or all follow up care is delivered by the audiologist, rather than a paraprofessional.

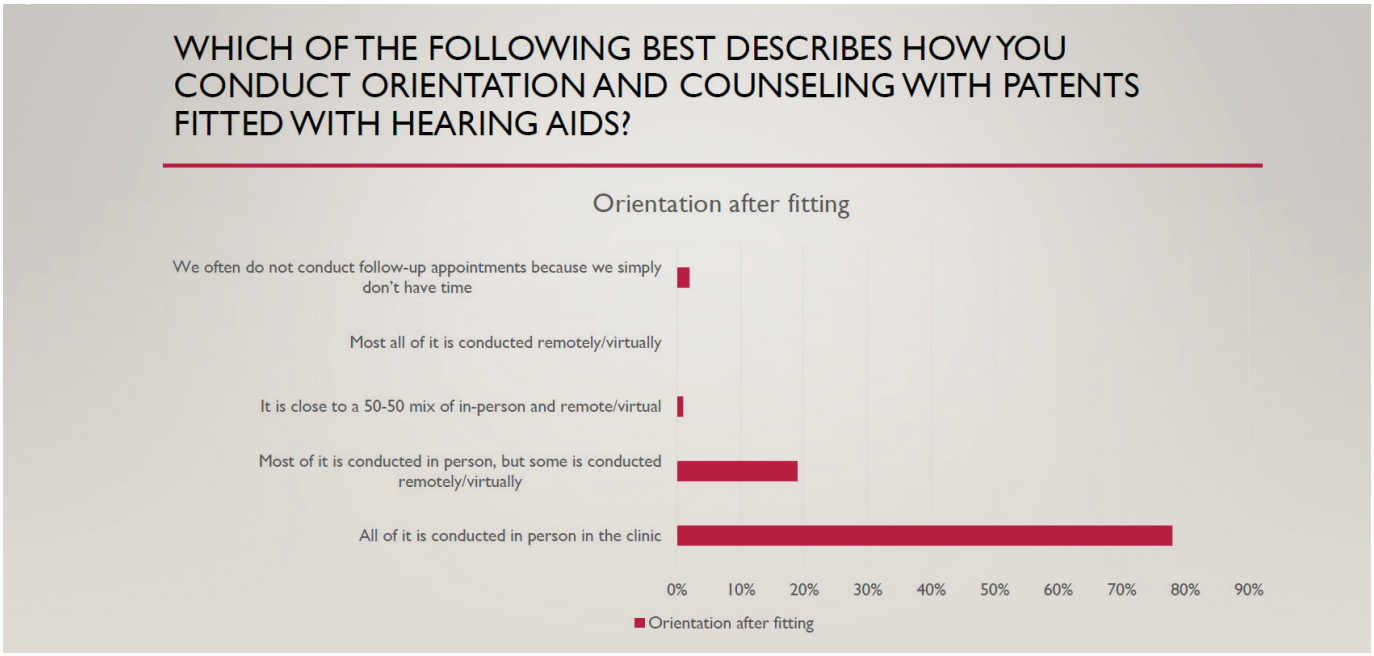


Figure 21. How follow-up care is delivered by the respondents.

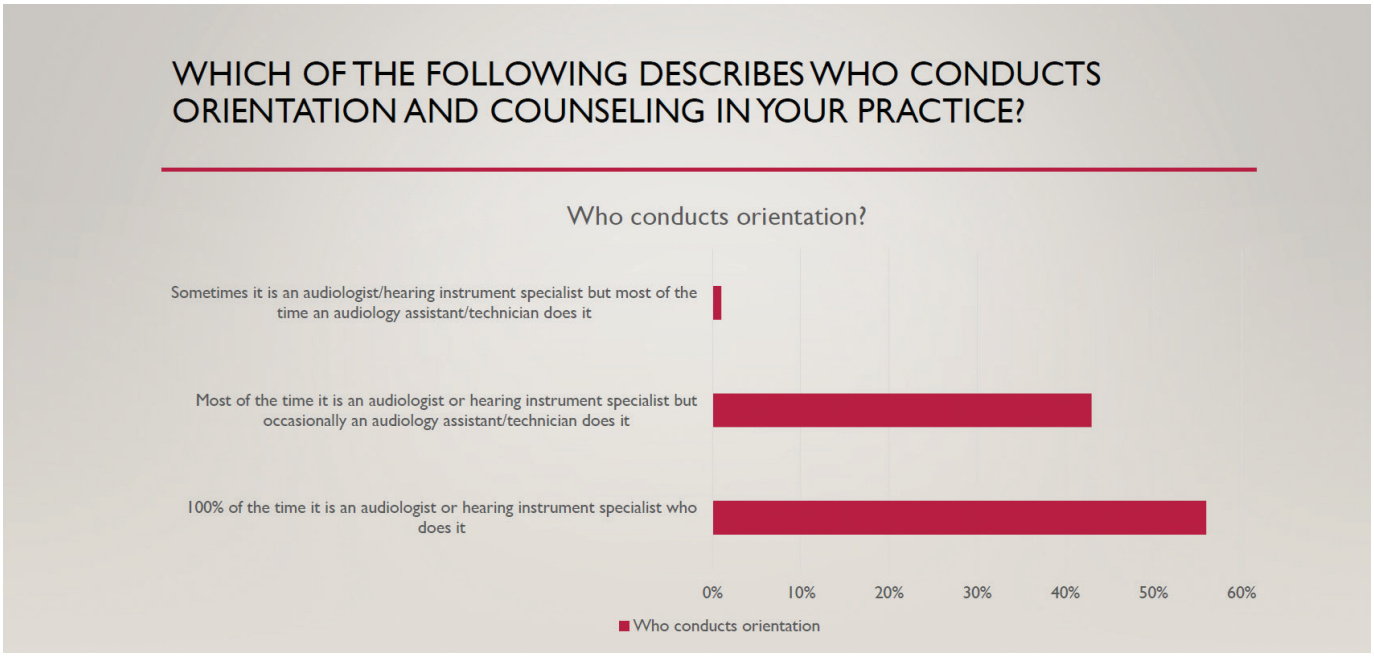


Figure 22. Who delivers follow-up care as reported by the respondents.

Considering that nearly 75% of patients are returning for three of more follow-up visits, and nearly all these follow-up visits are conducted in person by the audiologist, there is ample opportunity for practices to serve more patients through thoughtful division of labor. This is a common practice in the vision and dentistry professions but has yet to be widely embraced by audiologists.

Additionally, as the results of this survey indicate, follow-up care is rarely conducted via tele-audiology. Consequently, there is also ample opportunity to improve access to care by decreasing the burden associated with multiple in-person visits by using tele-audiology and other types of remote care. For help seeking individuals in need of hearing care, regardless of their location, tele-audiology has yet to be widely embraced as a means of reducing their travel burden for follow up care. Even after the COVID-19 pandemic, which forced most clinicians to rely on telecare for a year or more, the results of this survey suggest that audiologists have stopped relying on it and have instead migrated back to almost 100% of appointments conducted in person.

Conclusions: Are APSO Standards Moving the Needle on Popular Practices?

In 2017 John Greer Clark and colleagues conducted a similar online survey of 1,220 randomly selected members of the American Academy of Audiology which yielded only 88 responses. The results were published in the Dec/Nov 2017 issue of Audiology Today (Greer Clark, Huff and Earl, 2017). Table 1 compares results of their AT (2017) survey to the data reviewed in this article (HHTM 2024). Table 1 compares routine practice between the two surveys for five different clinical procedures that are part of the APSO S2.1 standard. The values in Table 1 were derived from the Top-2 Box scores in the two surveys for each of the five clinical procedures listed below.

	AT (2017)	HHTM (2024)
Pre-fitting Self-Assessment	28%	69%
Post-fitting Self-Assessment	33%	65%
Speech in Noise Testing	29%	33%
Unaided LDL Testing	30%	28%
Verification with REM	63%	60%

Table 1. A comparison of routine practice between two surveys: AT (2017) and HHTM (2024).

For three of the five clinical procedures listed in Table 1, speech in noise testing, LDL measures and verification with REM, there is essentially no difference between the two surveys in the percentage of respondents reporting these as "routine practice." In both surveys roughly one-third of respondents routinely conduct these measures. On the other hand, the more recent HHTM (2024) survey shows a rather dramatic increase in the number of respondents who report that they routinely conduct pre- and post- self-assessments.

It is difficult to explain why two common measures which are part of the APSO standard, pre- and post- fitting self-assessments, showed a dramatic increase between the surveys while the other three measures (speech in noise, LDLs and REM verification) did not. What has changed in seven years to warrant the sudden popularity of self-assessments? Perhaps self-assessments using validated self-reports are more readily available in hearing aid manufacturers' fitting software, thus making the process easier to implement, or maybe third-party payers are requiring documentation of outcomes, driving the use of self-reports to higher levels.

The popularity of REM for verification also warrants further analysis. Note that both the AT (2017) and HHTM (2024) surveys indicate the use of REM as part of the verification process is popular. Both surveys indicate that 60% or more of respondents conduct REM. Some skepticism of this number is warranted for a couple of reasons. One, Mueller and Picou (2010) conducted a similar survey which indicated 40% of respondents routinely conduct REM. In their commentary they note this relatively low number has remained unchanged over the past 30 years. Two other questions in the HHTM (2024) survey, pertaining to REM, suggested that comprehensive use of REM is not popular. Although matching a prescriptive target might be popular practice today, measures such as REAR85 and RECD are not routinely conducted.

Finally, it is worth noting that response rates for the HHTM (2024) survey are remarkably low. The survey was emailed to 5,859 US-based audiologists, of which just 3% (186) completed the entire survey. Because the survey was 30 questions, those that responded dedicated the time and attention to detail to complete the rather long process of completing it — the same type of discipline required to implement new practice standards. For that reason, it is possible that the 3% of those who received the

emailed survey are not a representative sample of typical rank and file audiologists and are more likely to actually follow practice standards.

Most audiologists, however, probably agree that best patient care is directly related to how decisions are made in the clinic. And these decisions, whenever possible, should be informed by the best available evidence that comes from research which is reflected in new clinical standards. As Greer Clark at al, (2017) stated, "Palmer (2009) points out that audiology's code of ethics is clear that failure to follow best-practice guidelines is a violation of professional ethics. The continuation of inferior practice patterns that do not ensure best outcomes negatively impacts both patients and the profession. Patients expect that professionals are using the latest technologies and established best-practice protocols to ensure satisfactory outcomes."

Since 2021, audiologists have had access to a new set of clinical standards for selecting and fitting hearing aids on adults. This current survey strongly suggests that a large gap, perhaps even a chasm, exists between access to the standards and actually implementing the standards. You don't have to be an Einstein to see that what is popular practice is seldom best-practice.

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THE UNDERTREATMENT OF SEVERE TO PROFOUND HEARING LOSS:

UNLOCKING THE POTENTIAL OF THE COCHLEAR PROVIDER NETWORK IN YOUR PRACTICE

with Jennifer LaBorde, Au.D.

COCHLEAR IMPLANTS HAVE BEEN THE STANDARD OF CARE FOR ADULTS WITH SEVERE TO PROFOUND HEARING LOSS FOR MORE THAN A GENERATION. RECENTLY, THE CANDIDACY REQUIREMENTS HAVE BECOME LESS STRINGENT (ZWOLAN, ET AL 2020); YET UTILIZATION RATES REMAIN STUBBORNLY LOW.

Recently, Zhan and colleagues (2024) used a large medical claims database to better understand the utilization of cochlear implants. Their analysis found that cochlear implant utilization was 0.33% of all patients with sensorineural hearing loss. Utilization of cochlear implants did not significantly correlate with age at diagnosis of hearing loss, audiology utilization, or any socioeconomic variables. As shown in Figure 1, there are large swaths of the US, particularly in the Southeast, where utilization is practically non-existent for both diagnostic audiology and cochlear implantation.

On the other hand, there are parts of the US, namely the Eastern US, Southern California and a few other places denoted in red in Figure 1, where utilization of diagnostic audiology services is high and cochlear implantation is low. This finding suggests that significant under-referral and poor awareness are big drivers of poor cochlear implantation uptake rates. Further, using this data, the authors determined that 5.55% of all adult patients with bilateral hearing loss have severe-to-profound hearing loss, but just 6% of this group (6% of 5.55%) used a cochlear implant. Although the recent loosening of cochlear implant candidacy requirements may not yet be reflected in this abysmally low number, it is clear that severe and profound hearing loss is an undertreated condition.

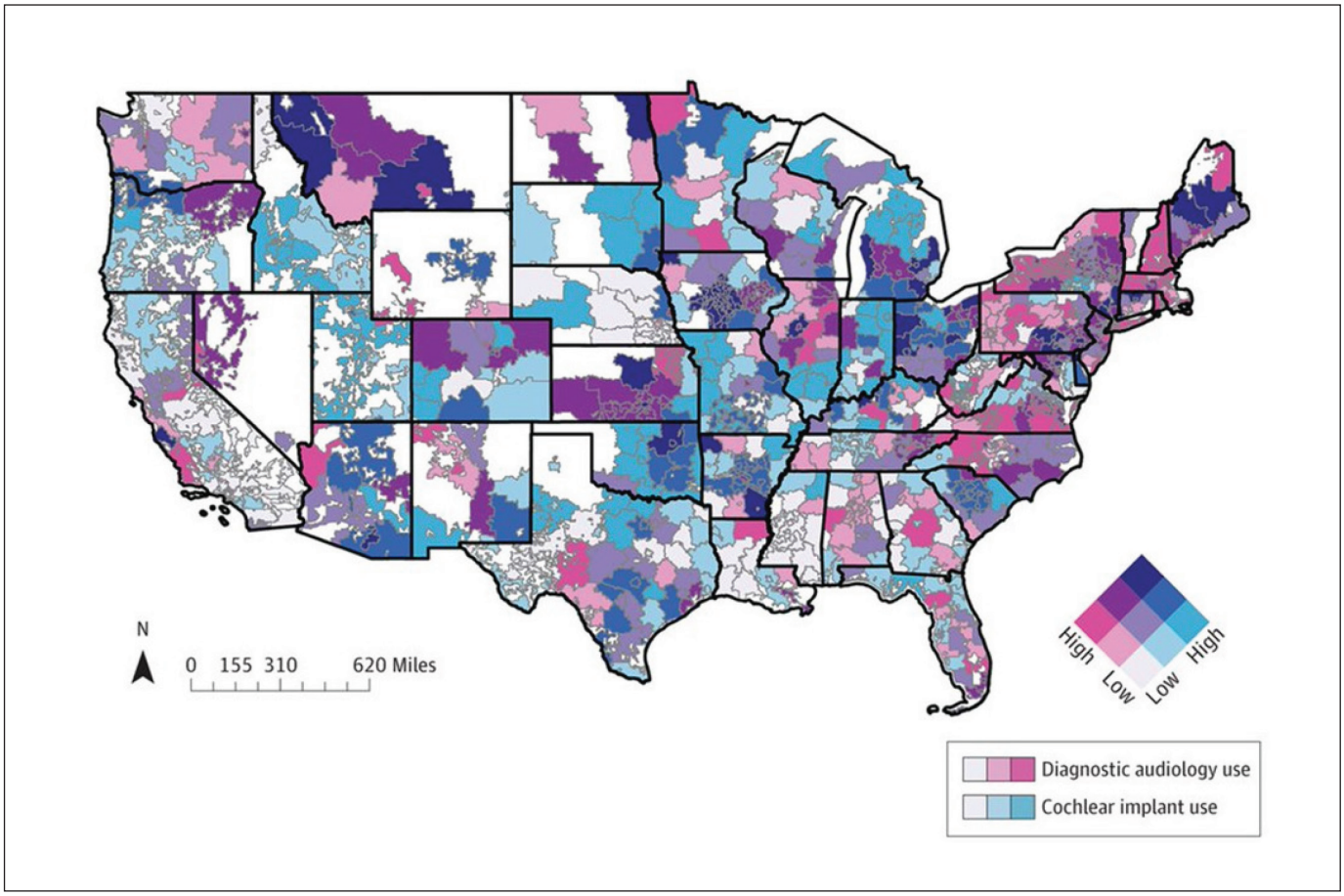

Figure 1. Cochlear implantation and diagnostic audiology utilization comparisons. From Zhan et al 2024.

Given the significant under-referral and poor awareness, combined with the overall low cochlear implantation utilization rates, there has never been a better time to revisit the Cochlear Provider Network (CPN). To better understand how CPN works, is Jennifer LaBorde, AuD, director of audiology at The Hearing Center in Pensacola, Florida.

AP: Tell us about your career journey and your practice.

I have been practicing audiology since 1999, initially in a non-profit Speech and Hearing Center; however, since 2001 I have been employed in a large physician-owned multi-specialty clinic providing audiological services and functioning as department director since 2003. I describe the practice setting as a hybrid ENT/ private practice, as we support a robust ENT practice with complete audiological diagnostic services, but also have a strong focus in audiological rehabilitation services. The practice is entrepreneurial and continuously looking for ways to grow in order to provide services with best practices and an excellent patient experience for our community.

AP: What is the Cochlear Provider Network?

The Cochlear Provider Network (CPN) is a group of audiological practices who do not have in-house cochlear implant surgeons. We provide cochlear implant (CI) services ranging from candidacy evaluation and recommendation for cochlear implants, initial activation of implants, and follow-up CI mapping services.

AP: How do you position the CPN in your practice (that is, how do you talk about it with patients, how might you advertise it?)

Being a member of the CPN has set our practice apart as a full-service audiological practice from hearing conservation on one end of the continuum to a practice that offers rehabilitative services even for surgical solutions with hearing loss. This full-service continuum elevates the practice in our community as a medical practice offering services beyond a traditional hearing aid. For patients who know that we are trusted partners with the surgeons we refer them to, they feel an immediate and natural trust in our services and abilities.

AP: Take us through the evaluation and treatment process. What are the criteria for a CI evaluation?

Patients who are struggling with speech understanding ability with their traditional hearing devices can be evaluated for a cochlear implant. We accept referrals for cochlear implant evaluations from many sources, including our ENT colleagues, other non-CPN audiologists, as well as patients who self-refer because they have read or heard about the benefits of cochlear implants for improved speech understanding.

We prefer to have a prior audiometric evaluation to ensure that the patient's hearing ability would be in the range of candidacy. The next step is ensuring that the patients are currently utilizing hearing aids that are set to prescriptive targets. This is typically our starting point for the CI evaluation, as the testing and candidacy requirements are conducted in an appropriately aided condition. Hearing aids would then be adjusted to meet targets, if necessary. Acoustic properties such as dome size or custom earmolds are changed/added in order to meet these prescriptive targets. The patient is then tested in the best aided condition with each hearing aid individually using CNC words to determine if word understanding is poor enough to meet CI candidacy. Further testing is then conducted with sentence material in both quiet and noise to determine a patient's functional abilities in the best aided condition. Interestingly, patients many times are attending these appointments with hearing aids that are not fit to the patient's current hearing ability and once verification is performed and necessary adjustments are made, speech understanding improves to above the level that would indicate cochlear implant placement. If it does not, however, I begin counseling the patient on the

benefits of cochlear implantation and help them understand the audiological benefits of improved audibility with this type of a device over a traditional hearing aid.

AP: How does the referral process work?

If the patient is interested in meeting with a surgeon, our practice will refer the patient with their test results and an audiological recommendation for cochlear implantation. The surgeon's office will then coordinate with the patient what is needed for that surgical consultation. Most times, the patient has an MRI prior to meeting with the surgeon, so that he/she has all necessary information to make a medical determination that cochlear implantation is recommended. And then the surgery is scheduled! It's quite a simple process for our office, the patient, and the surgeon. The next time the patient will see the surgeon is typically the day they receive their implant!

AP: How does the Cochlear Provider Network benefit your practice?

The ability to provide a full spectrum of audiological solutions to help manage even the most severe impacts of hearing loss as a member of the CPN, we have the benefit and availability of resources such as the Recipient Engagement Manager and Recipient Services Manager. These are people who are employed by Cochlear to aid recipients in their cochlear implant journey, assisting in answering questions about equipment, surgical expectations, and outcomes that a patient may have not remembered or asked during the initial consult with me or their surgeon. These professionals provide support to audiologists and surgeons by taking care of tasks such as helping patients decide on color, style and accessories for their cochlear implant; they provide connections for patients with other recipients who have similar hearing journeys and have been through the cochlear implant process.

AP: Tell us about follow-up and what happens after a patient receives a CI?

Once the patient has had surgery, he/she will return to our office in 3-4 weeks for activation. We have an excellent working relationship with our partner surgeons in the CPN and can communicate with them directly and with ease to address any concerns we might see, which is very rare, otherwise, we can begin activation of the cochlear implant.

AP: Take us through the types and duration of follow-up appointments

This initial activation is typically scheduled for an hour in order to evaluate post-operative hearing status, orient the patient with new equipment, and provide an initial sound stimulation.

The patient then follows up in one month and we measure audibility of sounds, address any sound quality issues, and optimize measurements based on audibility and loudness comfort.

The three-month appointment then consists of re-measuring audibility and now measuring speech perception performance. At this visit, we can review datalogging and continue to optimize MAP settings if necessary. At this point, we can determine if the patient should be scheduled for an annual check, follow up as needed, or return sooner for any specialized concerns that may arise. Most patients are fine to schedule in one year. These appointments are anywhere from 30-60 minutes long.

AP: How do you manage the time needed with longer follow-up appointments? Do you use telecare or audiology assistants?

Cochlear has a wonderful remote care program that allows for both synchronous telehealth mapping as well as an asynchronous remote check of the processor that can be reviewed by the audiologist. This is a great way to triage concerns and address needs in an efficient and expeditious way. Our office also utilizes our audiology assistants for equipment troubleshooting and triaging to empower patients when they need to directly contact the cochlear implant manufacturer or truly need to be seen by an audiologist.

AP: What CPT codes can be used for CIs in adults?

I am certainly no coding expert, but we utilize codes for diagnostic analysis of cochlear implants for both initial and subsequent reprogramming (92603 and 92604 for those older than 7 years). We utilize the evaluation of auditory rehabilitation status codes for candidacy evaluations as well as speech perception testing, validation measures, and counseling on the implication of the results with the cochlear implants (92626 and 92627, both of which are time-based codes).

AP: At a high level, what are the typical reimbursement rates for these CPT codes?

Generally, reimbursement rates for these codes are typically covering the time spent for the procedures, however the transition from hearing aids to cochlear implants does require a learning curve for both patients and providers. Nearly all patients and providers are accustomed to bundled devices and professional services, but with cochlear implants, insurance does not reimburse for our time assisting with equipment troubleshooting and rehabilitative services for these patients. Clinics can handle this in a variety of ways, such as charging per service or implementing a service plan for these types of encounters so that patients experience a similar level of access to our services as they were likely accustomed to with hearing aids.

AP: What support does Cochlear provide for the CPN providers?

Another way to help provide ongoing support to our patients is using the CPN resources that are available such as the Recipient Service Managers. These professionals can assist patients with orientation of their equipment, finding ways to utilize listening accessories, and even assisting patients with upgrade equipment when necessary.

Cochlear also has community engagement events for potential recipients to help answer questions for patients considering cochlear implantation. Further, should an audiologist want to being offering cochlear implant services, Cochlear provides consistent, reliable support to help implement these services into the practice, provide continuing education and support for providers to feel confident, and provide real-time assistance from audiology on-call services and remote assistance during patient encounters.

AP: How can other practices get involved with the CPN?

Contacting Cochlear directly is the best way to get involved with CPN. For our office, being a part of the CPN has been a great collaboration with surgeons in our region and allowed us to offer continued hearing care services to our patients when amplification is no longer providing adequate benefit. You can find all you need to get started with the CPN at cochlear.com.

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How Big Data Can Nudge People into Action…Faster

Terry Mactaggart

According to the World Health Organization (WHO), approximately 5% of the entire world's population – or 430 million people – require rehabilitation to address their disabling hearing loss (including 34 million children). It is estimated that by 2050 over 700 million people – or 1 in every 10 people – will have disabling hearing loss. When unaddressed, hearing loss impacts many aspects of life at individual level: communication and speech, cognition, social isolation, loneliness and stigma, and effects on years lived with disability (YDLs) and disability adjusted life years (DALYs). The WHO estimates that unaddressed hearing loss poses an annual global cost of US$ 980 billion. This includes health sector costs (excluding the cost of hearing devices), costs of educational support, loss of productivity and societal costs. Of these costs, 57% are attributed to low- and middle-income countries.

Early identification of hearing loss and ear diseases is key to effective management. This requires systematic screening for detection of hearing loss and related ear diseases in those who are most at risk. This includes newborn babies and infants, pre-school and school-age children, people exposed to noise or chemicals at work, people receiving ototoxic medicines and older adults.

Hearing assessment and ear examination can be conducted in clinical and community settings. Tools such as the hearWHO app and other technology-based solutions make it possible to screen for ear diseases and hearing loss with limited training and resources. Once hearing loss is identified, it is essential that it is addressed as early as possible and in an appropriate manner, to mitigate any adverse impact. The WHO has done yeomen work raising awareness of the global need for hearing loss awareness and treatment. Closer to home, others are trying to further the cause.

What is happening in the private sector?

Hearing aid innovation continues with the advent of multitasker-type devices such as the Airpod Pro with its new "hearing aid mode" that will be found in the new iOS 18. Results for the first year of over-the-counter (OTC) device availability in the United States have been tabulated. They show that the current OTC market is dominated by the existing hearing aid manufacturers without much disruption from consumer electronic and other start-up companies. Although uptake of OTC hearing aids remains low at this time, it is possible that lower OTC price points and rising awareness of the availability of these devices will drive demand. Additionally, behind prosthetic devices, a possible "cure" for certain types of hearing loss is being explored by several well-funded start-up companies.

Individually and together, these developments are progressive. But are they really making a difference if the goal is to stimulate many thousands more to understand their hearing status and take account of the actions indicated to preserve and/or rehabilitate it? Before these burgeoning treatments can be fully realized, all sectors of the hearing health care industry must work together to build awareness of the harmful effects of untreated hearing loss across the life span.

It is possible that as more extensive analysis of the deleterious effects of hearing loss is undertaken, shortcomings in hearing health awareness and action will continue to grow among all age cohorts. We are gaining a better understanding of the reasons why those who know their hearing status tend to delay. And we understand from emerging research that the stakes of maintaining the status quo have become more severe.

Reducing this dilemma to its bare essentials may shake out in some unforeseen ways. For example, hearing loss is unlike other chronic conditions for the following reasons.

- Hearing is a "tricky" sense as problems (particularly permanent losses) usually develop over time – they tend to "sneak up" on people.
- Unlike sight, early decline can often be managed by finding new ways to get by - learning to "re-hear just good enough" allows many people to cope in challenging listening situations.
- Research indicating the perils of delay, albeit still nuanced, is under communicated – not nearly enough people know about it.
- The industry continues to focus primarily on selling hearing aids, retaining most of its expensive business model.

Summus Hearing Solutions, a Canada-based company, pioneered one of the world's first tablet-based, AI-enabled self-guided hearing health test platforms for use in trusted healthcare settings. Based on more than a decade of data collection, we know that structured and interpreted hearing test results across a wide demographic indicate those who should be considering some form of hearing instrumentation represent only about 30% of the total of those tested. The majority (more than 65%) of those tested are either "normal" or have a "conductive" component that requires some type of medical intervention.

Yet most of the self-guided testing platforms being used today are seeking or confirming hearing aid candidates. That is to say, well over 50% of those conducting a self guided test are essentially being ignored when it comes to hearing health and maintenance, which is perhaps the most important conundrum of all. Not nearly enough people are tested and, when tested, are not evaluated rigorously, without bias.

One way of starting to address these questions is to break out the "hearing problem" into various components examining the state of play with each. Recently at Summus we created the following infographic highlighting seven common issues.

"The Hearing Problem"

Only 2% are tested

This estimate for the United States is dated and may be different today. In any event, it's an exceptionally low percentage of the relevant population and stands out when compared, say, to testing for eyesight or blood pressure.

CONCLUSION – More people need to obtain a baseline hearing test.

Testing, when done, is often inadequate

Screening tests abound, particularly online. But unless undertaken by an unbiased provider, these tend to be skewed towards acquiring hearing aids. Adequate interpretation of results is a problem as almost all lack that capability.

CONCLUSION – This bias needs to be rectified if an entry into one's hearing journey or a check along the way is to be trusted. Most people who get a hearing test today, do not need hearing aids. The test is the beginning of the journey toward greater self-awareness of your own hearing, not the start of wearing hearing aids.

Wait time between awareness and action is too long

5 years minimum, 10-plus years maximum defines the range, the median appearing to be 6 to 7 years; and that applies only to those who have been assessed and ultimately decide to act.

CONCLUSION – Encourage people to self-test to monitor any changes **in their hearing over time**. Encourage people to see an audiologist when they have questions about their hearing or the results of their self-guided hearing test.

Relationships with other disease states require greater emphasis

Co-morbidities have multiplied and become more obvious.

CONCLUSION – In addition to further research, these relationships provide promising leverage. Much more could be done to insert a hearing test as part of the follow-up protocol when a relevant disease state is detected or being managed. At a minimum, physicians and nurses who specialize in geriatrics must be educated on these co-morbidities.

Learning and behavioral issues need to be confronted

We know that undetected and untreated hearing loss compromises the learning and lifestyle trajectory of many children.

CONCLUSION – Testing of public-school age children should be mandated, and in many cases re-established.

Key healthcare providers are left out

This problem is enormous as family physicians and pharmacies (to name two prominent exclusions) are not connected sufficiently, if at all, with hearing health.

CONCLUSION – The imperative of mandating physicians to counsel and test appears to be gaining ground. More pharmacy chains are adding hearing as a new revenue source. Engaging both fully would make a significant difference.

Productivity loss and social costs that result from untreated hearing loss are too high

More than $900 billion dollars per year in the global economy are lost due to lost work hours and poor productivity that result from untreated hearing loss.

CONCLUSION – Freeing up even a third of this monetary value represents a large amount that could be allocated to other pressing, underfunded public health problems.

Messaging to a 42-year-old male in a high-paced job who plays in a band, for example, should be quite different than to a 72-year-old female encountering problems playing bridge with her friends.

We encourage audiologists to print this infographic and share it with all members of your medical community. It is imperative for all of us to educate key stakeholders in our communities. Further, Summus is embarking on a significant project aimed at addressing aspects of the problems related to poor awareness. For some time, we have referred to our mission as providing "hearing health guidance" rather than simply "hearing testing."

Providing a competent screening test on an internet-connected device at any time is an obvious entry point. The more important aspect in the application of "Hearing Triage", a term we set when our proprietary pattern recognition algorithms allowed pure-tone thresholds to be sorted into four standard audiological categories. From there we can produce and send a medical grade report as well as coach the user about what next steps make most sense given his or her classification.

While this technology is available in English, French, and Spanish and has been widely applied, it's impact in "Moving the Meter" is still limited. Most who are deemed to have a sensorineural hearing loss, for example, when consideration of hearing aids often represents an effective response, balk at taking that next step. Frequently, this delay continues for some time, three to seven years being commonplace. Likewise with other classifications, when used within the medical environment tend to be followed to a greater extent.

The issue we're grappling with involves providing guidance that takes account of age, gender, lifestyle, and other health conditions. Messaging to a 42-year-old male in a high-paced job who plays in a band, for example, should be quite different than to a 72-year-old female encountering problems playing bridge with her friends. When combining classification, age (in cohorts), comorbidities and "lifestyle", a complex array of messages results – 100's in fact. And if somehow, user response to the original message can be captured, follow-up messaging can be created thus moving the user further along in "their journey" while compounding the technical challenge of continuing the follow up even more.

What's sought is a process that "nudges" the person by taking account of attitudes and behavioral differences – an innovation that is beginning to be talked about with little evidence of becoming mainstream in healthcare to date. The recent isolation of consumer archetypes for different individuals with hearing difficulties is one early example in the hearing space, as Brian Taylor discusses in his editorial in this issue of Audiology Practices.

Our "hearing health guidance" prototype provides a roadmap for how nudging people into action could be accomplished by using a combination of big data (large pools of information), previous knowhow, and an added dose of AI. We anticipate experimentation with and acceptance of this enhanced form of guidance can ultimately make a difference with several of the issues cited above. Success will depend on timely financing, and interplay with a variety of partners including audiologists on the forefront of technological innovations that can be used to raise awareness in their communities about the harmful effects of untreated hearing loss.

Terry Mactaggart *is the founder and CEO of Summus Hearing Solutions, Inc. He can be contacted at terrym@summus-hearing.com* ■

Being a Better BOSS in the Age of REMOTE WORK

Bryan Hanson

Since the winddown of COVID-19 restrictions, a growing number of people continue to work from home. It is also common these days to manage a group of people that either work from home or work in other satellite offices. Whatever the specifics, having a group of employees who report to you, all working in different locations, is now the norm.

The rise of a remote workforce places new challenges on managers. One common example is that managers are now tasked with getting workers with disparate interests – and residing in different physical locations during the workday – to achieve a common goal. For these reasons, many business management experts believe that the following skills are important in leveraging better results from the team you are managing in the new age of remote work.

Assure Technical Connections

Whether it is home-based or a satellite office, ensure that each staff member has everything they need to seamlessly log into your preferred on-line meeting service. This includes a stable Wi-Fi connection, capable internet browser and a laptop with high quality sound and video camera. The need for solid information technology (IT), including people on staff who know how to evaluate and troubleshoot this valuable component of infrastructure, is fundamental to managing a remote work force.

Instill a Sense of Purpose

Of course, everyone needs to have a sense of purpose when they come to work each day, but for those that work at home or alone in a satellite office, it is doubly important they are instilled with a strong sense of purpose. It's the responsibility of the manager to ensure that staff has this sense of purpose. Employees need to be consistently reminded they are making a positive difference in the lives of customers. Here is why: When you are working alone, say in a small satellite office where one or two people are responsible for all daily operations, it is easy to become bogged down in the minutiae of the daily grind. It's the role of the manager to periodically ensure employees of their value to the customers

who they serve. Given the quality-of-life improvements that come from better hearing and balance, instilling a sense of purpose in the staff of an audiology-related business (a true helping profession) might be easy, but it still requires a manager methodically remind employees that they are making a difference.

During monthly or quarterly business review meetings, when the manager is reviewing financial statements and other operational variables – you know, information that has a lot of dollar signs in it – make a deliberate effort to discuss the number of people that your business has helped or served over that timeframe.

Manage and Maintain the Organization's Culture

Culture, perhaps best defined as "the way our organization gets things done," is relatively easy to maintain when people work together in person. In contrast, when your team is scattered in many different places, establishing and keeping a sense of office culture is extremely challenging. One simple tactic to use with a remote work force is to simply talk about your office culture and what you want your clinic or business to be known for in your community. Even if you are managing people in multiple locations, everyone is still accountable for the reputation of the organization. Let people know about the importance of reputation and how managers expect work to be done. More importantly, especially in a healthcare business, make sure you are constantly talking about how you expect patients to be treated. Outstanding patient care – expecting staff to deliver it, each and every day – is a cornerstone of a healthy culture.

Go Out of Your Way to Foster Collaboration

One of the challenges of managing a group of people who all work in separate locations is encouraging collaboration. This should be a surprise to no one. Each person is working independently and it's understandable for staff to feel disconnected from one another. Managers must make a deliberate effort to find projects or activities that foster a sense of teamwork. This can be as simple as working together during a weekly Zoom call to organize an annual department party or as complex as developing a strategic plan.

Know Your Financial Numbers and Teach Others About Them

You don't have to manage a team of remote employees to appreciate this point. We live in a world where most employees are at least curious about the business side of their job. That is, they want to know a little something about how dollars are generated, or costs are managed. Regardless of role, each employee on your team is entitled to know how their daily tasks contribute to the financial success of the entire organization. For employees who interact directly with customers (e.g., clinical audiologists), the discussion can center on the amount of revenue that can be generated through assessments and dispensing of hearing aids. For employees on your team that may not directly interact with customers (e.g., custodians or accountants), the conversation needs to focus on how their expertise frees up time for the manager or clinicians to focus on their own expertise more effectively. The bottom line is everyone on the team needs to know how their role synchs with others on the team, so that financial success has a better shot at being optimized. When staff understand their financial contribution to the business, either on the top-line revenue line or bottom-line cost and profit lines, they often take a more active, vested interest in daily operations.

Overcommunicate but Avoid Micromanaging

It should not be a surprise that a critical component to being a successful boss is knowing how to effectively communicate. After all, as a boss, you need to hire and fire people, develop people, articulate expectations and strategies, and oversee both financial and clinical success. In short, as a boss, your plate is really full, and because of that, it is easy to be perceived as a micromanager. In fact, one of the biggest pitfalls associated with clinicians who get promoted to manager is they live in fear they will be perceived by their direct reports as the "dreaded micromanager." This often leads to timid, passive-aggressive managers who are uncomfortable sharing feedback – critiques, opinions and comments that are intended to improve workplace performance or solve a problem. The irony is that the more authentically you communicate, the less likely you are to be perceived as a micromanager. Authenticity starts with your ability to understand and personally connect with each member of your team, and then sharing a common interest in the striving to continually fine-tune the reputation of your clinic.

No one likes to feel like they are being monitored all the time. Everyone likes to have a sense of autonomy as to how they perform their job. To avoid the reputation of a micromanager, it can help to reframe your style as overcommunication. When you inform your team that you like overcommunication, it invites them to be more open with you. This is why weekly one-on-one meetings and other informal chats with staff are so essential. Assuming you have developed a sense of trust, getting your team to overcommunicate with you, has many benefits. It keeps you in the loop on important developments that ordinarily fly under the radar, and it empowers your team to maintain an open line of communication with you.

Being a good boss takes a lot of patience. And even more patience when many people on your team work remotely. At the heart of being good boss, regardless of where staff might be working, is the ability to effectively communicate about good and bad news. With some attention to some of the details outlined here, you can hone some foundational skills that will help you be a better boss to those who work remotely.

Being a good boss takes a lot of patience. And even more patience when many people on your team work remotely.

To quote the cattle rancher, cyberlibertarian and Grateful Dead lyricist – a true Renaissance man, the late John Perry Barlow, "Avoid the pursuit of happiness. Define your mission and purpose and pursue that." There is no better place to pursue that ideal than as a manager who is leading a team, helping them all row in the same direction – even for those on your team who are in a satellite office or work from home. We can make the world a better place – even if we must rely on Zoom.

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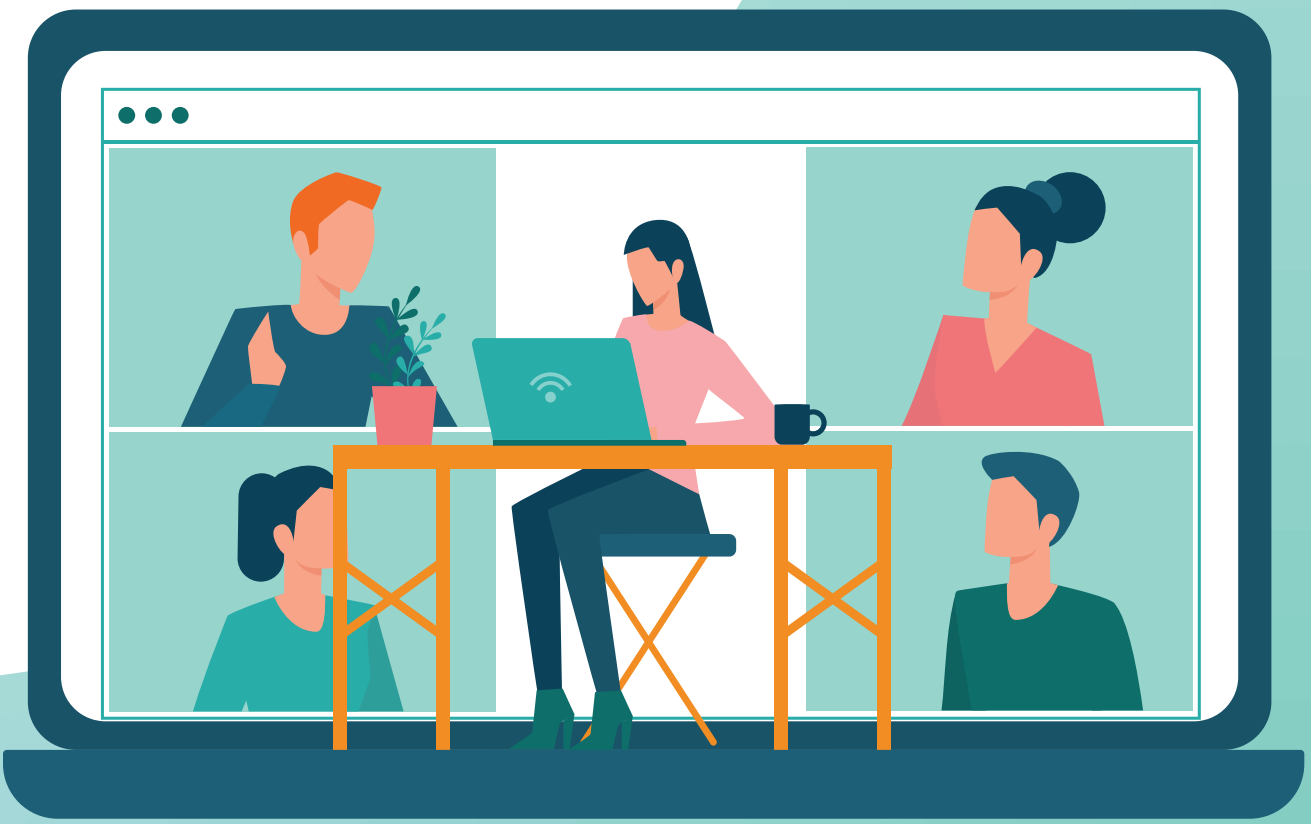

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HAVE YOU HEARD?

Audiology Practices Impacted by the Corporate Transparency Act

By Brandon Pauley, Esq.

The Beneficial Ownership Information Rule was adopted as part of the Corporate Transparency Act passed by Congress in 2021 and intended to help prevent and combat money laundering, terrorist financing, corruption, and tax fraud.

Effective January 1, 2024, the Beneficial Ownership Information (BOI) Rule requires small businesses across the United States to report personal information about owners, beneficial owners, and others who own or exercise control over the company. Visit the Financial Crimes Enforcement Network (FinCEN) BOI site here: www.fincen.gov/boi.

Who Must Report?

All domestic and foreign corporations, limited liability companies (LLCs), or other entities created by the filing of a document with the Secretary of State or similar office in the United States must file, unless it qualifies for one of the several enumerated exemptions identified in the Rule.

A business required to file (a "reporting company") will need to include certain specified personal information concerning:

- The business itself.
- Any owners holding 25% or more of the stock, voting rights, or ownership interests in the company.
- Any other individuals (such as senior officers or other important decision makers), whether or not they are owners, who exercise substantial control over the company's finances, structure, or business operations.
- Individuals who filed, or directed the filing, of the organizing documents that created or registered the company (for entities formed after 1/1/2024).

The personal information for any individual required to be disclosed includes the individuals full name and address, date of birth, and other identifying information such as a passport number, driver's license number, etc.

Broadly, 23 various exemptions exist, but mostly apply to entities already subject to some other reporting requirements. For example, banks, publicly traded companies and/or public utilities are exempt. There is no exemption that squarely applies to independent audiology practices.

Timing to Report.

As the intent of the legislation is to gain information from small businesses, those businesses existing on January 1, 2024, will have one (1) year to comply. Any businesses formed after January 1, 2024, will need to disclose and file the beneficial owner information within thirty (30) days of the entities formation. In addition, any changes in the information disclosed must be updated within thirty (30) days.

Penalties for Failure to Comply.

A failure to report complete or updated information to FinCEN, or an attempt to provide false or fraudulent information, may result in civil penalties of up to $500 for each day that the violation continues, or criminal penalties including imprisonment for up to two (2) years and/or a fine of up to $10,000. Senior officers of an entity that fails to file a required report may be held accountable for that failure.

Recent Developments - Challenges

It is worth noting challenges to the enforceability of the Corporate Transparency Act. On March 1, 2024, a federal district court in the Northern District of Alabama concluded that the Corporate Transparency Act ("CTA") exceeded Congressional powers and enjoined the Department of the Treasury from enforcing the CTA against the plaintiffs. *National Small Business United v. Yellen*, No. 5:22-cv-01448 (N.D. Ala.). On March 11, 2024, the U.S. Department of Justice appealed the district court's decision to the Eleventh Circuit Court of Appeals. That case is currently pending.

In a March 11, 2024 statement, the U.S. Treasury Department's Financial Crimes Enforcement Network ("FinCEN") specified that the district court's decision enjoined enforcement of the CTA with respect to the plaintiffs of the litigation detailed above. However, aside from these named plaintiffs, FinCEN specifically provides that "reporting companies are still required to comply with the law and file beneficial ownership reports." Thus, the potential for associated fines and penalties may still be enforceable while the appeals process plays out, but it is unclear.

How to Comply?

If you determine you have a reporting obligation, the information is reported to, and maintained by FinCEN as part of the Beneficial Ownership Information Rule. FinCEN is a bureau of the U.S. Department of the Treasury. Per the above, it is unclear whether the CTA remains enforceable. Despite the developments, most resources suggest filing to ensure timely compliance in the event the law is upheld as enforceable.

If you have questions or concerns regarding the CTA and/or steps to comply, please contact a knowledgeable attorney to provide relevant guidance. ■

BCBS Updates Policies in Response to Widespread Advocacy Efforts Among Audiology and Hearing Aid Dispensing Professionals

BY KIM CAVITT, Au.D.

Following considerable advocacy from members and all stakeholders in the audiology and hearing aid dispensing communities, including but not limited to the representatives of the Academy of Doctors of Audiology (ADA), the Blue Cross/Blue Shield Federal Employee Plan (FEP) has updated its utilization management guidelines for hearing aids, effective April 1, 2024. We strongly encourage all members and their staffs to thoroughly read and review these updated guidelines themselves, which can be found at https://www.fepblue.org/-/media/PDFs/Medical-Policies/2024/March/Mar-2024-Medical-Policies/Remove---Replace/FEP-UM-Guideline-005-Hearing-Aids-2024-benefit.pdf.

The changes and chief considerations for audiologists in the updated guidelines are as follows:

BCBS FEP requires prior authorization for all hearing aids.

Medical Necessity Requirements for Hearing Aids (initial or replacement)

- "Must be approved, listed, and/or registered with the FDA as a prescription device,
- Dispensed by prescription or signed written order from a licensed healthcare provider who is practicing within the scope of their license. a. Hearing aid purchase within 6 months of the date of prescription,
- Hearing loss determined and documented by audiometric testing (hearing test) completed in the 6 months prior to hearing aid purchase,
- **The degree of hearing loss is confirmed by audiometry or other age-appropriate testing to be greater than 26 dB hearing loss (HL)** for: a. conductive hearing loss unresponsive to medical or surgical interventions b. sensorineural hearing loss c. mixed hearing loss (combination of conduction hearing loss and sensorineural hearing loss)"

Medical Necessity Requirement for Replacement Hearing Aids

- "Member's past history of hearing aid use
- Pertinent medical history, description of functional status, relevant prior treatment
- Comprehensive audiometric testing: date, type of testing and results that demonstrates the hearing loss and need for a replacement hearing aid.
- The currently used device is no longer functioning adequately and has been determined to be non-repairable and is not under warranty, OR
- Significant change in the person's hearing that requires a different hearing aid (at least a 15 dB change in at least one frequency between 500 and 4000 Hz)
- Recommendation for type of replacement device
- Follow-up plan for assessing effectiveness/outcome of use of the replacement hearing aid, including trial period and warranty information."

Definition of Medical Necessity

"Medical necessity shall mean healthcare services that a physician, hospital, or other covered professional or facility provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice in the United States; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient's illness, injury, disease, or its symptoms; and
- **Not primarily for the convenience of the patient, physician, or other healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury, or disease, or its symptoms;** and
- Not part of or associated with scholastic education or vocational training of the patient; and
- In the case of inpatient care, able to be provided safely only in the inpatient setting.

Not Medically Necessary

- Accessories which are for convenience and not medically necessary (such as streamers, TV adaptors, phone clip, remote controls, remote microphones, and apps).
- Hearing aids that have been returned for a refund during the trial/adjustment period.
- Repair of hearing aid performed under warranty.
- Repair or replacement of hearing aids due to loss, misuse, or abuse.
- Over-the-counter hearing aids/ hearing assistive devices/ personal sound amplification products (PSAPs) available without a prescription.

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PRESIDENT'S MESSAGE

Continued from page 3

It is important to understand that ADA does these things very well, however, there is always room for improvement. Our board has been working hard to move the needle and will continue using these team-based approaches throughout this year. We also have been working together with our colleagues at the American Academy of Audiology (AAA) and the American Speech-Language-Hearing Association (ASHA) to move our legislation forward! Our manufacturing partners hosted the Hearing Industries Association (HIA) conference in DC and on March 20th, Dr. Bopanna Ballachanda and Dr. Tena McNamara, and myself charged The Hill in DC as a united front to support the Medicare Audiology Access Improvement Act. We had some great meetings and I look forward to gaining further support from Members of Congress through the year. I want to thank the HIA for putting on the conference and giving the academies the opportunity to attend and lobby together. ADA, ASHA, and AAA also hold a monthly president meeting to discuss professional issues and identify areas where we can align to better move forward on the big-ticket items on which we agree. These communications build trust and will ultimately move our profession forward.

For the first 4 months of this year, ADA has been focusing on the fundamentals of communication and gaining relationships within our organization and with our extended partners. I look forward to the next 8 months as we continue to see where this goes. ■

EDITOR'S MESSAGE

Continued from page 5

ago, combined with the fact that the schematic is still widely discussed at many state and national professional meetings today, underscores just how little hearing aid uptake rates have changed. Or perhaps it is our thinking about untapped markets and poor uptake rates that needs to change. Which brings us to perhaps a fresher approach to understanding the challenge, one first published about four years ago.

Although the data in Figure 1 is directionally correct, it doesn't tell the whole story. In February 2020, Seminars in Hearing published an insightful article by Brent Edwards of NAL that built on Oliveira's pyramid and helps us better understand the challenges associated with poor hearing aid uptake rates. Using two variables, degree of hearing loss on the audiogram and self-reported hearing difficulties, Brent was able to shift the focus away from singular attention on the audiogram and degree of hearing loss by adding the individual's own perception of their hearing difficulties to the mix. He devised the four-quadrant matrix, shown in Figure 2, as a way to fully capture the unmet need for hearing devices and professional services.

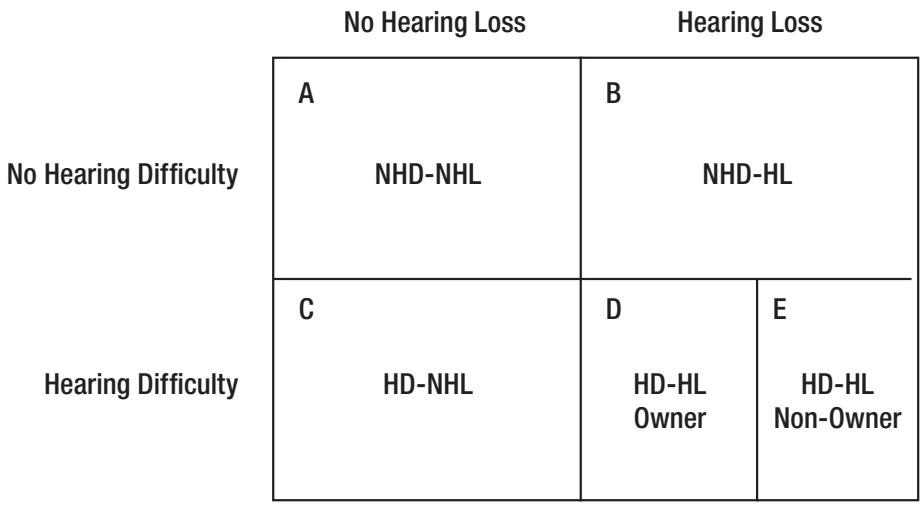


Figure 2. The population segmented by hearing loss and self-reported hearing difficulty. Edwards, 2020.

By thinking about persons with measured hearing loss on the audiogram and self-reported hearing difficulties as two separate, yet overlapping, categories of potential consumers, Edwards expanded our understanding of different segments of the market and how each individual's perception of value differed — depending on the quadrant they fell into. With over-the-counter (OTC) hearing aids on the drawing board in 2020 when this article was published, Figure 2 helped us realize at the time that OTC and other direct-to-consumer devices and services would probably appeal to an untapped segment of the market that rejected in-person clinical care and medical grade hearing aids. It also helped us realize there were other segments of the market that would see value in devices like multitasking hearables/earbuds or other yet-to-be-defined products or services.

Today, although we are now more than a year removed from the FDA's codification of OTC hearing aids, and despite ample evidence demonstrating their technical viability, uptake rates for OTC are mired in the low single digits while the uptake of prescriptive hearing aids remains unchanged.

Fortunately, some recent research, published in late 2023, has evolved beyond the more traditional medical model of care in which we view the consumer through the lens of their audiogram or hearing handicap score. Instead, this new bit of research relies on understanding the consumer archetypes of people who might be shopping around for hearing care. First, it helps to know a little about customer archetypes. In short, they are a pattern of behaviors and attitudes that describe a group of consumers. More specifically, consumer archetypes are abstract, symbolic representations of various customer groups — highlighting their motivations, characteristics, and needs. Consumer archetypes are commonly generated by behemoths like Coca-Cola, Proctor & Gamble, and Nike to help them build their brands and develop messaging that resonates with distinctive market segments. By developing archetypes, businesses can identify target markets, understand the values of various market segments, and determine the most effective ways to communicate with each segment.

In an open access December 2023 AJA article (Singh, Dhar 2023), Singh and Dhar, maybe for the first time in our profession, applied customer archetypes research to hearing care. They found there are two unique consumer archetypes in hearing healthcare: Explorers and Entrusters. Table 1 describes some of the important characteristics of each of these archetypes.

Explorers	Entrusters
Highly independent	Rely heavily on others in the buying process
Comfortable buying online	Not comfortable buying online
Verifies sources prior to buying	Does not check multiple sources prior to buying

Table 1. Brief descriptions of the two major customer archetypes in hearing care. Singh and Dhar, 2023.

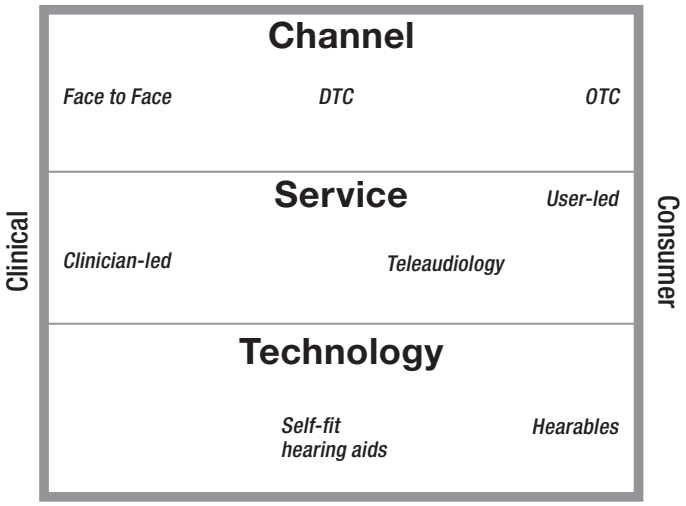
Interestingly, according to their research, both Explorers and Entrusters have a strong preference for in-person delivery pathway as 84% of both groups preferred in-person pathway to online/direct-to-consumer care. Their reliance on the in-person pathway for care delivery probably reflects both a lack of knowledge and trust in the OTC channel. Some time and effort building this channel in a responsible way could yield some real improvements in uptake rates, especially among the Explorer archetype who might come to value the OTC channel in time.

Oddly enough, another 2023 article mentions customer archetypes. And it too helps us gain a deeper understanding of the untapped market for hearing devices and the professional services that often accompany them. Their framework, illustrated in Figure 3, shows there are three elements of hearing care: Technology (hearing devices), Service (assistance, counseling) and Channel (the way in which technology and service is delivered). All three of these elements exist independent of each other and exist on a continuum with clinic-driven care on one side and consumer-led, self-directed care on the other.

This framework allows us to see how technology, service and channels can be mixed and matched, depending on the needs or wishes of the person with hearing difficulty. For example, someone could begin their journey with the purchase of OTC devices on-line and eventually find their way into a clinic for an assortment of professional, counseling-related services.

The authors suggest there are eight archetypes of solutions that stem from this framework. A topic that will be the focus of an upcoming article published here.

Figure 3. The hearing care framework created by Brice, Saunders & Edwards, Seminars in Hearing Vol 44, No. 3, page 222.



When customer archetypes data is combined with our knowledge of the more medically oriented four-box approach shown in Figure 2, we have a much more nuanced view of hearing care. A more refined approach to understanding the diverse market for hearing care products and services will enable us eventually to devise more effective clinical and business strategies. Strategies that improve the uptake rates of hearing devices and create more customer value in various types of services. Let's hope 2024 brings even more fresh thinking to improving how we address the unmet need of hearing loss in adults.

Given the more nuanced view of the market that is emerging, there is certainly room at the table for prescriptive hearing aids, OTC hearing aids and the direct-to-consumer (DTC) acquisition of products and services.

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Singh J. Dhar S. Customer Archetypes in Hearing Health Care. *J American Journal of Audiology*. V32 (941-949). 2023. doi:10.1044/2023_AJA-23-00095. https://pubs.asha.org/doi/abs/10.1044/2023_AJA-23-00095

Brice S, Saunders E, Edwards B. Scoping Review for a Global Hearing Care Framework: Matching Theory with Practice. Semin Hear. 2023 Jun 6;44(3):213-231. doi: 10.1055/s-0043-1769610. PMID: 37601536; PMCID: PMC10436796. ■

HEADQUARTER'S REPORT

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5. Organize a reverse fly-in and host legislators at audiology practices throughout the state! ADA can help you coordinate a request to the scheduling offices for your state's Congressional delegation. There is no better way to demonstrate the value of audiology than for legislators to see what you do first-hand.
6. Spread the word about MAAIA to local media and on social media. ADA can assist your state in developing media advisories and social media posts with information and facts that are specific to your state.

State audiology associations are indispensable allies in the push to pass the Medicare Audiology Access Improvement Act. Their advocacy work not only elevates the profession of audiology but also promises to significantly improve the lives of Medicare beneficiaries across the nation. As the legislative process unfolds, the contributions of state associations will undoubtedly be key to achieving the goal of expanded access to audiological care for all who need it. Please contact me at sczuhajewski@audiologist.org if I can assist your state association in putting together resources to advance the Medicare Audiology Access Improvement Act in Congress. Thank you, to all of the state audiology associations that are actively working to advance this important legislation! ■

THE SOURCE

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Recommendations

- **Follow the utilization management guidance** (https://www.fepblue.org/-/media/PDFs/Medical-Policies/2024/March/Mar-2024-Medical-Policies/Remove---Replace/FEP-UM-Guideline-005-Hearing-Aids-2024-benefit.pdf)
- **For initiating the prior authorization process**, use your Availity or BCBS portal, the pre-certification contact phone number and/or fax number for your state FEP plan, or have your office or the FEP member contact the number on their insurance card.
- **Documentation:** Based upon the medical necessity guidance, it is important to document, in the medical record, the medical necessity of the make, model, type, style, and features of the hearing aid for each specific patient. FEP covers what is minimally medically necessary.
- **For prior authorization requests**, you must include the results of a comprehensive audiogram (air conduction, bone conduction, speech reception threshold, and speech discrimination) performed in the past six months.
- **For appeals**, request a "like specialty review" and clearly document medical necessity as outlined above.

Please do not hesitate to contact Kim Cavitt at kim.cavitt@audiologyresources.com or Stephanie Czuhajewski at sczuhajewski@audiologist.org with any comments, questions, or concerns. ■

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3 – The ADA dues of $115 are paid every year when you spend $25,000 or more in every subsequent calendar year after the first year. Annual value of $115 per practice. You still have to pay your dues as normal. We will simply credit you back the $115 value in the form of a statement credit. Your Card account must not be canceled or in default at the time of fulfillment of any offers. If we in our sole discretion determine that you have engaged in abuse, misuse, or gaming in connection with the welcome offer in any way or that you intend to do so, we may not credit Rewards points, we may freeze Rewards points credited, or we may take away Rewards points from your account. We may also cancel this Card account and other Card accounts you may have with us.

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The Changing Role of the Hearing Healthcare Professional

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