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Serving a Culturally Diverse Pediatric Population
Audiology, like many health-care professions, serves an incredibly diverse patient population across the age range. To provide the highest-quality care, audiologists need to adjust their service provision to accommodate patients from many cultures, ethnicities, races, and backgrounds.

By Lindsay M. Bondurant

Women in Audiology: Stories of Courage and Strength
As the pandemic moved into weeks and then months, Dr. Gyl Kasewurm connected with colleagues who shared how the many stresses and challenges were affecting their lives and businesses.

By Gyl Kasewurm

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By Rebekah F. Cunningham and Suzanne M. Foley

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Personal-adjustment counseling is fully within our professional domain and audiologists must be comfortable providing this form of counseling to patients, including those with terminal illness, as a normal part of clinical exchanges.

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Audiology Today (ISSN 1535-2609) is published bimonthly by the American Academy of Audiology, 11480 Commerce Park Drive, Suite 220, Reston, VA 20191; Phone: 703-790-8466. Periodicals postage paid at Herndon, VA, and additional mailing offices. Postmaster: Please send postal address changes to Audiology Today, c/o Membership Department, American Academy of Audiology, 11480 Commerce Park Drive, Suite 220, Reston, VA 20191.

Members and Subscribers: Please send address changes to membership@audiology.org.

The annual print subscription price is $129 for US institutions ($154 outside the US) and $62 for US individuals ($116 outside the US). Single copies are $15 for US individuals ($20 outside the US) and $25 for US institutions ($30 outside the US). For subscription inquiries, telephone 703-790-8466 or 800-AAA-2336. Claims for undelivered copies must be made within four (4) months of publication.

Full text of Audiology Today is available on the following access platforms: EBSCO and Ovid.

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Inspiration, Gratitude, and Indebtedness to Our Colleagues

Recently, Kitty Werner, MPA, the Academy’s vice president of public affairs and executive director of Accreditation Commission for Audiology Education (ACAE), mentioned that James (Jay) Hall, III, 2018–2020 chair of the Board of Directors for the ACAE, has been in continuous service to the Academy and the profession of audiology since participating as an Academy Founder in 1988.

This got me thinking a lot about service and commitment. When I think of the people I most admire in life, they are typically those who have dedicated themselves to service. They identify a need and they enthusiastically seek to be part of the solution. They positively impact the present and the future through service to others, service to great ideas or philosophies, and service and dedication to making a difference.

These individuals appear to have huge hearts. According to DeAnn Hollis, a volunteer coordinator, “the heart of a volunteer is never measured in size, but by the depth of the commitment to make a difference in the lives of others.”

In addition to Dr. Hall, we have several inspirational leaders in our profession who have been serial contributors. Past President Brad Stach, who served as the first secretary-treasurer of the Academy under the leadership of the first Academy President James Jerger, just completed another term on the board of directors. Dr. Stach continues to serve on the Academy’s Practice Policy Advisory Committee, which represents the Academy at the American Medical Association’s Relative Value Update Committee/Current Procedural Terminology Editorial Panel, alongside Paul Pessis, another Academy past president.

I would challenge anyone to tell me of a year in which Erin Miller, past president (2014–2015), has not served as a volunteer since joining the Academy. Many other past presidents continue to serve on multiple committees, with the Academy Foundation, and ACAE, including being on an advisory council for the current president.

As an inspirational activity, you might review the list of Academy Founders (www.audiology.org/about-us/academy-leadership/academy-founders) and past presidents (www.audiology.org/about-us/academy-leadership/board-directors/academy-presidents). You will find a number who are still actively serving in various roles in the Academy.
Professionals at various stages of their career and students serve in many volunteer roles making significant contributions to the Academy and to the profession of audiology. There is not space here to mention all the committed volunteers who have been instrumental in securing the future of audiology, but you can review current council and committee members on the Academy’s website (www.audiology.org/get-involved/volunteer-opportunities/councils-committees-subcommittees-and-task-forces).

These professionals all have “day jobs”—typically very demanding “day jobs”—and multiple other professional and personal responsibilities, but they have dedicated much of their time, talents, and resources to the betterment of our profession, for their fellow audiologists as well as the public we serve.

Tom Brokaw noted that “it’s easy to make a buck. It’s a lot tougher to make a difference.”

I feel a tremendous sense of inspiration, gratitude, and indebtedness to our colleagues who have previously, and are currently, truly making a difference in the trajectory of the field of audiology.

If you have not done so already, I hope you will consider joining them as a volunteer (www.audiology.org/get-involved/volunteer-opportunities). As the Academy of, by, and for audiologists, members who volunteer define the Academy and shape our profession. ●

Volunteerism is the voice of the people put into action. These actions shape and mold the present into a future of which we can all be proud. —Helen Dyer

Angela Shoup, PhD
President
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www.amauditorysoc.org/annual-conference

March 18–20
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Michigan Speech-Hearing Association Annual Conference
www.michiganspeechhearing.org/annual_conference.php

April 8
Virtual Meeting
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www.AcademyResearchConference.org

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www.AAAConference.org

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Despite limited published research, there is some evidence that the SARS-CoV-2 virus or COVID-19 can be found in the cerumen in about a third of newly diagnosed patients.

Published January 23
www.facebook.com/theamericanacademyofaudiology

The 2020 Advocacy Year in Review provides an overview of the Academy’s legislative, regulatory, and political resources used to advocate for audiologists amidst the COVID-19 global pandemic.

Published February 4
www.twitter.com/academyofaud

Helping students develop their skills and passions to advance audiology and hearing and balance sciences, the AAA Foundation is accepting applications for its 2021 student scholarship programs.

Published on January 29
www.linkedin.com/company/american-academy-of-audiology

As states begin vaccination efforts, many have questions about when audiologists, as health-care providers, will have access.

Published January 25
www.instagram.com/academyofaud
Serving a Culturally Diverse Pediatric Population

By Lindsay M. Bondurant
We must examine how cultural diversity affects the provision of pediatric services and look for ways to help better serve our youngest patients and their families.

A s audiologists continue the much-needed and long-awaited discussion about ways we can improve service provision to a culturally diverse patient population, we have an obligation to include the unique needs of our pediatric patients and their families. This consideration is critical because, if we don’t connect with parents in a way that supports them along their journey, it can disrupt the audiologist-parent relationship that is so crucial to the success of children with hearing loss.

This article offers an overview of cultural diversity in health care (generally) and audiology (specifically), a discussion of the needs of children and their families from an array of backgrounds, and a list of suggestions and resources for audiologists working with a culturally diverse pediatric population.

**Defining Cultural Diversity**
Cultural diversity relates to the heterogeneity within a given group of people, including a range of beliefs, values, traditions, languages, religions, political ideals,
education levels, physical abilities and disabili- 
ties, ages, sexual orientations, genders, 
races, and ethnicities. In recent decades, 
many Americans have moved away from 
the idea of the American melting pot, with 
its implications of assimilation and accul-
turation, and instead have moved toward 
the idea of the American salad bowl, in 
which people from diverse backgrounds 
retain the customs and qualities that make 
them unique.

As the population of the United States 
becomes increasingly diverse—currently 
40 percent of all Americans identify as a 
category other than white, non-Hispanic— 
there is an increasing need for educators 
and health-care professionals to be able to 
effectively support students, patients, and 
families who come from a wide array of 
backgrounds, traditions, and belief systems.

The Need in Health Care and 
in Audiology for Cultural 
Competence

It has long been known that physicians do 
not accurately reflect the ethnic, racial, and 
cultural backgrounds of the Americans they 
serve. As recently as 2019, the Association 
of American Medical Colleges reported that 
only six percent of active physicians identi-
ﬁed as Hispanic (compared to 18 percent of 
the general population) and only five percent 
of physicians identiﬁed as Black (compared 
to 13 percent of the general population).

In the realm of audiology, the differences 
between providers and patients appear 
equally stark. According to government 
statistics compiled by online aggregator 
Data USA, only eight percent of audiologists 
identify as Hispanic/Latino and less than 
four percent identify as Black. Given that, 
according to the information published by 
Data USA, only 18 percent of audiologists 
identify as something other than “white, 
non-Hispanic,” it is likely that there are 
many encounters in which the patient’s 
background is quite different than that of 
the audiologist.

This disparity between the ethnic, cul-
tural, and racial background of audiologists 
compared to that of our patients may con-
tribute to a lack of effective care for people 
in need of hearing and balance help.

What Is Unique About the 
Needs of Children as Related 
to Cultural Diversity?

One of the biggest joys of working with chil-
dren is the opportunity to work with their 
parents and, often, with extended family. It 
is also one of the biggest challenges, as our 
youngest patients are completely reliant on 
their families for all aspects of their care.

For children with hearing loss, much of 
their language, cognitive, and social growth 
over time can be attributed to the family’s 
adherence to their chosen intervention, 
whether that’s listening and spoken lan-
guage (which typically requires 10+ hours 
per day of hearing aid or cochlear implant 
use) or manual communication (which 
requires robust exposure to sign language 
or cued speech). For families to be success-
ful with an intervention plan, they must 
ﬁrst understand it, understand why it’s 
important, and identify tools to help them 
incorporate the intervention into their 
daily lives.

Given the increasing presence of diverse 
racial, ethnic, and cultural backgrounds in 
the children who need care from audiolo-
gists, it’s quite likely that the parents and
families seeking care in our clinics and practices will have different cultural backgrounds than ours and that their daily lives might look very different than that of their audiologist. For this reason, it is absolutely essential that audiologists who work with children have an approach to patient care that includes respect, empathy, and responsiveness.

Guidelines for Audiologists Working with a Culturally Diverse Pediatric Population

There are many ways to meet families where they are:

Language: Audiologists should make every effort to interact with children and their families in the language preferred by the family. If the audiologist is not fluent in that language, an interpreter can be arranged. Online or phone-based interpreters are a cost-effective way to address the needs of your non-English speaking patients. Audiologists should remember that it is never appropriate to use children and adolescents as interpreters for their parents and family members.

Communication style: Families from cultural backgrounds that differ from that of the audiologist may have culturally linked behaviors that influence the audiologist-patient/family interaction, including eye contact and body language. The provider should follow the parent’s lead with regard to communication style. When possible, learn about the family’s cultural background so that your communication style can be more carefully adapted to help the family feel more comfortable.

In recent decades, many Americans have moved toward the idea of the American salad bowl, in which people from diverse backgrounds retain the customs and qualities that make them unique.
toned, ethnicities, and cultures. Families will feel more comfortable if they see that you respect and appreciate the contributions of a wide range of people. In addition, children will feel more empowered if they see that your practice celebrates diversity in a way that includes children and adults who look like them.

**Collaboration:** Coordinate resources and services for patients and families with community groups including agencies, businesses, cultural and civic organizations, colleges and universities, and local physicians’ practices.

**Awareness of implicit biases:** Many factors can affect interactions across cultures, including the biases each person in the interaction has toward the other. This is true even for well-meaning audiologists whose goal is to help children achieve better hearing and balance. We all have deeply internalized ideas and views of the world and the people we may encounter. By working to become aware of your biases and learning to take a step back when your biases might be affecting the support you’re providing to the parents and family of a child with hearing loss, you’ll become a better audiologist and care provider for all of your patients.

**Information sharing:** It is common for people of all backgrounds, but particularly for people who have been marginalized in the health-care system, to be reluctant to admit that they do not understand what is going on. If you follow up your explanation with *Does that make sense?*

---

**THE PROVIDER SHOULD FOLLOW THE PARENT’S LEAD WITH REGARD TO COMMUNICATION STYLE.**

**Respect:** Listen to parents’ concerns and reserve judgment. Remind yourself that things you perceive as barriers to care (such as a lack of punctuality or limited engagement) may have a basis in cultural differences that reflect a different value system than the one automatically (and often unconsciously) applied to the situation by the audiologist. Know that, regardless of cultural differences, your goal for your pediatric patient is the same as the parent’s goal for their child: the opportunity for growth, learning, and success.

---

The provider should follow the parent’s lead with regard to communication style.
or Did you understand all of that?, they may tell you yes, regardless of the extent to which they actually understood what you shared with them. Instead, have them demonstrate the action you’ve described (changing the battery, inserting/removing the child’s hearing aid) or have them tell you about some language-stimulating activities that might fit into their daily routine. Close the appointment with an open-ended request that they ask you at least one other question before they leave, rather than just asking them Do you have any questions?, which often leads parents to respond with No.

**Additional Resources**

There are many resources online to help develop your cultural competence. Below, I’ve listed a few that I found particularly helpful.

The Cleveland Clinic Foundation (2017) has a Diversity Toolkit resource that provides information about 70+ cultural backgrounds to help health-care practitioners improve the care and support they provide to patients and families from diverse backgrounds.

The Pacer Center (2015) in Minneapolis has an excellent list of suggestions for
“Getting off to a good start: Positive interactions with diverse families” that was written for educators, but applies to health-care providers as well. Their recommendations include:

- Set the stage for positive and productive appointments by having interpreters available and involved from the earliest points of contact with families. Call the family in advance of the appointment to clearly explain the purpose of the appointment and what the child and parent should expect.

- Build trust by sharing some information about yourself, including why you went into audiology and what you enjoy about working with children and their families. Direct your comments and questions to both parents and respect the family structure, even when it is not your own experience or value system. Recognize the importance of extended family members, community elders, and spiritual leaders.

- Consider differences in literacy levels. Many families from diverse backgrounds may struggle to read written information, particularly if it is written at a higher reading level. In a sensitive and indirect way, check frequently for understanding and provide information in a variety of formats (verbal, written, pictorial).

- Incorporate differences in culture as you work to understand your pediatric patients and their families. Consider the following:

  - In many Asian and African cultures, it is better not to initiate a handshake unless the individual extends their hand to you first.

<table>
<thead>
<tr>
<th>PILLAR</th>
<th>CLINICIAN GOAL</th>
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<tbody>
<tr>
<td>Communication</td>
<td>Demonstrate, by attitude and behavior, an openness to different cultures.</td>
</tr>
<tr>
<td>Adaptability</td>
<td>Adjust clinical practice, when possible, to acknowledge patient and family/caregiver culture.</td>
</tr>
<tr>
<td>Growth</td>
<td>Demonstrate a commitment to professional development aimed at acquiring new cultural-competence knowledge and skills.</td>
</tr>
<tr>
<td>Open-Mindedness</td>
<td>Consider that often the variability within cultures may be more pronounced than the variability among cultures and that there is also significant variability among recent immigrants and those who have been in the United States for one or more generations.</td>
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</table>
• Families from Asian, African, South American, and indigenous backgrounds may use a combination of traditional or tribal medicine along with Western medical approaches. It may be helpful to learn more about the other practices the family is incorporating into the child’s care so you might include them in your recommendations.

• Many non-Western cultures have different standards for eye contact and physical distance. Follow the family’s lead in these areas.

• If immigration status is a concern, the family may be cautious in disclosing information or they may take longer to develop a trusting relationship with you.

• At the conclusion of your appointment or meeting, end on a positive note by praising the child and thanking the parents for their input and participation.

The American Academy of Pediatrics (Cora-Bramble, 2020) has a Providing Culturally Effective Care Toolkit that can easily be adapted for audiologists working with children and families from diverse backgrounds. Their suggestions include the four pillars outlined in Table 1.

Conclusion
As many audiologists are working toward a better understanding of their culturally diverse patients, it is important to remember that children and their families may have unique needs that are significantly affected by their family’s background, traditions, culture, and beliefs. By demonstrating an attitude of openness, respect, and collaboration, we can show our patients and their families how much we value them and wish to support them on their unique journey with hearing loss.

Lindsay M. Bondurant, PhD, is director of the Pennsylvania Ear Institute at Salus University in Elkins Park, Pennsylvania, and has been a practicing pediatric audiologist since 2000.

References


Data USA


Women
in Audiology
Stories of Courage and Strength

BY GYL KASEWURM
As the pandemic moved into weeks and then months, Dr. Gyl Kasewurm connected with colleagues who shared how the many stresses and challenges were affecting their lives and businesses.
Let’s face it. In many situations, women make the world go around, especially in the world of audiology, where women make up 82 percent of the workforce (American Academy of Audiology, 2019).

The COVID-19 pandemic has caused women to show their true strength. The pandemic forced audiologists to rethink and restructure their method of service delivery, as many of our patients are at the highest risk for morbidity. In addition, a record number of audiologists have been furloughed or forced to reduce their workload.

The group that began with a mere 50 individuals has grown to almost 2,000 women. I have been amazed, inspired, and comforted by so many women in this group. This article highlights a few of the many amazing women in audiology.

The new “normal.” The workplace is not what it once was. The doors are now locked, there are no walk-ins, telehealth is present, there is constant sanitizing and mask wearing. Stress is up and revenue is down.

A’ja Penn, owner of Penn Audiology, remarked: “My patients have been understanding and I am happy that I am still open. However, my work-life balance scale is now tipped in the opposite direction, leaving me with much more time for family. As great as that may be, it is simply the inverse of the pre-pandemic and it’s difficult to adjust to.”

For Sarah Roggenbuck, field sales representative at Starkey Hearing Technologies, the change in business practices forced significant alterations to lifestyle and thinking.

“How do you stop a perfectionist in her tracks? Invite her to a conference call and announce that she and many of her teammates were selected to be furloughed,” said Sarah. “I suddenly found myself immersed in quarantine, navigating...
unemployment, and in a new role as my
daughter’s teacher. I missed my customers
dearly, as I was instructed not to discuss
any business matters during furlough. For
months, I pondered who I was without
my career.

“After four months, I received the call to
come back. I worried whether I was even
capable of doing my job well. One morning,
my seven-year-old came to me and said, ‘You
know Mom, you don’t have to be perfect.’

“I realized that I am stronger than I give
myself credit for and my determination will
get me through whatever obstacles I encoun-
ter. At the end of the day, it is far more
significant to be present rather than perfect.”

Randa Monsour-Shousher, owner of
Northwest Ohio Hearing Clinic, shared that
COVID-19 presented both challenges and
opportunities.

“When the stay-at-home order went into
effect, I made the decision that our services
were essential,” she said. “How could I deny
the emergency room physician’s request to
fix his hearing aid so he could treat patients?

“I felt fortunate to be financially strong
and knew that was one less concern I
needed to handle. I cherished Zooming with
my employees wanting to get ahead of the
game fulfilling many tasks for 2020. We
knew meeting the goals early on would give
us the opportunity to hit the ground run-
ning when we would be allowed to reopen.
Operating during a pandemic produced a
new definition of ‘difficult.’ What COVID-19
is teaching me is to slow down, breathe, and
literally look at the snow out the window.”

Finding Strength and Rising to
the Challenge

Angela Alexander, owner of Auditory
Processing Institute, has experienced the
unexpected before.

“I lost my first clinical job during another
crisis, the 2008 global financial crisis,” she
said. “I was working in an ENT office with
my master’s degree and suddenly found
myself without a job, with a six-month
restraint of trade, and a year left in my
AuD program.

“I was also working in Jack Katz’s office
on Saturday mornings, seeing his overflow
patients for evaluation and therapy at his
clinic. I started working three days a week
for myself, making similar money as I did
working previously, and it made me realize
that life didn’t have to be about working 40
hours a week dispensing hearing aids. This
change in perspective was huge for me.

“In addition to making a living wage, I
now spend time doing what makes my heart
beat 100 percent of my work hours and I get
to support others as they pivot in audiology. Somehow, I’ve created the best job I’ve ever had.”

Kristi Mendoza, owner of Optimum Audiology, experienced COVID herself.

“When I did, I regretted not having started my own business after 30 years of being an audiologist. In addition, I have a 17-year-old entering college next year who wants to be an audiologist and I realized that I would like to pass a business on to her.

“I decided it was time to grow and to start training and preparing for a business of my own. The past six months of planning, executing, and meeting with architects and builders has made this transition one of beauty. Even I stand amazed, but I am ready to further create and grow. This new office is the beginning of so much more.”

Jessie Dimmick, owner of Hearing Doctors of Iowa, remembered: “On career day in high school, I remember looking at the variety of paths before me, wondering how it would feel to choose just one.

“Fast forward to five years into my career as an audiologist and in between jobs, I again found myself at a crossroads. I took the big step toward founding my own private practice.

“The business grew steadily and I approached 2020 with strength and tenacity. Amid this pandemic, I discovered that I was expecting a baby. At my first appointment with the obstetrician, I found out I was pregnant with twins. During a pandemic, through uncertainty, I was responsible for growing two tiny humans, my patients, and my business. Would I be enough?

“I watched my business account drain to keep employees paid and the bills paid. My practice survived. I delivered full-term healthy twins. We braved the storm and became better because of it. It has been a major risk, but audiology private practice (and motherhood) is so worth it.”

Staying Positive and Staying Safe
“In these trying times, I have been challenged more than ever to keep the morale of my staff positive,” admitted Sheryl Figliano, owner of Centers for Hearing Care. “As the leader of the staff, I must make everyone understand that this ‘new normal’ is to keep patients and staff safe.

“We have closed lobby doors and patients must call before they come in. Both staff and patients must have a mask in place.
Unfortunately, we have experienced a continual stream of negative patients that literally beat on our doors demanding that we open the doors for them. They even gave us negative reviews on Google, stating that ‘there is no reason to close our doors.’

“Having a staff of all female employees, I must ensure that each person feels safe when dealing with patients. When someone is around mean, angry people all day, it is very difficult not to become mean and angry. Now more than ever, we need to thank staff, cheer them on, and tell them ‘you’ve got this.’ If staff members are still with you after this year, they are very special and dedicated.”

Working 38 years in private practice, Kay Young, owner of Shelby Hearing Center, has many stories to tell in terms of changing, adapting, and surviving disruptions, both industry-wide and within her business.

“Life has been a struggle during this pandemic and it’s been challenging,” she said. “However, we have also been amazed by our patients, their understanding, and, at times, their patience with us. Reinforcing our patients’ confidence in our services when they are already coping with unprecedented times forced me to dig deep and to focus on my ‘why.’


Throughout my years in practice, I have been faced with many difficult situations with employees and patients,” Noël Crosby, owner of Advanced Hearing Solution shared. “A pandemic has a way of forcing you to see things that you really don’t want to see.

“I recently realized that an employee, who I genuinely liked and cared for, wasn’t the right person for the job. Instead of addressing this head on, I spent quite a few years changing my office to accommodate the employee, instead of doing what needed to be done, which was discharging him. It has nothing to do with the person; it has to do with what is going to work best for the business.”

Strong women don’t pretend they know everything. Instead, they are curious and they are learning something new all the time. Strong women are confident in their talent, intelligence, and strengths, and aren’t afraid to ask questions or the opinions of others. Strong women ask questions, gather information, and then make up their own mind.

Leading During Difficult Times and Addressing Workplace Bias

Women make up 82 percent of the audiology workforce and their annual salary is only 85 percent of the average male audiologist’s salary (American Academy of Audiology, 2019). While the gap is closing somewhat among younger women who are more likely to ask for raises and promotions, women are far from equal when it comes to wages and leadership roles in audiology.

A.U. Bankaitis, vice president of Oaktree Products, reflected: “For decades, we’ve seen headlines discussing gender bias in the workplace. We know mixed gender leadership teams boost companies’ profitability—so why is bias still an issue?

“The stubbornness of this problem lies in the fact that it is rooted in our societal beliefs about men, women, and leadership.
We believe men should be ‘agentic’ (assertive, decisive, strong) and women should be ‘communal’ (warm, caring, sympathetic).

“These gender stereotypes clash with the leadership prototype, i.e., the societal view of what a prototypical leader should be. The leader prototype shares characteristics with the male stereotype: self-reliant, assertive, dominant, and competitive. This prototype is widely shared and, if I asked you to close your eyes and picture a leader, most people would automatically picture a tall, white, middle-class man. Conversely, women are seen as caring, sympathetic, and sensitive to the needs of others.

"Empowerment is the process of becoming stronger and more confident. It is accomplished by surrounding yourself with people who mentor, inspire, and support you to become your most authentic and awesome self. It took a pandemic to remind me of the many individuals who shaped my professional life.”

"Pandemic crisis management is yet another opportunity to cultivate more skills," surmised D’Anne Rudden, owner of Longmont Hearing and Tinnitus Center.

“The year 2020 brought my first worker’s compensation claim in 18 years of owning a business, which was the result of a dog bite to an employee. The thought of someone looking to sue me would have crushed me into a puddle of tears just a few short years ago.

“What I have learned is that there is a big difference between being fragile, being resilient, and becoming ‘antifragile.’ If you are fragile and life hits you hard, you break. If you are resilient and life hits you hard, you withstand more and eventually… you break.

“If you’re ‘antifragile,’ when life hits you hard, you actually get stronger.”

Tish Gaffney, a professor at Nova Southeastern University, reported that: “Women have long been the majority-identified gender of audiologists in the United States. Although women make up most audiologists, there continues to be a bias in favor of male audiologists.

“Even within the category of one to three years of experience,
male audiologists have higher salaries than their female counterparts. In addition, many featured lecturers or well-known researchers tend to be men. So, we should be asking ourselves why this continues.

“I believe that much of this comes down to confidence and risk. There are some great resources available, such as the book The Confidence Code (Kay, 2014). We must encourage girls, teens, and women to be more confident, take risks, believe in their abilities, and not to doubt what can be accomplished.

“COVID-19 has been a wake-up call to the possible potentials that surround us and our need to re-invent ourselves, strategize our futures, and shape our own success.”

Loren Lunsford, owner of Sonus Hearing Professionals, shared: “I’ve been in management and leadership roles for many years. At the age of 31, I was leading a large team of hearing-care professionals; most of the group was male. When I was presented with the opportunity to become co-owner of 26 Sonus Hearing Professionals locations in southern California, I didn’t have much time to ponder.”

“Fear of failure couldn’t really be a factor or I’d lose my chance. I said ‘yes’ and joined forces with a wonderful partner who happens to be a male. It is interesting how people react to our leadership styles. If I get passionate about something, I can be perceived as harsh or rigid, whereas it is more expected and acceptable for my partner, as a man, to react strongly to situations.

“It’s not uncommon for folks to assume that I work for him. When something like this occurs, I had to learn that I have a choice to react calmly or take it personally. Being too reactive feeds into stereotypes of women being too emotional for leadership roles. Taking care of everyone but yourself isn’t a strength. Strong women respect others enough not to feel responsible for them. However, it is particularly difficult for women to know the difference between being responsible to someone and being responsible for someone.”

After hearing these heartwarming and inspiring accounts from audiologists, I’m confident that the profession is filled with strong, resilient women and that the future looks bright.

As Eleanor Roosevelt liked to say: “A woman is like a tea bag. You never know how strong it is until it’s in hot water” (The Franklin Delano Roosevelt Foundation, 2018).

Gyl Kasewurm, AuD, is an audiologist and practice owner in St Joseph, Michigan.

References


The Effects of COVID-19 on 136

BY REBEKAH F. CUNNINGHAM AND SUZANNE M. FOLEY
A survey examines the effect of the pandemic on hearing assessments and interventions for infants born in the United States in the time of COVID-19.
COVID-19 and Audiology
The novel coronavirus (COVID-19) has had an unprecedented effect on the delivery of health care in the United States. Most states instituted public quarantine mandates from March to June 2020, and many healthcare practices closed for weeks and, often, for months, delaying or suspending health-care access. Audiology practices and services also were affected, which sparked a debate on whether audiology services were essential.

COVID-19 and Early Hearing Detection and Intervention Programs

BENCHMARKS
Congenital hearing loss is considered a neurodevelopmental emergency and concerns about services related to newborn hearing screening (NBHS) and follow up were forefront in discussions regarding essential health-care services.

Moats and Creel (2020) presented readers with guidance and resources related to early hearing detection and intervention (EHDI) during these unprecedented times with assurance that NBHS and follow-up services are indeed essential. The American Academy of Pediatrics (AAP) advised pediatricians to continue to follow federal and state guidelines on newborn screenings, including NBHS and follow up (AAP, 2020).

Unfortunately, early guidance from national audiology professional organizations conflicted with state and local government mandates, leading to confusion on which health-care facilities and services were essential. As a result, most audiology facilities and services ceased operation for weeks or months.

The 2000 Joint Commission on Infant Hearing (JCIH) guidelines (2019) describe and mandate each state’s EHDI program to achieve benchmark goals for

Between March and August 2020, approximately 1.8 million infants were born in the United States.
The Effects of COVID-19 on 1–3–6 children at one month of age, three months of age, and six months of age, or 1-3-6. These goals state that infants should undergo NBHS prior to discharge from the hospital, but no later than one month of age. In addition, if the infant does not pass their NBHS, they should receive an audiologic evaluation to confirm hearing status no later than three months of age and enroll in early intervention (EI) services as soon as possible after identification or no later than six months of age.

THE CORONAVIRUS PANDEMIC
Between March and August 2020, approximately 1.8 million infants were born in the United States (CDC, 2020b). Due to the COVID-19 pandemic, NBHS, diagnostic, and EI services were interrupted for infants born from late 2019 to 2021. While audiologists around the globe adjusted their health-care practices to provide services differently and more safely, front-line hospital personnel had to ensure that nearly two million infants received NBHS.

In the early months of 2020, infants who did not pass their NBHS were referred to audiology for diagnostic evaluations or for a second NBHS, as required by established EHDI protocol. As the pandemic progressed, many infants who did not pass their NBHS did not receive a referral for further evaluation because diagnostic audiology services were not available.

“Our colleagues who focus on pediatrics have difficult decisions, such as timing for re-screening of an infant. There is no question that initial diagnosis and intervention will be delayed at this time,” American Academy of Audiology President Catherine
Palmer reported in a president’s message published online in April 2020 (Palmer, 2020).

The Survey
To gain insight into NBHS services and the ability to meet the 1-3-6 EHDI goals during the pandemic, an informal survey was sent to pediatric audiologists and EHDI coordinators throughout the country. Six pediatric audiologists and four EHDI directors responded.

Responses were received to the following questions:

1. For audiologists not directly involved in the EHDI process, what do you think they need to know about the impact of COVID-19 on the screening, diagnostic evaluations, and early intervention for children born during this time? How might they be affected?

2. Specifically, how do you think COVID-19 is affecting the EHDI goals of 1-3-6? This can be your opinion or, if you have data, please share. You may also report here any anecdotal observations.

3. Do you have any suggestions to provide to audiologists to help reduce the impact of COVID-19 for children going through the 1-3-6 process?

A summary of the responses follows.

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**BY ONE MONTH OF AGE**

All infants should undergo hearing screening prior to discharge from the birth hospital and no later than one month of age, using physiologic measures with objective determination of outcome (JCIH, 2019).

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The Centers for Disease Control and Prevention (CDC) collects and analyzes state-level EHDI data annually to monitor the goals of 1-3-6 in the United States. In 2018, the CDC (2020d) reported that 97 percent of infants born in the United States received their NBHS by one month of age. Similar results are expected for 2019, but percentages for 2020 may be negatively affected by the COVID-19 pandemic.

While home births in the United States typically account for less than one percent of births in the nation (ACOG, 2020), this number has been rising and is expected to rise even more as women avoid giving birth in a hospital during the COVID-19 pandemic (Ayres-Brown, 2020; Ries, 2020). Many pregnant women and their families worry that they or their infants will contract COVID-19 in the hospital. Others consider home birth because of hospital restrictions on the number of support people permitted to accompany pregnant women during the birth of a baby.

Although data are limited, most newborns with COVID-19 had mild or no symptoms
and recovered (CDC, 2020e). Yet the number of women seeking birth options outside of the traditional hospital setting continues to rise. There is an overwhelming increase in demand for midwives who can deliver infants at home or in facilities that are not part of the traditional health-care system (de Freytas-Tamura, 2020).

There are no statistics documenting home births and births outside of hospitals in this time period, but there has been a marked reduction in the number of babies born in hospitals. It is reasonable to conclude that these infants did not receive their NBHS, or in the best-case scenario, received it later than the recommended one month of age.

Another issue is an increase in the number of infants who did not pass their NBHS, likely due to infant discharge sooner than 24 hours (per parent or birthing facility request) to reduce exposure to COVID-19. Early discharges may result in infants not being able to receive the second confirmatory NBHS with normal results.

According to CDC 2018 data, 68 percent of infants who did not pass their NBHS received a diagnostic evaluation by three months of age (CDC, 2020c). Data for most of 2019 are not yet available, but it is reasonable to assume that the percentage will be similar or higher. For infants born in late 2019 or in 2020, a different story emerges.

Since the COVID-19 pandemic began, EHDI programs and pediatric audiologists report a reduction in the number of infants who failed NBHS receiving their diagnostic evaluation by three months of age. This includes infants born in late 2019 and those born within approximately the first six months of 2020.

This issue has been addressed by most state EHDI programs with published online guidance for health-care professionals and parents. The National Center for Hearing Assessment and Management (NCHAM) has many resources for hearing screeners, parents, early interventionists, and audiologists to guide them during these times.

The NBHS training curriculum was modified in the early months of COVID-19 to include more information for parents whose infant did not pass the NBHS. The following language was included: “We just finished screening your infant’s hearing and your infant did not pass. Our hospital knows that hearing screening is a very important part of monitoring the health of every newborn. Due to the current COVID-19 situation and our hospital’s directive, we are unable to schedule an outpatient hearing screening today. Please share this with your infant’s health-care provider...As soon as restrictions have been removed, you will be contacted about scheduling an appointment for follow-up testing” (NCHAM, 2020).

**By three months of age**

All infants whose initial birth-screen and any subsequent rescreening warrant additional testing should have appropriate audiologic evaluation to confirm the infant’s hearing status no later than three months of age (JCIH, 2019).
In the spring of 2020, clinic closures, limited providers, and canceled appointments resulted in decreased availability of diagnostic testing for infants who did not pass their NBHS. Survey responses supported these findings, with 70 percent of respondents reporting that diagnostic infant evaluations for babies not passing their NBHS were delayed due to clinic closures, the rescheduling of patients who were originally scheduled before closures, and concern about the virus from parents who did not want to reschedule, no-showed, or cancelled even after being rescheduled.

In 2018, the CDC reported that 64 percent of infants identified as d/Deaf or hard of hearing were enrolled in EI by six months of age (CDC, 2020d). The 2019 data is not yet available, but we do know that, over the past decade, this number has improved steadily. Speculation on the data for 2020 must take into consideration the delays the COVID-19 pandemic has caused for infants receiving confirmatory audiological identification and, subsequently, the timeliness of EI services.

Once identified as d/Deaf or hard of hearing, infants and young children should receive services by professionals who are experienced in working with children who are d/Deaf or hard of hearing and their families.

Traditionally, EI evaluations and ongoing services are conducted in face-to-face appointments in the child’s home. Due to the COVID-19 pandemic, most evaluations and EI services are now delivered remotely via telehealth.

Telehealth is a new type of service provision for many early interventionists and patients (ASHA, 2020). The transition to virtual services will likely have an effect on infants and young children identified as d/Deaf or hard of hearing. Yet we know EI services must continue, even during a pandemic. Family-to-family support and the continuation of EI for children identified as d/Deaf or hard of hearing is critical (Yoshinaga-Itano, 2020).

There are many resources for families, including ways to find support from other families, and telehealth can be very effective. However, as with many other health-care services, such as educational systems, the effects of going virtual and the
inability to receive in-person services are yet to be seen.

EI enrollment delays will be a natural result of the diagnostic delays. These delays and lack of in-person therapeutic services for children will likely impact developmental outcomes for children who are d/Deaf or hard of hearing.

THE ‘CATCH-UP’ PHASE

Beginning in June 2020, many audiology services resumed and there has since been a significant “catch-up” phase, with infants who were referred for diagnostic evaluations being seen in large numbers. Many pediatric audiology offices are prioritizing appointments for infants who failed their NBHS and even working overtime to minimize the effects of the COVID-19 pandemic on 1-3-6 results. Unfortunately, however, many infants have not yet been seen, possibly due to continuing fears of the virus.

Eighty percent of the survey respondents recommended two or more suggestions for audiologists, such as: Improve communication with families regarding the importance of follow-up testing; answer questions more completely; if possible, provide telehealth; prioritize appointments for infants/children for initial diagnostic testing or hearing aid fittings; and share the safety precautions of your practice with families to improve their confidence in coming to appointments.

Due to the COVID-19 pandemic, most evaluations and EI services are now delivered remotely via telehealth.

It may be years before we can confirm how the COVID-19 pandemic affected the early identification of children who are d/Deaf or hard-of-hearing. What we do know is that children whose hearing losses are identified earlier demonstrate significantly better language
The Effects of COVID-19 on 1–3–6

Do not assume that children born in 2019 and 2020 received an NBHS.

Wherever in the 1-3-6 process a child may have been lost is not as relevant as the inability of EHDI programs to contact families to ensure services are available and received to maximize a child’s development.

Conclusions

Do not assume that children born in 2019 and 2020 received an NBHS.

Finally, there will be a significant increase in the number of children considered lost to follow up (LTFU) to EHDI programs due to the pandemic. Infants not receiving their NBHS, infants identified by a professional not familiar with EHDI reporting procedures, infants who never received a diagnostic evaluation, or infants or young children identified early in 2020 but who could not obtain EI will all contribute to the increase in LTFU.

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to work to ensure infants receive NBHS and follow-up services, all audiologists have an increased responsibility to be aware of the potential impact the COVID-19 pandemic has had on hearing screening for these children.

Audiologists have a responsibility to educate and provide resources for patients and their families, other health-care providers, and their communities to improve care and minimize the impact the pandemic has had on children born during this time. 

Rebekah F. Cunningham, PhD, has more than 20 years of experience in teaching and mentoring audiology students and providing audiology services to children and adults. She currently is an adjunct associate professor at A.T. Still University. Rebekah is also an associate editor of Audiology Today and the Academy’s website.

Suzanne M. Foley, AuD, is director of the Indiana early hearing detection and intervention (EHDI) program at the Indiana State Department of Health in Indianapolis. A clinical audiologist, she has provided audiology services to adults and children in her private practice for more than 20 years.

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Heightening Our Vigilance to the Taboo of Discussing Death During Patient Encounters
Personal-adjustment counseling is fully within our professional domain and audiologists must be comfortable providing this form of counseling to patients, including those with terminal illness, as a normal part of clinical exchanges.

BY JOHN GREBER CLARK AND MICHAEL A. HARVEY
Mrs. Jones came to her hearing-test appointment with her daughter-in-law. She looked more than her 84 years, arriving in a wheelchair with an oxygen tank strapped to the back. She was quiet during most of the intake interview and cooperative during testing. But when the topic of hearing aids was broached, Mrs. Jones looked the audiologist directly in the eyes for the first time, saying in a weakened voice: “I don’t think all that will be necessary. I doubt I’ll be on this earth that much longer. I should’ve gone before Henry those 20 years ago.”

The audiologist was surprised at her words and not fully certain how to respond. After a moment, he said in a reassuring tone: “I’m sure you’ll feel better once we get you hearing again.” With a sign of resignation, Mrs. Jones looked down at her hands resting on her lap blanket, as the audiologist continued to outline a treatment plan for her hearing loss.

There are many cultural taboos in life, both real and perceived. Certain topics have been ingrained within us not to broach. Topping the list are sex, politics, and religion. In an audiology practice, the taboos are often (tongue in cheek) said to be politics, religion, and battery life. But possibly one of the greatest taboos in our culture is the discussion of death.

For many, our discomfort with the dead and dying creates an avoidance of talking about, or possibly even thinking about, death. As Hess (2020) so succinctly put it, “American society is a death-denying culture.” Or, as Woody Allen said, “I have nothing against death. I just don’t want to be there when it happens.”

Yet, death is part of the roller-coaster pattern that makes up the very existence of our being.

**TABLE 1. Stages of Grief, based on the work of Kübler-Ross.**

<table>
<thead>
<tr>
<th>Stages</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denial</td>
<td>A thought that circumstances or diagnoses cannot be true</td>
</tr>
<tr>
<td>Anger</td>
<td>A questioning of why this would be happening to me</td>
</tr>
<tr>
<td>Bargaining</td>
<td>Attempting to postpone death with various behaviors</td>
</tr>
<tr>
<td>Depression</td>
<td>A resignation to impending death</td>
</tr>
<tr>
<td>Acceptance</td>
<td>A final rest before continuing forward</td>
</tr>
</tbody>
</table>
Death is inevitable in all things, from animated life forms to the more inanimate celestial bodies of planets and stars. In some ways, it seems odd that something so natural should be so difficult to confront. But such is the oddity of self-contemplation and interpersonal interaction.

Within clinical practice, however, we must recognize that not all patients are reluctant to broach this topic. Moreover, many older patients associate issues of mortality and death with, as one patient put it: “Getting my ears fixed.” Accordingly, they are often eager to discuss death with their audiologists.

We need to be ready to heighten our vigilance to mortality issues that patients have and engage supportively. Contrary to the expression “What you don’t talk about can’t hurt you,” the “elephant in the room,” may become an impediment to patients’ adherence to our recommendations.

During her early research on death and dying, Elisabeth Kübler-Ross (1970) was initially blocked from interviewing dying patients because their attending physicians assumed that such conversations would be too emotionally disruptive. However, she reported that all but one of the many patients she interviewed were relieved and pleased to be able to have conversations about their impending deaths.

Kübler-Ross’s findings provide audiologists with a roadmap of sorts. When we are open to engaging in a dialogue with patients about their aging and inevitable death, or the dying or death of a loved one, we may similarly find the conversation is appreciated. Furthermore, we may find we also benefit from such conversations.

Every second of my remaining time is precious.

The Experience of Impending Death

The interviews by Kübler-Ross led to her groundbreaking book, On Death and Dying. She described how individuals talk about dying and outlined that those diagnosed with a terminal illness go through a series of emotional stages (see TABLE 1). Kübler-Ross (1970) emphasized...
Heightening Our Vigilance to the Taboo of Discussing Death During Patient Encounters

that these stages were meant to be a loose framework, not an ordinal ladder for grieving. Her goal was simply to begin a conversation about a taboo topic.

As Berger (2011) noted, the grieving process is neither linear nor generic. Dealing with loss occurs over time, with considerable variability and creativity.

“One facet of this creativity is the emotional benefit of impending death. For example, after a patient we will call Mrs. Smith informed her audiologist that she had been diagnosed with terminal cancer, she gratefully accepted his heartfelt sympathy. So far, a predictable sequence.

However, to the audiologist’s astonishment, she then said:

“Having cancer has kind of liberated me! I’m appreciating and staying close to my family and close friends more. I don’t care what people think of me anymore. Every second of my remaining time has become precious. Frankly, in some ways, I’m happier than I used to be.” She gave a wide smile.

Mrs. Smith gained a wisdom that often takes people a lifetime to learn.

Psychologist Laura Carstensen and her colleagues (2011) wondered why: “If we shift as we age toward appreciating everyday pleasures and relationships rather than toward achieving, having, and getting, and if we find this more fulfilling, then why do we take so long to do it?” These clinicians found that our change in needs and desires has to do with perspective, our personal sense of how finite our time in this world is.

Several months after Mrs. Smith passed away, her widowed husband sent the following e-mail:

“Our last months together were the most intimate in our marriage. Almost every night, we went out for ice cream, often driving over an hour to a new place. I remember one night when we were driving home and she was eating a sundae and it went flying as I made a sharp turn. Hot fudge, marshmallow, and melted ice

We simply need to be present to a fellow human being.

Our last months together were the most intimate in our marriage. Almost every night, we went out for ice cream, often driving over an hour to a new place. I remember one night when we were driving home and she was eating a sundae and it went flying as I made a sharp turn. Hot fudge, marshmallow, and melted ice
cream got over everything—my face, all over my pants, the windows, the car seats.

Then an odd thing happened. When I stopped the car, we both started laughing. And then, covered with that gooey mess, we began to kiss—hard and passionate kissing—in a way that we hadn’t since we first met over 52 years ago.

I miss her terribly—always will—and sometimes it’s unbearable, but I cherish these memories more than I can tell you. For that, I feel incredibly lucky.”

As exemplified by this couple’s last months, when life’s fragility is primed, individuals’ motivations for quality of life often take on greater priority. Stated differently, the battle of being mortal is the battle to maintain the integrity of one’s life—to avoid becoming so diminished or dissipated or subjugated that who you are becomes disconnected from who you were or who you want to be (Gawande, 2014). This is where audiologists can play a huge role.

How Should We Respond?
Audiologists are not trained in how to respond to patients discussing death. Even without the training of a mental-health professional, we can recognize that the audiologist’s response to Mrs. Jones in the opening vignette was not helpful. The
response given essentially invalidated the patient’s expressed feelings. Unfortunately, this scenario is not uncommon.

The death taboo can have a strong hold on any of us. The reassurance that the audiologist provided served to protect his own feelings and insecurities and failed the patient. Such reassurance essentially implied that her anxieties do not—or should not—exist, even though her words indicated otherwise (Clark and English, 2019). We can easily see why patients report that hearing-health professionals appear at times insensitive and indifferent (Glass and Elliot, 1992).

The analogous psychological term for person-centered or patient-centered care is the relational stance of appreciative ally. We position ourselves in alliance with patients and facilitate them to view us as being curious about their experiences and then we provide validation (White, 2007).

Appropriate responses by audiologists, when our patients allude to the inevitable ending of life or comment at length on the topic, are couched within an inquiry and/or validation of their underlying emotions. Mrs. Jones would have been better served if her audiologist had responded: “I imagine you miss your husband very much” or “A lot has changed for you over the years, likely not always as you would have wanted.” Statements such as these acknowledge what Mrs. Jones said and, when followed by a brief attentive silence, give a patient permission to expound on underlying feelings.

When considering the example of Mrs. Smith, we are not implying that we should congratulate a terminally ill patient for the benefits of impending death, as outlined above. However, a clear acknowledgment of her emotional state of acceptance is appropriate. For example: “Mrs. Smith, it is not often I get to hear such a positive outlook toward the end of someone’s life. I hope that I’m able to adopt such a view when my time comes. Thank you for sharing.”

In all cases, a response of compassion—“I’m so sorry to hear that, how are you doing?” is appropriate. However, when we ask how patients are doing, it is important to be open for their response. They may be grieving, such as in the Kübler-Ross model, liberated like Mrs. Smith or anywhere in between. Note that the ensuing dialogue rarely takes long and does not require proposed solutions or reassurance from us. We simply need to be present to a fellow human being, who may be in a stage of life never anticipated and who only wants their feelings and experiences to be accepted.

When Patients Do Not Initially Accept Our Help

Patient-centered ethics put health-care decisions in the hands of patients. Specifically, when terminally ill patients do not desire to pursue our recommendations, we may feel a disconnect between our perceived responsibility to improve a patient’s communication dynamics and the patient’s desire to be left alone.

We must be prepared to accept patients’ wishes, even when we perceive them to be erroneous (Clark, 2007). However, we may gently facilitate a motivational engagement with the patient, using techniques of motivational interviewing (Clark, 2012; Clark and English, 2019; Harvey, 2010, 2003). This could start with an acknowledgment of the
approaching end of life, while suggesting a purpose for the remaining time, based on information gleaned from intake forms that might suggest withdrawal from family or family frustrations with communication, etc.

In the words of Gawande (2014): “The only way death is not meaningless is to see yourself as part of something greater: a family, a community, a society. If you don’t, mortality is only a horror.”

An attempt at motivating Mrs. Jones in the opening vignette might proceed with: “Mrs. Jones, the decision on what we do here is totally in your hands. We certainly don’t know how much time you have left with your family. It could be a matter of months or possibly several years. We never know.”

Pause for a response and then suggest: “It’s difficult to find a purpose in life sometimes, especially later in life. But, during your remaining time, if it would be possible for you to contribute to making home life more pleasant for you and your family, would this be a good thing for all of you?”

We might even ask: “On a scale of 0 to 10, how important do you believe it would be for your family if we could all work together to make life easier at home through better communication?” (Clark and English, 2019).

When asked what made him decide to take the plunge and get hearing aids, one terminally ill patient responded: “Well, I told you about my grandchildren. They’re both adorable kids and they always sit on my lap and tell me stories about a play they’re in or about their favorite desserts, TV characters, or whatever. But what they tell me doesn’t matter that much anymore because most of it sounds like gibberish.” He shook his head.

The audiologist asked: “And what would it be like for you, if in the time that you have
left, their gibberish would become clearer and more understandable?”

He didn’t respond with words, but he didn’t have to. His mind left the room for a moment, but it was clear that his grandchildren were sitting on his lap and that he understood absolutely every word they said (Harvey, 2020).

**Our Takeaway**

When we acknowledge and emotionally support patients’ experiences of grieving, this facilitates patients’ expressions of their own grief and reflections on that grief in a participant-observer fashion (Walter, 1991).

This is not to suggest that audiologists take on the role of a death-and-dying grief counselor. Rather, it is to suggest that how we respond can cause a patient to feel shut down and unheard or acknowledged and accepted. When we do the latter, we are in a better position to help patients take the reins of their own hearing-health care and to determine what is the best-considered option moving forward.

Personal-adjustment counseling is fully within our professional domain and audiologists must be comfortable providing this form of counseling to patients, including those with terminal illness, as a normal part of clinical exchanges.

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**References**


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John Greer Clark, PhD, is professor emeritus, University of Cincinnati, and co-author of *Counseling-Infused Audiologic Care*, 3rd edition, Inkus Press/Amazon.com.

Michael A. Harvey, PhD, ABPP, works in private practice, is a clinical psychologist, and is author of *Listen with the Heart: Relationships and Hearing Loss*, DawnSignPress.
Three things to know about incorporating cochlear implants into your practice:

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If you are interested in learning more about cochlear implants, cochlear implant referral criteria or new products, we hope to see you at the exhibitor hall at AAA 2021 virtual conference. To learn more about AAA conference sessions we are excited about, please visit https://pronews.cochlearamericas.com/aaa-2021/.

If you are looking to implement cochlear implants into your practice, the Cochlear Provider Network (CPN) enables independent dispensing audiology/audiology-ENT practices to expand their services to include cochlear implants and become part of a medical network that helps people with hearing loss achieve optimal outcomes.

To learn more, please visit www.cochlear.us/aaa
Online Screeners Help Clinicians Safely Connect and Prioritize Patients During a Pandemic

By Vanessa Gauthier-Davidson

SHOEOBOX Online was designed as a way for audiologists to easily identify appropriate referrals, but the current pandemic has shown it also can serve to help clinics offer a modified form of service in a safe and physically distant way.

Current conditions have required that clinicians find new ways to broaden their services. SHOEOBOX Online doesn’t replace a clinical hearing test, but it is an intuitive tool without the exposure risks of an in-person visit. When added to a clinician’s toolbox, it can improve patient engagement and triage.

Reduced booth time due to new cleaning protocols and reduced clinic hours has created a critical challenge for hearing health-care professionals. For customers requiring treatment, the sooner it can be provided, the better. SHOEOBOX Online has proven useful for triaging patients to help determine next steps.

Patients experiencing possible hearing loss can complete an online hearing screening from home. Based on the results viewed remotely on the HIPAA-compliant web portal, clinicians can determine how to proceed. Priority for a full assessment can be given to patients experiencing significant, unidentified hearing loss or a sudden drop in hearing. It also can help address patients whose hearing is stable from their last test and may not require re-evaluation but hearing aid troubleshooting instead.

Learn more: www.shoebox.md.

A Smarter Way to Work

Digital ear scanning opens doors when it comes to added benefits for both audiologist and patient. One priority on everyone’s list is reducing patient contact. How do you provide exceptional patient care while keeping a safe distance during a pandemic? Do it by reducing the amount of touch points.

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CONTENT PROVIDED BY NATUS.

Vanessa Gauthier-Davidson, MSc Reg. CASLPO, CPS/A, is an in-house audiologist with SHOEOBOX in Ottawa, Ontario, Canada.

CONTENT PROVIDED BY SHOEOBOX.
From Student to Practitioner: Administrative Steps to Take After Graduation

By Mariah Cheyney and Delphanie Wu

For graduates of AuD programs across the country, understanding the steps required to become an independent audiologist can be helpful for a smooth transition from student to practitioner.

Applying for a national provider identifier (NPI) number is an important first step in gaining the independence to bill for professional services. A current state license is also required for practice, with requirements varying from state to state. Collecting the necessary documents for employment and becoming aware of continuing education requirements can facilitate the post-graduation transition process.

Frequently Asked Questions About the NPI

What Is an NPI Number?
A national provider identifier (NPI) number is a unique identification (ID) number for health-care providers. It is a provision of the Health Insurance Portability and Accountability Act (HIPAA) and is a requirement for all transactions completed under HIPAA standards, including billing procedures (Centers for Medicare and Medicaid Services, 2020a).

An NPI number will not change if a provider moves to a different state or changes
specialization (Department of Health and Human Services, 2016). Any time a license number or a work address is changed, the NPI account should be updated.

**Why Is an NPI Number Required?**

Any provider involved in patient transactions regulated by HIPAA must have an NPI number.

Determining enrollee eligibility or enrollee benefits under a particular provider requires the use of an NPI number. Billing for services requires the NPI as well (U.S. Department of Health and Human Services, 2000). Having an NPI number is also a requirement to enroll as a Medicare provider (Department of Health and Human Services, 2016).

**Who Is Eligible for an NPI Number?**

All health-care providers are eligible for an NPI number. New applications or NPI account updates should use the taxonomy code for an audiologist (Centers for Medicare and Medicaid Services, 2020b). The NPI is required if the health-care provider is directly involved in patient-care transactions completed under HIPAA standards, such as prior authorizations or billing for services.

**How Do I Apply for an NPI Number?**

An online application can be completed at https://nppes.cms.hhs.gov/#/ or an NPI application/update form can be downloaded from the website, completed, and submitted by mail.

**State Licensure**

Professional licensure laws vary from state to state. To access information on the requirements by state, go to the Academy website at www.audiology.org/advocacy/state/state-licensing-laws.

Students can apply for licensure upon graduation and the completion of any additional state requirements. Common items needed to apply for licensure may include an official diploma or transcript, passing results on the national Praxis examination, and/or documentation of clinical experience hours.

Other requirements may include proof of certification from one of the nationally recognized audiology certification programs or completion of a jurisprudence exam. Some states may also require individuals to obtain a separate license for dispensing hearing aids.

It is advisable to keep copies of all materials and to verify the receipt of the license materials you submitted by contacting the licensing board. If you previously obtained a provisional license in your state as an extern, a specific application process may be required for upgrading to full licensure in that same state.

**Employment Documents**

When preparing for employment, have a copy of your license on hand and your certification, if applicable. Employers may also ask for vaccination records, official transcripts, or CPR certification documents. Some employers may require additional items, such as a physical examination or a criminal background check.

**Continuing Education**

Continuing education unit (CEU) requirements vary from state to state. For example, California requires 24 clock hours of
continuing education every two years (California Department of Consumer Affairs, 2019) and Pennsylvania requires 20 hours every two years (Pennsylvania Department of State, 2020).

Keep in mind that continuing education requirements may differ for new graduates during their first licensure cycle.

Some states also have specific requirements related to the subject area of CEUs obtained within a licensing cycle. For example, Illinois requires at least two clock hours of training in ethics or legal requirements for every two-year licensing cycle (Illinois General Assembly, 2020).

CEU reporting may also be required for certification and license renewal. Currently, for the American Board of Audiology (ABA) Certified credential, the ABA requires 20 clock hours of CEUs every year for certification, with five Tier 1 hours and one hour in ethics education required. Tier 1 hours are interactive continuing education activities that are at least one hour in duration, focused on one subject area or various aspects of one subject, and provide intermediate- or advanced-level content.

The American Speech-Language-Hearing Association (ASHA) requires 30 clock hours of CEUs every three years to maintain certification, with one hour of ethics education required.

The hours will be reported separately for each certification. It is advisable to maintain records noting CEU affiliations as hours are accrued.

CEU registries are available through professional organizations to keep track of completed continuing education activity. Each CEU registry lists hours that are approved by the respective organization only, so keeping a personal log of completed CEU hours can be helpful, especially if you are required to report CEU hours through an audit.

Starting Your Professional Journey
Navigating newly earned professional duties and practice as an independent clinician is a busy and exciting time, filled with growth. It is our hope that this resource will help guide you through the administrative tasks necessary to get you started and working with patients.

DISCLAIMER
The information provided in this article by the American Academy of Audiology Coding and Reimbursement Committee is to provide general information and educational guidance to audiologists. Action taken with respect to the information provided is an individual choice. The American Academy of Audiology hereby disclaims any responsibility for the consequences of any action(s) taken by any individual(s) as a result of using the information provided, and the reader agrees not to take action against, or seek to hold, or hold liable, the American Academy of Audiology for the reader’s use of the information provided. As used herein, the “American Academy of Audiology” shall be defined to include the Academy’s directors, officers, employees, volunteers, members, and agents.
Mariah Cheyney, AuD, is a clinical assistant professor at Northern Illinois University in DeKalb, Illinois. She is a member of the Academy’s Coding and Reimbursement Committee.

Delphanie Wu is a fourth-year AuD student at Vanderbilt University. She is completing her externship at MedStar Georgetown University Hospital in Washington, D.C.

Resources


This conference is supported by the National Institute of Deafness and Other Communication Disorders (NICDCD) Grant R13DC016546 and by the American Academy of Audiology.
2021 marks the start of a new administration, a new Congress, and the end of a year punctuated by a global pandemic, economic strain, and political turmoil. The start of 2021 will be dominated by efforts to contain the pandemic, as well as efforts related to transitions in the House, Senate, and federal agencies.

The new administration headed by President Joe Biden and Vice President Kamala Harris places Democrats in control in the White House. In addition, Democrats control the House of Representatives and, with a slim margin, the Senate.

The House now includes 118 women, which is the highest number yet. The previous record was set in the 116th Congress, when 106 women served in the House.

Of the 118 women sworn into the House for the 2021–2022 term, 89 are Democrats and 29 are Republicans. In the Senate, out of 100 seats, Republicans will hold 50, Democrats will hold 48, and Independents caucusing with the Democrats will hold two seats. With the tie-breaking vote of Vice President Kamala Harris, Democrats will hold the majority in the Senate.

President Biden, throughout his campaign, highlighted his interest in several health-care issues, including modernizing Medicare by expanding eligibility and coverage. President Biden has also stated his support for increasing transparency in health care and lowering drug prices. Given the fact that the Administration, the House, and the Senate are now under unified Democrat party control, President Biden’s stated health-care priorities will receive serious and concerted attention.

2021 Outlook for the Medicare Audiologist Access and Services Act

In 2019, the Academy, the Academy of Doctors of Audiology (ADA), and the American Speech-Language-Hearing Association (ASHA) worked together to draft the Medicare Audiologist Access and
Services Act. The three organizations then worked collaboratively to garner additional co-sponsors and support for this legislation. This measure would grant audiologists “practitioner” status in Medicare, remove the physician referral requirement, and allow audiologists to provide and be reimbursed for diagnostic and treatment services.

At the close of the 116th Congress, this “joint” audiology legislation had 65 cosponsors in the House of Representatives and eight cosponsors in the Senate. Due to the start of a new Congress, this legislation will be reintroduced.

Building upon the success and support for this legislation in the last Congress will remain the top priority for the Academy. The Academy will again team up with ADA and ASHA to secure additional co-sponsors and seek out any and all opportunities to advance this legislation, either on its own or by attaching it to other pieces of “must pass” legislation.

2021 and Over-the-Counter Hearing Aids

Under the terms of the Over-the-Counter (OTC) Hearing Aid Act of 2017, the U.S. Food and Drug Administration (FDA) was supposed to release proposed regulations in August 2020 designed to implement this law. However, the statutory deadline came and went and, as we go to press, these proposed regulations have yet to be issued.

Once the proposed regulations are released, there will be a mandatory comment period that will enable the Academy to submit detailed suggestions and comments in response to the FDA proposal. The delay in the release of these regulations has been widely attributed to the COVID-19 pandemic and many estimate that these regulations may not be released until at least the second quarter of 2021, after COVID-19 vaccination efforts are more fully under way.

Change Equals Opportunity

The COVID-19 pandemic exposed the flaws in the way audiology is treated in Medicare, with its unnecessary physician-order requirement, limited covered services, and outdated audiology classification of “supplier,” as many beneficiaries struggled to gain access to critical audiology services.

However, a new Administration and a new Congress signal new elected officials, transitions in the leadership of key congressional committees and federal agencies, and fresh opportunities for audiologists to advocate for the changes needed to advance the profession.

Now is the time to reach out to your elected officials and educate them about the critical and necessary services that audiologists provide to patients. Also, be sure to urge them to support the Medicare Audiologist Access and Services Act, as part of any Medicare modernization effort, as well as any effort to address social determinants of health.

Change can be daunting, but also can uncover new opportunities for growth. The Academy will continue its work to build on the success of the past and to take advantage of emerging pathways to success. ☛

Susan Pilch, JD, is the Academy’s senior director of government relations.
2021–2022 BOARD OF DIRECTORS ELECTIONS

Vote

The members presented in this issue of *Audiology Today* are nominees for the president-elect and three member-at-large positions on the Academy’s Board of Directors.

One of the nominees for president-elect will be elected by the general membership to serve a three-year term (one year as president-elect, one year as president, and one year as past president) beginning October 1, 2021, and ending September 30, 2024.

Three of the candidates for member-at-large positions will be elected by the general membership to serve a three-year term, beginning October 1, 2021, and ending September 30, 2024.

The 2021 American Academy of Audiology election of new board members will be held April 19, 2021, through May 14, 2021, immediately following AAA 2021 Virtual.

All Fellow members with a valid e-mail address in the Academy’s database will be sent an e-mail linking them to the election website. Please note the election website is separate from the Academy website. The information received in the e-mail is unique to the recipient and can only be used by the member receiving the email. Once a vote has been cast, the election website can no longer be accessed by the member.

It is anticipated that the new board members and new president-elect will be announced in early June 2021.

Expanded biographical information, additional candidate information, and short videos are available on the Academy website, www.audiology.org. Voting for the Academy leadership is an important privilege of membership for Fellows of the Academy. Be sure to vote!

You are encouraged to vote and let your voice be heard!
I've been active in an Academy volunteer position consistently since I first served on an Academy committee as a student through numerous committees, task forces, and the board of directors. I've dedicated numerous hours to the Academy because I so strongly believe that the Academy is the home for all audiologists.

When I previously served on the Academy Board of Directors, I knew that the work we were doing advanced the profession. We made thoughtful and deliberate decisions to benefit our members. My goal is to lead our organization for the next three years alongside the other members of the executive committee, board of directors, and Academy staff to improve the lives of audiologists, students, and our patients.

The Academy president can steer the profession toward the path of change. COVID-19 has been a disruption to everyday life, clinical practice, and employment. But often from disruption comes opportunities, opportunities to look at areas where we are succeeding and failing and push forward with new objectives and prospects. I believe we need leadership that can be innovative and make tough decisions and I know that I can bring that to the Academy.

For the sake of the patients we serve, I believe that, as a member of a health-care profession, it is my inherent obligation to contribute to its future. As the organization “of, by, and for audiologists,” the Academy is the most effective vehicle we have for achieving our professional goals. The American Academy of Audiology is the true home of the hearts and minds of the vast majority of audiologists in the United States. As the professional home for audiology, the Academy Board carries the demanding, but rewarding, responsibility of serving the
needs of a group of professionals with highly diverse practice settings, professional needs, and patient populations.

In addition, the membership of our organization will continue to evolve to more substantially include audiologists of greater individual diversity. Fittingly, the Academy goals for 2021 fall under the umbrella of "accessibility." Having served on the Academy Board, I understand the challenges inherent in advocating for the requirements of all our members and their patients.

It is a monumental task. However, I believe that we are entering an era of maturity as a profession, in which we have been well-prepared by our predecessors to meet the needs of all of our members. To this end, I am eager to ensure that our newer professional members, with their vitality, skill, and passion, have a clear pathway to continue the work on behalf of the profession. We are stronger together, and the engagement of all members is the foundation of this strength.

2021–2022 BOARD OF DIRECTORS NOMINATIONS

Member-at-Large

The Academy serves as an important catalyst in advancing the audiology community and also serving the general community. I cannot think of a better way to contribute to the profession in giving of one’s time, talent, and service.

Throughout my professional career, I have had the privilege of working on various Academy committees, as well as civic organizations. The benefits I obtained from the Academy contributed to my preparation and growth when leadership positions or opportunities have arisen in either professional or personal settings.

One of the most memorable experiences for me was participating in the inaugural Jerger Future Leaders of Audiology Conference (JFLAC). The experience exposed me to the tireless work the Academy does on behalf of the profession. During that time, I was also introduced to other Future Leaders who continue to support and encourage each other to this day.

I have watched the Academy grow and engage its members to volunteer and provide their expertise on the many committees, task forces, and councils. Now more than ever, diverse voices are needed to assist in moving the Academy forward and laying the groundwork for current and future
I am interested in serving on the Academy board because I hold an ardent belief that engaging in service to entities that are important to us is the only way one can truly make a meaningful contribution. You simply have to be the one to stand up and put the work in. With the ever-evolving landscape for our profession on both the state and national level, I have actively sought out ways to impact forward movement for audiology through service.

At the state level, I have volunteered through my state audiology organization, first as sponsorship chair and now as president. Much of the work that needs to be done is at the state level, but national initiatives are vital to our professional future as well. Through my work as the chair of the Academy’s Health-Care Relations Committee, I have been able to meaningfully contribute to several processes aimed at increasing the visibility of audiology as the home of hearing and balance care to referring providers.

I am now moving on to the chair-elect of the Outreach Council, where I look forward to continuing my service to outreach for audiology and expanding it beyond interfacing with referring providers to communicating with consumers, audiologists, and allied health-care providers alike. Being able to move my service to the next level within the Academy board will help me make the meaningful contributions I would like to make for the betterment of our field.

Ursula M. Findlen, PhD
Director of Audiology and Assistant Professor
Nationwide Children’s Hospital and The Ohio State University Wexner Medical Center

BS: Communication Sciences and Disorders, 2001, Syracuse University
MA: Speech and Hearing Science, 2003, The Ohio State University
PhD: Speech and Hearing Science, 2009, The Ohio State University
In our changing audiology landscape, we can’t sit idly by and watch the changes happen around us while other interests push for changes that require less audiology and more big business. I’m all-in for a grassroots, boots-on-the-ground philosophy that may require me to work outside my comfort zone and outside my neighborhood to make sure that audiology is strong for the next generation of audiologists—and the next—and so on.

It must start somewhere. Let it be with me. I was challenged during my experience at the James Jerger Future Leaders Conference (JFLAC) to put on the work gloves and step into a leadership role, first in my community, then nationally. I would love the opportunity to continue doing the hard things for the betterment of my profession at the national level.

I also think it is important to have a wide array of experiences represented on the board. I hope my experience as a private-practice owner gives me a unique opportunity to weigh in on the challenges and topics that are unique to the private-practice space. If my peers see fit to elect me to the board, I will add to the diverse perspectives of current and future board members, while also being a voice for those practicing on the front lines every day.

As a mid-career audiologist who has experience in medical-based practice, private practice, and in university settings, I am well positioned to understand and advocate for my colleagues, my students, and my profession.

Our profession continues to need servant leadership to maintain progress toward our collective goals that I can provide. Audiology is more than just a profession and the Academy is more than just an organization I belong to. I recognize the importance of what having an Academy does for the profession and know firsthand that its survival is dependent on dedicated, passionate volunteers.

While I have been involved in the Academy through committee work, task forces, and annual conference attendance, I feel that now is the time for me to step up my level of commitment and serve at the board level. I will use my past experiences, keep an open mind, and represent my fellow audiologists if elected.
I owe many of my opportunities to the professionals who have dedicated their career to shaping the field of audiology into what it is today. These leaders realized that we, being a relatively young profession, had the opportunity to define who we are, whom we serve, and how we may best serve.

Our profession grew exponentially due to a strong adherence to evidence-based practice, a keen focus on the education of future audiologists, a push for advocacy, and effective leadership. While the health-care climate is dynamic with transitions occurring in the model of hearing-health-care delivery, as well as reimbursement for our services, the foundation of our profession should be solid, rooted in education, and guided by evidence-based research.

I believe strongly that this foundation is crucial to the advancement of our profession. It is an exciting time for our profession, as we not only adjust to our growth and success but also prepare for the health-care transitions ahead. I wish to serve the future of my profession by partnering with the Academy board so that together we can address the challenges that face our profession and help guide the next generation of professionals to promote clinical excellence, to advocate for themselves on both a state and national scale, and to advocate for their patients.

I am honored to be nominated for the position of member-at-large on the Academy Board. I have witnessed my peers and predecessors work tirelessly to serve the Academy and the profession, and it is my time to give back.

The changing landscape of health care in the United States brings both challenges and opportunities for audiologists. With clear goals and efforts directed in a unified manner—being meaningfully inclusive of diverse clinicians, researchers, and consumers—we will continue to advance this profession forward.

These efforts include legislative advocacy (e.g., Medicare Audiology Access, VA Mental Health Care Improvement Act, annual revision of CMS...
Physician Fee Schedule), public outreach, scientific and research development and support, and the continued advancement of education and training in academia and beyond.

Through my leadership opportunities over the last seven years, I brought people of varying perspectives and opinions together by being intentional about listening to multiple constituents. I made decisions based on diverse sources of information and paid attention to the reactions that occur when making hard decisions so as to not alienate team members from the process. If I am fortunate to earn your trust, I will bring these practices to the board in ways that reflect and unite the membership of the Academy.

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Dr. Samantha Kleindienst Robler, PhD, AuD
Population Health/Clinical Informatics Lead
Norton Sound Health Corporation

Samantha Kleindienst Robler’s well-rounded contributions in clinical practice, research, and patient care warrant the 2021 Early Career Audiologist Award. Dr. Robler currently serves as a clinical audiologist and population health informatics lead with Norton Sound Health Corporation in Nome, Alaska, as well as an adjunct assistant professor at the University of Hawaii.

Dr. Robler’s accomplishments are diverse and extensive. She holds both AuD and PhD degrees with two post-doctoral fellowships, has 11 peer-reviewed publications, and has contributed to more than 50 lectures and posters at professional meetings, in addition to numerous invited presentations. Her work has led to significant innovation and transformation. Dr. Robler has filed 13 invention disclosures and several patent applications.

Dr. Robler has served on five ASHA committees, two Academy committees, and was recently elected to the Academy Board of Directors. During the COVID-19 pandemic, she shared her knowledge of telemedicine and remote patient-management solutions and
volunteered to assist many audiologists get their clinics functioning in communities that were locked down.

As stated in her nomination letter, “Dr. Robler is humble, kind, and works tirelessly to promote the well-being of her patients through clinical care, research, and innovation. If the past is prologue, we have every reason to expect great things from her.”

Honors of the Academy
Awarded to one audiologist and/or one non-audiologist for his or her exceptional support of the field of audiology and/or the patients we serve by focusing on issues that directly affect the profession and/or consumers with hearing loss and balance disorders. The recipient shall have made notable contributions in one or more of the following areas: outstanding clinical practice and/or patient care, teaching or mentoring; advocacy; research; and/or exceptional service to the profession of audiology.

Erin L. Miller, AuD
Professor of Instruction
NOAC Coordinator
School of Speech-Language Pathology and Audiology
University of Akron

A role model of integrity and leadership, the Academy is pleased to bestow its 2021 Honors of the Academy to Erin L Miller in recognition of her significant contributions to the field audiology.

Dr. Miller has maintained an unbroken record of professional service and leadership, working tirelessly in the public eye and behind the scenes. She has served on more than 60 committees and councils.

Nationally, she served on the Academy Board of Directors, is a past president of the Academy, and chaired the 2019 AAA Annual Conference. She also served as president of the Ohio Academy of Audiology and as the representative for the Ohio Speech and Hearing Governmental Affairs Coalition for 15 years. Through her work, Dr. Miller brings a consistent and unruffled approach to leadership.

As coordinator of the Northeast Ohio AuD Consortium, Dr. Miller ensures The University of Akron, Kent State University, and Cleveland Clinic act as one entity to benefit their students. She teaches multiple courses, deftly weaving theory and practice from classroom to clinic, and precepts in the clinic.

Dr. Miller also teaches beyond the university, including multiple presentations and publications. She is especially renowned on the complex topic of professional ethics, advancing this issue as a mainstream value shaping our professional identity.
Jerger Career Award for Research in Audiology

Awarded to an individual for innovative research contributions in the field of audiology/hearing and balance sciences and whose work has groundbreaking impacts on the field and/or practice of audiology.

René Gifford, PhD
Professor, Department of Hearing and Speech Sciences
Vanderbilt
Director, Cochlear Implant Program
Vanderbilt School of Medicine

René Gifford is an active clinician/scientist who maintains a clinical practice in the cochlear implant clinic at Vanderbilt, seeing adults and children who use cochlear implants and hearing aids.

Her research interests include combined electric and acoustic stimulation (EAS) with cochlear implantation, speech and auditory perception for adults and children with hearing loss, and spatial hearing abilities of individuals combining hearing aids and cochlear implants.

Dr. Gifford’s research has been funded by the National Institutes of Health for nearly 20 years and she has published more than 120 peer-reviewed articles, multiple book chapters, and a book, now in its second edition, Cochlear Implant Patient Assessment: Evaluation of Candidacy, Performance, and Outcomes.

She was a featured scientist on the National Public Radio, Science Friday broadcast, Breakthrough: Portraits of Women in Science—Hearing a Whole New World.

Dr. Gifford has especially enjoyed teaching and mentoring the next generation of clinicians and clinician-scientists. She couldn’t have wished for a more fulfilling career and looks forward to many more years of scientific discovery, teaching, mentorship, and evidence-based practice ensuring that every individual can achieve their maximum hearing potential.

Marion Downs Pediatric Audiology Award

Awarded to an audiologist for exceptional contributions in pediatric audiology, as an educator, mentor, clinician, advocate, or scientist.

Eileen Rall, AuD, ABAC
Senior Audiollogist and Program Coordinator
Department of Audiology and the Center for Childhood Communication
Children’s Hospital of Philadelphia (CHOP)

During her impressive 33-year career in audiology, Eileen Rall has served as an exceptional educator, clinician, and leader in pediatric audiology.

Most recently, Dr. Rall served as the clinical coordinator at the Center for Childhood Communication of the Children’s Hospital of Philadelphia. In this role, she successfully improved multidisciplinary services for children and their families by creating a distinctive program with ongoing services for comprehensive coordinated assessment and intervention for infants and toddlers with hearing loss.
Dr. Rall is a highly sought presenter on a variety of pediatric topics, including the assessment of infants and children and how to support teens and families. She has published widely about the psychosocial development of children with hearing loss, pediatric amplification, and counseling. She also has taught courses in pediatric topics at Salus University for nine years.

Dr. Rall has been a productive volunteer for countless organizations and committees, including the Society for Ear, Nose, Throat Advances in Children; Knowledge Implementation in Pediatric Audiology; the Joint Committee on Infant Hearing, the Pennsylvania Department of Health Infant Hearing Screening Advisory Committee; and many others. Most recently, she was the 2018–2020 chair of the Taskforce for Audiologic Guidelines for the Assessment of Hearing in Infants and Young Children Revision.

**International Award of Hearing**
Awarded to an audiologist and/or hearing scientist who lives and works outside of the United States and who provides outstanding contributions to the profession of audiology in a clinical, academic, research, or professional capacity.

**Suzanne C. Purdy, PhD**
*Head of School of Psychology*
*University of Auckland, New Zealand*

Suzanne C. Purdy is a true international audiologist, having made substantial contributions to the profession of audiology in New Zealand and globally over her 30-plus year career.

After earning her PhD at the University of Iowa, she helped establish New Zealand’s first audiology master’s program and then spent three years as senior research scientist at National Acoustic Laboratories in Sydney, Australia.

She has held multiple academic positions at the University of Auckland, New Zealand, where she is currently head of the School of Psychology.

Dr. Purdy has published 160 peer-reviewed articles in top audiology and medical journals and is in high demand as an international speaker.

Her extensive research interests range from auditory-processing disorders to the effects of socioeconomic deprivation on hearing loss and language delay in children. With colleagues, she has originated novel approaches to rehabilitation for neurological conditions, including Māori-led community initiatives.
Dr. Purdy’s professional service is extensive, but most notably, her ancestral links to the indigenous Māori people of New Zealand have led her to take a strong interest in Māori hearing health and wellbeing. She is held in high esteem and affection by her patients, students, and international colleagues, evidenced by supporters of Dr. Purdy’s awards nomination from six nations.

Clinical Excellence in Audiology Award

Awarded to a clinical audiologist whose dedication and clinical excellence have resulted in improved quality of life for individuals with hearing or balance dysfunction, who has distinguished his or herself through innovation in service provision, superior clinical education, and/or effective efforts to educate and inform the public about the prevention and intervention of hearing loss, dizziness, and/or tinnitus.

Richard Roberts, PhD
Associate Professor and Vice Chair Clinical Operations,
Vice Chair of Clinical Operations and Assistant Professor in the Department of Hearing and Speech Sciences
Vanderbilt Bill Wilkerson Center
Vanderbilt University School of Medicine

Richard Roberts is a distinguished clinician whose expertise in vestibular assessment and management has resulted in improved quality of life for countless individuals. He regularly presents at professional conferences and has published numerous chapters and peer-reviewed articles on aspects of vestibular sciences.

He co-authored the clinical practice guidelines regarding positional vertigo, stemming from work on an expert panel with the American Academy of Otolaryngology-Head and Neck Surgery Foundation.

In addition to his current administrative role, he has influenced the careers of hundreds of AuD students through his academic abilities in teaching vestibular courses, mentorship of student research projects, and preceptorship of students in the respected Balance Disorders Clinic.

Prior to Vanderbilt, he was director of clinical research at American Institute of Balance and, more recently, co-owner/director of Alabama Hearing and Balance Associates. In 2015, Audigy Group recognized his clinic with the Outstanding Practice Achievement Award. Dr. Roberts has served on the Academy Board of Directors, has been program chair for the Academy’s annual conference, and has been a trustee on the Academy’s Foundation board.
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For more information about the program, contact Eric Gershowitz at eric.gershowitz@mci-group.com.

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