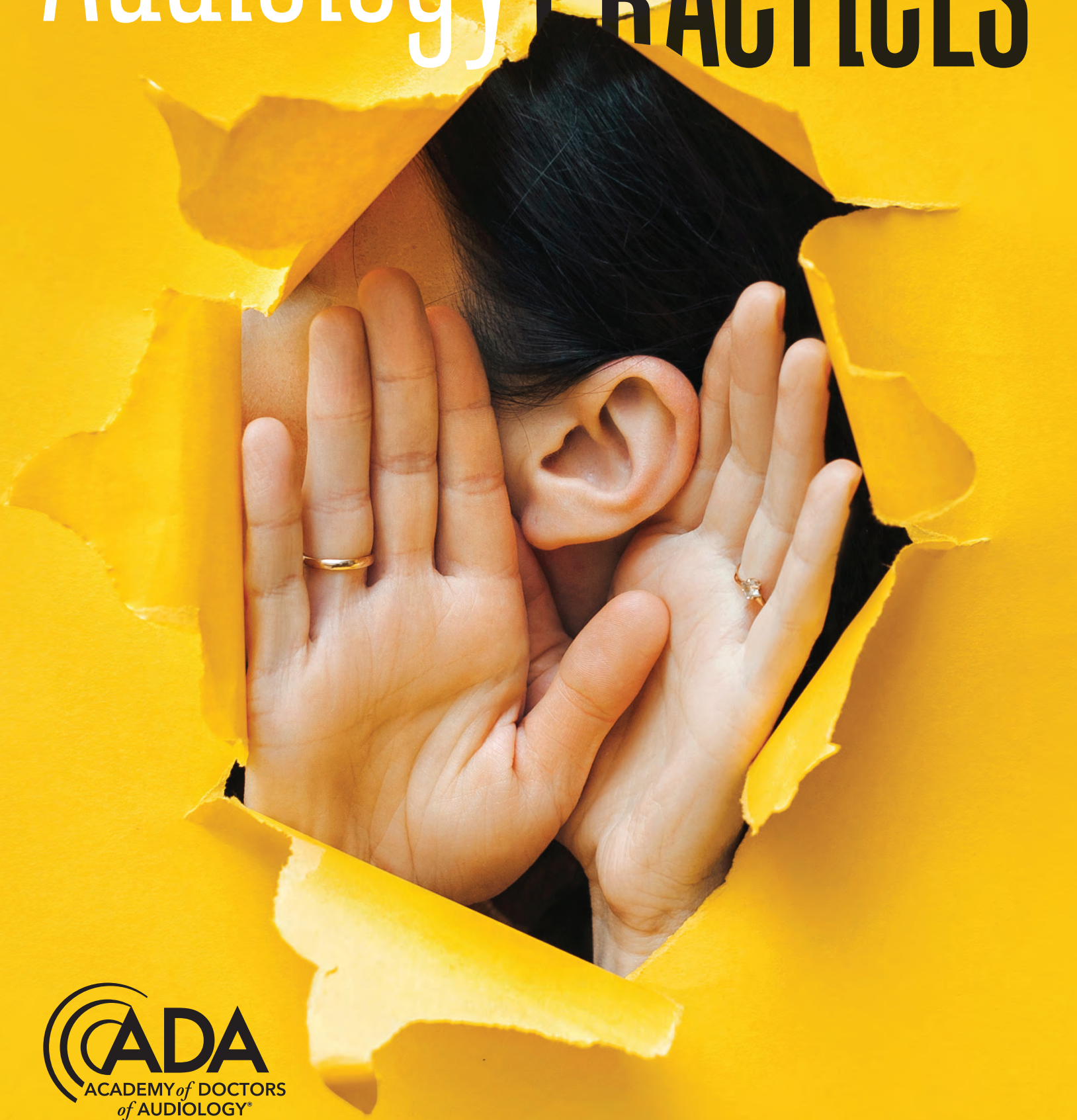
THE OFFICIAL PUBLICATION OF THE ACADEMY OF DOCTORS OF AUDIOLOGY®

Audiology PRACTICES



ACADEMY of DOCTORS of AUDIOLOGY®

The Power to Practice

VOLUME 13, NUMBER 3 ■ SEMPTEMBER 2021 | WWW.AUDIOLOGIST.ORG

Top Digital Strategies to Help Your Practice Grow

In today's digital world, prospective hearing patients are now active partners in their medical journeys. Like their younger counterparts, they are using digital tools to find clinics and research the care they are looking for to achieve better hearing health.

Michele Ahlman, CEO of Clear Digital Media, shares the *Top Digital Strategies to Help Your Practice Grow* and provides practical insights on how to use video content effectively and boosting your SEO to attract more patients.

In a relatively short period, thanks to digital information, today's consumers have had to adjust to thinking and processing information differently. Still, emotion drives behavior. If practices can connect on an emotional level, it does more to drive a person to action. Starting from the beginning of the patient's experience in the practice, how important is the first impression?

AHLMAN The first impression is everything! For prospective patients, new patients and yes, even returning patients, the impression they get when they walk through your doors lays the groundwork for not only that appointment but for your relationship with the patient. It tells those patients in seven seconds or less how you manage your practice and how you value them. If that first impression isn't managed well, it becomes much more difficult to effectively inspire patients to continue with your practice in their hearing healthcare journey.

What can a practice do to improve the first impression?

AHLMAN To improve the first impression, you should try and experience it through your patient's eyes. Make it a habit to step inside your clinic as a patient. Take a good look around. Is your patient greeted with a clean, attractive lobby or waiting room? Do you have a screen in the waiting area that presents prospects and patients with video content that engages and presents information that, even if viewed in a couple of minutes, inspires questions and provides insights that result in better outcomes? Do not underestimate the value of a patient engagement system in the waiting room. We see clinics experience a 10 to 1 ROI with a custom program like Clear Digital Media, a service that develops digital signage networks individualized for medical practices. When you add informational videos that share info on financing options such as the CareCredit credit card, the ROI can be even higher.

What is the most important digital tool hearing healthcare providers should start using in their practices today?

AHLMAN Video content management. Video is such a powerful tool. According to the 2017 Forrester Research study, A 60 second video has the same impact as 1.8 million written words.[1] Video engages all the patient's senses and is far more effective in teaching, telling stories, presenting testimonials or marketing in-clinic than any other medium. Using video in the waiting room and exam/consult room is a very powerful and effective way to engage, educate and precondition your patients.

Another important digital tool is SEO or Search Engine Optimization. SEO can be a scary term to some practices because they don't exactly know what it is or what they can do to improve it. Can you help explain what SEO is and provide some easy tips practices can start employing immediately to improve it?

AHLMAN Search is an indispensable tool in the patient journey. SEO involves techniques to improve the organic ranking of your website when people search for specific keywords or phrases. 77% of patients used search prior to booking an appointment,[2] meaning that they used a search engine to find a local practice that meets their hearing healthcare needs. To be easily found on a search, your clinic needs to have outstanding SEO. Updating your site regularly, having a mobile friendly layout and adding video to your website are all ways to boost your SEO and make it easier for new patients to find you.

Is mobile marketing important to the senior population?

AHLMAN Smartphone adoption is 86% among Americans age 50 to 59 and 81% for those 60 to 69. Meanwhile, 62% of those surveyed 70 and older use smartphones.[3] In today's world, we literally freak out if we leave our smartphone at home when we leave the house. This is true of all demographics. We rely on it for everything: maps, communication, searching and entertainment. A mobile phone is a constant research companion that is in the pocket of every patient. Not only should your website be adaptive to work on mobile phones, but also you may want to consider including mobile advertising into your marketing plan. You can reach prospective patients on the device that they hold most dear and spend the most amount of time on. Digital tools like Geofencing, which draws a digital border around locations and delivers a mobile ad to target prospects that enter that border with their mobile phone, can be a very affordable way to reach potential patients on their mobile devices. Advertising financing options in addition to the services you offer can be a very effective lead generation tool. ■

1 Swerdlow, Fiona (February 28, 2017). "The State Of Retailing Online 2017: Key Metrics, Business Objectives, And Mobile." Forrester. https://www.forrester.com/report/The+State+Of+Retailing+Online+2017+Key+Metrics+Business+Objectives+And+Mobile/-/E-RES137185?objectid=RES137185.

2 Staff (2017). "How first impressions online affect patient acquisition and hospital revenue." Beckers Hospital Review. https://www.beckershospitalreview.com/hospital-management-administration/how-first-impressions-online-affect-patient-acquisition-and-hospital-revenue.html.

3 Kakulla, Brittne Nelson (January 2020). "Older adults keep pace on tech usage." AARP Research. https://www.aarp.org/research/topics/technology/info-2019/2020-technology-trends-older-americans.html.

We're looking forward to participating in AuDacity 2021!

Visit us in the Exhibit Hall to learn about new product information, referral criteria and services to help you and your patients. In addition, join us for an exciting presentation, on Monday, October 25, 2021.

The Keys to Successful Integration of Implantable Hearing Solutions in a Private Practice

Presented by:

Ginger Grant, Au.D., Senior Manager of the Cochlear Provider Network and Catherine Richardson, M.A., Director Market Expansion and Integration

When:

Monday, October 25th @ 3:00PM

Part 1: 3:00PM – 3:45PM
Part 2: 3:50PM – 4:25PM

Adding any new service to an audiologist's private practice offering requires extensive consideration of business growth and development requirements and opportunities while always focusing on obtaining the best possible patient outcomes. It is now well established that audiologists in a private practice setting can successfully integrate implantable hearing solutions, allowing providers to both keep existing and attract new patients, while developing partnerships in the medical community and tapping into an alternate revenue source for the practice. The purpose of this session is to review various considerations necessary to elevate this opportunity to the highest level for the practice owners and patients alike.

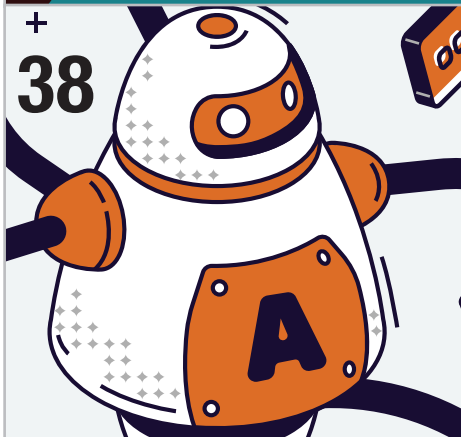
If you are interested in learning more about implementing cochlear implants into your practice with the Cochlear Provider Network, visit **www.cochlear.com/us/ADA**

"We wanted to be more than just the place people went for hearing aids. We wanted to be the type of practice where any audiological need could be met, and when we had a patient who was a cochlear implant candidate, we didn't want to have to refer them elsewhere."

Eric Sandler, Sc.D. – Member of the Cochlear Provider Network

CAM-MK-PR-533 ISS1 JUL21

Features



INCREASE PATIENT RETENTION WITH AUTOMATED MARKETING

With on-demand access to patient data, through various CRM integrations, BlueWing Hearing Care is able to implement set-and-forget patient-driven marketing efforts for your practice. These data-driven, automated campaigns target the right patients, at the right time, which improves response rates.

10X HIGHER RESPONSE RATE with Automated Trigger-Based Direct Mail Programs

The Benefits of BlueWing's Automated Marketing with CRM Integration

- **Set it and forget it –** Direct mail campaigns automatically send to patients based on their actions or buying behaviors.
- **Powerful reporting –** BlueWing will match back campaign response and demonstrate the path from lead to sale, showing your true return on investment.
- **Weekly mail drops –** Creates a steady flow of traffic while minimizing cancellations and no shows.
- **No monthly fees or subscription costs –** Pay the price per piece and nothing more.
- **Plus! The ability to target new patient groups based on the collection of current patient data.**

Learn more and see samples at
bluewinghearing.com/trigger-marketing

Contact me to get started with BlueWing Today!

Brad Dodson
Account Executive

708-689-3395
bdodson@bluewingdirect.com
bluewinghearing.com/trigger-marketing

BlueWing® HEARING CARE

Why BlueWing?

BlueWing is a full-service marketing agency that has specialized in hearing care marketing for over 25 years. BlueWing is your one-stop-shop for creative, data science, production and fulfillment all in-house.

*"We've worked with BlueWing on multiple **direct mail campaigns**. Our past campaign **we invested $2,550 and we've already received over $25,000 in revenue from it**. If you're looking for measurable results from your marketing turn to BlueWing."*

– Charles, Owner

HOW TO REACH US

ADA Headquarters
1024 Capital Center Drive, Suite 205
Frankfort, KY 40601
Phone: 866.493.5544
Fax: 859.271.0607

www.audiologist.org

Departments

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

Audiology Practices (USPS 025-476) ISSN (21645248) is published quarterly by the Academy of Doctors of Audiology, 1024 Capital Center Drive, Suite 205, Frankfort, KY 40601. Periodicals Postage Paid at Lexington KY and at additional mailing offices. Subscriptions are $25 as part of membership dues. POSTMASTER: Send address changes to *Audiology Practices*, 1024 Capital Center Drive, Suite 205, Frankfort, KY 40601.

Contact Your Legislators!

Urge them to support the **Medicare Audiologist Access and Services Act** (H.R. 1587 and S. 1731)

ADA
ACADEMY of DOCTORS of AUDIOLOGY®

The Medicare Audiologist Access and Services Act of 2021 (H.R. 1587 and S. 1731) will remove unnecessary barriers, allowing patients to receive appropriate, timely, and cost-effective audiologic care. This legislation can improve outcomes for beneficiaries by allowing direct access to audiologic services and streamlining Medicare coverage policies so that audiologists can provide the full range of Medicare-covered diagnostic and treatment services that correspond to their scope of practice. The legislation would also reclassify audiologists as practitioners, which is consistent with the way Medicare recognizes other non-physician providers, such as clinical psychologists, clinical social workers, and advanced practice registered nurses.

Support the future of audiology!
Contact Congress today and express your support for H.R. 1587 and S. 1731.

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

Victor Bray, MSC, Ph.D., FNAP.

We Have Friends in High Places Talking About the Importance of Audiologists

In parallel with the transition to the Au.D. degree, audiology organizations have, for over two decades, been regularly introducing legislation that would allow our new doctoring profession to play a greater role in the nation's hearing healthcare. Frankly, for two decades, no advancements have been made. With the recent unification of ADA, AAA, and ASHA behind the Medicare Audiologist Access and Services Act (MAASA), the possibility is real that positive change can happen, in 2021, for audiology and the patients we serve.

While it may seem incredulous to you (and certainly is to me), there are still thousands of our colleagues who do not know about MAASA, know why MAASA is important, and know what MAASA means to the Au.D. movement. It is important that you share with all your colleagues and patients the important provisions in MAASA and obtain their buy-in and support. One way to describe MAASA is from this recent Senate testimony which lays out the big picture:

> ***Senator Elizabeth Warren:*** *"Audiologists provide critical services to people with hearing loss. That's why I am joining Senator Paul and Senator Grassley in reintroducing the Medicare Audiologist Access and Services Act [S. 1731]. This is a bill that would expand senior's access to hearing services by reclassifying audiologists as practitioners in the Medicare program and that will allow them to bill for services without a physician referral and to provide patients with both the kind of diagnostic and treatment services that are within an audiologist's scope of practice. It seems to me that the COVID-19 pandemic has forced us all to reconsider bureaucratic limitations to health care, including hearing care. So, I believe the Senate should prioritize the passage of our bill to help seniors get the care that they need."*

Of the three components to MAASA – direct access, treatment services, and practitioner status – two are focused on today's Medicare Part B beneficiaries (direct access and treatment services) and one is aimed at the future of our profession (practitioner status). 'Practitioner status,' as opposed to 'diagnostic, other, supplier status', advances the professional recognition, rights, and responsibilities commensurate with a doctoring healthcare profession. For example, with practitioner status comes the ability to be reimbursed for telehealth services, something we have been granted on a temporary basis during the COVID-19 public health emergency (but will end with the expiration of the national public health emergency order). The importance of telehealth, and direct access, to hearing healthcare patients in rural populations was addressed in this recent House testimony:

> ***Congressman Tom Rice:*** *"I've got three very rural counties with majority-minority populations that are very much underserved in terms of healthcare facilities and telehealth has been a very big boon to them, particularly in a time of COVID." … "I have a bill up [H.R. 1587] that would allow people to have direct access to audiologists because, again, I've got very rural populations that are very much underserved by primary care physicians and the requirement that they have to go to get a referral is very onerous to them."*

Continued on page 51

Compelling Data Connecting Hearing Loss and COVID-19

Studies have already shown sudden sensorineural hearing loss, vestibular balance dysfunction and tinnitus to be linked to COVID-19. What's more – these conditions are more prevalent than many realized early on in the pandemic.

In one study, 10% of patients self-reported persistent changes to their hearing status or tinnitus when surveyed 8 weeks after their discharge from the hospital following treatment for COVID-19.*

This new white paper, sponsored by Hamilton® CapTel®, explores emerging data and studies linking hearing loss to COVID-19, the long- and short-term effects on patients and its impacts on hearing healthcare professionals and clinical practice.

Get the white paper now at **HamiltonCapTel.com/ADA821**

*Kathleen Faulkner, Ph.D., "COVID-19 and Hearing Loss: What We Know Now" Hamilton CapTel, April 2021

062821

Brian Taylor, Au.D.

To Boost Outcomes for Hearing Aid Wearers, the Profession Should Commit to Telehealth Services

It should concern every audiologist that anywhere from 5 percent to one-quarter of patients never use their hearing aids. Or that by some accounts, an astounding 98 percent of hearing aid owners say they had at least one problem with their hearing aids in the first year. Or that 54 percent of problems go unreported to HCPs, and 46 percent remain unresolved even after seeing an HCP.

I think we can all agree, such findings indicate that the hearing patient journey, at least for some, can be complex, and has room for improvement.

All this is happening at a time when more people are seeking the services of an audiologist. Not only do 20 percent of people aged 60 or older suffer disabling hearing loss, but up to 18 percent of U.S. adults self-report communication difficulties despite normal audiograms.

And many of the latter are apparently looking for help. In a recent survey of more than 200 audiologists, 68 percent reported seeing individuals with self-reported communication difficulties but normal hearing. We know that people with mild hearing loss don't usually acquire hearing aids, so it's fair to assume those with subclinical hearing loss rarely seek assistance, even though today's advanced hearing aids could enhance their ability to communicate in a variety of situations.

Whatever we're doing—and however we're doing it—there continue to be unaddressed gaps in hearing aid usage and overall adoption. If people are going to get the hearing care they need, we must make it easier for them to adopt hearing aids. The profession (audiologists) and industry (hearing aid manufacturers) must work in partnership to find ways to solve both wear-time and uptake problems.

High-quality, regulated devices in a range of price points and form factors are, of course, part of the solution. But we should employ another important strategy if we're to expand the market and improve hearing aid wear-time: widescale embrace of telehealth services in audiology.

Growing Acceptance

In April, the Centers for Medicare & Medicaid Services acknowledged the importance of telehealth in delivering audiology services by significantly expanding the number of telehealth services that audiologists could bill directly to Medicare during the current public health emergency. The Department of Veterans Affairs has long pursued innovative ways of delivering hearing care to veterans living far from VA facilities, including through telehealth audiology. And today, most states now allow licensed audiologists to offer telehealth services.

For a variety of reasons—some brought into stark relief by the Covid-19 pandemic—ongoing telehealth will prove important to delivering hearing care. It will also help address aspects of the hearing patient journey that might otherwise hinder hearing aid use and uptake. As a member of the HIA's Telehealth Task Force, I encourage professional and industry organizations to endorse telehealth

Continued on page 52

AuDACITY 2021

AUDIOLOGY UNLEASHED

Join us at the Marriott Downtown Waterfront Hotel in Portland, Oregon, October 25 - 27 for AuDacity 2021!

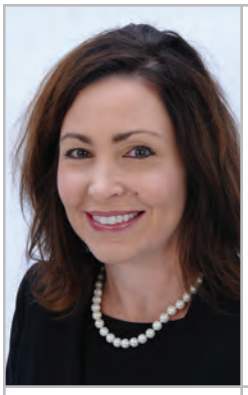
AuDacity is designed to bring together bold and innovative audiologists to share bold and innovative ideas. Registration is now open—visit **audiologist.org/2021**.

OCTOBER 25–27

PORTLAND, OREGON

ADA
ACADEMY of DOCTORS of AUDIOLOGY®

Stephanie Czuhajewski, MPH, CAE, Executive Director



AuDacity 2021 Here We Come! Unleash Your Potential in Portland, Oregon, October 25-27

AuDacity is the place where audiology's potential and purpose meet. It's where audiologists gather to design their future, to reminisce the past, and to make the most of the present--in the presence of great company and great ideas that challenge us to go further and toward greater purposes.

AuDacity 2021, Audiology Unleashed continues that *AuDacity* tradition with a program that will encourage you to push back on status-quo thinking and push forward an ambitious agenda to support audiology's transition to a doctoring profession. *AuDacity's* next-level course line up and curated networking activities will maximize opportunities for engagement and learning. Attendees and content leaders will explore the essential role of audiologists in improving access to care, patient outcomes, and audiovestibular health equity using evidence-informed practices and interprofessional approaches that span the care continuum.

AuDacity: In-Person Precautions

A jam-packed program is delightful—jam-packed meeting rooms are not. ADA is committed to hosting the *AuDacity 2021 Conference* in a safe and responsible manner. The ADA staff team is in regular contact with public health officials and hotel representatives to plan and implement strategies to ensure that *AuDacity 2021* is held in a physical environment that fosters the health and safety of participants.

AuDacity attendees will notice other changes including "touch-limited" on-site conference registration/check-in processes and directional pathways to reduce crowding. Meals and breaks will offer delicious grab and go options, rather than traditional buffets, and the conference agenda and continuing education information will be available electronically from a smart device.

While ADA strongly encourages COVID-19 vaccinations for *AuDacity* attendees who have not otherwise acquired immunity, proof of vaccination is not required as a condition of attendance. ADA trusts and expects *AuDacity* attendees to take the following actions:

- To evaluate available evidence regarding immunization and other safeguards designed to prevent the spread of COVID-19 and other communicable diseases,
- To make informed decisions, based on their own health and circumstances,
- To take appropriate actions and precautions in order to protect themselves *and* others, and
- To comply with public health mandates, hotel requirements, and directives from conference organizers.

All registered *AuDacity* attendees will receive access to conference session recordings and accompanying opportunities for continuing education credit beginning approximately two weeks after the close of the conference. Please visit **www.audiologist.org** for the latest *AuDacity 2021, Audiology Unleashed,* conference information. I look forward to seeing you soon! ■

Understanding the CORE of Any Business

by Brian Taylor, Au.D.

In simple terms, the case study method is a proven approach to operating a business. Pioneered by the Harvard Business School more than 50 years ago, and adapted by entrepenuers around the world to better understand what options manifest the best outcomes, the case method presents the greatest challenges confronting organizations and places the student (or audiologist) at the center of the decision making process, often using a real world example from an operating business. In this issue of *Audiology Practices* we review two case studies, but before you read any further, it might be helpful to review the inner workings of a business.

Regardless of the business there are several univeral components. These are shown in Figure 1. Let's briefly examine each of these variables and how they relate to the case study method.

The Inner Core. Like a tight knit family, the inner core forms the basis for a meaningful and profitable business.

Customers (Who?). Professor Peter Drucker said, "the purpose of any business is to create and keep a customer." For audiologists, customers are typically indivuduals with hearing loss or balance problems.

Value Proposition (What?). The service or product you are offering customers must be of value. It must be something they believe will solve a problem. It must have enough value that customers are willing to take the time and commit the financial resources to acquire it. To differentiate your offerings to customers from those competitors, it is imperative that what you are offering is attractive or appealing.

Value Chain (How?). The way value is created; the clinical process, the way hearing devices are ordered from a vendor, the buying journey for the customer– these are essential components of any value chain.

The Outer Core. Like the earth's atmosphere, the inner core would not survive without a healthy, properly functioning outer core

Revenue Model (Why?). An essential, yet often overlooked component of the inner core of any business is the revenue model. The revenue model is the turnkey template or process in which the business generates revenue as well as profit. Bundled versus fee-for-service pricing, subscription or leasing services are examples of revenue models.

Ethics. A set of moral rules that govern how businesses operate, how business decisions are made and how people are treated. Doing what is in the best interest of patients is job #1.

Analytics. The ability to collect, evaluate and manage key performance indicators that drive business growth, profitabilty and quality.

Business Intelligence. A process by which businesses use strategies and technologies for analyzing current and historical data of customers.

People. Qualified, motivated and trained indviduals who operate all the day-to-day activites shown in the figure on the following page. ■

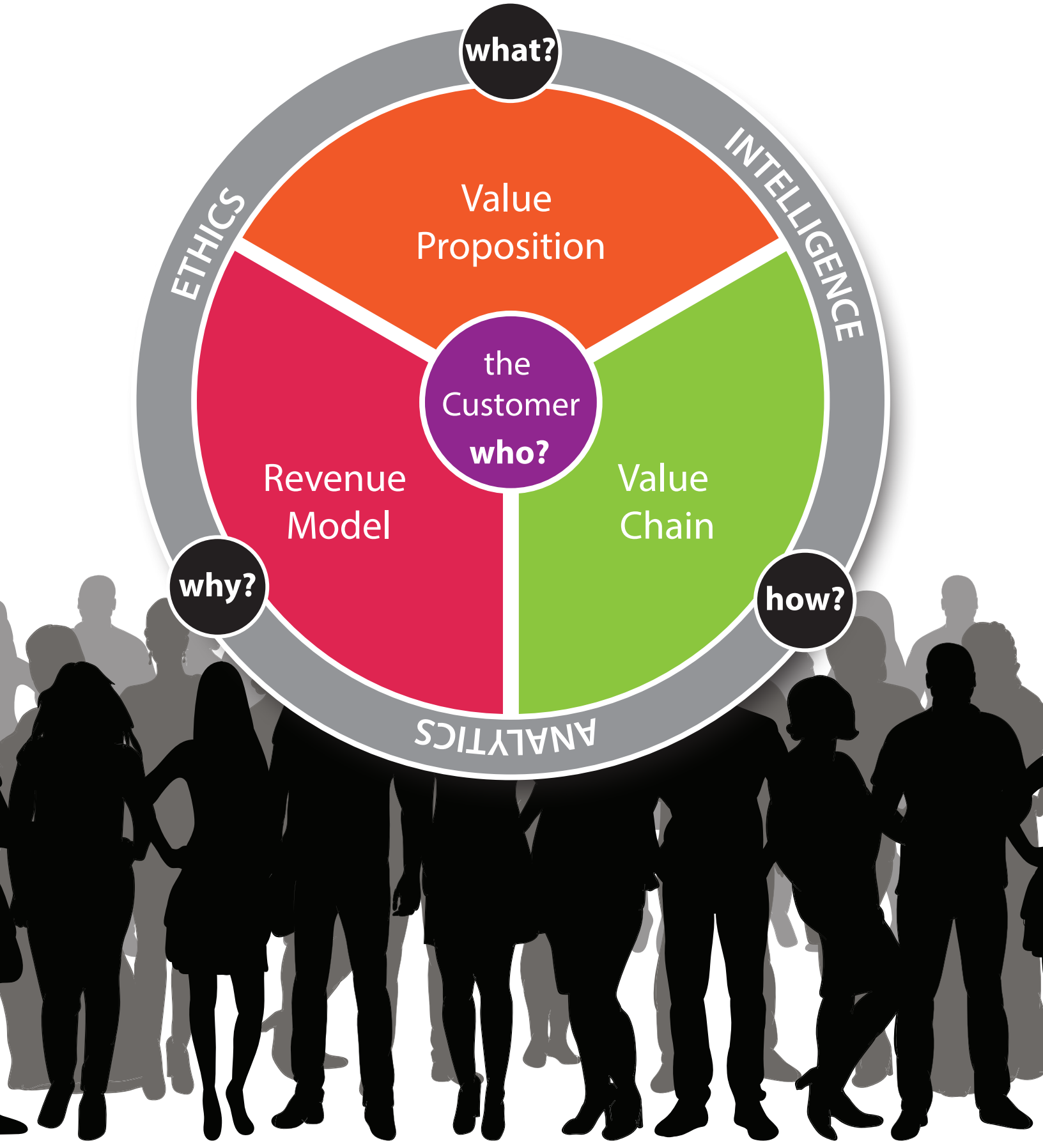
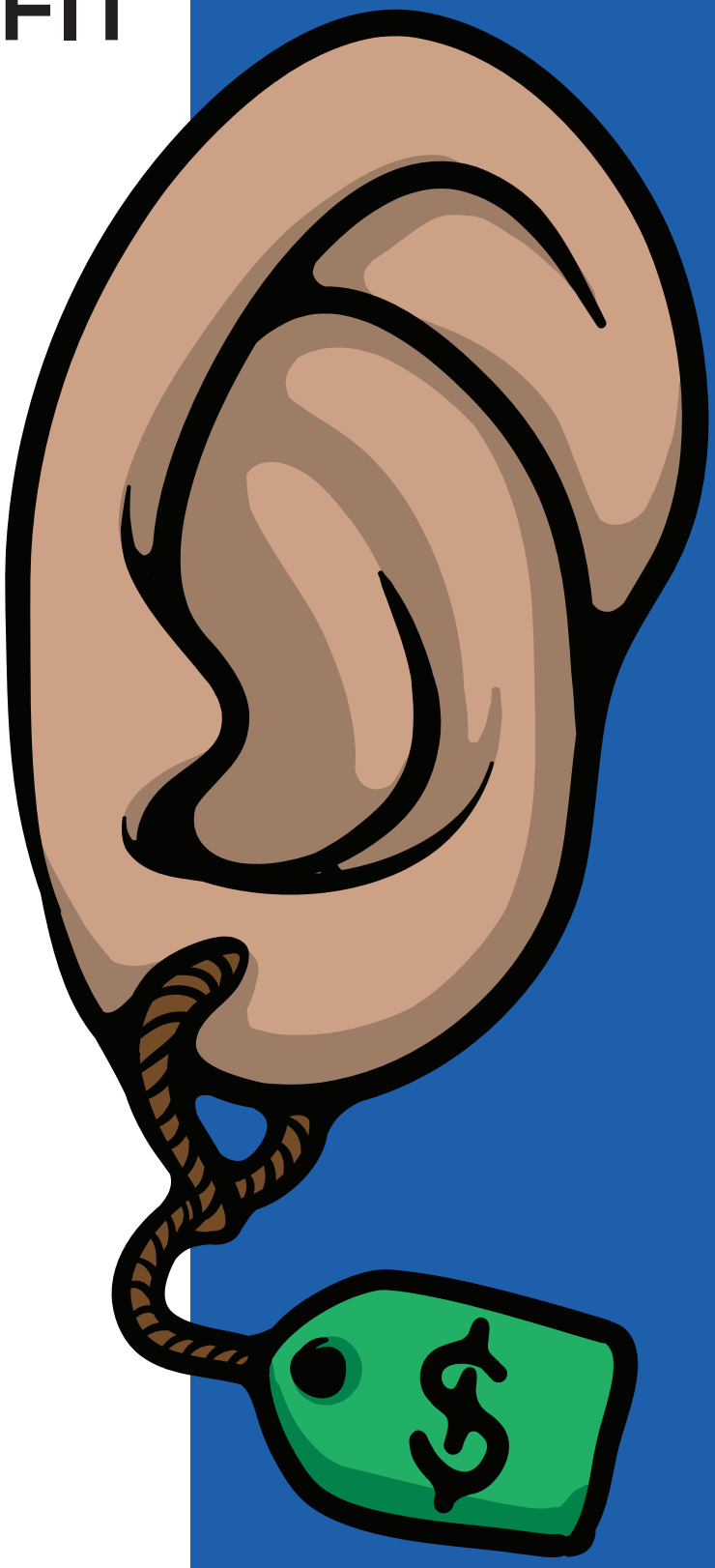

what?
Value Proposition
INTELLIGENCE
ETHICS
the Customer
who?
Revenue Model
Value Chain
why?
how?
ANALYTICS

Figure 1.

MANAGING GROSS PROFIT MARGINS

Negotiating Wholesale Hearing Aid Prices

by Brian Taylor, Au.D.



Wholesale price is best defined as the price the clinic pays directly to the hearing aid manufacturer for each device that is then, in-turn, resold to a patient. Perhaps more than other business metrics associated with hearing aids, wholesale price, commonly known as cost-of-goods or COGs, is a mandatory calculation for all business managers and effectively managing it contributes significantly to profitability of the clinic.

As a strategic imperative, business managers are often tasked with optimizing the wholesale price their clinic pays for hearing aids from manufacturers. Essentially, optimizing wholesale price or COGs is equated with receiving the lowest possible price from the hearing aid manufacturer or vendor. However, it is not this simple and the process of optimizing cost of goods within a clinic can be fraught with several challenges: Each audiologist is apt to have a preferred hearing aid brand. Hearing aid manufacturers may also entice audiologists to recommend their hearing aids by providing an incredibly low introductory price for a brief time frame. Further, audiologists, who usually have little formal business training, are not attuned to the impact COGs have on profitability. In a clinic with several providers, as these challenges intensify, the overall cost of goods for the entire clinic can be difficult to manage and it often rises, thus affecting profitability.

For these reasons, the business manager must work closely with the clinicians in the practice to ensure they are optimizing their cost of goods without compromising the quality of care. The objective of this case study is to outline how one large practice better managed the factors associated with optimizing a clinic's cost of goods, and the effect the execution of a sensible strategy had lowering COGs and increasing profitability.

Scope of Challenge

Cost of goods (COGs), which is the money paid directly to the manufacturer for each hearing aid, typically represents, along with the cost of labor, the largest expense in a clinic. Survey data suggest the average COG for hearing aids range from 40 to 45%. (This calculation means that 40 to 45% of the retail cost is comprised of the wholesale cost, or stated differently, the wholesale cost of the hearing aid is marked up by a factor of about 2.25 or 2.5.) Contrast the relative high COGs of 40 to 45% with more efficient practices that operate with COGS of between 25 and 30%. If the cost of goods can be lowered by, say, $150, that can save the practice thousands of dollars in expenses over the course of an entire year when factored across hundreds of hearing aids dispensed in a given year.

Given the impact a high COGs have on overall clinical profitability, practices can lower them through effective negotiating tactics with their vendors and changes in clinician behavior toward the dispensing of hearing aids. However, simply asking the hearing aid vendor for a discount is an ineffective strategy. To even consider a significant discount of 10% or higher, the hearing aid vendor is likely going to ask for an additional unit commitment. Considering the number of hearing aids dispensed in a year is relatively fixed (even the most productive full-time provider has time limitations that keep this number fixed), negotiating a lower COGs with a hearing aid vendor requires the clinic to make some tough choices about product lines and technology tiers they routinely fit.

Compounding the challenge of lowering COGs are the attitudes and behaviors of audiologists. For various reasons, many audiologists are loyal to a specific hearing aid brand, and like any brand loyalist, there is often an emotional attachment to the brand that must be acknowledged and respected. However, the manager, through effective communication, has the opportunity to use data to sway the opinions of even the most avid brand loyalist.

Project Description

Clinic X employs five full-time audiologists. The clinic operates an active, commercially-based hearing aid dispensary. Although the practice often dispenses more than 1,000 hearing aids per year, which yields approximately $2 million in annual revenue, the new business manager has been tasked with increasing hearing aid profits without compromising quality of care or clinical efficiency. Specifically, the manager has been asked by the owner of the clinic to increase profitability without raising retail prices of hearing aids.

Given the goal set by the owner, the first task of the business manager was to review the prior year's unit sales, how they are distributed across both provider and manufacturer, and to examine the wholesale pricing across product lines and technology tiers. This distribution is shown in Tables 1 and 2.

After reviewing this data with the five audiologists, the clinic created a plan to lower cost of goods and improve profitability. After the staff agreed upon a plan to lower cost of goods, they were expected to execute the plan over the next year, carefully monitoring progress along the way. The expectation being that a lower cost of goods yields more profits that can be re-invested back into the practice.

Methods and Results

Table 1 shows a distribution of hearing aid sales for this large medical practice that employs five full-time audiologists. According to the distribution, 1,000 units were dispensed from seven different hearing aid manufacturers. The total number of units equates to an average of 20 hearing aids dispensed per month for each audiologist. Further, Table 1 shows the average wholesale cost per unit (rounded to the nearest $50) across three levels of hearing aid technology.

Table 2 shows the total dollar value, for each of the three technology levels, from each of the seven manufacturers used by the clinic. The total wholesale cost of hearing aids for this clinic for one year was $948,750. This wholesale figure generated $2,087,000 in hearing aid sales for the practice for the one-year period. Table 3 provides a breakdown in the financial figures for one full year.

Table 1. An analysis of wholesale prices from 7 hearing aid manufacturers. The number of units dispensed for one calendar year per each level of technology is listed.

	Basic	Mid-level	Premium	Total Units Per Manufacturer
Manufacturer 1	$400 26 units	$800 74 units	$1350 20 units	120
Manufacturer 2	$450 24 units	$850 56 units	$1200 18 units	98
Manufacturer 3	$450 26 units	$750 159 units	$1000 82 units	267
Manufacturer 4	$450 30 units	$750 168 units	$1350 15 units	213
Manufacturer 5	$400 36 units	$800 95 units	$1400 18 units	149
Manufacturer 6	$550 10 units	$950 26 units	$1600 14 units	50
Manufacturer 7	$400 46 units	$700 22 units	$1350 43 units	112

Table 2. The total wholesale costs per technology level for hearing aids dispensed from 7 manufacturers over the course of one calendar year. Table 2 revenue corresponds to the unit totals in Table 1.

	Basic	Mid-level	Premium	Total Cost Per Manufacturer
Manufacturer 1	$10,400	$59,200	$27,000	$96,600
Manufacturer 2	$10,800	$47,600	$21,600	$80,000
Manufacturer 3	$11,700	$119,250	$82,000	$212,950
Manufacturer 4	$13,500	$126,000	$20,250	$159,750
Manufacturer 5	$14,400	$76,000	$25,200	$115,600
Manufacturer 6	$5,500	$24,700	$22,400	$52,600
Manufacturer 7	$19,200	$15,400	$58,050	$92,650
Total Wholesale Cost	**$85,500**	**$606,750**	**$256,500**	**$948,750**

Gross margin is calculated by subtracting the cost of goods (wholesale price) from the gross hearing aid revenue. The gross margin is the amount of "profit" generated from the sale of hearing aids *before* all other clinical expenses are calculated. Note in the previous sentence that profit is in quotation marks because the gross margin is not really profit because several other expenses, like payroll, rent, utilities and marketing have not been deducted from it. However, since gross margin is the difference between what the clinic pays the manufacturer for each hearing aid and what the patient pays the clinic for the hearing aid, gross margin is one type of profit. This case study assumes a traditional bundled pricing model in which clinical services are not charged separately.

Table 3. Cumulative key totals for one year

Gross Hearing Aid Revenue	Cost of Goods	Gross Margin	Cost of Goods as % of Gross Hearing Aid Revenue
$2,087,000	$948,750	$1,138,250	45%

The financial calculations shown in Table 3 indicate there is an opportunity to improve profitability by lowering the cost of goods or increasing retail prices. Now is an appropriate time to pause and consider the options of the manager. Given that the COG's percentage is in alignment with industry norms, a COG of 45% is customary per industry survey data, the manager could decide to leave this variable alone and raise retail prices. However, if the average retail price of hearing aids in the practice is $1750 each, even a modest 5% increase in retail price adds over $150 to a pair of newly purchased hearing aids. This is costly to patients and challenging for clinicians who may have to explain why costs are increasing. Before deciding to make a snap decision to raise retail prices, the manager takes a closer look at the expenses related to wholesale hearing aid purchases made by the clinic. After all, money saved on cost of goods might be used for other items that could benefit the practice. For example, it is money that could be used to invest in new equipment, new office furniture or to increase the pay of staff –all things that maintain or create competitive advantages. And, saving money, rather than raising prices, is sure to keep patients and clinicians happy.

Table 4 is a rough calculation the manager made to see approximately how much money the practice could save by doing nothing more than lowering the price they pay the hearing aid manufacturer for hearing aids.

Table 4. A breakdown of potential savings by lowering the cost of goods at three different discount rates.

Annual Cost of Goods = $948,750	Money Saved
10% reduction	$94,875
15% reduction	$142,313
20% reduction	$189,750

Discussion of Tactics

Armed with the information in the three Tables above, the manager worked directly with the clinicians to formulate a strategy to strategically lower the cost of goods for the entire organization. This process began during a monthly staff meeting when this information was shared with the staff. At the same time, the staff, led by the manager, discussed why lowering COGs would be beneficial to the practice. This discussion included an overview of the amount of potential money saved by the practice per Table 4 and how the money could be used to benefit the practice. Also, it was emphasized that retail prices would not be increased, and quality of care could not suffer because of the lowering of COGs. After reviewing the COGs data as a group and allowing for questions, the manager explained that the primary approach to lowering COGs would be to try and whittle the number of vendors from seven to two or three primary vendors. As the manager explained, if the objective was to lower COGs, then the clinicians had to come to some agreement on their primary vendors. By narrowing their primary vendors to two or three, the manager informed the clinicians, they could negotiate a more favorable wholesale price because they would be able to commit to more units, spread over a smaller number of manufacturers. At the meeting, the manager calculated the percentage of units for each of the seven manufacturers used by the clinic. This information is depicted in Table 5.

At the end of the meeting, the clinicians were asked to come to an agreement within the next two weeks on the three primary manufacturers in which they could commit 90% or more of their business. The clinicians were informed that whatever three manufacturers they agreed to be their primary suppliers, the manager would negotiate directly with the vendor to get a lower COG in exchange for a larger monthly unit commitment with each of the primary hearing aid manufacturers. Also, it was acknowledged by the manager that reducing the number of vendors would be a challenging project and some difficult choices and compromises would need to be made, but the staff had the ability to choose their primary vendors and agree to use them for 90% of their business.

Within the next few days, the lead clinician, with the help of the staff, created a list of the characteristics or features the staff believed were needed from their primary hearing aid suppliers. The clinicians were asked to keep their list to items that benefited the patient or the patient-clinician relationship, not just the clinician. The condensed list, which also shows the manufacturers the clinicians

Table 5.

Total Units Per Manufacturer	Percentage of Business (By Unit)
120	12%
98	10%
267	27%
213	21%
149	15%
50	5%
112	11%

believe represent each trait, is shown in Table 6. It is important to note that this list generated some contentious debate among the staff, as most had rather strong opinions about their favorite suppliers. After some heated debate the majority of the staff came to an agreement on three top choices.

Table 6.

Feature or Characteristics	Supplier
Full line of products for all hearing losses	2,3,4,6,7
Customer service	1,3,4,7
Technical support	1,2,4,5,7
Quality of fit	1,2,3,4,6,7
Software	2,3,4,
Track record/Patient results	1,3,4,5,6
Most current or modern technology	3,4,5,7

Based on the information in Table 6, the manager, who now has the support of the clinicians, plans to approach Manufacturer 4, Manufacturer 5 and Manufacturer 7 and re-negotiate terms for wholesale pricing. During a phone call with the director of sales with each of the three manufacturers, the manager explained the practice's goal of lowering their COGs and how the staff gained an agreement on their top manufacturers. The manager then asked for a 20% reduction in their wholesale price in exchange for a commitment of 300 hearing aid units for the entire year from the practice. The director of sales for each manufacturer agreed to consider the proposal.

Within a week, the manager heard from each of the three manufacturers. Manufacturer 4 made a counter proposal of a 15% reduction in their current price, while Manufacturers 5 and 7 both agreed to the 20% discount in exchange for the 300-unit commitment. The clinic manager agreed to the updated terms from all three manufacturer partners and asked that each commit to a 3-hour staff training to ensure that all clinicians and staff, especially those somewhat unfamiliar with the products and software, receive the proper training and support.

(Note: An alternative negotiating strategy, not employed here, would have been to approach all seven vendors asking for a competitive bid in exchange for a greater unit commitment. Additionally, the managers could have delineated by technology tier and asked vendors for steeper discounts for greater unit commitment for specific technology tiers. Readers should think about the advantages and limitations of these alternative negotiating tactics relative to the actual tactic employed above.)

Outcomes

Table 7 shows the new wholesale pricing for the three primary manufacturers used by Clinic X. The new prices here can be compared to the previous wholesale prices shown in Table 1. Note that for the non-preferred vendors, wholesale prices did not change.

Table 7.

	Discount Level	Basic	Mid-Level	Premium	Annual Unit Commitment
Manufacturer 4	15%	$382	$638	$1148	300
Manufacturer 5	20%	$320	$640	$1120	300
Manufacturer 7	20%	$320	$560	$1080	300

Following staff training by the three vendors, the expectation set by the manager was that 90% or more of all hearing aids would be ordered from one of the three primary partners. The updated wholesale pricing plan was now fully implemented.

Table 8 shows the breakdown of units for all seven vendors, one year after their plan was fully implemented with new prices from the three primary partners.

Table 8.

Manufacturer 1	26 units
Manufacturer 2	0 units
Manufacturer 3	88 units
Manufacturer 4	278 units
Manufacturer 5	372 units
Manufacturer 6	0 units
Manufacturer 7	322 units
	1,096 total units

Following one year of implementation of the new pricing strategy, there are a few consequences of the decision to narrow the number of vendors to improve COGs that readers should consider. One, the 300-unit commitment for one full year was met for two of the three primary vendors. Failing to meet just a single unit commitment could be cause for some concern, as the clinic could lose their discount. Two, Manufacturer 1 and Manufacturer 3 still received some units, mainly from one audiologist who was insistent on sticking with those vendors for most of her hearing aid recommendations. This could be a concern for the manager, but since the audiologist is experienced and well-liked by patients, the manager decided not to intervene in her recommendation process now. Three, largely due to training and support from other staff, two of the audiologists successfully shifted their recommended hearing aid from Manufacturer 3 to Manufacturer 7. This resulted in substantial savings to the clinic in COGs and patient satisfaction was not affected.

Finally, although the practice dispensed almost 100 additional units in the second year, by negotiating more favorable terms with three vendors, and strategically bringing more than 90% of unit sales to those three companies, the clinic was able to save more than $300,000 in COGs in the second year. Table 9 shows the breakdown of units per technology level for the seven vendors. Notice that two of the vendors did not receive any business in Year 2, which is a by-product of effective communication and training on the part of the staff. Table 10 shows the cumulative wholesale prices paid to the vendors. These numbers can be compared to Table 2 from Year 1 to gauge the level of improvement in COGs and profit that was generated through strategic renegotiation.

Table 9.

	Basic	Mid-level	Premium	Total Units Per Manufacturer
Manufacturer 1	$400 8 units	$800 10 units	$1350 8 units	26
Manufacturer 2	$450	$850	$1200	0
Manufacturer 3	$450 14 units	$750 62 units	$1000 12 units	88
Manufacturer 4	$382 0 units	$638 168 units	$1158 20 units	288
Manufacturer 5	$320 206 units	$640 95 units	$1120 71 units	372
Manufacturer 6	$550	$950	$1600	0
Manufacturer 7	$320 148 units	$560 102 units	$1080 72 units	322

Table 10.

	Basic	Mid-level	Premium	Total Cost Per Manufacturer
Manufacturer 1	$3,200	$8,000	$10,800	$22,000
Manufacturer 2	0	0	0	0
Manufacturer 3	$6,300	$46,500	$12,000	$64,800
Manufacturer 4	0	$107,184	$23,160	$130,344
Manufacturer 5	$65,920	$60,800	$79,520	$205,840
Manufacturer 6	0	0	0	0
Manufacturer 7	$47,360	$57,120	$77,760	$182,240
Total Wholesale Cost	**$122,480**	**$279,604**	**$203,240**	**$605,324**

Although Clinic X was able to save more than $340,000 in cost of goods through a strategic negotiation process, the financial contribution to the bottom line of the practice is remarkable. Because the clinic also dispensed 96 more hearing aids in Year 2 at a much lower cost of goods, the gross margin in Year 2 increased by nearly $500,000, as summarized in Table 12. Importantly, this gross margin improvement occurred without raising retail prices on hearing aids, increasing staff headcount or adding more appointment slots to the already busy schedules of the audiologists. These stellar financial results transpired through deliberate negotiating tactics, as well as effective communication and management skills in which the clinic and three of its vendors all benefited.

Table 11.

Gross Hearing Aid Revenue	Cost of Goods	Gross Margin	Cost of Goods as % of Gross Hearing Aid Revenue
$2,231,000	$605,325	$1,625,675	27%

Considerations

There are several lessons from this case study that can be applied to any audiology practice engaged in the commercial sale of hearing aids.

1. **Be inclusive.** By involving the staff from the beginning on the decision-making process, the buy-in from most clinicians was excellent and likely contributed to better execution of the strategic plan.
2. **Use data in the decision-making process.** Rather than making a knee-jerk decision to raise retail prices, which would undoubtedly have unintended consequences, the manager systematically looked at the prior year's financial data and decided to deliberately target COGs as an area of improvement.
3. **Be willing to make trade-offs.** The manager understood that the negotiation process had to be a win-win for all parties. Thus, the manager targeted a select few manufacturers that the clinicians had gained an agreement on and approached them with a specific plan. When asking for a discount in their wholesale price, he agreed to commit more business to each of their preferred vendors.
4. **Be flexible.** Although buy-in from staff on the narrowing of vendors was generally good, there was one hold out. Since this clinician was an experienced and valued member of the staff, the manager tolerated her hearing aid selection approach.
5. **The power of compound numbers is astonishing.** Given the substantial reduction in wholesale price when this discount is spread over more than a thousand in unit sales for the year, combined with the slight uptick in total business, the practice was able to generate an additional one-half million dollars in gross margin from their hearing aid business. This case study is a good example of how one strategic decision – reducing COGs – that is systematically executed by the entire staff can have a profound impact on overall profitability and growth. ■

complete OMS

One Solution. Infinite Possibilities.

- Intuitive & Flexible Scheduling
- Appointment Email & Text Reminders
- Virtual Claims Assistant
- Paperless Superbills & Claims
- Advanced Business Reporting
- QuickBooks™ Integration
- Noah Ready - Standalone & Cloud
- To Do List & Pop-Up Alerts
- Device & Inventory Tracking
- Call Tracking
- Online & HIPAA Compliant
- Unlimited Document Storage
- Unlimited Faxing
- Seamless Data Conversion

PLUS
CounselEAR Connect

- Professional Reports
- Patient Counseling Summaries
- Chart Notes

All for One, Low Monthly Fee

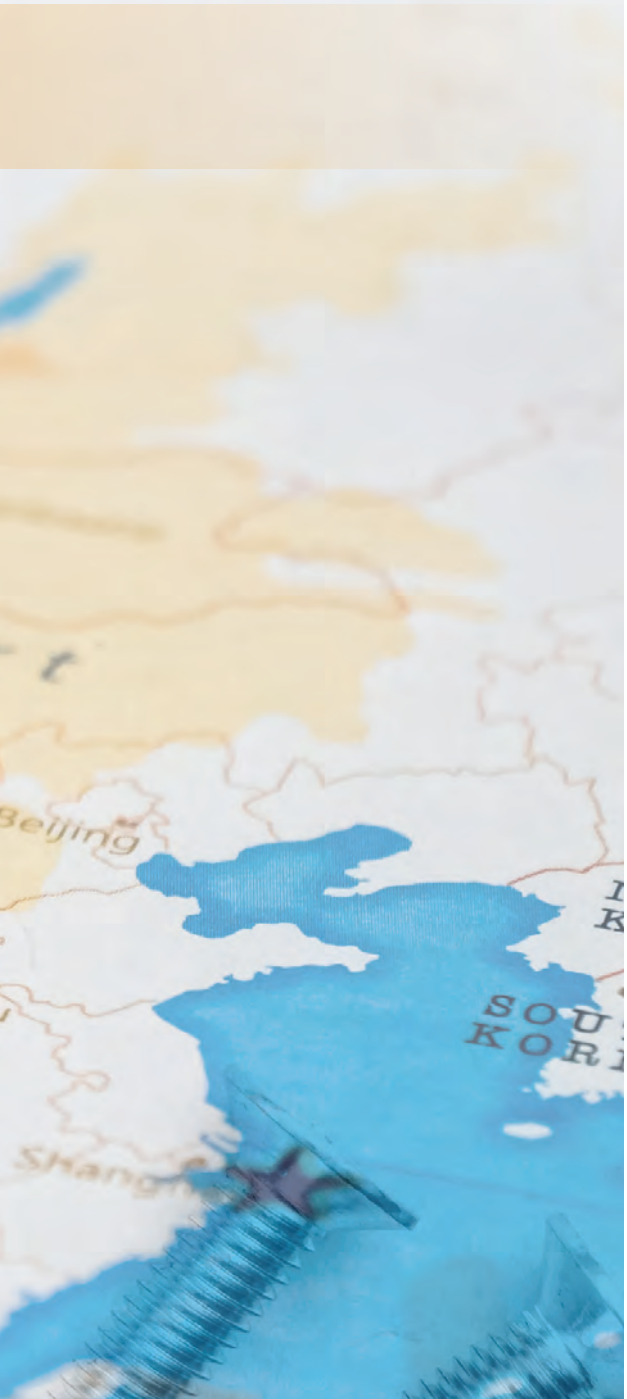
COUNSELEAR
PRACTICE MANAGEMENT SOLUTIONS

Visit **www.CounselEAR.com** for more information!

UNDERSTANDING THE NUTS & BOLTS OF A SUCCESSFUL BUSINESS

A Case Study From China

by David Xu



Many readers are aware of the American business model as it relates to hearing aids. In that model, which is popular in Europe, Australia and Canada, professional services are associated with the sale of hearing devices. However, in other parts of the world, that business model was virtually non-existent until recently. There are several reasons you do not see the traditional business model, in which services and devices are sold through a licensed professional. First and foremost, there is a shortage of licensed hearing care professionals in places such as China. Audiology is a modern profession that was established in the US in the 1940s to serve the communication needs of WWII veterans. Many parts of the world lack the resources to train mid-level medical professionals–and the enormous middle-class population, often taken for granted in North America, Western Europe, Australia, and New Zealand, that can afford the out-of-pocket costs associated with hearing aids. Many places lack the medical infrastructure to support widespread clinical support. Even when a place like China or India graduates an audiologist (a growing number of audiologists originating from these countries are attending AuD programs), their home country has a paucity of brick and mortar clinics where they can practice. For these reasons, alternative business models are crucial to address the needs of millions of individuals with hearing loss. Fortunately, Chinese entrepreneurs have been able to attend conferences in the United States to learn business practices from American audiologists and apply them to the Chinese market. This case study explores the impact of American business practices on hearing aid use rates in China. Readers should consider the high rate of non-hearing aid wearers in their own community and consider how key points from this case study apply to their own business in the US.

Hui'er Hearing

Location of Business

Hui'er Hearing was established in 1987. There are more than 800 Hui'er Hearing clinics in China and its professional service network covers more than 240 cities in China.

Who is their core customer?

There are more than 1600 professionals who provide high-quality services to patients with hearing problems in Hui'er Hearing, which provided services to more than 120,000 patients in 2020. Most of the patients (70%) who received help from the Hui'er Hearing are older than 55 years of age. The retirement age in China is 50 years for women and 60 years for men.

According to officials at Hui'er Hearing, older patients usually purchase hearing aids with basic technology, whereas most parents want their children to be fitted with premium-level technology.

The average price for hearing aids selected by older adults is approximately $1,000 (US) and the average price for hearing aids dispensed to children and teenagers in 2020 was $3,000.

Like Americans with hearing loss, many patients who are older than 18 are concerned about cosmetic appearance. Hence, many persons with hearing loss prefer to wear invisible hearing aids such as CIC-type devices. For most patients, especially older adults, the ability to understand others in noisy situations is the most important feature, and they don't care as much about advanced features.

There are large wealth disparities in China where the average income is $14,000--and yet China had the most billionaires worldwide in 2021. China also has the largest middle-class consumption market in the world today. These consumers are readily able to find effective hearing aid technology with a high quality-to-price ratio, and many are able to afford premium technology, professional services through Hui'er Hearing as well as U.S. and European hearing aid manufacturers. Because Hui'er has its own hearing aid factory, it is also able to offer basic technology to serve the needs of low-income citizens.

What is their value proposition?

Hui'er Hearing is able to provide the most professional audiological services with the least possible cost to persons with hearing loss. What's more, Hui'er Hearing wants to raise awareness on how to prevent hearing loss and promote hearing care across all of China, a nation of more than 1.3 billion people.

Furthermore, they want to improve most patients' quality of life and help more children with hearing loss to engage in social activities, improving their academic performance, or even getting more success in the future by using their hearing aids.

What is their value chain?

Hui'er Hearing has four main links in their value chain that create value for the customer:

1. Hearing health fairs and free hearing screenings
2. Financial assistance to those who qualify
3. House call hearing care
4. 30-day free trial period without any fees

World Hearing Month is March and that is a prime time to explain how the Hui'er Hearing company creates value in a public relations campaign. During World Hearing Month this year, Hui'er Hearing organized 1,013 hearing health fairs in more than 240 cities. This campaign attracted thousands of patients with hearing loss and their family members into Hui'er Hearing locations. More than 25,260 people made appointments for free hearing screenings and 11.4% of the tested population had measured hearing loss. For financial assistance, after checking patients' proof of low income, Hui'er Hearing gave them appropriate

subsidies. Furthermore, Hui'er Hearing also designated about 6,130 free hearing aids for patients, especially young kids who are not able to afford the costs of hearing aids. For some older patients, they provided house call hearing care. In all, Hui'er Hearing provided house call hearing care to at least 2,100 patients in March. What's more, 3,576 patients who have made appointments will come to Hui'er clinics in different cities for fitting hearing aids with a 30-day free trial period.

All patients can get free hearing evaluations in a Hui'er Hearing location and attend activities such as hearing health fairs to learn how to protect their ears, take care of their hearing aids, and obtain some helpful knowledge for free.

What is their revenue model?

Almost 99 percent of Hui'er's revenue comes from the sale of hearing aids. The Hui'er company provides free hearing tests for patients who come to their clinics in China. Also, because most patients in China do not use rechargeable hearing aids, Hui'er Hearing also generates some revenue from selling batteries. What's more, every year, Hui'er company recommends about 500 patients to some hospitals for fitting cochlear implants. Some cochlear implant companies give Hui'er Hearing a finder's fee; a practice that is unethical or even illegal in many parts of the world.

What are their cost structures?

The following is a breakdown of the various costs, expressed as a percentage in a typical Hui'er Hearing location. Note the percentages for cost of goods, marketing and labor are, on average, slightly less than the typical American audiology practice that provides most of its care to the private pay market. Hui'er Hearing uses its relatively sizeable net profit to open more clinics in the underserved areas of China.

Table 1. A breakdown of average revenue and costs, expressed as a percentage, for Hui'er Hearing

Hearing aid revenue	99%
Battery revenue	1%
Gross revenue	100%
Cost of Goods	25%
Gross Margin	75%
Marketing Costs	10%
Building + Utilities Costs	10%
Labor Costs	25%
Taxes	10%
Net Profit	**20%**

What Key Performance Indicators (KPIs) are managed on a weekly or monthly basis?

There are two main KPIs for the Hui'er Hearing. First, an annual growth rate in revenue of 18% is expected. That is, each month, they compare the total revenue of that month with the total revenue in the same month last year and check whether it meets a growth threshold of 18%.

A second KPI is related to the number of new clinics opened each year. Hui'er Hearing expects four new clinics per month to open in 2021. Readers should note these aggressive KPIs reflect the growth mode of an under-penetrated market. This is considerably different than the market in the US.

Let's look more carefully at how these two KPIs are managed. For total revenue, if the increasing year-over-year rate of total revenue is lower than 18%, the manager will spend more money on marketing over the next month or two. Additionally, managers are encouraged to give patients substantial discounts in order to get a sale. Although these actions may decrease the net profits, now it is a critical time in China for hearing aid companies to capture the market, increase awareness of the company, and attract more new patients. Strategically, it is important to win more market share at the expense of monthly profitability.

KPI for opening new clinics;, if the number of new clinics do not meet goal, Hui'er will hire more administrative staff or increase the workload of existing staff responsible for opening new clinics, in order to meet the KPI goal. This is a strategy that is not customary in the United States, but in an under-penetrated market, it is proving to be successful.

What demographic or psychographic data is used in marketing plans?

The World Health Organization (WHO) reported 1 in 4 people (2.5 billion) are projected to have hearing problems by 2050. In 2012, the prevalence of hearing aid use in the United States, among elderly people with mild-to-moderate hearing loss was less than 25%, but the rate of hearing aid adoption is even lower in developing countries. China's population is 1.4 billion with 9.5% of the population aged 65 years or older. The hearing aid use in mainland China was less than 17% in 2015. Hence, it is easy for us to find that in the future, China will be one of largest hearing aid markets in the world. This explains the strategy of managing the two KPIs mentioned in the previous section.

How does the business balance business needs with quality of care?

First, they provide free hearing screenings for different communities across China, and they also provide free hearing evaluations for all patients. Furthermore, for hearing aids which are made by Hui'er Hearing, they provide 3 years warranty and 5 years of free further adjustments in a bundled cost model. Also, if patients are fitted with another company's hearing aids in different clinics of Hui'er Hearing, they still guarantee a 3-year warranty and 5 years of free further adjustments. The professionals of Hui'er Hearing only fit hearing aids based on patient's hearing threshold, configuration, their personal needs and affordability. If entry level technology hearing aids are able to give patients enough help, they will let patients know that and not recommend premium technology level hearing aids, unless patients really insist on higher-end devices. Hui'er Hearing also offers customer service resources and contacts to assist customers on an ongoing basis.

What are the results of a SWOT analysis?

SWOT stands for Strengths, Weaknesses, Opportunities and Threats. It is a common business practice in China, similar to other parts of the world, for business managers to conduct a so-called SWOT analysis annually.

Strengths

There are more than 1600 professionals who provide high-quality services to patients with hearing problems in Hui'er Hearing. They provided services to more than 120,000 patients in 2020. There are more than 800 clinics in China and every year, Hui'er Hearing plans to open at least 50 new clinics. Hui'er Hearing has more clinics and professionals in China than any other company, which is a competitive advantage. Furthermore, they have some experts who are very familiar with Chinese policies and marketing. What's more, Hui'er Hearing is the most famous hearing aid company in China, and has had a sea of repeat customers.

They also have their own hearing aid factory and by comparing with some European and American hearing aid companies, they have cheaper labor costs, which may put them in a favorable position in comparison to other foreign hearing aid companies. Also, they have a solid relationship with Chinese universities. There are only a few universities which have audiology training programs in China, and most of their excellent students are willing to work for Hui'er Hearing.

Interestingly, more international students from "belt and road" countries are coming to China to study audiology than ever before (China's belt and road initiative (BRI) is a strategy initiated by China that seeks to connect Asia with Africa and Europe with the aim of improving regional integration, increasing trade, and stimulating economic growth). Many of these students are working in Hui'er Hearing for their internship. Hui'er Hearing has a really good relationship with them and some of them may be hired by Hui'er Hearing. Others go back to their home countries and open new Hui'er Hearing clinics, which allows Hui'er Hearing to become favorably positioned in some European and African countries.

Weaknesses

There are not very many audiologists at Hui'er Hearing because the Chinese government does not require people to have a college degree in order to conduct hearing aid evaluations and fit hearing aids. As a result, many staff lack audiologic knowledge that could best serve patients.

Additionally, although Hui'er Hearing can manufacture their own hearing aids, they must buy microchips from other companies. Due to the COVID-19 pandemic, there is a microchip shortage all over the world. Hence, demand for hearing aids is currently outstripping production.

Opportunities

There is no doubt that in the future, there will be more patients with hearing loss in China. In 2019, China's GDP

of $14 trillion was the world's second largest, after that of the United States. This suggests China has a good economy and an attractive market, but the adoption rate of hearing aids in China is significantly lower than developed countries. With the development of the economy in China, more and more patients with hearing loss can afford hearing aids. Furthermore, there are mature industrial systems, modern supply chains, and cheap labor costs in China, which may put Chinese hearing aid companies into a favorable position in making some OTC hearing aids and selling them in the US. Also, the Belt and Road Initiative may give Hui'er Hearing a big push for developing European and African hearing aid markets!

Threats

A rising number of European and American hearing aid companies have entered the hearing aid market in China recently. Some younger Chinese people, with mild hearing loss, are willing to buy cheap hearing aids online, instead of coming to clinics and getting a hearing evaluation before buying hearing aids. Recent economic development in China has resulted in increased fixed costs including labor and rental lease payments recently.

An overall assessment of this business

Hui'er Hearing has amazing potential in the future and many investors wanted to invest in his IPO in Hongkong or NASDAQ. Hui'er Hearing will have more clinics in China and they will also enter the Southeast Asian and African markets by manufacturing cheaper hearing aids relative to European and American hearing aid companies. Furthermore, Hui'er Hearing is working to meet FDA criteria for OTC hearing aids in the United States, with the intention of selling them in the United States and in some European countries in the future. More and more international students from Belt and Road countries come to China to learn audiology and are working at Hui'er as interns. Hui'er Hearing has an excellent relationship with them and some of them are hired by Hui'er Hearing and go back to their counties to open clinics, which may put Hui'er Hearing into a favorable position in some European and Asian countries. In a nutshell, Hui'er Hearing has kept the 18% increase rate of total revenue for almost 10 years and now they generate more than $85 million in total revenue per year. In the future, Hui'er Hearing may become one of the largest hearing aid companies in Asia.

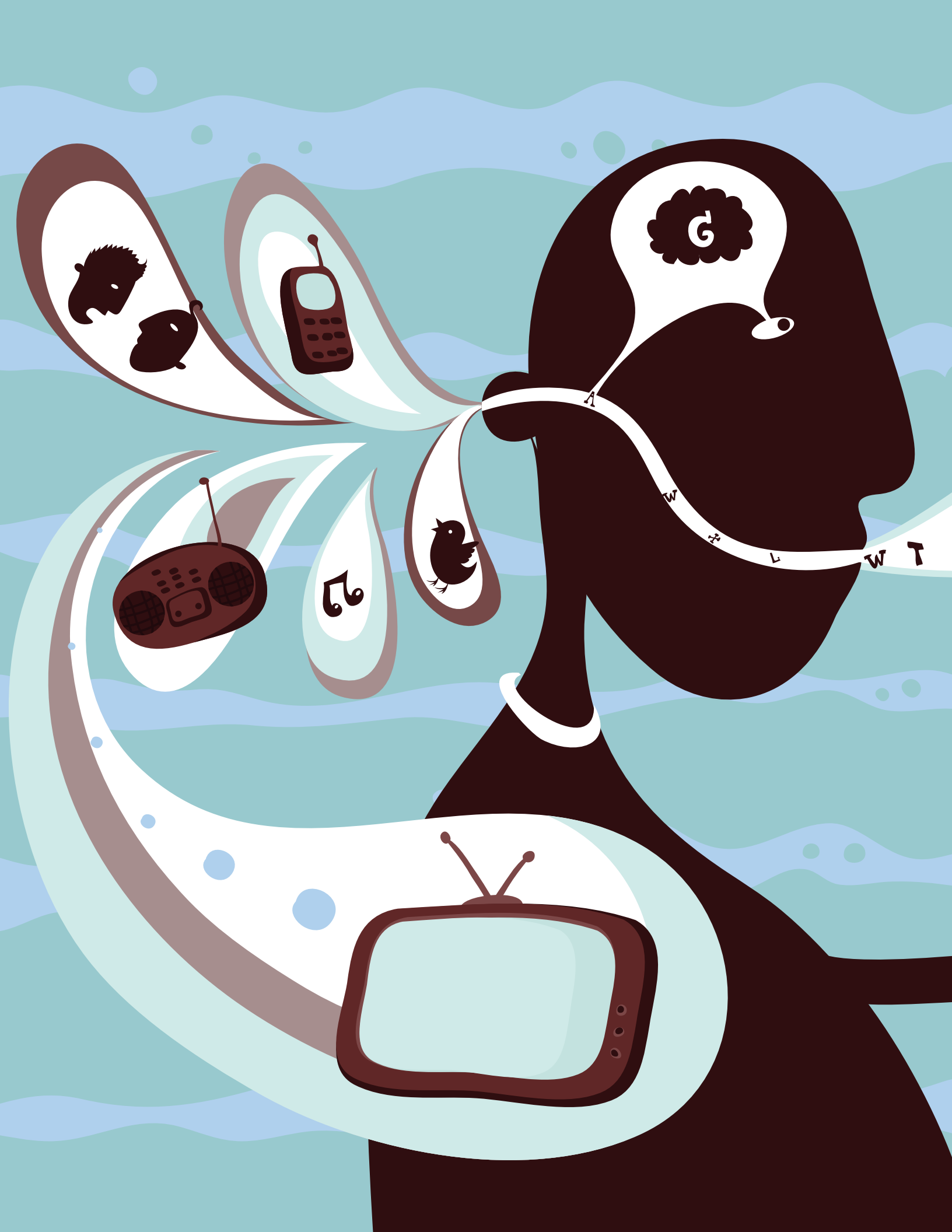
If Hui'er Hearing can obtain more professional audiologists who receive a quality clinical education, they may provide better services to their patients. Also, because most older patients in China have endured poverty throughout their lifetime, even though most of them can afford hearing aids today, many are hesitant to spend money on the technology to improve their quality of life. This is one of the main reasons that the adoption rate of hearing aids in China is significantly lower than the USA. In the future, with the development of its economy, coupled with more young people getting good audiology training to address the growing needs of those with hearing loss, the hearing aid market in China will increase significantly.

To learn more how Hui'er Hearing's strategic initiatives fit into the broader market of hearing care services, readers are encouraged to explore these two articles:

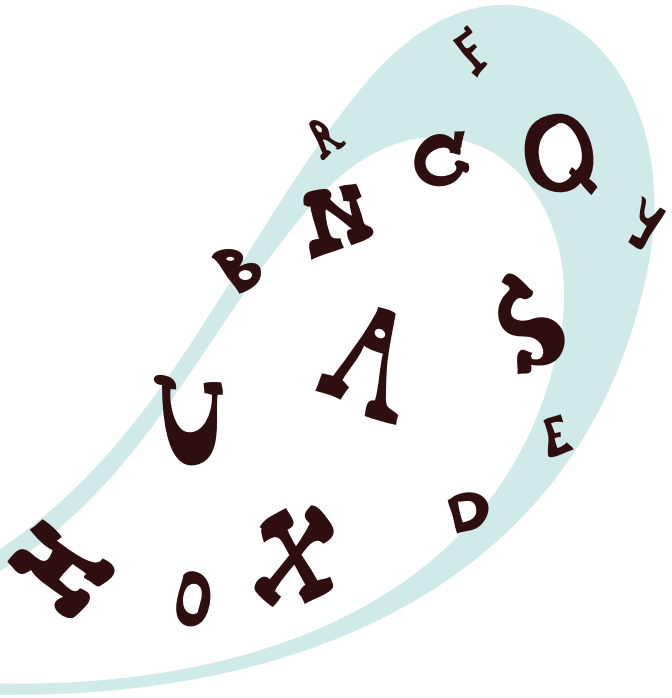
Said, A. E. (2017). Health-related quality of life in elderly hearing aid users vs. nonusers, *Egyptian Journal of Ear*, 18, 3, 271-279. org/10.1016/j.ejenta.2017.11.006.

Tahden, M., Gieseler,A., Meis, M., Wagener, K.C.& Colonius, H. (2018) What Keeps Older Adults With Hearing Impairment From Adopting Hearing Aids? *Trends Hear.* 22. ■

David Xu *is an AuD student at UW-Stevens Point. He can be reached at hxu899@uwsp.edu.*


G
A
W
H
L
W
T

A CASE STUDY in the Use of Cognitive Screening



An Interview with Al Turri, Au.D.

AP *Let's start by telling us your path to private practice.*

AT I feel like I've built three different successful practices over the years and had a couple major fails intertwined with the successes over the last 20 years. Audiology is a second career for me and I was drawn to it quickly after shadowing a few private practice audiologists that fit patients with aids while I was with them (thank you Dennis Uken for making this almost-SLP grad student shadow AuDs). The immediate improvement that was reported by patients and the hearing smiles hooked me, as did the ability to hang my own shingle one day since I had been self-employed in my previous career.

Larry Hagen, of MicroTech fame really gave me my start when he acquired five retail locations in AZ and hired me as an operations manager. I really cut my teeth and learned a lot, as SoundPoint Audiology grew from five locations in Tucson to over 20 in four states prior to me moving back to Florida and hanging my own shingle, which ultimately became Harmony Hearing Centers of America in Central Florida.

I sold those nine locations in 2015 to focus on my current project as the audiology director of The Villages Health System, which is the premier health system in the largest retirement community in America. It started as one of my physician contracts while I was in private practice and has morphed into a team of eight audiologists embedded in eight medical practices throughout the community.

AP *Where is your current practice and how long have you operated it?*

AT The Villages Health LLC is located in the Villages Florida (an hour north of Orlando) and has been around for almost nine years. I've been involved since the beginning as their director of audiology. Additionally, I am a member of the LLC, and a member of its leadership cohort.

AP *With OTC hearing aids looming, what do you see as some of the opportunities and threats to audiologists in clinical practice?*

AT The only threat I see to audiology are audiologists, unfortunately. For whatever reason we refuse to band together and utilize our numbers, buying power and expertise to own our scope of practice. OTC will increase the number of people raising their hand asking for help and at some point many of them will seek the professional services of audiologists. I'm ready and doing everything I can to position myself as the local expert in the villages.

AP *I know Florida is one of the most competitive commercial hearing aid markets in the country. What are some of the strategies you use to differentiate your practice from the competition?*

AT And, I might add, the Villages is probably the most competitive in Florida with over 50 locations to acquire hearing devices in and around the Villages.

Primarily, we stay away from focusing on the widget and devote our energy on educating the community that hearing loss is a progressive degenerative disorder that needs to be identified and treated as early as possible by doctors of audiology utilizing best practices. We devote significant resources to screening cognition and educating the community on ear to brain health.

AP *I understand you are an early adopter of computerized cognitive screening. Could you tell us what that is?*

AT In my opinion, computerized cognitive screening tools are a game changer. I've been screening cognitive ability since 2016, with paper and pencil batteries, but finding it hard to translate those results into meaningful conversations with patients regarding their ear-to-brain health. Now, using an automated cognition screening tool, I have data on three cognitive domains and two speed performance parameters that translate well to cognitive ability. The results of this screening changes the direction of my conversations with patients and their treatment plan.

AP *What is your take on the value of conducting cognitive screenings in an audiology practice?*

AT It's huge! Audiologists are on the front lines when it comes to cognition. Performing cognitive screenings provides the opportunity to identify potential cognitive decline early and refer the patient appropriately for assessment. Additionally, it stimulates incredible conversations with patients and referring physicians. I have also found that it increases the likelihood that the patient will seek help to address their hearing loss.

AP *Take us through the process you use with the cognitive screener. How have you implemented it in your practice?*

AT We have a screener in every location and all of our new patients and annual check-ups receive a screening. Additionally, new fittings also receive a screening four months post fitting to assess any improvement to cognition. Some providers, including myself have the screener in their suite and incorporate the screening into the consult. Other providers have their support staff conduct the screening before seeing the patient and simply review the results along with the hearing assessment. The key is to make sure that the patient understands that neither the screening tool nor the audiologist can diagnose cognitive decline and that the results today will be used to direct treatment recommendations. We are seeing improved memory and executive functions results regularly in my clinic, following four or more months of hearing aid use.

AP *Could you share with us how you bill for it? Is it bundled with the sale of hearing aids or more of a fee-for-service?*

AT Some clinics charge an unbundled fee, while others incorporate it into their functional hearing assessment. I have opted to bundle it in and not charge for it.

AP *What has patient feedback been like for cognitive screening?*

AT They love it and can't wait to take their four month screening post fitting. For many, it puts their mind at rest since they pass the screening, while others are finally motivated to speak to their physician about a subject that they have been avoiding.

AP *I am really curious about how cognitive screening affects patient benefit with hearing aids. What have you observed in your clinic with respect to hearing aid benefit with cognitive screening as part of your process?*

AT It changes the conversation and helps people move towards treatment like nothing else I've ever implemented. It keys me into patients that are going to need more counseling, slower compression speed, assistive devices and family involvement immediately as opposed to several visits after the initial hearing aid fitting. Most significantly, it reinforces the ear-to-brain message that we have been discussing with patients in our practice since 2017, especially when coupled with incredible research from the realm of cognitive hearing science.

AP *What is your approach with patients who score poorly on the cognitive screening?*

AT Poor results prompt referral back to the primary care physician or neurologist for further assessment. If hearing aids are part of the patient's treatment plan, I use technology with slower compression speed, counsel with written materials and frequently reinforce the need for aural rehab. I also incorporate TV devices and remote microphones more frequently as part of the treatment plan for these patients. Finally, I try to make sure to involve the patient's family in the entire process..

AP *Beyond cognitive screening, what other tests or counseling tools do you routinely implement in your practice that contribute to patient outcomes and business success?*

AT Speech-in-noise testing, aided as well as unaided is hands down the most important test that I perform, especially when coupled with memory and executive function scores from the cognitive screening. For years I focused on the widget and got away from aural rehab, but today aural rehab is integral to my patients' success. Additionally, I love questionnaires and use them pre- and post-fitting as well as at routine follow-up visits.

AP *Thanks for the insights, Dr. Turri.*

AT My pleasure. ■

Dr. Turri can be reached at alturriaud@gmail.com.

Connected Hearing Clinics

Using Artificial Intelligence (AI) and Marketing Automation

by Brad Dodson

Big data, artificial intelligence (AI) and machine learning is of big importance for your practice and a top trend for 2021. While the importance itself is nothing new in terms of marketing trends, in 2021, we're seeing marketing spend especially focused on taking control of customer data and analytics efforts to further automate and improve patient retention.

Data and machine learning is imperative for businesses to gain insights into who your loyal customers are. According to a 2020 article by *Adastra*, research estimates that it is four times more expensive to acquire a new customer than it is to keep an existing one. The key isn't just having the data, but leveraging it to better understand your customers. Deliver stronger performance results by learning about your opportunities, weaknesses, financials, and risks through the data. Target loyal customers that bring value to your company, build on those relationships, and learn what makes them stick with you.

Many new marketing trends now revolve around big data, analytics, machine learning, and AI. Connecting patient data platforms to Marketing Automation solutions is a growing category seeing widespread implementation, and investment to enhance the customer journey and utilize vast data that spans far beyond what exists in current systems.

Leverage your data by using AI and Marketing Automation. Hearing care practices, big and small, gather data from patients daily. AI and Marketing Automation helps your practice stay connected directly to the data, in turn helping you stay in front of patients and top of mind throughout their hearing care journey.

Integrating direct mail with AI and Marketing Automation allows for data-driven, triggered sends at optimal times for patients, which improves response rates. All this data can be used for marketing, targeting audiences, and improving patient retention.

Let's dive deeper into how AI and Marketing Automation works and how it will benefit your practice.

Your Data Drives Machine Learning and Marketing Automation

In my 2020 *Audiology Practices* article, "The Future of Healthcare Marketing: It All Begins with Your Data", I examined how the future of health care marketing starts with your data. But what exactly is machine learning, AI, and Marketing Automation?

Machine learning and AI is software that can collect, store, and update your patient data and ultimately learn more about your patients. Investing in machine learning and AI helps you capture granular insights and target patients with more accurate messaging. You can see their buying behaviors and actions to help determine and further inform your communication.

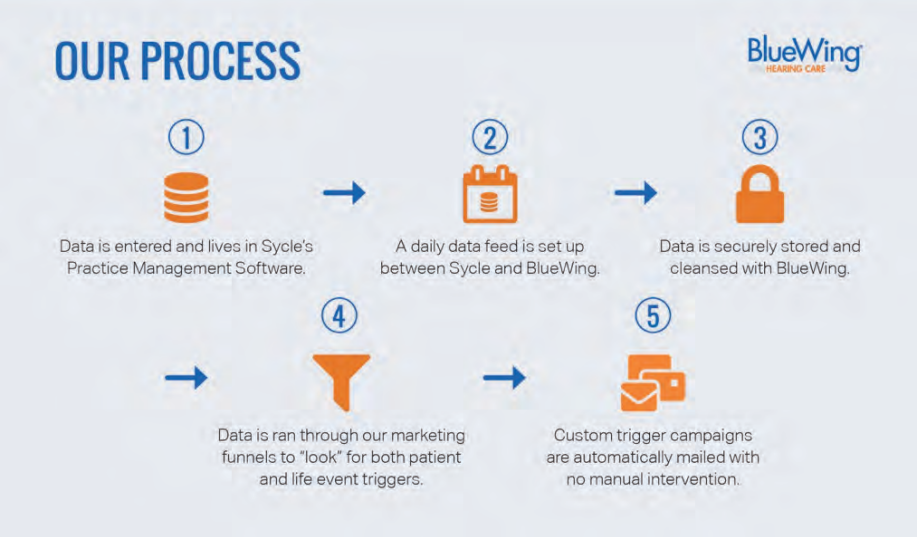
Marketing Automation is the process of the type/form of communication sent based on a consumer's buying behaviors or actions. Data connected from AI is directly translated so that the machine can understand what direct mail to send through the Marketing Automation process.

For example, if patient "A" buys a hearing device, the data tells the machine to send a customized mail piece with the patient's name and address and messaging that thanks them for their recent purchase. Automatically sending out branded messaging directly to patients after they meet certain flags in the data creates a positive, timely follow-up from your brand. Knowing where your patients are in their hearing care journey directly impacts the type of campaign sent through automation.

Robust Machine Learning and Prospect Models

With on-demand access to patient data, through customer relationship management (CRM) integrations, AI can also build robust, machine learning prospect models, and improve your prospect outreach using a limited or refined budget. Once integrated with your CRM, a daily flow of up-to-date data is sent to the AI software. The AI software is constantly collecting data, learning more about your patients, and providing valuable insights into your potential market.

This evolving process provides deeper insights about your patients; where they live, their demographics and their purchasing behaviors, which influences how the model selects new prospects to which to market. With this technology, and the process of matching back to marketing files used, you can see who came in for appointments, who bought hearing devices and you can properly track the marketing piece that influenced the patient or prospect to interact with your practice. This data-informed process ensures you pick marketing pieces that perform.



What once was a one-dimensional view with your marketing and its performance (purely using call tracking data) now becomes a comprehensive view of your patient and prospect outreach with a higher level of performance reporting.

Why Use Automated Direct Mail?

The response rate for direct mail is 10 times higher than traditional paid searches, email marketing, and social media marketing. Sending your patients customized direct mail directly helps drive a higher return on investment (ROI) and improves patient retention by keeping your brand in front of them throughout their hearing care and buying journey.

By utilizing your current patient data through a CRM integration, automating your marketing and converting to a hands-off system has never been easier. All your patients' actions are trackable and marketable through machine learning, AI, and Marketing Automation.

Using targeted campaigns with automated mail is also more practical. It helps you narrow down your audience to customers who are actively engaged with your brand and more likely to become brand ambassadors and make referrals. With variable customer data, you can target the right customers, at the right time, and promote the right products/messaging to increase conversion rates and ROI.

Set It and Forget It

Sending communications consistently can turn one-time buyers into loyal patients, maximizing the lifetime value for your practice. One way to send consistent, custom automated mail is through a "set and forget" trigger program.

Trigger-based programs allow you to set up direct mail campaigns that automatically send to your patients based on their actions or buying behaviors – visiting your website, making an appointment, buying a hearing device, moving into the neighborhood around your practice or even cancelling an appointment – to improve customer retention.

Based on the trigger that is enabled, the machines know which creative campaign needs to be printed and sent to the patient; following up on the action or behavior that was completed. Using an automated trigger program does not require any manual work from your staff, taking the stress out of your marketing.

As a practice owner, all you need to do for this patient-driven marketing is pick out and customize the creative templates you would like to send for each stage of the patient's journey. Once you select those, the AI inputs the patient data and when triggered, the campaign will be printed and sent automatically. So, you set it up once and can forget about it as it requires no additional interaction.

Because this is an automated program, you don't have to worry about your patient outreach falling through the cracks no matter how busy you or your staff are. The AI and Marketing Automation process takes care of the follow-up for you.

Patient Retention and Intelligent Prospect Marketing

From a marketing point of view, AI and Marketing Automation can help to lock-in on the right population to target. AI will analyze a combination of your data and the data it collected to key-in on the "Consumer DNA" of your patients. Looking at this combined data, you can find out which attributes or buying behaviors they have in common or most importantly what makes them stand out from generic two-dimensional qualifiers like age and income.

For instance, you can determine how rooted they are in their communities by looking at their length of residence or if they donate money to local or national causes as an indicator of liquidity and whether they can afford hearing aids. Once you find out the "DNA" of your ideal patients, AI creates a customer profile and scores the remaining population (not your patients) around your territory to prospect for new patients based off the similarities to your existing patients (look-a-like modeling).

Existing patients and automation: For existing patients, you want to consistently send campaigns to keep your practice top-of-mind and create positive interactions with your brand. These interactions are imperative as they can determine how likely a patient is to continue with your practice or leave for a competing one. Automation takes out the guess work and runs consistently behind the scenes on your behalf. You want to make sure to reach these patients in a timely manner as they are meeting certain milestones in their customer journey.

People who have already done business with you and trust you are the most important, most high-yield candidates for future services. Staying connected with your patients through automated marketing increases the rate of your touchpoints and likeliness that they will continue and ultimately return as a repeat customer.

Below are successful patient retention results collected across hearing care practices currently using AI and Marketing Automation.

Patient Retention Results:

Appointment Rate: 13.02%

ROI: 4,348%

Cost Per Appointment: $5

Cost Per Unit: $80

Patient trigger or automated marketing programs result in higher appointment rates and ROI. But most importantly this automated marketing reduces the amount of time your staff spend following up with patients as your patients are now calling you.

Prospecting for New Patients: With your data, you can understand the overarching makeup of your patients, the "Consumer DNA," and use this insight to create a customer

profile of what your typical patient looks like. From this profile, you can prospect for new patients who look/behave like your existing patients and convert them into return customers.

The higher quality prospects – those more likely to respond – are hit more frequently, while those who don't exactly match your current customers' profile are hit less frequently or perhaps with other less expensive digital tactics.

So, how does the "Consumer DNA" customer profile for prospected patients get created?

From your patient data, AI can create data models to identify top responders in the market based on current attributes (over 300) and behaviors of current patients. These curated data models allow marketers with limited budgets to focus on the prospects with the highest propensity to respond and convert. Figure 1 and Figure 2 contrast a traditional approach to identifying potential customers (Figure 1) to a more targeted, modeled approach (Figure 2).

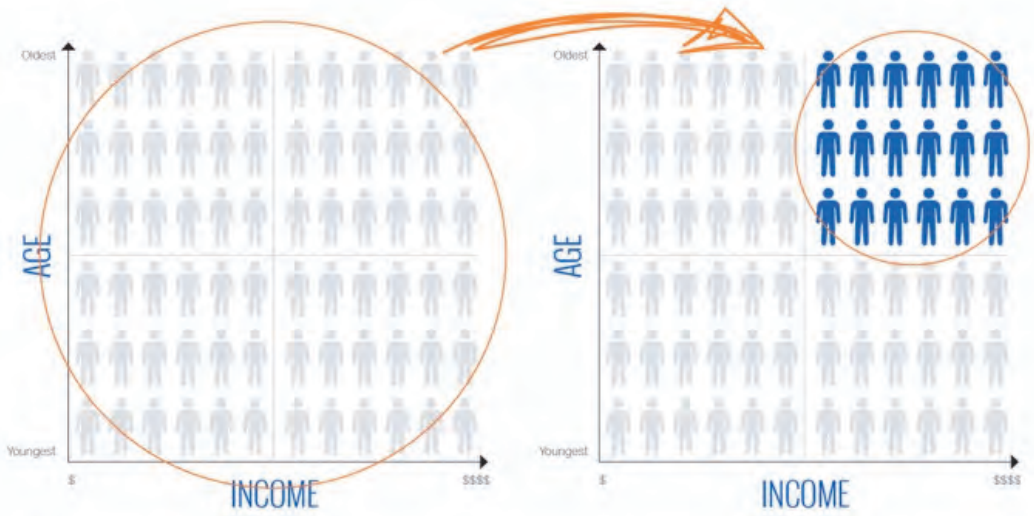


Figure 1. Traditional Selection. Traditional selections organize your market by a few key demographic filters.

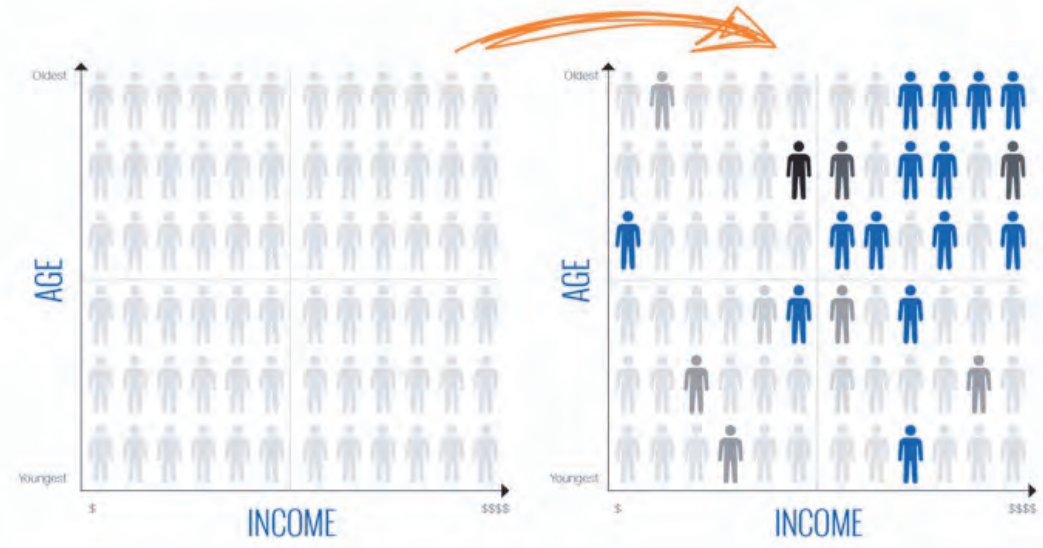


Figure 2. Modeled Selection. The modeled approach applies the learnings from our in-depth analysis of your customer database to identify both top responders and importantly, non-responders. This approach lets us rank everyone in your target market by their propensity to respond.

AI response models continue to learn and evolve as new data is passed daily from the practice management software (PMS) to the AI. Machine learning and improvements to your model continues behind the scenes with each transfer and sweep of your patient data. This allows you to market data-backed, highly variable, response driving direct mail campaigns to targeted prospects.

Start in the Right Place with AI and Marketing Automation

Integrations provide your practice with an opportunity to start in the right place. By integrating AI and Marketing Automation into a company's process, you take the guess work and human interaction out of it. The benefits and results seen with these technologies are astounding. Large and small businesses alike can now get a clear picture of who their patients are, and most importantly how to access their future patients in a precise, more orderly, and efficient way. All of which is measurable through an ROI analysis by matching the marketing leads used to the response leads and attributing it back to the campaign served.

With over 20 different predetermined direct mail trigger campaigns, you can effectively communicate with your patients and prospects and get them to act. Building a consistent communication schedule with your patients is key.

Some examples of patient triggered mail that can be sent out include:

- Appointment cancellation or no show
- Mail after product purchase
- Hearing evaluation but no sale was made
- Quarterly newsletters
- Annual hearing appointment reminder
- Hearing device upgrade eligibility
- Hearing device warranty expiration notice
- Happy birthday cards
- Hearing device clean and hearing check reminders

In addition, as patient data is passed from your PMS to the AI software, it runs through an address verification and National Change of Address cleansing process to ensure that the records are clean and available for trigger marketing and comprehensive match back/results reporting.

Not only can you target the right people and boost your engagement, but you also always know that you're not wasting budget on bad addresses. The AI is constantly learning and combing through the data to make sure that you are sending to the right people, improving your accuracy.

Powerful Performance Reporting

The big question is: How do we measure our marketing's performance using machine learning and AI? The AI software offers your practice intelligent results-based reporting. By having access to on-demand data from your PMS, AI can interpret data and report back on more information from more important indicators rather than just two-dimensional call tracking data.

The AI reporting provides a deeper and transparent look into how your Marketing Automation is performing by matching the real-time appointments and sales in the PMS files to the mail files used in the original marketing campaigns. The daily feeds between your PMS and AI allow you to clearly see how productive your patient and prospect marketing campaigns are.

Additionally, AI allows for higher levels of performance reporting. It's not two-dimensional as it was before. Now with AI, who came in for appointments, who bought hearing aids, and what mail campaign was attached to each stage of their care is recorded and analyzed. This response data impacts and evolves the models used for future outreach to existing and prospective customers. Being able to prospect new patients based on these models results in a greater ROI and better patient retention.

Final Thoughts

Put your data to work. Using machine learning, AI, and Marketing Automation saves your practice time, money, and increases ROI. AI and machine learning have rapidly advanced in recent years making it cost effective, less data intensive, and consistent in performance. If you want to take your marketing seriously and see a positive ROI, then you should highly consider integrating AI and Marketing Automation into your overall marketing strategy. The results speak for themselves.

As your target market's behaviors evolve, so must your marketing efforts. This influx of data must be at the core of your omnichannel marketing plan. This way, people see your hearing care practice's name through multiple platforms for the highest impact. Marketing your practice is more efficient and setting up a set-and-forget program will alleviate some of the stress involved with managing your marketing.

Companies that successfully take advantage of new technologies like machine learning, AI, and Marketing Automation will consistently see higher performance and returns in their marketing and relieve themselves of the day-to-day stressors of manually managing a moving target. ■

Brad Dodson *is a regional account executive for BlueWing Hearing Care. He can be reached at bdodson@bluewingdirect.com.*

Sources

Adastra. "CMOs' Top Strategies for 2021 Hinge on Data Quality." 5/10/2020, Adastra Group, https://www.adastracorp.com/discover/articles/cmos-top-strategies-for-2021-hinge-on-data-quality/

Dodson, Brad. "The Future of Healthcare Marketing: It All Begins with Your Data." 1/10/2020, Audiology Practices, https://www.audiology-practices.org/the-future-of-healthcare-marketing-it-all-begins-with-your-data

THE NEED FOR AUDIOLOGY IN SKILLED NURSING FACILITIES

Observations, Anecdotes,OBRA, State Laws and ASHA Guidance

By Kathy Dowd, Au.D.

Laws and professional guidance exist that are intended to foster hearing care for residents of skilled nursing facilities. There appears to be widespread reliance on observation for identifying hearing loss, and this leads to frequent, under-identification of hearing loss. The consequence is that residents often have hearing losses that impact their daily communication and possibly the outcomes of other screening and diagnostic testing (e.g., cognitive assessment) that is verbally administered. This discussion will first present selected laws and professional guidance advisements and then offer examples of unidentified hearing loss, and its consequences in this population. Finally, a specific recommendation for change is offered.

The Omnibus Budget and Reconciliation Act of 1987 was a large federal law encompassing regulation for many sectors, including the needs of skilled nursing homes. This law states that hearing and vision must be assessed within 3-5 days of admission to the nursing home. In response to this law, Medicare wrote CMS Minimum Data Set assessments for hearing and vision. The CMS MDS hearing assessment is basically an observation of a hearing problem by an assessment nurse, which can include simply asking the resident if they perceive a hearing loss. Research since the CMS MDS hearing assessment was developed indicates that hearing loss is severely under identified by use of this tool.

The Omnibus Budget and Reconciliation Act of 1987 states: REQUIREMENTS RELATING TO PROVISION OF SERVICES. — (1) QUALITY OF LIFE IN GENERAL. — A skilled nursing facility must care for its residents in such a manner and in such an environment, as will promote maintenance or enhancement of the quality of life of each resident, and SCOPE OF SERVICES AND ACTIVITIES UNDER PLAN OF CARE: A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care.

In addition to OBRA, many states have laws mandating a hearing assessment within 3-14 days of admission to the nursing home. The reason for this mandate is to ensure quality of life and quality of care for the resident.

In 1996, the American Speech-Language Hearing Association (ASHA) published guidelines for Audiology services in skilled nursing facilities. They noted the incidence of hearing loss among residents in these facilities was 80%. The high incidence of hearing loss, and associated consequences presented in those guidelines, demonstrated the need for residents to have hearing testing. Specifically, these guidelines stated that "identifying and managing hearing loss often can reverse the diagnosis or lessen the severity of a confusional state".

A valid assessment of hearing is even more critical now, since CMS has implemented a new PDPM initiative in October 2019, that highlights cognitive issues among residents of nursing homes. Unfortunately, many speech language pathologists do not screen hearing before they do a cognitive test or treat for cognitive issues. Rehabilitation agencies that hire and deploy speech language pathologists to skilled nursing homes, do not give them the equipment to screen hearing.

Anecdotal example:

One speech language pathologist commented that her inpatient rehabilitation office had 12 audiometers in the basement; but would not get them calibrated for use.

MEDICAL NECESSITY FOR HEARING ASSESSMENT ON ADMISSION TO SKILLED NURSING

Most residents come to skilled nursing facilities after hospitalizations for diabetes, cardiovascular events, kidney failure, severe infections, and traumas from accidents. Each one of these medical issues, in addition to ototoxic medications treatments, is associated with hearing loss.

Part of the conundrum with obtaining an audiological evaluation on admission to the nursing home is the absence of a referral to audiology on hospital discharge. One hospitalist confirmed that many of her patients are unable to hear well during their hospital stay and that she must wait for family visits to discuss diagnoses and plans of care. A speech language pathologist at another hospital stated she would refer for a hearing test, if she thinks the patient has a hearing problem. And if the person already wears hearing aids, then she does not refer for an audiology evaluation, assuming the patient has already been evaluated and treated for hearing difficulties. A central office nurse for a large southeastern hospital system stated the hospital personnel are already too busy to get everything done with service delivery, charting and other duties, to even be concerned about hearing loss. Therefore, the hospital patient is discharged to the nursing facility, with no referral for a hearing evaluation.

The CMS MDS hearing assessment given on admission to the nursing facility, has been found to significantly **under identify hearing loss.** This leads to false and inaccurate diagnosis of cognitive and disruptive behavior issues in residents who have hearing loss. Nursing staff often recognizes the need for better tools to screen for sensory impairments in residents. Sadly, few audiologists are contracted in skilled nursing facilities and may not know of the significant need for services in this setting.

Speech language pathologists (SLPs) performed aural rehabilitation for many years in the 1990's, with no screening for hearing or referral to an audiologist for assessment and treatment to correct a hearing loss, based on the observations of an audiology practice with numerous contracts in nursing homes. Aural rehabilitation appears to have been abandoned a decade ago as SLPs moved into the realm of evaluating and treating cognitive linguistic problems in nursing home residents. Yet, even with this development, in many facilities there is no valid hearing screening before the cognitive evaluation and no amplification or medical treatment is considered before cognitive treatment.

Anecdotal example:

Invalid cognitive test. *An older lady was admitted to the nursing home with a severe reaction to new medication. The nursing home told the audiologist daughter that her mother was evaluated and had a moderate cognitive issue. The daughter asked if her mother was tested using the remote microphone that came with her hearing aids. The nurse said no because it would have given the mother 'an undue advantage'. The daughter went to the nursing home to discuss this with the staff, since the daughter did not believe there was a cognitive issue. At the nursing home, the nurse confirmed her mother was indeed moderately, cognitively, impaired and asked to walk to her mother's room. When they arrived, the mother, in a private room, was lying in bed, laughing and talking. No one else was in the room. The nurse turned to the daughter and said, "See? She does this all the time!". The daughter then said, 'My mother is talking on the phone. She has Bluetooth in her hearing aids. She's talking to family!'. The audiologist says her mother was just fit with the hearing aids a few months before the medical crisis, and that a cognitively impaired person would not have been able to operate hearing aids with Bluetooth as well as her mother was able to.*

Anecdotal examples of invisible/untreated hearing loss:

Unintended weight loss. *One example of lack of proper assessment and treatment of hearing and communication disorders was seen during an ombudsman visit at a skilled nursing facility. The first room visited was a double occupancy room with 2 ladies. One lady was sitting by the window with the bed made and a bedside tray that was empty. The other lady was bedridden and in the process of eating breakfast. The ombudsman went to the lady by the window first. She introduced herself and her reason for the visit. The lady on the bed watched her carefully. As the ombudsman began asking questions about the resident's care, the resident continued to*

stare at her with no emotions or response to the questions. Finally, the ombudsman said impatiently, 'Well, let's move on. This lady is out of it'. The ombudsman walked to the bedridden resident close to the door and successfully interviewed her about her care and an inquiry into any issues. Before leaving the room, the ombudsman in training asked if she could go over to the first lady to try to talk to her. Bending down close to the lady's ear, she shouted, "Hi Ms. Smith. How are you today?" The lady smiled and said, "Fine, but I'm hungry". The ombudsman in training leaned down into the resident's ear again and yelled, "Did you get breakfast?". She responded, "No and I'm hungry". The experienced ombudsman said, "OMG, I had no idea. Tell her we will make sure the CNAs bring a tray." Going on to the next room to visit, there was a lady in bed eating breakfast. When the ombudsman introduced herself and asked if the resident had any issues, the lady said, "Yes! And no one is doing anything about it. Almost every morning if I am in the bathroom when breakfast is served, the lady next door comes over and eats half my breakfast. No one is doing anything about this." This example is one of many, showing how staff do not know that a resident cannot hear and are thinking there is no interest in eating, when in fact, the person does not hear them ask if they want a meal tray. Many staff and administrators speak of residents with cognitive issues or behavioral problems, when the current CMS MDS hearing observation or inquiry about hearing difficulties, does not reliably assess a hearing problem.

Disruptive behavior. *In another example, a gentleman resident was evaluated by an audiologist and found to have a bilateral, severe, hearing loss. Hearing aids were recommended, but staff were skeptical. They stated this man was very physically combative. For example, when they came to take him for a shower, he physically fought with them (and was very strong). The audiologist felt it was still important to try the amplification based on the evaluation. The two-week follow-up visit at the nursing home, had a surprising outcome. The staff expressed amazement about how this man's behavior had calmed down. He seemed much happier and engaging when the staff came to his room. Staff said they were able to explain what they were going to do, and he was now agreeable to taking showers and other activities, now that he could hear them.*

Invisible hearing loss. *A more recent conversation with a nursing home administrator indicated he felt there were behavior problems and cognitive issues amongst most of his residents. He did not provide hearing services in his facility and was concerned about losing hearing aids or keeping up with their care.*

AN AUDIOLOGY SNF PROGRAM

Unidentified and untreated hearing loss affects both health and quality of life.

It is important that new admissions to nursing homes are properly assessed for hearing loss, because they are likely to have medical history, medication history and current medications, as well as history of noise exposure, traumatic events, and hospital events, that may be associated with hearing loss. Hearing loss is an invisible handicap that is one of the most common unmet medical needs for adults. A referral to an audiologist ensures that hearing evaluation, auditory processing evaluation, and/or hearing management can be addressed.

OBRA 1987 states that a skilled nursing facility, "must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity". Residents admitted to skilled nursing facilities must receive quality care from staff, to ultimately enhance their quality of life. Many individuals in skilled nursing homes have hearing loss, which is challenging due to low incidence of hearing aid use and group communication situations that are common for social activities, interactive dining environments, and the need for telephone connection with loved ones. Busy staff and family members may not be aware of the impact of decreased hearing on quality of life, as well as caregiver burden. From initial assessment, to treatment, to use of communication access services, to a management program for listening tools, an audiologist can train and educate nursing home administration, staff, families, ombudsmen and residents on best practices for hearing and communication.

There is an urgent need for audiology management and monitoring of hearing and auditory processing in nursing home residents. These services must be onsite, with transportable equipment, using insert earphones and testing in a quiet location in the facility. Facilities accept between 15-40 new admissions every month, so the need for a hearing evaluation is constant. ■

Kathy Dowd, Au.D. *is the Executive Director of The Audiology Project, based in Charlotte NC. She can be reached at kdowd01@att.net.*

CALL TO ACTION

According to a recent publication entitled *Hearing Loss: Why Does It Matter for Nursing Homes?*:

"Hearing loss disrupts communication, leaving those affected especially vulnerable to social isolation and depression. Our analysis of the MDS data suggests—but does not prove—that the previously documented failure, to recognize hearing loss in individual facilities, translates to a nationwide pattern of under-detection of hearing loss, among nursing home residents. Facilities should be aware that hearing loss is a recognized disability under the Americans with Disabilities Act (ADA). Nursing homes (as covered entities) are required to ensure "effective communication" with residents. In other words, recognition and accommodation are not just good clinical practice; they are required under the law."

Specifically, there needs to be a validated screening of hearing, which might include one of several new online tools/apps (e.g., HEAR X; Sound Scout) and referrals to audiologists for hearing evaluation, auditory processing evaluation and/or the selection and use of hearing devices.

REFERENCES

Hearing loss and its impact on residents in long term care facilities: Asystematic review of literature, Renée Punch, Louise Horstmanshof, Geriatr Nurs. Mar-Apr 2019;40(2):138-147

H.R.3545 - 100th Congress (1987-1988): Omnibus Budget Reconciliation Act of 1987, pp 161-2. https://www.congress.gov/bill/100th-congress/house-bill/3545

Guidelines for Audiology Service Delivery in Nursing Homes. https://www.asha.org/policy/GL1997-00004/

Risk factors for hearing impairment among U.S. adults with diabetes: National Health and Nutrition Examination Survey 1999-2004. Kathleen E Bainbridge, Howard J Hoffman, Catherine C Cowie, *Diabetes Care.* 2011 Jul;34(7):1540-5. doi: 10.2337/dc10-2161. Epub 2011 May 18.

The influence of cardiovascular health on peripheral and central auditory function in adults: a research review. Hull RH1, Kerschen SR, *Am J Audiol.* 2010 Jun;19(1):9-16

https://www.ncbi.nlm.nih.gov/pubmed/20538964

Cochlear function in patients with chronic kidney disease. Govender SM, Govender CD, Matthews G. S *Afr J Commun Disord.* 2013 Dec; 60:44-9.

http://www.ncbi.nlm.nih.gov/pubmed/25158373

Hearing Loss Prevalence and Management in Nursing Home Residents. Garahan, Margaret Bunce, et al. *Journal of the American Geriatrics Society (JAGS)*, vol. 40, no. 2, 1992, pp. 130–134

Exploring the sensory screening experiences of nurses working in long-term care homes with residents who have dementia: a qualitative study. Fiona Höbler, et al. *BMC Geriatr.* 2018 Oct 4;18(1):235.

Hearing Loss: Why Does It Matter for Nursing Homes? Ellen M. McCreedy, PhD, Barbara E. Weinstein, PhD, Joshua Chodosh, MD, MSHS, and Jan Blustein, MD, PhD, *J Am Med Dir Assoc.* 2018 Apr; 19(4): 323–327.

ADA 2022 Proposed Rule Comments

BY KIM CAVITT, Au.D.

On September 10, 2021, ADA provided the following comments and recommendations in response to the Centers for Medicare & Medicaid Services (CMS) Notice of Proposed Rule Making (Proposed Rule) on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year (CY) 2022, published in the Federal Register (Vol. 86, No. 139 FR, pages 39104-39907) on July 23, 2021:

Continued Reductions in Reimbursement Threaten Access to Audiology Services

The 2022 Medicare Physician Fee Schedule (MPFS) Proposed Rule decreases the 2022 conversion factor (from $34.89 in 2021 to $33.58 in 2022). This reduction in the conversion factor will translate to at least an estimated 3.75% reduction in reimbursement for audiology and vestibular services. This continued, annual assault on Medicare reimbursement, exacerbated by budget neutrality requirements, is unsustainable and devastating for practices as they attempt to grapple with reduced clinic capacities and the increased costs of personal protection equipment (PPE), and other infection control measures associated with combating the COVID-19 pandemic and public health emergency (PHE). Reductions in reimbursement for audiology services negatively impacts access to hearing and balance services for seniors and threatens the sustainability of audiology clinics across the nation.

Eliminate Physician Order Requirement for Coverage of Audiology Services

Currently, Medicare coverage of audiology services provided by licensed audiologists is contingent on the services being first ordered by a physician or appropriate non-physician practitioner. As audiologists are already responsible for medical necessity under Medicare Part B, the order requirement is redundant. It creates inefficiencies and red tape for ordering providers, considerable confusion for beneficiaries, unnecessary beneficiary and system costs and barriers to access, and delayed care.

ADA respectfully requests that CMS eliminate the physician order policy so that Medicare beneficiaries can avoid an extra office visit as a condition of coverage for the hearing and balance care that they need. CMS' order requirement for coverage of audiology services is not statutorily required, nor is it a requirement for other public or private health insurers in the United States, including Medicare Part C, Medicaid, the Federal Health Benefit Plans (FEHP), or the U.S. Department of Veterans Affairs (VA).

According to an independent legal opinion (Medicare Coverage of Diagnostic Audiology Services, 2016), obtained by ADA, CMS has the authority to eliminate the physician order requirement for coverage of audiology services administratively. Congress attests to the Secretary's authority in legislation passed in the U.S. House of Representatives in 2019, which states "The Secretary of Health and Human Services may promulgate regulations to allow qualified audiologists (as so defined) to furnish audiology services (as so defined) without a referral from a physician or practitioner…" (H.R. 3, 116th Congress)

A study conducted by the Moran Company in 2020 estimates that rescission of Medicare's physician order requirement for coverage of audiology services would save CMS $108M and save beneficiaries $34M in out-of-pocket costs over 10 years (Moran Co., 2020). This savings could be applied to offset proposed increases in coverage for primary care and telehealth services.

Recognize Certain Audiology Services as Category 3 Telehealth Procedures

CMS requested comments regarding certain audiology services being added to Category 3 Telehealth status to allow for additional time, after the PHE expires, for continued data collection on utilization and clinical viability. The ADA wholeheartedly supports transitioning all currently assigned Category 2 Telehealth procedures to Category 3 procedures through CY2022.

The ADA also respectfully requests that the following audiology and vestibular codes be considered for addition to the Telehealth Category 3 list:

- 92620: Evaluation of central auditory function, with report; initial 60 minutes.
- 92621: Evaluation of central auditory function, with report; each additional 15 minutes.
- 92540: Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal or peripheral stimulation, with recording, and oscillating tracking test, with recording.
- 92541: Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording.
- 92542: Positional nystagmus test, minimum of 4 positions, with recording.
- 92544: Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording.
- 92545: Oscillating tracking test, with recording.
- 92546: Sinusoidal vertical axis rotational testing.
- 92547: Use of vertical electrodes.
- 92537: Caloric vestibular test with recording, bilateral; bithermal (i.e., one warm and one cool irrigation for each ear for a total of four irrigations).
- 92538: Caloric vestibular test with recording, bilateral; monothermal (i.e,. one irrigation in each ear for a total of two irrigations).
- 92548: Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report.
- 92549: Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT).
- 92517: Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report, cervical (cVEMP).
- 92518: Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report, ocular (oVEMP).
- 92519: Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report, cervical (cVEMP) and ocular (oVEMP).

- 92650: Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis.
- 92651: Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report.
- 92652: Auditory evoked potentials; for threshold determination at multiple frequencies, with interpretation and report.
- 92653: Auditory evoked potentials; neurodiagnostic, with interpretation and report

Provide Parity for Audiology Codes Analogous to E&M Codes

The ADA strongly urges CMS to apply adjustments uniformly across analogous services and specialties, including assessments furnished by audiologists. Audiologists specialize in preventing, evaluating, diagnosing, managing, and treating audiologic and balance (vestibular) disorders, using standardized quantitative and qualitative measures, including quality of life (QoL) handicap inventories, observations, procedures, and audiologic and vestibular diagnostic testing with appropriately calibrated instrumentation.

Audiologic and vestibular testing leads to the diagnosis of audiologic and/or balance disorders. The audiologist's assessment includes performance and interpretation of test results identifying the probable cause of impairment and functional ability within hearing, balance, and other related systems. Audiologists often identify the underlying disorder and diagnosis. Audiologists serve on care teams and the results of audiologic and vestibular assessments play a critical role in physician and other qualified health care professional management of Medicare beneficiaries with audiologic and vestibular disorders.

Given an audiologist's role in improving communication and mitigating falls risk, the ADA respectfully requests that CMS review audiology and vestibular services and adjust work Relative Value Units (RVUs) for analogous evaluation codes primarily reported by audiologists, to ensure relativity within the MPFS.

We offer the following examples of audiology evaluations that include work analogous to office/outpatient E/M services:

CPT Code	CPT Descriptor	ADA Description
92540	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording	Obtain comprehensive audiologic, vestibular, and medical case history. Assesses vestibular function using a comprehensive battery of tests to aid in the differential diagnosis of balance disorders and distinguish between aural, peripheral, and central pathologies. Informs a plan of care to manage and/or treat a balance disorder and prevent falls.
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	Obtain comprehensive audiologic, vestibular, and medical case history. Assesses behavioral responses from the patient using pure tone air and bone conduction, and speech threshold and recognition to aid in the differential diagnosis of hearing loss and audiologic disorders and determine the need for additional testing. Informs a plan of care to prevent, manage, and/or treat a hearing disorder.
92620	Evaluation of central auditory processing, with report; initial 60 minutes	Obtain comprehensive audiologic, vestibular, and medical case history. Assesses central auditory function through specialized audiologic testing to aid in the differential diagnosis of hearing and communication disorders. Informs a plan of care to manage and/or treat resulting central auditory disorders.
92625	Tinnitus assessment (includes pitch, loudness, matching, and masking)	Obtain comprehensive audiologic, vestibular, and medical case history. Assesses behavioral responses from the patient to aid in the differential diagnosis of bothersome tinnitus and associated audiologic disorders and determine the need for additional testing. Informs a plan of care to manage and/or treat the tinnitus and any possible accompanying hearing loss and/or vestibular complaints.
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour	Obtain comprehensive audiologic, vestibular, and medical case history. Assesses auditory function through behavioral and audiologic testing for medically necessity of and suitability for a surgically implanted hearing device, as well as post-surgical implant performance and outcomes. Informs the final surgical decision and post-surgical plan of care to improve functional hearing and communication abilities.

Allow Audiologists to Supervise Procedures with TC/PC Split

The 2021 MPFS proposed rule allowed for non-physician practitioners (NPP), such as Nurse Practitioners, clinical nurse specialists, Physician Assistants, and certified nurse-midwives to supervise the performance of diagnostic tests performed by technicians. The ADA again requests that licensed audiologists be added to this list, allowing the audiologist to directly supervise a technician performing procedures in the audiology code set that have a technical/professional component (TC/PC) split (i.e., 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92546, 92547, 92548, 92549, 92587, and 92588). Currently, non-physician practitioners, many who have limited clinical knowledge or expertise in the performance or interpretation of audiologic or vestibular procedures, supervise the performance of these procedures; therefore, audiologists, who independently perform and interpret these procedures daily, should also be allowed to supervise the actions of technicians completing these procedures and have these services covered.

Add Audiologists as Covered Recipients Under Open Payments Provisions

Audiologists prescribe, order, and/or dispense durable medical equipment (DME), specifically hearing aids, cochlear implants, and osseointegrated devices, to Medicare Part C, Medicaid, FEHP, and VA beneficiaries. *Including audiologists as covered recipients, subject to Open Payments reporting, would ensure greater transparency regarding financial relationships between audiologists and manufacturers, provide information on the nature and extent of these relationships, help to identify relationships that can both lead to the development of beneficial new technologies but also produce wasteful or fraudulent healthcare spending, help prevent inappropriate influence on research, education, and clinical decision making, specifically kickbacks, and level the playing field for providers across the clinical spectrum.*

Enhance and Mandate Hearing Screenings and Falls Risk Assessments at IPPE and AWV

Untreated hearing loss and balance difficulties have been found to significantly increase healthcare costs and utilization (Reed et al, 2019, Kovacs, et al, 2019) and significantly affect quality of life (Li-Korotky, 2012). The ADA requests that hearing screenings and falls risk assessments be enhanced and mandated in the Initial Preventative Physical Examination (IPPE) and Annual Wellness Visit (AWV). Like substance abuse screenings, otoscopy, cerumen management, acoustic hearing screenings, and falls risk assessments should be required procedures in every IPPE and AWV visit.

Add MIPS Measures to the Audiology Specialty Set

As it pertains to the Merit Based Incentive Payment System, the ADA requests that the following measures be added to the Audiology Specialty Set:

- Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (Quality ID #431 (NQF 2152))
  - Assigned to procedures: 92517, 92518, 92519, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92546, 92547, 92548, 92549, 92550, 92552, 92553, 92555, 92556, 92557, 92550, 92567, 92570, 92584, 92587. 92588, 92650, 92651, 92652, 92653, 92620, 92621,92625, 92626, and 92627.
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented (Quality ID #317)
  - Assigned to procedures: 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92546, and 92625.
- Closing the Referral Loop: (Quality ID #374)
  - Assigned to procedures: 69200, 69209, 69210, 92517, 92518, 92519, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92546, 92547, 92548, 92549, 92550, 92552, 92553, 92555, 92556, 92557, 92550, 92567, 92570, 92584, 92587, 92588, 92650, 92651, 92652, 92653, 92620, 92621,92625, 92626, 92627, and 95992.

Clarify Planned 2022 Low-Volume Threshold Application

The ADA requests clarification about language in the 2022 Proposed Rule regarding application of the low-volume threshold to group practices. In 2022, will the low volume threshold be applied to group data rather than merely individual data? This

HEAR AND NOW

Early Career AuD Resources

The Academy of Doctors of Audiology offers a variety of resources for early career professionals.

Early Career Resources: A collection of resources that will help you in your transition from student to professional.

Mentorship Program: What did you do right? What was harder than you expected? What do you wish you could change? As a recent graduate, you are a perfect candidate to help shape the future of audiology by becoming a mentor! Mentee opportunities are also available.

Monthly Virtual Networking/Learning: Join fellow early career professionals in an informal virtual environment for networking and learning and participate in an early career messaging group.

Visit **audiologist.org** for access to these resources and more!

ADA
ACADEMY of DOCTORS of AUDIOLOGY

detail is extremely important to audiologists; currently many are excluded from required reporting because they (1) individually have allowed charges for covered professional services less than or equal to $90,000; (2) provide covered professional services to 200 or fewer Medicare Part B-enrolled individuals; and (3) provide 200 or fewer covered professional services to Medicare Part B-enrolled individuals. A large percentage of these audiologists would be required to report (to avoid a penalty) if these same threshold requirements were applied to group or sub-group data. The clarification is essential for audiologists prior to the creation and implementation of the 2022 participation tool. ■

References

Kovacs E, Wang X, Grill E. Economic burden of vertigo: a systematic review. *Health Econ Rev.* 2019;9(1):37. Published 2019 Dec 27. doi:10.1186/s13561-019-0258-2

Li-Korotky, H. Age-Related Hearing Loss: Quality of Care for Quality of Life, *The Gerontologist*, Volume 52, Issue 2, April 2012, Pages 265–271, https://doi.org/10.1093/geront/gnr159

Reed NS, Altan A, Deal JA, et al. Trends in Health Care Costs and Utilization Associated with Untreated Hearing Loss Over 10 Years. *JAMA Otolaryngol Head Neck Surg.* 2019;145(1):27-34. doi:10.1001/jamaoto.2018.2875

The Moran Company. HR 4056 - Medicare Audiologist Access and Services Act: Fiscal Implications. July 2020.

Medicare Coverage of Diagnostic Audiology Services. Kanner Sheree. Hogan Lovells. October 14, 2016 (previously submitted to CMS).

H.R. 3. Elijah E. Cummings Lower Drug Costs Now Act. 2016. Accessed on September 9, 2021 at the following link: https://www.congress.gov/bill/116th-congress/house-bill/3/text.

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

HAVE YOU HEARD?

ADA Board of Directors Election Results: Drs. Heiman, Amlani, and Rogers Elected to Serve

The Academy of Doctors of Audiology (ADA) is pleased to announce that **Dawn Heiman, Au.D.** has been elected to serve as ADA's president-elect for the 2022 program year.

Dr. Heiman is the founder of Advanced Audiology Consultants, LLC, a private practice in Woodridge, Illinois. She is also the visionary and president of EntreAudiology, which offers peer-to-peer learning, ad training programs for patients and caregivers. She holds a Doctor of Audiology (AuD) degree from George Osborne School of Audiology at Salus University.

Amyn Amlani, Ph.D., has been elected to serve as a director-at-large on the ADA Board of Directors. Dr. Amlani is president of Otolithic, LLC, a consulting firm that provides competitive market analysis and support strategy, economic and financial assessments, segment targeting strategies and tactics, professional development, and consumer insights. He holds a Doctor of Philosophy (Ph.D.) in Audiology/Psychoacoustics from Michigan State University.

Liz Rogers, Au.D., has been elected to serve as a director-at-large on the ADA Board of Directors. She is the owner of Southeast Kentucky Audiology, a private practice in Corbin, KY focused on being full scope and providing best practices to a rural community. Dr. Rogers is the past treasurer and past president of the Kentucky Academy of Audiology (KAA), a past board member of EarVenture, and currently sits on a Community Action Board researching intervention methods for children with hearing loss. She holds a Doctor of Audiology (Au.D.) degree from Indiana University-Bloomington.

Drs. Heiman, Amlani, and Rogers will begin their terms on January 1, 2022. Continuing in service on the ADA Board of Directors will be Drs. Victor Bray (Immediate Past President), Kristin Davis (President), along with Drs. Jason Leyendecker, and Stephanie Sjoblad. Ending their terms on the ADA Board of Directors are Drs. Debbie Abel, Audra Branham, and Tim Steele. ADA is grateful for their service.

ADA 2021 Student Business Plan Competition Finalists to Square-Off at AuDacity

The ADA 2021 Business Plan Competition finalists have been selected—and final plans are underway for the live, in-person competition, to be held during the AuDacity Conference on Wednesday, October 27th at 7:00 a.m. Pacific Time at the Marriott Portland Downtown Waterfront Hotel in Portland, Oregon.

This year's competition was dominated by students from Northwestern University who make up three of the four finalists/teams. The University of North Carolina is also represented with a two-person team.

Finalists include the following:

Jill Greenberg, Northwestern University

Jill Greenberg is pursuing her Doctorate of Audiology at Northwestern University. She received her Bachelor of Science degrees in Retail Management and Communication Sciences & Disorders from Syracuse University. Jill is currently completing her externship with Pittsburgh Ear Associates, a neurotology practice with a complete balance center. Clinically, Jill is interested in vestibular testing and aural (re)habilitation because of the strong rapport built with patients during these tasks. Jill believes teaching communities about the impact of hearing loss on communication, cognition, and balance will encourage patients to become strong self-advocates as well as expand audiology's outreach.

EmilyAnn Duffley, Northwestern University

EmilyAnn Duffley is an aspiring pediatric audiologist and private practice owner. She is currently pursuing her Doctorate of Audiology at Northwestern University and working as the audiology extern at Child's Voice, a full-service pediatric audiology clinic and school for children with hearing loss in Wood Dale, IL. She served as the Northwestern Campus Representative for the Illinois Academy of Audiology in 2020. EmilyAnn earned dual degrees in Speech and Hearing Sciences and Vocal Performance from the University of Illinois at Urbana-Champaign in 2019.

Ryan Sprouse, University of North Carolina (UNC) – Chapel Hill

Ryan Sprouse is a fourth-year audiology doctoral student at UNC-Chapel Hill. He graduated Summa Cum Laude from West Virginia University with a Bachelor of Science in Communication Sciences and Disorders. He is currently completing his clinical fellowship at the University of Pittsburgh Medical Center in Pittsburgh, PA.

Alyssa Fischer, University of North Caroline (UNC) – Chapel Hill

Alyssa Fischer is a fourth-year audiology doctoral student at the University of North Carolina at Chapel Hill. She graduated Magna cum Laude from the University of Georgia with a Bachelor of Science in Education in Communication Sciences and Disorders and a certificate in Disability studies. She is currently completing her clinical fellowship at the Durham VA Healthcare Center in Durham, NC.

Miranda McDonnell, Northwestern University

Miranda McDonnell graduated from Cal State East Bay in 2019 with a Bachelor of Science degree in speech, language, and hearing sciences. She is pursuing a Doctor of Audiology degree at Northwestern University and completing her externship at Evergreen Speech and Hearing in Washington. After graduation, scheduled for 2022, McDonnell hopes to improve communication within her home community of Stockton, CA. She is the first student to make it into the final round of the ADA Student Business Plan Competition two years in a row. In 2020, McDonnell took home the third-place prize.

ADA would like to thank CounselEAR and BlueWing for their sponsorship of the 2021 Student Business Plan Competition. Please visit www.audiologist.org for more information.

AuDACITY 2021

AUDIOLOGY UNLEASHED

Thank You to Our Sponsors and Exhibitors!

CareCredit | Allegro Credit

Financing Provided by Synchrony Bank

Starkey

amplifon Hearing Health Care

CapTel from T-Mobile

BlueWing HEARING CARE

COUNSELEAR PRACTICE MANAGEMENT SOLUTIONS

HAMILTON CAPTEL

signia

AudBoss

HEARWORKS

Alpaca Audiology
The American Institute of Balance
Amplivox
AudBoss
AuDConnex
Audigy
AudiologyDesign
Audioscan
CaptionCall
Cochlear Americas
Consult
Entheos Audiology Cooperative
Fuel Medical Group
Grason-Stadler
Hamilton CapTel
HearVu
Hearworks
InnoCaption
Interacoustics
Lenire by Neuromod Devices
Levo Medical Corp
MAICO Diagnostics
MiraCell, Inc.
Natus Medical
Oaktree Products
Oregon Academy of Audiology
Oticon, Inc
Pacific University School of Audiology
ReSound
SafKan Health
Signia
Sycle
TIMS Software
Weave
Wells Fargo N.A.
Whisper
Widex

2022 ICD 10 Coding Updates Go into Effect October 1, 2021

ICD10-CM coding is used to represent diagnoses, symptoms and encounters. These codes are required for most managed care claims, including those billed to Medicare, Medicaid and private, commercial insurance.

The ICD 10 updates go into effect on Friday, October 1, 2021.

There is one meaningful ICD10-CM update for audiology in the 2022 ICD10 CM system.

P09.6: Abnormal findings on neonatal screening for neonatal hearing loss

Please use this code, either by itself or in conjunction with Z01.110 (Encounter for hearing examination following failed hearing screening), and the specific ICD 10 code to reflect the type of hearing loss in each ear, to represent a failed newborn hearing screening and the resulting hearing loss. Please reach out to Kim Cavitt, AuD at kim.cavitt@audiologyresources.com with additional questions or concerns regarding ICD10 or other coding matters.

PRESIDENT'S MESSAGE

Continued from page 7

MAASA is not the only federal legislation currently in play that is of importance to audiologists and their patients. The proposed budget reconciliation bill being considered by Congress, if enacted, would authorize Medicare to provide hearing aids to beneficiaries with severe-to-profound hearing losses. This, coupled with the coming implementation of the OTC Hearing Aid Act for persons with perceived mild-to-moderate loss, would dramatically change device-delivery models and accentuate the need for our professional services. The need for these services, and needed legislative change for coverage by Medicare of our services, was addressed in this recent STAT First Opinion podcast:

> ***Physician Frank Lin:*** *"To this day, audiologists can be reimbursed for doing testing, but sadly enough, they are not covered to provide any treatment services around hearing loss. It seems like a pretty bitter paradox, a bitter pill to swallow, that you can see an audiologist to be told you have a hearing loss but yet to do nothing about it." … "Audiologists get paid to do your hearing test and that's it; not to even teach you about hearing, tell you what it means, how it can impact you, how to communicate better, anything about a hearing aid. Zip, zero, none." … "[With regard to new OTC hearing aids and possible inclusion of hearing aids in Medicare] Medicare would begin covering hearing care services for anybody with hearing loss, so basically the services of an audiologist to educate [the patient], to provide counseling, to say possibly what kind of devices would you need, where are you struggling with communication help, to provide unbiased guidance from audiologists."*

Over the next one hundred days in the fall legislative session, the future of audiology may be transformed, or potential advancement once again may be stalled. Now, more than ever, all of us must take action to see that the three MAASA provisions of direct access, recognition for treatment services, and achievement of practitioner status, pass through Congress and are signed into legislation.

Act now! This call to action is about you, your colleagues, your patients, your friends, your family, and all who care about the future of audiology and hearing healthcare. Go to chooseaudiology.org, select Congressional Connect, select the Legislative Issue MAASA, choose the appropriate Letter Template (Audiologist Urges Support …, Audiology Student Urges Support …, Citizen Urges Support …, or Medicare Patient Urges Enactment), identify your Legislators, and send your Letters of Support now for MAASA, the Au.D. movement, and your profession. Seize the unique opportunity we have today and act in advocacy for your future! ■

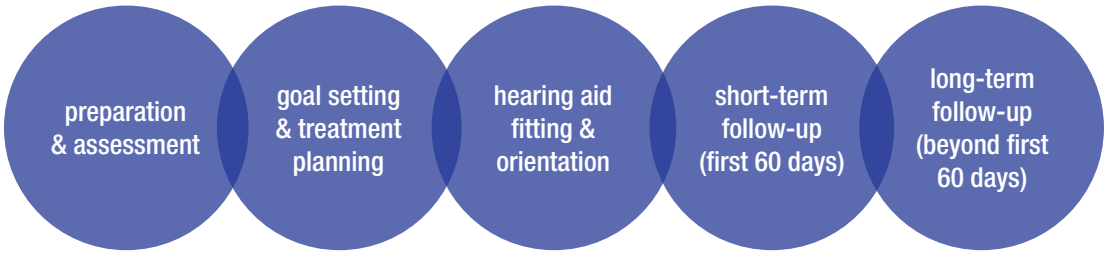
References

Congressional testimony, Senate Finance Committee, 19 May 2021.

Congressional testimony, House Ways and Means Committee, 08 June 2021.

STAT First Opinion Podcast, Episode 28: An ENT physician and patient on the high cost of hearing loss. 18 August 2021.

Continued from page 9



options, establish best practices, and set us on a path toward vastly improved hearing outcomes through the acceptance and promotion of telehealth services.

Telehealth at large has already begun to prove its value. When the Covid-19 pandemic struck, healthcare providers and their patients were urged to adopt telehealth services—care provided virtually, at a distance, via telephone or computer-based videoconferencing software. According to recent analysis by McKinsey & Company, telehealth utilization spiked in spring 2020 and has now leveled off at 38 times what it was before the pandemic. This would indicate a positive, long-term shift in healthcare delivery. Today, McKinsey & Company reports 13 to 17 percent of all office and outpatient visits, across all tracked specialties, are telehealth visits. Moreover, researchers see skyrocketing investment in virtual care.

Now consider hearing health, specifically. The patient journey toward better hearing can be time-consuming. Each of the pictured five key steps has traditionally required at least one in-person visit with an HCP, taking an average of 30 to 60 minutes of facetime, not including travel. By enabling the patient and HCP to pick and choose when and how they interact, telehealth has the potential to empower the patient to become a more effective hearing aid wearer over the long haul.

Promising Developments

Already, the industry is identifying ways to implement telehealth successfully. At Signia (my day job) we've spent several years developing telehealth solutions designed to help audiologists engage remotely with their patients after the initial in-office fitting, including remote tuning, troubleshooting, and video calls. Other manufacturers have invested similarly in telehealth. All of these investments further the patient-provider partnership – even after COVID-19 is in our rear view mirror.

Although a telehealth model is not for everyone—some patients may not be comfortable with technology while others simply prefer face-to-face care—we're reaching a point when a permanent, full-time telehealth option is not just viable, but also critical to the growing need for better hearing.

It's been shown in other specialties that when given a choice, many patients prefer a telehealth option, especially for routine appointments. And increasingly, older adults—many of whom would benefit from hearing aids—have shown they're comfortable with the technology needed for telehealth. They've used online tools to connect with family and friends during a pandemic; now, recognizing the convenience, many are willing and able to try telehealth when offered the tools.

Not every element of in-person hearing care can be delivered virtually (yet), but enough of the patient journey can be achieved via computer or smartphone that when both patient and audiologists agree to it, telehealth should be used whenever possible. Audiologists are trained to follow the science, and in the case of telehealth, the science shows that under the right circumstances, it is a viable, important, and effective tool for improving uptake and outcomes.■

References

Aazh, H., Prasher, D., Nanchahal, K., & Moore, B. C. (2015). Hearing-aid use and its determinants in the UK National Health Service: a cross-sectional study at the Royal Surrey County

Solheim, J., & Hickson, L. (2017). Hearing aid use in the elderly as measured by datalogging and self-report. International journal of audiology, 56(7), 472–479

Bennett, R. J., Kosovich, E. M., Stegeman, I., Ebrahimi-Madiseh, A., Tegg-Quinn, S., & Eikelboom, R. H. (2020). Investigating the prevalence and impact of device-related problems associated with hearing aid use. International journal of audiology, 59(8), 615–623.

Bennett, R.J. (2021) Underreported hearing aid problems: No News is good news, right? Wrong! Hearing Journal Feb 16-18.

Tremblay, K. L., Pinto, A., Fischer, M. E., Klein, B. E., Klein, R., Levy, S., Tweed, T. S., & Cruickshanks, K. J. (2015). Self-Reported Hearing Difficulties Among Adults With Normal Audiograms: The Beaver Dam Offspring Study. Ear and hearing, 36(6), e290–e299.

Koerner, T., Papesh, M., & Gallun, F. (2020). Questionnaire survey of current rehabilitation practices for adults with normal hearing sensitivity who experience auditory difficulties. AJA. 29:738-761.

CALL FOR VOLUNTEERS

Help build the future of audiology, while building your leadership experience and your professional network. No experience required.

Visit audiologist.org and volunteer today.

ADA
ACADEMY of DOCTORS of AUDIOLOGY®

The Power to Practice

Academy of Doctors of Audiology®
446 E. High Street, Suite 10
Lexington, KY 40507

Frequency Lowering Amplification

This comprehensive Continued Audiology Master Class demystifies frequency lowering amplification technology. Gain a new level of understanding that will empower you in your clinical decision-making. Presenter Joshua M. Alexander, PhD, covers general guidelines for verification using probe microphone measurements and demonstrates the differences between various techniques. This course is offered for AAA, ASHA, and IHS CEUs.

VIEW COURSE:
AudiologyOnline.com/**FrequencyMC**

"I felt that this was a fantastic course. The subject matter was broken down in tangible, informative, and memorable ways. I really enjoyed the organization and the material. Well done."

–Ryan O., AudiologyOnline member

UNLIMITED CEU access | $99 per year

AUDIOLOGYONLINE
866-481-2739 |