GAME CHANGER

Creating Value in a Changing Health-Care Landscape

BY SARA SABLE-ANTRY
One of the biggest challenges independent audiologists face today is remaining competitive in an industry that many consider “under attack.”

Internet sellers, the success of hearing aid centers in Big Boxes (Stock, 2013), and the emergence of several third-party payers brings new competition the likes of which we haven’t seen before. More than ever, audiologists are being challenged to “prove” their inherent value to those patients whose only concern is price, despite reports of average selling prices (ASPs) of hearing instruments remaining flat or declining (Gleitman, 2014).

In many ways, the industry is under attack, and audiologists are on the front line. The good news is that recent changes to the health-care landscape bring forth new opportunities for audiologists to differentiate their practice and establish themselves as local experts. In truth, these opportunities have existed for several years, though were under-used because of indifference or lack of education, or because they were difficult to understand. At AudiologyNOW! 2014, Siemens set out to address these challenges by introducing a turnkey physician’s marketing program. One of the goals of this program is to help audiologists take back control of the industry with an easy-to-follow plan and the right ammunition.

To better grasp how new health-care provisions affect audiologists and their practice, we first need to understand how and why these changes took place. Then we’ll examine the three elements of what I call the Health-Care Value Cycle (HCVC) and how they work together to lead to better patient outcomes.

Health-Care Reform History 101

Although most people associate health-care reform with the Affordable Care Act (ACA), or “Obamacare,” the topic has been the subject of numerous laws and debates for nearly a century. From the early 20th century through the new millennium, the majority of discussions centered on the role of insurance in treatment rather than prevention. This led to an environment where the practice of “triage-based” health care had become the norm. For example, suppose a 55-year-old man presents with lower-back pain, chronic fatigue, and moderate obesity. In the past, the physician’s primary concern may have been treating the back pain—with little focus on obesity, which may be causing the back pain and fatigue.

Dynamics started to change about ten years ago. An overburdened health-care system, plagued by patients with chronic illnesses, coupled with rising insurance and physician costs, underpinned the need for a more sustainable system. The government conducted various studies of patients with multiple chronic illnesses, looking into their past medical history. They found a pattern. The patients who now needed high-cost procedures showed clear warning signs eight to 10 years earlier. The studies concluded that if the underlying health issues of these patients (dubbed “high-risk” patients) were addressed early on, the need for high-cost medical intervention now may have been averted (U.S. Department of Health and Human Services, 2003).

This was the dawn of preventive health care as a complementary approach to traditional treatment-based methods. The passage of the ACA in 2010 has further highlighted the need for preventive approaches. Among the goals of the ACA is to reduce health-care costs through an emphasis on quality and prevention. So in the case of our 55-year-old man, a preventive approach may focus more on weight loss, knowing that obesity is not only linked to back pain and fatigue but also to more serious illnesses like heart disease.

So how does all this relate to audiology? The Centers for Medicare and Medicaid Services (CMS) now includes a hearing-impairment screening as an important element in their patient evaluation/screening guidelines. These screenings are intended to assess the patient’s functional ability while promoting wellness and disease detection. Let’s take a closer look.

New Health-Care Initiatives

The ACA’s new focus on quality and prevention resulted in significant changes for primary-care physicians (PCPs) and audiologists. CMS governs these initiatives and provides incentives for carrying them out when requested by Medicare Part B. New health-care
initiatives constitute one component of the HCVC (FIGURE 1) and include the following:

- Initial Preventive Physical Examination (IPPE), or “Welcome to Medicare Visit”
- Annual Wellness Visit (AWV) containing a Personalized Prevention Plan-of-Services (PPPS)
- Physician Quality Reporting System (PQRS)

**IPPE and AWV**

The IPPE, or “Welcome to Medicare Visit,” is a one-time benefit made available to new Medicare Part B beneficiaries 12 months after the patient becomes eligible for Medicare. One year after the IPPE (and every 12 months thereafter), patients are entitled to an Annual Wellness Visit (AWV). For qualifying Medicare recipients, there are no out-of-pocket costs for the IPPE or subsequent AWVs. However, for PCPs to submit claims to Medicare and receive payment for either of these services, they must assess numerous preventive health topics. Hearing loss is now one of the topics that must be addressed. Audiologists know that a subjective questionnaire by a PCP is not sufficient to accurately diagnose a hearing impairment. This is why a physician outreach program is so important. More on that later.

**PPPS**

An essential part of the AWV and the IPPE is the Personalized Prevention Plan-of-Services (PPPS, or “Personal Plan”). The Personal Plan helps physicians take a patient’s “health snapshot” and establishes a preventive screening schedule for the next five to 10 years, based on individual risk factors. Since the Personal Plan is a crucial part of the AWV, we know that hearing impairment must be assessed. Of course, primary-care physicians aren’t expected to do this alone. Most will opt to refer to a qualified hearing-care professional. This is where you come in.

**PQRS**

The Physician Quality Reporting System (PQRS) was designed to improve the quality of care to Medicare beneficiaries by encouraging eligible health-care professionals (EPs) to report on specific quality measures, including clinical conditions treated, types of care provided (e.g., preventive, chronic, acute), and quality improvement goals (CMS, 2014). EPs include any professional who provides services that get paid under the Medicare Physician Fee Schedule (PFS), including physicians, licensed practitioners, and therapists. The program began voluntarily in 2006 and then became a paid incentive between 2013 and 2014. However, starting January 1, 2015, EPs who do not participate in PQRS will receive payment penalties, or “adjustments,” of up to two percent on Medicare billings (TABLE 1). To avoid future payment adjustments, audiologists who bill for outpatient Medicare Part B beneficiaries must participate in the PQRS program. For the past

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**FIGURE 1.** Health-care value cycle.

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several years, however, most EPs didn’t pay attention to PQRS, or weren’t aware of it.

All of the above represent game changers for audiologists. For many years, audiologists have looked for ways to share a common language with physicians—especially PCPs. Credibility and a sense of urgency around hearing loss have always been a challenge. The switch to a preventive health-care system that recognizes the importance of hearing health changes everything. It’s proof that the government, health-care organizations, and other entities have taken untreated or undiagnosed hearing loss seriously.

Comorbidity Studies

Physician buy-in is critical if they are to become a reliable referral source. After all, when a physician typically tells a patient, “I want you to do this,” the patient normally complies. This is why having physicians on board is so important, but it’s easier said than done. Audiologists have been in need of a compelling argument for why PCPs should refer to them. Comorbidity studies now fill that need and represent the second component of the HCVC. These studies augment the new health-care initiatives by helping to provide the rationale behind them. In other words, while health-care legislation may have provided the means to promote hearing health within the health-care system, clinical research now provides the justification.

It’s Bigger than Just Hearing Loss

Although they don’t typically deal with life-or-death conditions, audiologists have a professional obligation to inform physicians that “it’s bigger than just hearing loss.” They may now be in a position to be quasi–Paul (or Paula) Reveres for future serious illnesses—especially among seniors and baby boomers. Consider the following statistics:

- Untreated hearing loss can affect cognitive brain function (Science Daily, 2011) (especially in older people), and is associated with the early onset of dementia (Lin, 2011).
- Hearing loss is tied to a three-fold higher incidence of injury-causing falls (Lin and Ferrucci, 2012) and more frequent and longer hospitalizations (Journal of the American Medical Association, 2013).
- Hearing loss is linked to increased risk of depression in adults of all ages, especially women under 70 (Chuan-Ming et al, 2014).
- Low-frequency hearing loss is associated with, and could be considered an early marker for, a higher risk of cardiovascular and cerebrovascular events (Friedland et al, 2009).
- Twenty-one percent of diabetics have hearing loss compared to nine percent of non-diabetics (Bainbridge et al, 2008).
- High-frequency hearing loss is a side-effect of cisplatin and carboplatin, both chemotherapy medications used to treat certain cancers (Nitz et al, 2013; Vanderbilt, 2014).

Clearly, the last few years have yielded a wealth of published research showing a direct correlation between hearing loss and various diseases. Moreover, these studies show us that hearing loss is no longer a benign process to be passively dealt with but, rather, an early indicator of—or in some circumstances result of—other serious health conditions or treatments. This is exactly why hearing screenings play such a key role in a preventive health-care society.

Treat the Hearing Loss, Treat the Patient

The new health-care initiatives and the research on co-morbidities share a common takeaway: when you treat the hearing loss, you treat the whole patient. This is the core message that audiologists must embrace if they are to evangelize physicians as hearing-health advocates. After all, physicians are concerned about life-threatening issues, such as dementia, increased risk of falls, heart disease, and diabetes—all of which have been linked in some

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way to hearing loss. Armed with the proper tools, audiologists can show physicians why treating hearing loss is a holistic approach to patient wellness.

But is it really an audiologist’s responsibility to address “bigger” patient health issues like depression? I ask this question whenever I present the Siemens Physician Outreach Program, and the responses always spark a lively debate. This is a good thing. Historically, audiologists have tended to avoid addressing other health concerns for fear of getting involved in an area “outside the scope” of their practice. Phrases like “under the radar” and “not qualified” have become ingrained in our professional lexicon. Obviously, audiologists are not qualified to treat illnesses like depression or dementia—nor am I suggesting they market themselves as people who can. But just as PCPs now have a responsibility to practice preventive medical care, so do audiologists. This is why educating physicians about the consequences of untreated hearing loss is so important. It’s no longer a question of whose responsibility it is. Rather, it’s about working together to achieve better patient outcomes.

Physician Outreach

Over the years, there have been numerous attempts to market to physicians. Unfortunately, they have rarely achieved the success they intended. Despite valiant attempts to recruit physicians and vice-versa, the reality is that there has never been a strong incentive for physicians to refer their patients to audiologists. There are three reasons for this:

- Hearing loss has never been considered a “life-threatening” issue.
- As a condition, hearing loss has been a low priority for physicians and perceived as an expensive, out-of-pocket proposition for the patient.
- There was never a government-backed initiative to assess hearing loss.

This has all changed. New health-care provisions (IPPE/AWV/PQRS), coupled with the myriad of evidence-based research linking untreated hearing loss to various diseases, address all three of these issues. Unfortunately, this doesn’t mean physician referrals will start magically flowing into audiology practices around the country. Health-care legislation and research studies have softened the ground for hearing-care professionals. It’s still up to audiologists to get in there and plant the seeds. A proper physician outreach program can help accomplish this. As the third component of the HCVC, it needs to combine elements from health-care reform and comorbidity research.

A Turn-Key Solution

Physicians have a lot of patients and very little time. Audiologists need a low-cost, easy-to-implement program that effectively gets them in front of physicians, practice managers, billers/coders, and, of course, new patients. The program needs to communicate the elements of health-care reform and comorbidity research in a clear, professional, and easy-to-digest manner.

The program should convey why audiologists working hand-in-hand with PCPs provide value for everyone—especially the patients. Physicians need help understanding the new guidelines as well as the various diseases that are triggered by or are linked to hearing loss. They also need to be convinced that referring patients to audiologists can help preserve their patients’ health and independence, improve patient well-being and satisfaction, and at the same time uncover additional sources of revenue for their practice.

The Stars Have Aligned

There has never been a better time for audiologists and physicians to join forces in a win-win-win scenario for hearing-care professionals, the medical community, and patients. Think about it. Audiologists are looking for new referral sources and new ways to compete with Internet sellers and Big Boxes. Physicians are being incentivized...
to take preventive approaches to health care, while, at the same time, looking for new revenue streams. Patients are being encouraged to take preventive steps toward better health and now have access to highly advanced hearing instruments that are more affordable than ever. These factors work together and build off one another, creating the virtuous cycle that is the HCVC. The stars have truly aligned.

New federal guidelines to screen for hearing loss coupled with an abundance of evidence linking hearing loss to serious diseases has elevated the audiology profession to new heights. Audiologists are now in a position to control the messaging by separating hearing loss away from its singular association with hearing aids (and the notion that “it’s just aging”) and now link it to more serious conditions like dementia. In short, the treatment of hearing loss can now be considered part of a holistic plan to address prevalent conditions like heart disease and diabetes. By controlling the message, audiologists can take back control of an industry under attack. It is the perfect time to implement a turn-key physician outreach program. The change in focus from ears to preventive wellness raises the profession’s credibility and makes audiologists more relevant than ever before.

It’s more than just a shift in the right direction—it’s truly a game changer.

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References


