What will be Your Legacy to the Profession?

by B. Walden, F. Bess, L. Beck, and J. Jerger...See page 11
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Call for Nominations 2005 President-Elect and Board of Directors

Nominations for the President-Elect and three (3) Board of Director positions of the American Academy of Audiology may be made by any member of the Academy.

The President-Elect serves a one-year term beginning July 1, 2005 followed by a year of service as President and a third year as Past President.

Members-at-Large serve a three-year term beginning July 1, 2005.

Submit your nominations in writing to:
Brad Stach, PhD, Chair, Nominations Committee,
American Academy of Audiology,
11730 Plaza America Drive, Suite 300, Reston, VA 20190,
Or email nomination to: bradstach@mac.com

Nominations must be received no later than
5:00 PM EDT, August 25, 2004.
Audiology stands ready to assume its role on the national stage among the well-respected and recognized health care professions. We have moved from a profession that was often below the radar screen, to one that is now clearly visible and acknowledged for its expertise in hearing and balance. This is in large part due to the American Academy of Audiology’s recent efforts in Washington, in its relationship with Congress and other government agencies such as Centers for Medicare and Medicaid (CMS), Occupational Safety Health Administration (OSHA), Food and Drug Administration (FDA), and the Department of Education (ED). For us to continue our march toward autonomy, we must commit ourselves to becoming a politically awakened profession, sophisticated in the processes of government and legislation. The way our federal government characterizes and defines audiology affects virtually every aspect of our profession including patient access to our services, how we are paid for those services, and the fees that we are paid for providing those services. Even the future of the new Accreditation Commission on Audiology Education (ACAE) depends on Academy efforts in Washington, as it seeks approval by the ED as an accrediting body for AuD programs.

**Direct Access**

Perhaps no single issue in our profession looms as important right now, as that of direct access. It has just been one year since the Hearing Health Accessibility Act (HR 2821/S 1647) was introduced. In that short time we have gathered 46 co-sponsors in the House and four in the Senate. This has been an exciting and productive beginning to our movement toward direct access within the Medicare program. Much of this early success has been a result of the letter and email communications written on the part of our Academy membership and their patients to Members of Congress. During the past year, the leadership of the Academy has made multiple trips to Capitol Hill. Your voices and the voices of your patients have been heard. But we must continue to make our legislators aware of this bill and the importance of its entitlements to Medicare beneficiaries.

Direct access to audiology services will allow Medicare beneficiaries a choice of seeking care from either audiologists or physicians. Presently, patients must initially go through a physician for referral to an audiologist in order that the audiologist can be reimbursed through the Medicare program. For those of you who attended the Salt Lake City Opening Ceremonies, you heard from Anne Ryun who provided a touching account of Congressman Jim Ryun’s struggle with hearing loss and how the care of an audiologist significantly improved his life. After hearing Anne’s talk, it is no wonder that Congressman Ryun is the sponsor and champion of the bill that will allow others to have direct access to the care of an audiologist without an initial visit to a physician.

Direct access to audiology is not a change or expansion in the audiologist’s scope of practice; direct access to our services simply allows Medicare beneficiaries the same access to audiologists that has been enjoyed by veterans since 1992 and federal employees (including members of Congress and their staff) since 1998. The bill seeks uniformity in the health care policies of the federal government. The announcement on May 28, 2003, by the Centers for Medicare and Medicaid Services (CMS), which finally changed the definition of a “qualified audiologist” as defined by the Medicaid program to match that of the Medicare program, took years for us to accomplish. Our professional stature, like that of other doctoring professions, should not be judged by a purchased certificate but by a degree from an accredited institution and state licensure. It is critical that we monitor and push for consistency in how we are defined by the government.

Our goal for the coming year will be to take the Hearing Health Accessibility Act (HR 2821) as far as possible. We know that it must be attached to a larger Medicare bill. It is unclear whether there will be such a bill available by year’s end, but when the next Congress convenes in January of 2005, it is quite likely that one or more opportunities will be available. Our leaders in the House and the Senate must be aware of the legislation, and we must have sufficient support in the form of co-sponsors to ensure that this can be passed.

A vital component of this plan is for the Academy to have in place a vibrant, well-funded and thriving Political Action Committee (PAC). This is crucial in today’s world for any profession to be heard in Washington. The ability to have access to this country’s major political leaders and those who champion the cause of our patients with impaired hearing transcends party lines or political dogma. We seek to educate all legislators at the state and federal level about direct access in order to make available and improve access to audiological care for the millions of Americans who need our services.

**Political Action**

During my speech at the Salt Lake City Convention, I asked that we raise $100,000 for the PAC each year for the next two years to help educate Congress about the importance of HR 2821/S 1647 for Medicare beneficiaries and the need to keep government programs consistent. This amounts to an average contribution of approximately $10 per member per year. Many of you have been far more generous, and I applaud your...
President’s Message

I am pleased to report that following the convention we have already met half our goal for this year at nearly $50,000. We cannot become complacent; we must remain steadfast in our commitment to make direct access a reality. In order to stay mobilized and on task, a new PAC Advisory Board has been created with its members reflecting geographical and professional diversity. The PAC Advisory Board will be organizing regional sub-committees to assist in the work we have at hand. A well-planned strategy is in place.

We will engage our greatest asset, our members, in these efforts. Our Government Relations, Coding and Practice Management, Marketing, and Education and Standards Committees will all provide significant contributions to the cause of autonomy as well. No resource will go untapped in this unified effort. Those of you who have been so selfless with your time and your willingness to work for your profession are to be commend-
ed. It is my honor to work with you. If you would like to become involved in the efforts of the Academy, please contact me at rgars@dizzy.com. There is no lack of work to be done.

My hope is that by the end of my term as President, our consciousness about participating in the process of government will become part of our professional culture. I have often heard audiologists remark when discussing the success of other doctoring professions like dentistry or optometry, “How did they do it?” I believe we know how. Now, it is Audiology’s turn, our turn. Together, we will get it done.

* The American Academy of Audiology PAC is a bipartisan political action committee operated by and in accordance to guidelines established by the Federal Election Commission. This political action committee is for members of the Academy to join together and contribute voluntary funds collected from members of the Academy to candidates for federal political office in accordance with federal election law. The information included in this communication related to the PAC is for Academy members only and is being provided for informational purposes, and is not a solicitation by, or an invitation to contribute to the American Academy of Audiology PAC.

AAA Foundation Honors

2004 Research Award Recipients

The AAA Foundation hosted the winners of the 2004 American Academy of Audiology research awards at a breakfast during Convention 2004 in Salt Lake City. The presentation of awards was made by Chair of the AAA Foundation, Barbara Packer, and Sherri Jones, Chair of the Academy Research Committee.

The New Investigator Research Awards Program is intended to support young investigators who have completed their formal academic training and are ready to begin independent research. The 2004 New Investigator Research Award recipients are:

Shaum Bhagat, Louisiana State University
Mentor: Sid Bacon, Arizona State University
Title: Electrophysiological correlates of modulation detection interference.

King Chung, Purdue University
Mentor: Fan-Gang Zeng, Associate Professor, University of California, Irvine
Title: Using hearing aid dynamic directional microphones to improve speech understanding of cochlear implant users.

Peter Torre III, San Diego State University
Title: Recruitment of participants and pilot data collection of hearing sensitivity in older Latino-American adults.

The Student Investigator Research Awards are intended for graduate students currently enrolled in a doctoral program in Audiology who wish to complete a research project as part of their course of study. The 2004 Student Investigator Research Award recipient is:

Karen Kushla, Doctoral Candidate, Seton Hall University
Mentor: Dr. Kelly Shea-Miller, Seton Hall University
Title: Middle latency response auditory evoked potentials in elderly individuals with and without non-insulin dependent (Type 2) diabetes mellitus.

The Summer Fellowship Research Award is intended for senior undergraduate students or students currently enrolled in a graduate program in Audiology who wish to gain a limited, but significant, exposure to a research environment. The 2004 Summer Fellowship Research Award recipient is:

Carol M. Vaudrey, Clinical PhD Student, James Madison University
Mentor: Jonathon Spindel, James Madison University
Project Title: Balance testing using computerized dynamic posturography (CDP) with a virtual reality based visual stimulus.

The American Academy of Audiology’s Research Awards are made based on the merit of the research and the application. Awards are made to non-profit tax-exempt institutions in the United States or Canada, public or private, to support research by investigators who are enrolled in a graduate program of study, are faculty or staff of that institution, or are formally attached to that institution. The 2005 Research Awards application is available at www.audiology.org/students/rap.
MORE AT COVER MATH

A recent Letter to the Editor in the May/June 2004 AT (16:3, p. 12) made a commendable attempt to show the importance of placement of parentheses in mathematical formulae. The writer questioned the way the formula for dB SPL was sketched on the Nov/Dec, 2003 (15:6) cover of AT. He felt there was an error of placement of the parentheses. However, the writer misconstrued the depiction of the formula and wound up misplacing the word “log.”

The writer cites the formula thus:

\[
\text{dB} = 20 \left( \frac{\log \left( \frac{\mu Pa}{20} \right)}{20} \right)
\]

Actually, the parentheses in this case are optional, and the formula could be written:

\[
\text{dB} = 20 \log \left( \frac{\mu Pa}{20} \right)
\]

Either way, they read 20 times the log of the result of dividing the numerator by the denominator.

Next, he rewrote the formula incorrectly with the word “log” on the same line as the numerator:

\[
\text{dB} = 20 \left( \log \frac{\mu Pa}{20} \right)
\]

Such representation is misleading, because one might rewrite the expression in either of two ways:

A. \[20 \left( \log \frac{\mu Pa}{20} \right)
\]

B. \[\frac{20 \log (\mu Pa)}{20}
\]

Formula A is incorrect because it means 20 times the log of \(\mu Pa\) divided by 20. The writer correctly implies version B in that the log is not of the numerator or for that matter of the denominator. Rather, the log is of the ratio of the numerator and denominator. dB are logs of a ratio. Therefore, the term “log” must be at the same level as the dividing line of the fraction and not on the line of either the numerator or denominator. Thus, the formula is correctly written on the November/December, 2003 cover.

—Jim Peck, Jackson, MS

WHERE’S THE REHAB IN SCOPE OF PRACTICE?

I was pleased to see an update of “Audiology: Scope of Practice” in the May-June issue of AT (16:3). However, I am very concerned that the revised scope of practice does not include auditory rehabilitation as a major part of the document. Although the document speaks to hearing aid, vestibular and cochlear implant “treatment” provided by audiologists, there is no description of our wide arena of other areas that should be included as aural rehabilitation. Many audiologists participate in traditional and non-traditional habilitation and rehabilitation of adults and children with hearing loss, including various aspects of auditory-verbal therapy (AVT). Auditory training, per se, is a common scope of practice element for audiologists working with children and adults when they receive hearing aids and is a treatment not just associated with cochlear implants. Audiologists are not just diagnosticians. We are all involved in aural rehabilitation as we provide our patients with optimal care.

—Jane Madell, Beth Israel Medical Center, New York, NY

RESPONSE TO AT COVER MATH

In my original Letter to the Editor, when I wrote “As depicted...you could take the log of the numerator...” I attempted to demonstrate that an ambiguity existed in the order of operations in the solution with the log within the parenthesis — instead of outside the parenthesis. I did not say this was a necessary way to solve the equation as written. In Peck’s letter, he appears to understand this ambiguity as he simply restates the two ways I wrote the solution examples. There is no ambiguity when the log is outside the parenthesis.

The use of the parenthesis in any equation is simply a way to formalize the order of operations of the solution. I accept that if someone truly understands the solution of the decibel equation, then parenthesis are unnecessary. Many audiologists did not think anything was wrong with the original cover equation because they all understood how to solve the decibel equation. However, based on my experience in teaching this material to our mathematically-challenged, present-day undergraduates, two semesters a year for ten years, those parenthesis served a valuable function in guiding the correct order of operations. Nearly all of our introductory textbooks aimed at our undergraduates utilized parenthesis or brackets to separate the log operation from the ratio derivation.

—Peter Ivory, La Canada, CA
Audiology is a rapidly evolving profession. Within a relatively short period of time — the past 25-30 years — we have evolved from primarily an academic discipline into a healthcare profession. There has been an explosion of knowledge that impacts the field. This expanding knowledge is not limited to hearing science, but includes genetics, pharmacology, biotechnology, and a host of other topics that affect our clinical practices. Changes in our educational models for training practitioners reflect this transition. The bachelor’s degree was replaced by the master’s degree many years ago, and we are now well into the transition to the Doctor of Audiology (AuD) as the entry-level degree for clinical practice.

It is important to note that the AuD degree is a means to an end, not an end in itself. Most audiologists share a vision of audiology that includes autonomy from other healthcare professions, an expanded scope of practice, and status within the healthcare community equal to that of the most respected professions. The AuD degree is the critical mechanism for achieving this vision; however, the degree itself does not guarantee that these goals will be achieved. The AuD degree provides a mechanism for increasing competency among practitioners. If academic standards are gradually increased, Doctors of Audiology will more and more deserve — and, therefore, can demand — the autonomy, scope of practice, and professional privileges that we seek. Without the knowledge and competencies that are rightfully expected of doctors, we will never enjoy the legitimate prerogatives of doctoring professionals.

Currently, we are at a critical time in our history because educational expectations for doctors of audiology are evolving. In setting these expectations we are defining the profession of audiology for the foreseeable future. The AuD has been envisioned, from its inception, as a four-year post-baccalaureate degree. Compared to the most respected healthcare professions, this is a minimum period of education for a doctoring profession. The recent emergence of three-year post-baccalaureate programs, therefore, is quite disturbing. In practice, these programs perpetuate the educational model that the AuD was intended to replace; that is, a two-year master’s degree, followed by a clinical fellowship year. It is inconceivable that this development supports audiology’s vision of its future or will help it to achieve its long-term professional goals. Rather, it seems only to serve the interests of the departments and faculty that have chosen to offer this three-year educational option. There is no doubt that obtaining a doctoral degree in three years will be attractive to many students and we should not blame them for choosing this option if we make it available. It is equally certain that students graduating from a three-year program will be less prepared than if they had received four years of post-baccalaureate specialized education and training in audiology before entering the profession. This will be the legacy of those educators who choose to offer the AuD degree in three years.

Of equal concern is the indefinite existence of distance-learning AuD programs that provide a mechanism for practicing audiologists to obtain the degree. The original distance-education AuD program was funded cooperatively by a grant from the Army, Air Force, Navy, Department of Veterans Affairs, the American Speech Language-Hearing Association, the American Academy of Audiology, the Academy of Dispensing Audiologists, the Deafness Research Foundation, and industry. It was always intended that distance-education AuD programs would exist only for a few years to allow experienced practitioners, who had entered the profession prior to the AuD degree being available, to acquire the degree without having to quit their jobs and attend a university. It was never intended that persons wanting to become audiologists, but not yet enrolled in academic programs, could earn a master’s degree and then obtain their Doctor of Audiology degree through distance education.

Distance-learning programs have been in existence for nearly five years. We are rapidly approaching a point, if we have not already reached it, where persons who had not made the decision to become audiologists when these distance-education programs were created are obtaining their AuD degrees via this mechanism. This was not the intention...
Submissions for Convention 2005 will be accepted online from June 29 – July 27, 2004.

Submissions that are innovative and state-of-the-science are encouraged.

- All submissions go through a blind review process by a panel of colleagues serving on the Convention 2005 Program Committee.
- Submissions are encouraged in all topic areas.
- All submissions are submitted and reviewed online.

Information on the submission categories (Student Research Forum, Research Podium & Posters, Instructional Courses and Exhibitor Courses) will be posted in June 2004 at www.audiology.org/convention

Deadline for Research Posters will be December 3, 2004.

SoundOFF: The Audiologists’ E-Mail Community
GOT A QUESTION? Need Information? Wanna Make a Suggestion?
Need to Rant (or Rave?)
Feeling Like Filing A Complaint?

Or would you just like to SOUND OFF on a topic that’s near and dear to your heart?

GO TO: www.audiology.org/professional/soundoff TODAY and sign up for SoundOFF

REAL AUDIOLOGY. RIGHT NOW.
of the government agencies and professional organizations that provided funding for AuD distance education. More importantly, such an educational model adopted indefinitely would not be appropriate for or worthy of a legitimate doctoring profession. Distance-education AuD programs have served a very useful purpose in the transition to the AuD degree. That purpose is nearly fulfilled: The profession’s master clinicians who obtained their degrees prior to the transition to the AuD have had an opportunity to earn the degree. It is time for these programs to agree on a date to terminate. This is necessary if they are to preserve a positive legacy to the profession.

In retrospect, the “AuD movement” has been remarkably rapid. Barely 20 years in the making, the AuD degree has become the accepted entry-level degree for clinical practice. As a profession, we owe a great deal to the founders of the AuD movement, who took great chances, expended incredible time and energy, and overcame considerable opposition to lay the groundwork for the transition to a doctoral-level profession that is occurring now. That is their legacy to the profession and it is a valuable one indeed.

As the major professional organizations representing audiology, the American Academy of Audiology and the Academy of Dispensing Audiologists have recently undertaken a thorough review of ethical practices within the profession. At times, this has been a painful process because it has required that each of us look at our own behavior carefully to see if it tends to uphold or could potentially diminish the image of our profession. When appropriate, members of the profession are changing long-standing practices to avoid any appearance of conflict of interest. By increasing professionalism, they are helping all of us to achieve our vision for audiology. This will be an important legacy that they will leave to the profession.

Today’s educators will also leave an important legacy. By creating the practitioners of the profession, they shape its character. The knowledge, competencies, and ethical standards of the practitioners created by our university programs are determined by the educational standards to which our educators hold students of the profession. Ultimately, the best method to assure that our goals for the profession are achieved is to develop and adhere to performance-based accreditation standards for our AuD programs that elevate the clinical knowledge and competencies of persons entering the profession. The AAA Board of Directors is actively working to facilitate the creation of such standards. For example, in recent months the Board expanded the role of the Education Committee to include responsibilities related to AuD educational standards and accreditation, partnered with the Department of Veterans Affairs and the AAA Foundation to sponsor a consensus conference on the 4th year AuD externship and, with the Academy of Dispensing Audiologists, jointly sponsor the Accreditation Commission on Audiology Education. Although setting outcome-oriented accreditation standards for our AuD programs is the appropriate method for increasing competency among practitioners entering the profession (rather than specifying how long or by what educational model AuD education should be provided), accreditation of audiology doctoral education is complicated by the Council of Academic Programs’ apparent willingness to accredit three-year Doctor of Audiology programs. Such programs, inevitably, must set lower educational expectations than can be set by four-year programs.

It is the case that the fate of the AuD movement — and, therefore, the future of the profession — is largely in the hands of a different group of people from those who originally envisioned audiology as an autonomous and respected doctoring profession. The original visionaries who gave us the mechanism to become a legitimate doctoring profession have done their job. The AuD degree is a reality. It is now up to others to implement their vision. They must honor that vision and work in ways that help audiology to achieve its goal to become a respected doctoral-level profession.

Members of a profession are bound together because they represent one another to other professionals and to the general public. So too, it is for audiology: Each of us is responsible for creating a profession that is worthy of our colleagues and the patients we serve. It is this consequence of our work that represents our legacy to the profession. Just as practitioners are called on to put the welfare of their patients ahead of their own financial or personal interests, so too educators, researchers, administrators, professional organizations, and regulatory groups must put the interests of the profession ahead of their own benefit when conflicts of interest occur.

Each of us is called on to rise above our own self-interests and put the good of the profession first. Whether we are able to do this will determine the nature of our legacy to the profession. We are all in the process of creating our legacy. What will be yours to the profession?

The opinions and assertions presented are the private views of the authors and are not to be construed as official or as reflecting the views of the Department of the Army, the Department of Defense, or the Department of Veterans Affairs.
Two organizations, the International Electrotechnical Commission (IEC) and the American National Standards Institute (ANSI), are primarily responsible for generating the standards that guide the manufacture and electroacoustic measurement of hearing aids. Manufacturers, engineers, researchers, and clinicians use these standards to ensure that the manufacturing process and the specification of the electroacoustic performance of hearing aids meet universally accepted criteria. Standards of both of these organizations are typically developed through the voluntary efforts of committee members who comprise designated working groups.

In the US, efforts were underway in the early 1930s to specify the acceptability of hearing aid performance. The Council on Physical Medicine of the American Medical Association (AMA) recommended that a hearing aid produce at least 30 dB of gain between 300 and 3000 Hz and have a low inherent noise level. Also, the aid’s materials and workmanship were to be of high quality, and the marketing and sales practices of the company were to be thoroughly ethical. Efforts to develop formal standards began in 1935. In 1940, Romanow described the substitution method and the use of a 2-cc coupler for measuring the output of a hearing aid. His work set the stage for future efforts to develop formal hearing aid measurement procedures.

Originally founded in 1918 as the American Engineering Standards Committee (AESC), ANSI has served as the national coordinator in the standards development process. In 1928, 1966, and 1969, respectively, it was renamed the American Standards Association (ASA), the United States of America Standards Institute (USASI), and, ultimately, ANSI. Shortly after World War II, in 1946, ASA joined with the national standards bodies of 25 countries to form the International Organization for Standardization (ISO). ANSI is the sole U.S. representative on the ISO and the IEC. ANSI, or its precursor organizations, has published numerous hearing aid standards. These cover a wide range of topics, including: hearing aid measurement procedures; methods for reporting test results; test conditions, environments, and stimuli; performance criteria for test equipment; hearing aid coupling techniques; physical construction and characteristics of couplers; physical and acoustic characteristics of the acoustic manikin KEMAR; measurement procedures used with various couplers and KEMAR; and specified tolerance values for various performance characteristics. With respect to hearing aids, adherence is mandatory only for the ANSI S.22 Standard (Specification of Hearing Aid Characteristics) because it is the only such standard adopted by a regulatory agency, the U.S. Food and Drug Administration (FDA). For all other ANSI hearing aid standards, adherence is voluntary.

While the ISO was created to promote international standards development and to facilitate the international unification of industrial standards, the IEC serves as the organization around which national standardization efforts occur in the manufacturing and testing of electrical and electronic equipment. The IEC was founded in 1906 in London, England, to secure the cooperation of the technical societies of the world in standardizing the nomenclature and ratings of electrical apparatus and machinery. By 1914, it had formed four technical committees, whose number grew to 10 by 1923. In 1938, it produced the first edition of the International Electrotechnical Vocabulary, which was translated into multiple languages. By 1980, the number of technical committees had grown to 80 and their work included new technologies such as semiconductor devices and electrical medical equipment. A 1973 IEC standard described the use of a coupler for measuring the performance characteristics of air-conduction hearing aids in the frequency range 200 to 5000 Hz. By the 1980s, the IEC had developed a variety of standards relevant to hearing aids, and today, more than 30 such IEC standards are available. There are both commonalities and differences among the various standards developed by IEC and ANSI.

In the mid-1990s, seminal studies of cell phone interference with hearing aids were done in Australia, with assistance from the National Acoustic Laboratories. This work led to the IEC 60118-13 standard on Electromagnetic Compatibility. At about the same time in the U.S., the Federal Communications Commission (FCC) mandated that manufacturers of cell phones and hearing aids work together to solve the interference problem, and as a result, ANSI C63.19 (Methods of Measurement of Compatibility between Wireless Communication Devices and Hearing Aids) was approved in 2001. The current goal is to harmonize the relevant ANSI and IEC standards by developing a single test method.

### TABLE 1 ANSI and IEC contact information

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<thead>
<tr>
<th>Organization</th>
<th>ANSI</th>
<th>IEC</th>
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<tbody>
<tr>
<td><strong>Headquarters</strong></td>
<td>Washington, DC, operations center and point of contact for press inquiries: New York City, NY</td>
<td>Geneva, Switzerland</td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td>1819 L Street, NW, Suite 600 Washington, DC 20036 25 West 43rd Street, 4th Floor New York, NY 10036</td>
<td>3, rue de Varembé P.O. Box 131 CH - 1211 GENEVA 20 Switzerland</td>
</tr>
<tr>
<td><strong>Phone/Fax</strong></td>
<td>Phone: +1 (202) 239-8200 NY: +1 (212) 642-4000</td>
<td>Phone: +41 22 919 02 11 Fax: +41 22 919 03 00</td>
</tr>
</tbody>
</table>

The ANSI and IEC Web sites (given in Table 1), the Web site www.nrvr.org/Interference%20Standards.htm (retrieved March 17, 2004), and the report by Lybarger, Preves, and Olsen (A bit of history on standards for acoustical measurements of hearing aids, *American Journal of Audiology*, 1999, 8[1], 1-3) were used in compiling information for this summary report.
It has been well established that patients are more likely to seek medical advice when they are unclear as to the cause of their symptoms. Because dizziness has been notoriously difficult to diagnose, imagine the confusion of the patient in selecting which specialist to consult when experiencing these symptoms. The vast majority of patients complaining of dizziness and/or vertigo are seen and treated by their primary care physician (PCP). In fact, only about ten percent ever make it to a practitioner that may be considered a specialist (Audiology, Otology or Neurology) for these complaints. Unfortunately, even many of these specialists are ill equipped and trained to provide comprehensive vestibular assessment — a fact that only reinforces the primary care position that referral for specialist evaluation is not useful for most dizzy patients.

Evidence exists to support the following:

- Most dizziness and vertigo is the result of a vestibular disorder.
- Patients complaining of dizziness use more medications, have lower quality of life, and have higher levels of anxiety and social avoidance behavior than do their non-dizzy counterparts.
- Physicians tend to underestimate (compared to the patients opinion) the effect of dizziness on quality of life.

It is well understood that physicians tend to treat conservatively the classic symptoms of vertigo, which often have self limiting causes, and to conduct more investigation when neurologic or cardiovascular diagnosis was expected. In a study of 142 dizzy patients, although the physicians estimated that one-third of the 142 patients complaining of dizziness were suffering from an “inner ear disorder,” only one patient was actually referred for vestibular evaluation. The majority of patients in the study were treated with medication, and/or reassurance and followed by observation.

This management approach implies that the Primary Care Physicians (PCPs) have little awareness or confidence that the “specialist” can provide faster, definitive diagnosis and treatment, or assume that the patient must be willing to “wait it out.” Nowhere is this more apparent than in the treatment of Benign Paroxysmal Positional Vertigo (BPPV). Numerous studies have indicated that Canalith Repositioning (CRP) is a safe, fast and effective treatment for BPPV, and that successful treatment leads to significant and rapid improvement in quality of life. Unfortunately, the most recent estimate is that only 4% of patients with BPPV are ever offered Canalith Repositioning. The rest of the patients apparently wait while being treated with ineffective vestibular suppressant medication. Preliminary results from a patient survey in our office reveal that over 90% of patients that have undergone CRP felt that the cost and time were “definitely worth it,” and would contact us for repeat CRP if their symptoms recurred.

Armed with a veritable treasure chest of incontrovertible evidence, we have the opportunity and responsibility to reach out to PCPs and offer them an evidence-based alternative. PCPs are obviously interested in the best care for their patients, but many are unaware of diagnostic and treatment techniques available today. It has been demonstrated that there is a lag of several years from the time a clinical study demonstrates the effectiveness of a particular treatment, and the time the new treatment is put into practice. There is a significant gap between “what works” and “what is done.”

The key to marketing to physicians lies in education. This can be accomplished in a number of ways. Newsletters or copies of relevant articles can be mailed to potential referring physicians. Personal contact with PCPs allows an informal way to let them know about available services. A very effective method of educating PCPs is by conducting Continuing Medical Education (CME) seminars for the local hospital or medical society. The seminar does not need to be extremely detailed, but should allow the PCP to better understand what type of patients can benefit from being referred to a balance clinic, and what will happen once the patient gets there. Be prepared to back up any statements by citing published clinical studies, and remember that the current thinking regarding treating vestibular disorders is almost 180 degrees in opposition to the methods historically employed by many PCPs.

References for this article may be obtained by contacting the author at BRHBC@comcast.net.
The profession of audiology is at a critical juncture in its development, requiring wisdom and consensus among stakeholders. Although the recent Reston conference was entitled “The 4th Year AuD Student Training Experience: Issues & Concerns,” it was clear from discussions that the issue is not what to do regarding the fourth year clinical experience but rather, how can each of our clinical doctoral programs plan their four years of clinical education so that the progression from in-house (university-based clinics) to externship (community-based) clinical practicum placements provides consistent clinical preparation across all of their respective graduates.

The AuD Externship

The pragmatics of our audiology clinical doctoral programs dictate that in most programs the first two years are composed of predominately didactic course work with the majority of supervised clinical education occurring in the third and fourth years. The ASHA 2007 certification standards state that each student must have “a 12 month full-time equivalent of supervised clinical practicum (roughly 1820 hours) sufficient in depth and breadth to achieve the knowledge and skills outcomes” and that this can be spaced throughout the educational program. Programs must be free to use all four years of their curricula to develop clinical education so that the progression from in-house (university-based clinics) to externship (community-based) clinical practicum placements provides consistent clinical preparation across all of their respective graduates.

Clinical placements must be an integral part of the program with mutually beneficial partnerships between the programs and externship sites.

It appears that we have consensus on what types of clinical experiences should be included in our clinical doctoral programs. It is also evident that the clinical sites available in the United States to provide the desired breadth and depth in these experiences are limited. The externship sites indicate that if they are to serve as clinical training resources for our programs, they must be equal partners with the academic programs that are sending them students. They need to have input into the students’ curriculum and ongoing communication with the faculty of the program as part of the ongoing student formative assessment and overall program quality improvement process. For this to happen, these sites are realizing that they cannot be accessible to all programs but rather, may need to limit access to their partner programs. To date examples of such partnerships include: The Cleveland Clinic and the Ohio Consortium AuD program, the Purdue Department of Audiology and Speech Sciences, IU School of Medicine Department of Otolaryngology—Head & Neck Surgery joint AuD program, the San Diego State University—University of California at San Diego Department of Otolaryngology joint AuD program and the East Tennessee State University—Mountain Home Tennessee VA program partnership. Even with formalized partnerships such as these, academic programs are realizing that they cannot serve all students and provide the broad scope of practicum experience with only one partner, but must also develop partnerships with educational audiology sites, private audiology and ENT practices, etc. Very often, because of the bottom line in the economics of the hearing health care industry, these partnerships require that the university doctoral programs bring resources (salary buy-out dollars, capital improvements, personnel, etc.) to the partnership in order to gain access to the externship facility. In some cases partnerships are precluded because of an inability of the site to bill for student services unless there is 100% supervision.

The result of the creation of these partnerships is that the students from partner audiology doctoral programs are the winners. Programs trying to start new audiology clinical doctoral programs must try, perhaps in vain, to assemble a continuum of consistent practicum placements from the quickly shrinking number of remaining quality externship sites. Our current dilemma is how to control the proliferation of audiology doctoral programs that do not have the availability of consistent...
high quality clinical externship sites (re: Big Ten Consensus Statement 14:5, AT, 2003) to meet the new entry-level certification standards, without putting many faculty in these programs out of work. The answer lies in the economics of the hearing health care industry and in the fact that not all audiology services require a clinical doctorate for delivery.

**Audiology Assistants**

If audiology is to survive and flourish as a profession, and if the value of the audiology clinical doctorate is to be elevated to the desired level, then the audiology education programs and the audiology professional organizations must define the continuum of audiology hearing health care and the related level of personnel preparation needed for delivery of these services. In other words, at the same time that we are defining the characteristics of and preparation for the doctoral entry-level audiologist, we must also define the characteristics of and preparation and supervision requirements for their support personnel (e.g., audiologist aids/assistants). This should be done prior to the creation of any audiologist assistant program.

In this new reconfiguration of audiology education resources, some master’s degree programs find that they are unable to meet the doctoral program resource requirements and are faced either with closure or possibly the reinvention of themselves as partners in the creation of audiologist assistant training programs. If they choose the latter, these programs would no longer provide the master’s degree, or even the bachelor’s degree, as entry-level audiologist assistant credentials but, rather, could partner with their community colleges to develop associate degree programs. The audiology faculty could use their knowledge and resources to deliver the program with the ultimate joint credential (audiologist assistant associate degree) offered by the four-year university in partnership with the community college. The most comprehensive revision of the hearing health care provider system would be to also create a special (advanced) track in these audiologist assistant associate degree programs, which would become the entry-level preparation for non-audiologist hearing aid dispensers. If this reinvention of the hearing health care personnel education system is done in a coordinated manner among all audiology programs, it would be possible to transform our audiology education resources in the United States in a way that would be beneficial for all.

This reconfiguration of audiology education resources would automatically reduce the number of audiology clinical doctoral audiology programs (AuD or other designators) and raise the economic value of the doctoral-level audiologist. It would allow more consistent preparation of doctoral-level audiologists, as more quality clinical externship sites would be available to the remaining programs for partnership development. It would supply enough audiology support personnel (under the supervision of doctoral-level audiologists, in the case of audiologist assistants) to economically meet the needs of our growing hearing-impaired populations. It would create new linkages between community colleges and community partners in the development of technical training programs (e.g., audiologist assistant and non-audiologist hearing aid dispenser). It would expand the number of hearing health care personnel available to serve people with hearing loss and their families and increase the consistency and rigor of their educational preparation.

**Legislative Issues**

Licensure boards are raising the following issues with the development of each new audiology clinical doctoral program: Do we need this many doctors of audiology? Will these programs significantly increase the supply of audiologists? Who will be doing all of the basic audiology work that results in overall improvement in access to audiology services by state residents with hearing loss? These issues were raised by the Indiana legislature with a corresponding willingness to look at the development/regulation of audiology support personnel. The key is to do this in an organized efficient way including all stakeholders, defining the relative educational requirements, program characteristics and supervision requirements and tying enrollments across assistant programs to enrollments in clinical doctoral programs (e.g., 3 or 4: 1). This would play well with the current White House administration, which is calling for the development of education programs between community colleges and community partners to increase the number of skilled jobs and provide the level of technical skills in workers needed for these jobs.

Of course, the development of audiologist assistant opens the doors to abuse of the use of these support personnel by other professions. This however, may happen with or without our proactive approach. If we take the lead, we will be in a better position to assert that the doctoral-level audiologists should be the only supervisors of audiology support personnel.

With the advent of the doctoral entry-level requirement for the practice of audiology, and in order to better serve our growing hard-of-hearing populations, it is now time to address the development of the remainder of the continuum of a hearing health care provider system. Audiology academic programs, audiology practitioners and the professional organizations claiming to represent the audiology profession must work together quickly and effectively to build consensus regarding a more perfect vision for the future of the audiology profession and its related non-medical hearing health care service provider system and make it happen.
Discussion at the recent AuD Externship Consensus Conference included the question, "Should AuD students receive financial support from off-campus clinical facilities?" As the AuD model is emerging and subject to change, we suggest that AuD student financial support be a non-salary stipend and we describe two funding mechanisms that have been useful to facilitate this support.

The Need for Extern Financial Support

AuD students, in comparison to master’s degree students, are required to invest four years instead of two with an associated increase in financial obligation. While studies have shown salaries for doctoral level audiologists are substantially higher than master’s level practitioners, most surveys completed to date have included practitioners with varying years of experience in the field including those who matriculated through a distance education program post-master’s degree. At this point the data are limited regarding the salaries for audiologists who are just entering the field following a 4-year residential program, the effect on salaries of the elimination of the master’s degree entirely, and whether the debt load following the four-year audiology doctorate degree is reasonable compared with entry-level salaries and predicted salary growth.

The 4th year AuD student has an additional year of didactic and clinical training compared to the traditional clinical fellow (CF) who was compensated as a paid employee. Since CF funding is often available at clinical sites, why not use these funds to support a future Doctor of Audiology? Since the AuD training model has completely eliminated the post-master’s CF, using these positions for 4th year AuD students may provide AuD clinical sites and funding. Universities provide a significant amount of funding to students in their first three years of training. If externship placement sites value the growth of their future colleagues and the services provided by students during this year, it would be beneficial to the student, the site, and the field of audiology to provide some amount of financial support while students are in their 4th year. Students supported during the final year of training will be able to dedicate more of their energy to clinical work and less time to meeting ongoing living expenses. Unfortunately, administrators may have difficulty justifying the funds to support a student who cannot bill and therefore does not contribute to the revenue of the department/business as the CF did. As the profession moves forward to eliminate provisional licensure, funding may be difficult to find.

First and second year students may have research, teaching, or administrative assistantship opportunities during their on-campus training. Third and fourth year students, training in off-campus externship rotations, are not as able to take advantage of on-campus funding opportunities. Students often work outside the university or clinical arena to support their studies. If mechanisms can be developed to provide financial support for audiology students during their externship, it will allow them to dedicate more time to clinical work.

There is need for financial support at a level sufficient to provide for the probable increase in educational and living expenses incurred during the fourth year. This may be especially true given the possibility that students may have to travel a distance from their educational institution, maintain a temporary residence, etc. It would seem that the easiest avenue is to shift current financial remuneration from “salary” to “stipend.”

Funding Mechanisms

We have utilized two mechanisms that offer fellowships or traineeships. In these instances, the student continues to function within the purview of the university, with liability insurance, and the off-campus site considered an extension of the learning environment.

Towson University has an “Audiology Doctoral Fellowship” agreement that is made between the fourth year off-campus facility and the university. The facility supporting the student establishes a contract with the university grants and contracts office. Under the contract, the facility pays the tuition/fees and student stipend to the university in installment payments. The university transfers the funds to enrollment services to cover the student’s tuition, and the student receives bi-monthly stipend checks. The terms under which the fellowship can be terminated and the responsibility of the university to provide liability insurance for the student are stated in the contract. In addition, supervision and evaluation requirements are specified in the contract. The stipend can be negotiable.

Kennedy Krieger Institute (KKI) supports audiology doctoral students via another training model. A Memorandum of Understanding was developed between KKI and Towson University in which the student is paid a stipend by KKI and is considered a “trainee.” Students meet the requirements of the Institute’s MCH funded Leadership Education Excellence in Caring for Children with Neurodevelopmental and Related Disabilities (LEND) training program. The requirements include a variety of observational and didactic experiences in an interdisciplinary setting for children with a variety of developmental disabilities. A contract is established between KKI and the university in which KKI pays a portion of the student’s tuition. In addition to clinical work, the student and the faculty members at Towson University are expected to engage in collaborative research and teaching projects. The objective of this fellowship is to provide future audiologists with specialized training and experiences with developmental disabilities while providing financial support during the first three years of doctoral study.

The opinions expressed in this Viewpoint are those of the authors and in no way should be construed as representative of the Editor, officers or staff of the American Academy of Audiology.
“Well, hearing aids are so unimportant in the grand scheme of medicine, I mean they really aren’t that important; why do they have to cost so much and why can’t patients choose their own device?” … “Who needs an over-educated, over-paid technician to fit simple amplifiers anyway?”

As we put our tray tables in the upright and locked position, we knew we were at a conversational impasse. I was not so upset about his comments as much as the reality of the wide-ranging impact of The Wall Street Journal article. The Wall Street Journal is read far and wide, from the White House to the courthouse, from boardrooms of health care insurance companies to the halls of Congress. All that was negative in that article, all the unnecessary denigration of an entire profession was put on a very large front burner. The ex-cardiologist-turned-entrepreneurial-sky-pilot not only read the article but clearly digested it.

Unfortunately, the negative impact was not just worldwide but local as well.

Within three days after my return to work, two patients carried the article into the office. It simply was not fading into the woodwork as I had hoped. Quotes such as, “We do such a poor job as an industry meeting the needs of masses of individuals…we develop instruments for people who have the most money and leave the other individuals on the sidelines” will haunt our industry for years to come. No one gets left behind with the social agencies, state assistance programming and vocational rehabilitation services readily available in every state to assist those in need.

Unfortunately, the damage is done. Even a retraction of the entire article from The Wall Street Journal would fall on deaf ears. It was all sensational impasse. I was not so upset about his comments as much as the reality of the wide-ranging impact of The Wall Street Journal.

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Plan to spend some of your continuing education dollars on the experiences of a lifetime! The 17th Annual Convention & Expo in Washington, DC promises to be a spectacular event. Not only will you enjoy stellar educational sessions while attending convention and the pre-convention workshops, you will be surrounded by a vibrant, accessible, world-class city. From its celebrated symbols of patriotism to its undiscovered neighborhoods, the sites and sounds of the nation’s capital inspire millions of visitors every year. Be sure to bring your camera because the city is filled with famous buildings and sculptures and memorials and parks. There are dozens and dozens of free attractions and an endless calendar of special events offering year-round experiences. The Washington, DC Convention Center is located in the middle of downtown, and many local attractions are within easy walking distance or a short Metrorail (subway) ride away. DC offers many guided tours as well, everything from bike touring to water taxis.

While attending Convention 2005, the 93rd annual celebration of the famous Cherry Blossoms Festival will be in full swing. While in bloom, these trees with their pale pink blossoms frame some of the historic sights located along the Tidal Basin. A leisurely walk along the National Mall will bring into view some of the most famous sights in the world; Lincoln Memorial, U.S. Capitol, Jefferson Memorial, National Gallery of Art, the buildings of the Smithsonian, White House, Vietnam and Korean and WWII Memorials and many other places of interest. You can visit the National Archives, which houses some of this nation’s most precious treasures, and you can visit the highest court in the land — The Supreme Court. Make plans to visit your elected officials in the House of Representatives and in the Senate and spend some time in the impressive government buildings having your say where the laws of the land are made.

There is so much to do and see ‘inside the beltway.’ Plan to come a few days early or stay a few days after convention to take it all in. Wherever you choose to visit in Washington, DC, just remember to stay on the right side of the Metro escalators to avoid looking like a tourist!

Check out Washington, DC by exploring some of these websites:

- [www.washington.org](http://www.washington.org) - Washington, DC - The American Experience
- [www.washingtongdc.gov](http://www.washingtongdc.gov) - Website of the Washington, DC Government
- [www.house.gov/Visitor.html](http://www.house.gov/Visitor.html) - United States House of Representatives - Visitor Information
- [www.senate.gov/pagelayout/visiting/one_item_and_teasers/capitol_hill_image_coll.htm](http://www.senate.gov/pagelayout/visiting/one_item_and_teasers/capitol_hill_image_coll.htm) - United States Senate - Visitor Information
- [www.dchomepage.net](http://www.dchomepage.net) - Official Washington, DC Home Page
- [www.si.edu/activity/planvis/museums/start.htm](http://www.si.edu/activity/planvis/museums/start.htm) - The Smithsonian Visitors Guide

Registration & Housing will open even earlier this year! Watch for details...
This was the American Board of Audiology and Board Certification in Audiology as envisioned by the Academy of Audiology in the 1990s—AN IDEA, A PLAN for the future, A REALITY. We continue with the framework for the future with ABA.

AN IDEA

The idea was to create an alternative source of high-quality continuing education, at reasonable rates, in venues for your convenience, without losing time from busy practice. With the rapid strides in this field, it is harder to keep up with the changes without leaving our practices for days at a time. Our certificants should be at the forefront in these areas, and so we envisioned courses created by “the experts,” updated regularly, and with some form of outcome measure.

THE PLAN

1. The “experts” in various areas will be asked to create a continuing education module on the newest topics. Each course will feature specific areas of audiology to enable enhancement of our professional knowledge base. Each course would be a minimum of three hours to maximize the information for each area. Each certificant would be able to set the pace for taking these courses, and the modules would be available to our certificants at extremely reasonable prices. New procedures, new equipment, changes in practice are occurring all the time and it behooves each of us to keep up; to this end, certificants would be encouraged to take courses in different professional areas. We must be at the minimum conversant with the latest advances and findings in our field, even if not in our specialty. This would allow for appropriate referrals and perhaps would whet interest in a new and dynamic area.

2. The second part of the plan concerns the types of courses and number of hours of continuing education for each certificant. The number of contact hours for recertification will change from 45 to 60 hours every 3 years with a two tiered system. Tier 1 CEUs will be high professional level courses of a minimum of three hours with some form of outcome measure. Of the above mentioned 60 hours, a minimum of 15 hours should be Tier 1. Tier 2 CEUs will be shorter courses that do not require outcome measures. Of the above mentioned 60 hours, 45 may be Tier 2.

There are many fine programs already available that would satisfy the new requirements. However, we understand professionals who find it difficult to leave the office or family, whose employer will not pay the price of the extended courses, and so we will offer these modules for the professional who wants this convenience.

THE REALITY

Our enhancement of the recertification program is in line with the profession’s push for limited practitioner status. The increase to 60 hours of CEUs will not be effective until January 1, 2008. We expect Tier 1 level courses to become available to you in early 2005.

• The reality is that ABA is here to stay.

• The reality is that your voluntary participation in this professional certification program is now recognized by many as the premiere certification. It identifies you as a professional committed to the highest standards, ethical practices, and continued professional development.

• The reality is that Board Certification elevates the professional status of the audiologist to consumers, employers, health care institutions, the general public, and private agencies.

• The reality is that ABA’s requirements will create professionals with a greater breadth of knowledge in more areas.

• The reality is that this will help ensure that patients are receiving superior care.

• The reality is that with this, everyone wins. The professional wins, the consumer wins, the institutions win, the employers win.

So keep looking for here for future updates and announcements of our new continuing education modules.
Otitis media is the most common disease among children. In the first 12 months of life, 80% of children have at least one episode of otitis media, and almost 40% of children have 6 or more episodes by age 7 (Bakaletz, Barenkamp et al. 2002; Cripps and Kyd 2003). Recurrent or chronic otitis media can cause significant hearing loss during a critical time for speech and language development. As a result, children who have had multiple episodes of otitis media are at risk for delayed speech and language development and/or learning difficulties. For all of these reasons, there is a great deal of interest in the development of a vaccine that could prevent (or significantly decrease) otitis media in children.

Developing a vaccine for otitis media has proven difficult for several reasons. First, “otitis media” is not a single disease. Instead, it is a description of inflammation in the middle ear that can be caused by a number of different bacteria and viruses. Three primary bacteria that are found in middle ears of children with otitis media are called Streptococcus pneumoniae, non-typeable Haemophilus influenzae, and Moraxella catarrhalis. A child with otitis media may have an infection that is caused by only one of these bacteria, or the middle ear may contain combinations of two or three different bacteria. Adding to this complexity is the fact that within each of these species of bacteria, there are multiple strains that may require different vaccines to prevent them. Finally, in up to 17% of cases both bacterial and viral infections are present concurrently.

The goal of vaccination is to “prime” the body’s immune system against a bacterium by introducing either whole bacteria that have been killed (and therefore cannot cause infection) or proteins that specific bacteria have on their surfaces. Once the immune system has “seen” these bacteria or proteins, it has to produce antibodies against them that will prevent infection the next time live bacteria are present. Therefore, an ideal vaccine would be one that: 1) causes the immune system to generate antibodies that will kill the bacteria, 2) will allow the immune system to recognize and kill multiple strains of bacteria, 3) will produce a strong immune response in infants and toddlers, who don’t always produce as strong a response as adults, 4) will result in a long-lasting immunity against infection, and 5) can result in an immune response in the middle ear without increasing the inflammation there (Bakaletz, Barenkamp et al. 2002).

Despite the complexity of the problem, scientists are optimistic that a vaccine can be developed that can significantly decrease the incidence of otitis media. The current approach is to develop vaccine “cocktails” that will allow the immune system to develop antibodies against all of the three major types of bacteria that cause most otitis media infections. This “tribacterial formulation” has been shown to prevent ear infections in mice caused by each of the three bacterial species individually (Cripps and Kyd 2003). It is not yet known whether the formulation can prevent infections when multiple bacterial species are present in the middle ear. Another question is whether the vaccine is more effective when delivered systemically or via a nasal spray. Finally, human studies must be done to determine whether the vaccine formulation that works in mice will prevent otitis media in humans.

REFERENCE
On May 28, 2004, the Centers for Medicare & Medicaid Services (CMS) published a final rule revising the requirements for audiologists providing services under the Medicaid program. This important regulation removes the barrier of private certification and bases eligibility for participation on state licensure.

The old regulation was a vestige of the pre-licensure days of the audiology profession. Under the old regulation, a Medicaid provider could go from being qualified to being unqualified simply by choosing not to re-purchase a proprietary, entry-level certificate. The new regulation addresses this unusual flaw and correctly identifies state licensure as the criterion for provider status. The new regulation also makes the Medicaid definition of a “qualified audiologist” consistent with that used in the Medicare program.

“This change in regulation is important to citizens who are part of the Medicaid program,” states Brad Stach, Past-President of the American Academy of Audiology. “Many of our Academy members who are licensed, qualified providers have chosen to no longer buy entry-level certification on an annual basis, effectively reducing the pool of qualified audiologists eligible to provide services for Medicaid recipients under the old definition. By changing the regulation to qualify those who are licensed, the potential pool of providers for Medicaid services is increased substantially.”

This change has been a long time coming. In 1999, the Academy worked with Congressman Ed Whitfield (R-KY) to introduce legislation to change how Medicaid “credentials” audiologists. At that time the Congress “urged” CMS to make this change. In 2001, HHS Secretary Thompson addressed the Academy in San Diego, reporting to the membership that he was “committed to getting the job done.” With publication of the Final Rule last Friday, the Secretary has followed through and made it easier for Medicaid recipients to receive hearing care services.

“We appreciate the hard work of the staff at CMS,” say Stach. “We are very supportive of their efforts to enhance access to audiology services for those enrolled in the Medicaid program.”

(Sections cut and pasted from Final Rule as it appeared in the May 28, 2004 Federal Register - for entire rule, see www.audiology.org/professional/gov/medicaidfinalrule.pdf.)

**NEW REGULATION TO EXPAND AUDIOLOGY PROVIDER BASE IN THE MEDICAID SYSTEM**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
42 CFR Part 440
[CMS-2132-F]
RIN 0938-AM26
Medicaid Program; Provider Qualifications for Audiologists
AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.
ACTION: Final rule.

After much research and consideration of the impact of each of the options, we concluded that...the standards contained in this rule-best satisfies the Secretary’s intention, and addresses the request raised by interested parties, to conform the definition of a qualified audiologist under the Medicare and Medicaid programs by recognizing the role of State licensure as a Medicaid provider requirement. We also concluded that the standards in this rule best continue to recognize the broad program discretion granted States under Medicaid by retaining program flexibility while at the same time also building in quality standards that continue to ensure Medicaid services are provided to all Medicaid-eligible individuals by recognized, highly trained professionals.

PART 440-SERVICES: GENERAL PROVISIONS
Subpart A-Definitions
_ 1. The authority citation for part 440 continues to read as follows: Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).
_ 2. In \$ 440.110, paragraph (c)(2) is revised, and a new paragraph (c)(3) is added to read as follows: \$ 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
_ 3. In \$ 440.110, paragraph (c)(3) is added to read as follows: \$ 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(2) A “speech pathologist” is an individual who meets one of the following conditions:
(i) Has a certificate of clinical competence from the American Speech and Hearing Association.
(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate.
(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(3) A “qualified audiologist” means an individual with a master’s or doctoral degree in audiology that maintains documentation to demonstrate that he or she meets one of the following conditions:
(i) The State in which the individual furnishes audiology services meets or exceeds State licensure requirements in paragraph (c)(3)(ii)(A) or (c)(3)(ii)(B) of this section, and the individual is licensed by the State as an audiologist to furnish audiology services.
(ii) In the case of an individual who furnishes audiology services in a State that does not license audiologists, or an individual exempted from State licensure based on practice in a specific institution or setting, the individual must meet one of the following conditions:
(A) Have a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association.
(B) Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience under completed a national examination in audiology approved by the Secretary.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)
Dennis G. Smith,
Acting Administrator, Centers for Medicare & Medicaid Services.
Tommy G. Thompson, Secretary.
With the influx of cicadas (which occurs every 17 years here), Washington, D.C. is under a “tinnitus alert.” A high-pitched buzz can be heard at most times of the day. Hopefully, the cicadas will provide Members of Congress with a subliminal reminder of the importance of hearing care.

With 2004 being an election year and the federal government distracted by international affairs, it is no surprise that this is not turning out to be a year of great legislative activity. On the regulatory side, the Centers for Medicare & Medicaid Services (CMS) has its hands full implementing last year’s Medicare Prescription Drug, Improvement, and Modernization Act (MMA) under the leadership of new administrator, Mark McClellan. So, for audiology, this will be a year for planting and tending to the seeds of fruits which will be harvested in future years.

Direct Access

Direct access remains the Academy’s highest priority. The Hearing Health Accessibility Act (HR 2821/S 1647), which would give Medicare beneficiaries the option of seeing an audiologist directly for hearing and balance tests, continues to gain additional cosponsors from both parties in both the House and Senate. At the time of writing this column, the bill has 45 co-sponsors in the House. This is a respectable figure, and the Academy should be proud of its efforts.

In our last column, we urged all audiologists to write their Congressman and Senators, as well as the Republican chairmen and ranking Democrats on certain key committees, requesting that they cosponsor this bill. Such grassroots support is critical and will remain so throughout the progress of this bill through the legislative process. (You can find model letters for this purpose on the Academy’s Government Relations web page at http://www.audiology.org/professional/gov/da.php under “Sample Letters.” Copies of the legislation and fact sheets are also there.)

The MMA

The Medicare Modernization Act passed last year contains some provisions relevant to audiology. Importantly, it provides that the annual update to the Medicare Physician Fee Schedule for calendar years 2004 and 2005 may not be less than 1.5 percent. This ensures that Medicare Part B reimbursement for all covered services, including audiology services, will remain fairly stable next year. It also requires the Comptroller General to submit a report to Congress on the appropriateness of the current statutory formula for determining the annual update to the fee schedule. The Academy is working with the health care community to support changes in the Medicare Sustainable Growth Rate (SGR) formula that has generated negative payment updates every year since 2001.

Other Provisions of Interest Include the Following:

- The MMA places limits on Medicare carriers’ pre-payment reviews and post-payment audits of claims. It restricts the circumstances in which a carrier may conduct a random pre-payment review (i.e., “a demand for the production of records or documentation absent cause with respect to a claim”) and requires that CMS develop a standard protocol for such reviews. Pre-payment reviews targeting a specific supplier may not be done unless the carrier identifies an improper billing practice by that supplier and there is a likelihood of a sustained or high level of payment error. If a carrier wishes to conduct a post-payment audit of a supplier’s claims, it must give the supplier advance notice of its intent to conduct the audit, an explanation of its findings, an opportunity to provide additional information, and an explanation of the supplier’s appeal rights.

- It requires CMS to develop a process whereby CMS will provide notice to classes or providers and suppliers in cases where a carrier has identified possible over-utilization of particular billing codes by that class of providers or suppliers. For example, if a Medicare carrier believes that audiologists are over-utilizing vestibular testing codes, CMS would provide notice to audiologists served by that carrier alerting them to this problem.

- It requires that CMS develop a process whereby, in the case of minor errors or omissions in Medicare claims, a provider or supplier would be given an opportunity to correct the error or omission without the need to initiate an appeal.
STARK LAW UPDATE

CMS has issued the long-anticipated “phase II” of its regulations implementing the Stark Law (§ 1877 of the Social Security Act). The Stark Law prohibits a physician from making a referral to an entity for the furnishing of “designated health services” if the physician (or a member of the physician’s immediate family) has a financial relationship with the entity furnishing those services. The entity that receives a prohibited referral is barred from billing for the services.

As the latest regulations make clear, the Stark Law has little impact on audiologists. The Stark Law only applies to referrals of “designated health services” (DHS). Hearing and vestibular tests are not DHS, nor are the new cochlear mapping and programming codes (CPT codes 92601-92604). CMS has now clarified that hearing aids also are not DHS. The only audiology services that are DHS are: (1) inpatient and outpatient hospital services and (2) CPT codes 92507 and 92508. Even in the case of these services, audiologists face little risk of liability under the Stark Law. In the case of inpatient and outpatient hospital services, it is the hospital, as the entity that receives payment from CMS, that may be held liable if there is a Stark violation. CPT codes 92507 and 92508, when performed by an audiologist, are covered by Medicare only if billed by a physician as “incident to” services. In that case, they would probably fall under the in-office ancillary services exception to Stark.

It appears audiologists have little to fear from the Stark Law. It should be kept in mind, however, that many states have their own Stark laws, which may differ from the federal law, and that there are several other federal anti-fraud laws that do apply to audiologists. If you have questions about whether particular practices or arrangements violate federal or state anti-fraud laws, we recommend that you consult legal counsel.

PAC Contributions Campaign

The Voice Of Audiology Must Be Heard!
Recently a concern about a business practice that could place you and/or your practice in legal and ethical jeopardy has come to the Academy’s attention.

Several of our members have been contacted by physicians (neurologists, family practitioners to name a few) who have established an independent diagnostic testing facility (IDTF) to perform vestibular tests without appropriate medical necessity in “fall programs.” In some facilities, technicians are performing these vestibular function studies or audiologists are supervising these technicians in order to be reimbursed by Medicare. It may be expected that the audiologist will train that technician and interpret that testing. Traditionally, vestibular tests are billed with the global component, which is comprised of performing the test in addition to the interpretation. This is fraudulent billing if the audiologist did not perform the test. However, this is only one aspect of the potential hazard.

In many of these IDTF’s, the physician may stipulate that others including themselves use an audiologist’s Medicare PIN number. This constitutes suspect and fraudulent billing. You are ultimately responsible for procedures billed using that number as it is your Medicare identifier. Again, you are placing yourself, your practice and/or your livelihood at risk. In the state of California, Medicare is examining these types of practices as there has been over a 700% increase in usage of vestibular codes. In fact, the Academy has worked with the CA carrier in helping institute policies which help control the proliferation of fraudulent billing. Many codes are being submitted repeatedly, often on a weekly basis resulting in weekly billings for office visits for “reviewing” patient progress. There is no documentation of a medical necessity and Medicare will likely deny these claims. Needless to say, this raises a red flag and an audit will likely result. The outcome of an audit may include returning payment with interest and penalties in addition to potential charges of fraud. This will impact your ability to practice and may result in the revocation of your state license where applicable. This practice of overbilling intertwines the AAA Code of Ethics Rule 4a: Individuals shall not exploit persons in the delivery of professional services. Rule 4c also applies as “individuals shall not participate in activities that constitute a conflict of personal interest.” And finally, Rule 5a “individuals shall provide persons served with the information a reasonable person would want to know about the nature and possible effects of services rendered, products provided or research conducted.”

When in doubt with any new potential business association with a fellow audiologist or a physician it is wise to consult with an attorney well versed in health care business practices. By placing a call to the Medical Director of your regional Medicare carrier, you may also be instituting a preemptive strike.

It is our intent to alert and educate our members as to the pitfalls of being involved with suspected business practices. Granted, there are physicians who are administrating legitimate “fall programs.” It is our intent to ensure that if you choose to participate in one of these programs you have the mechanisms to ensure legitimacy and legality.
Questions regarding the use of the Advanced Beneficiary Notice (ABN) and the Notice of Exclusions from Medicare Benefits (NEMB) have come to the attention of the Coding and Practice Management Committee recently. We have received additional guidance that may add clarity to this issue for audiologists. Both the ABN and NEMB forms are to advise Medicare recipients of their expected out-of-pocket payments, enable them to be more active participants in their health care decisions and provide an estimated cost of services. It is similar to receiving an estimate from your mechanic when your vehicle needs serviced.

For several years, the use of the ABN form with a GA, GY or GZ modifier had been advised. This was to alert the patient of the likelihood that most audiological procedures would not be covered statutorily or that the procedure did not meet the standards for medical necessity regardless of the diagnosis. It allowed the patient to accept or reject audiological services prior to the delivery of that service and stated that they would be financially responsible for that service if they chose to receive it. The ABN form was to be provided to the patient when there was a specific reason for denial and that reason was specified on the ABN form in the allotted box.

Since August 2003, the NEMB form has been available. It specifically states “when you receive an item or service that is not a Medicare benefit, you are responsible to pay for it, personally or through any other insurance that you may have.” It specifically cites that “Medicare will not pay for:... “because of the following exclusion from Medicare benefits: hearing aids and hearing examinations.” Many of our colleagues had been using ABN’s for annual audiograms and cerumen removal to name just a few procedures. This is no longer suggested. The NEMB form should be the alert notice of choice.

We have recently received additional clarification from Medicare. The NEMB form is to be used when “Medicare does not cover certain items and services because they do not meet the definition of a Medicare benefit or because they are specifically excluded by law; that is, when the use of an ABN is not appropriate. There is an NEMB (i.e., form CMS-20007) for general use in any case and other NEMBs customized for certain items and services.” See http://www.cms.hhs.gov/medlearn/refabn.asp for CMS guidance and links to forms. The NEMB is optional whereas the ABN is not. A copy of either should be given to the patient when a Medicare denial for a secondary payer is required, append the procedure code(s) with a GY modifier when billing Medicare.

Listed below are appropriate uses for an ABN by an audiologist:

- If that procedure might be covered by Medicare but denied on this particular occasion (e.g. medically necessary, exclusions and technical denials)

The ABN should be given to the patient before performing a procedure and a signed copy given to the patient.

Listed below are appropriate uses for the NEMB by an audiologist:

- Annual audiograms
- Hearing aid evaluations
- Hearing aids
- Cerumen Removal
- Initial audiogram without a medical referral
- Vestibular rehabilitation
- Tinnitus Treatment
- When a service is not billed to Medicare for denial purposes

The NEMB should be given to the patient before performing a procedure. No patient signature is required.

Be advised that you need to discern what is statutorily excluded for all audiological procedures. Charging the patient for services that may be covered by Medicare may be a violation of Medicare policy and may incur potential penalties. It is strongly suggested you visit www.cms.hhs.gov/coverage to be sure you are well acquainted with your own local policies. The local medical review policy (LMRP) is accessible at www.cms.hhs.gov/mcd.
The American Academy of Audiology offers members numerous benefits. Make sure you are getting the most out of your Academy membership by taking advantage of all the benefits available.

Have you just graduated or are you looking for a change? Do you have a job opening to fill? Whether you are a job seeker or employer, be sure to visit our HearCareers website at www.audiology.org/hearcareers to post a résumé or a job opening. HearCareers has everything to fulfill your career needs!

Help make your practice more visible to potential patients. As an Academy member, not only can you list multiple offices under the ‘Find an Audiologist’ feature, you can now list your Web site address with a live link to your site. There is an annual fee of $100 to list your Web site. Multiple office addresses are free. Please contact Sarah Sebastian at sssebastian@audiology.org to have your Web site listed.

The benefits mentioned above are only a few of those offered to you as a member of the Academy. Among others are professional liability insurance, conference call services, discounted U.S. and international long distance calls (when your cell phone is out of range), certificate framing and the online research subscription to Dome. Visit www.audiology.org/professional/members/benefits for a complete listing and information on all Academy benefits. Please contact Brittany Voigt at bvoigt@audiology.org with any member benefits questions.
The American Academy of Audiology Remembers Ronald Reagan

The American Academy of Audiology sadly notes the passing of Ronald Reagan, our nation’s 40th president, who died after his long struggle with Alzheimer’s disease on June 5, 2004 at the age of 93. Popularly known as “The Great Communicator,” he increased public awareness about many health-related issues including hearing loss. As the first President to openly acknowledge needing hearing aids, Reagan attributed his hearing loss to gunfire on a movie set some 44 years prior. Fitted in 1983, Reagan’s presidential hearing aid put hearing loss in the national spotlight. His hearing loss had been diagnosed at the House Ear Institute in California where hearing aids were recommended. His hearing loss and his use of hearing aids became public knowledge following wide media coverage including a feature story in the Sunday newspaper supplement, “Parade” magazine, as well as numerous articles in newspaper and weekly news magazines. The publicity created a sudden increase in consumer demand for hearing aids that threatened to cripple the hearing aid industry as the companies struggled to meet the needs for increased orders.

NEWS & announcements

The California Academy of Audiology will meet September 9-11, 2004, in beautiful Monterey, CA to continue the tradition of offering a wide variety of Audiology and hearing aid topics. Featured speakers will discuss the preferred practices in the practical delivery of audiology and hearing aid services. The Conference will also feature exhibits, raffles and a silent auction. CEUs will be offered: SLPAB, HADB and AAA. The host hotel is Embassy Suites by Monterey Bay, 1441 Canyon del Rey, Seaside, CA 93955 (831-393-1115). For Conference registration information, contact www.caaud.org, or CAA President, Mark Faulk, (805) 654-1566, msfhe@bogglobal.net.

**NEW SCHOLARSHIP PROGRAM FOR SCHOOL-BASED AUDIOLOGISTS**

School-based audiologists will be the beneficiaries of new scholarships in 2004. The Audiology Foundation of America (AFA) has established the AFA School-Based Practitioner Scholarship to encourage new applications to distance learning AuD programs by school-based audiology practitioners. Five scholarships of $1000 each will be awarded in 2004.

A recipient of the scholarship may be in the application process, but not currently enrolled in a distance learning AuD program at the time she/he applies for the scholarship. Recipients must enroll in a distance learning AuD program by December 31, 2004, or be on a verifiable waiting list. School-based practitioners may apply for a scholarship by submitting a nomination form to the AFA. The scholarships will be awarded on a first-come, first-served basis. The nomination form and detailed information about the scholarship can be found at www.audfound.org/Scholarships.asp.

**“A HOLE IN ONE FOR AUDIOLOGY”**

Henry C. Hecker passed away on May 12, at the age of 70. Hecker, a native Hungarian, emigrated to the US in 1957, escaping Hungary as a freedom fighter during the Hungarian Revolution. He was appointed Director of Audiology at Riverside Hospital, in Newport News, VA. He became the first audiologist in private practice in the state of Virginia in 1974. He received his AuD from the Arizona School of Health Sciences in 2001 at the age of 67. Hecker was instrumental in obtaining licensure for Audiologists in Virginia. He served as President of the Audiological Resource Association and the Southern Audiological Society. Memorial donations may be made to the Dr. Henry and Ruth Hecker Scholarship for Immigrant Students at Westminster College, 1840 South 1300 East, Salt Lake City, Utah 84105.

The Charles I. Berlin PhD Chair in Molecular and Genetic Study of Hearing has been established at the LSU Health Sciences Center in New Orleans. This is the first university-based endowed chair named in honor of an audiologist. The Louisiana Board of Regents appropriated $400,000 in matching fund to the $600,000 raised by Berlin’s grateful patients, colleagues and friends, to establish the chair in perpetuity. The purpose of the ‘chair’ is to attract world-class scientists to the university, with a primary interest in hearing and genetics, who may use the interest from the endowment as salary support or research funds.

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**CDC Launches Campaign for Autism and Other Developmental Disorders**

Despite the groundswell of attention on the topic of childhood developmental disorders, research shows that families and professionals do not fully understand some basic facts about early childhood development. As a result, they do not always recognize the warning signs of developmental problems, and parents do not always know when they need to share their concerns with their child's health care provider. To meet these deficiencies, the Centers for Disease Control and Prevention (CDC) is launching a consumer campaign to educate parents about the warning signs of autism and other developmental disorders, such as hearing loss and cerebral palsy. The campaign aims to help parents identify signs of developmental disabilities earlier, so children will have access to services sooner and have a greater chance to reach their full potential.

The campaign is a collaborative effort of the U.S. Department of Health and Human Services (HHS) and CDC, the Autism Society of America (ASA), Cure Autism Now (CAN), Organization for Autism Research (OAR), and the National Alliance for Autism Research (NAAR). In addition, the American Academy of Pediatrics (AAP), in collaboration with CDC, the National Center of Medical Home Initiatives for Children with Special Needs, and First Signs, recently developed screening guidelines to establish the following: Standard practices among physicians; Simplification of the screening process; and Assurance that all children receive routine and appropriate screenings and timely interventions. These guidelines are part of the Autism A.L.A.R.M. and can be found at www.aap.org or www.medicalhomeinfo.org. For more information about CDC's autism and developmental activities and to get the latest resources on developmental delays, milestones, and warning signs, please visit www.cdc.gov/ncbddd.

**The Marion Downs Hearing Center Symposium on Hearing in Infants**

This multidisciplinary conference will be held August 12-14, 2004 at the Beaver Run Resort in Breckenridge, CO. Sandra Gabbard of the University of Colorado Medical Center in Denver is the program director. The program committee is accepting abstracts until July 15. The program will feature topics of medical and genetic issues, audiological assessment and amplification, early intervention, neuro-diagnostic issues and diagnosis, management of hearing disorders in special populations, and parent, consumer and cultural issues. Hotel reservations may be made at 1-800-525-2253, and conference information is available from Patsy Meredith at 720-848-2828.

**New Website for Deaf Children**

The International Deaf Children-EUR™ Society (IDCS) has launched a new website at www.idcs.info. This is a global, online forum open to discussion of all aspects of childhood deafness. The purpose of the website is to encourage the exchange of information and ideas among professionals working with deaf children, young people, parents, care givers and volunteers. The website will provide case studies and articles written by professionals and individuals, permit sign up for news updates and links to hundreds of useful organizations using IDCSD-US™ online database of deaf organizations worldwide.
The American Auditory Society (AAS) 2004 annual meeting was held in Scottsdale, AZ, March 7-9. Nearly 300 members of AAS enjoyed beautiful spring Arizona weather while they listened to scores of papers and studied poster sessions representing the wide, wide world of hearing, hearing disorders, speech perception, tinnitus and vestibular topics. The Carhart Memorial Lecturer was William Brownell of the Baylor College of Medicine, Houston, TX, who spoke on “Piezoelectric Membrane-Based Motors in the Outer Hair Cell.” The AAS awarded Jack Vernon the Lifetime Achievement Award for his career contributions and voluminous research with tinnitus. Susan Jerger delivered the Mentored Doctoral Research Presentation, “The Craft of Research: What’s in it for You?” The next AAS Annual Conference will be held again in Scottsdale, AZ, March 20-22, 2005. For information about the 2005 meeting, contact Wayne Staab at www.amauditorysoc.org.

CEUs ARE JUST A CD AWAY!

Now you can learn and earn in the comfort of your home or office. Continuing Education CD-ROMs provide instant access to selected Featured Sessions presented at Convention 2003 and Convention 2004.

CDR1, from Convention 2003, includes two sessions: The Ethics of Audioligic Research & Collaboration with Industry (FS801) and Ethical Practices Board Draft Conflict of Interest Guideline (FS805). Presenters include Y. Sininger, R. Marsh, L. Wilber, A. Lowenbruck, C. Ellison, and T. Hamill. This CD-ROM fulfills the ethics continuing education requirements for ABA Certificants. This CD-ROM offers .3 CEUs and costs $75 for Members; $90 for Non-Members.

CDR2, from Convention 2004, includes one session: Reimbursement: Am I Playing by All of the Rules? (FS703). This CD-ROM offers .15 CEU and costs $35 for members; $50 for Non-Members.

Each CD-ROM includes: complete audio track and slides, learner assessment questions, session evaluation, and a user-friendly interface and CEUs (must be on the Academy’s CE Registry).

Special: Order both CDR1 & CDR2 for $95 (member rate). Order online at www.audiology.org/convention/2004 or call 1-800-226-2336 today!
Speakers at the recent annual meeting of the Association of Veterans Administration Audiologists (AVAA) held in Salt Lake City included Vic Gladstone (ASHA), Arlene Pietraton, David Miller (President, Association of Federal Audiologists/Speech Pathologists), Denis Moore (President of AVAA), Marjorie Grantham (President, Military Association of Audiologists), Angela Loavenbruck (Past-President of American Academy of Audiology), and Ross Cushing (President of National Association of Future Doctors of Audiolog).

Stephen Fausti receives the 2004 Paul B. Bagnuson Award for Outstanding Achievement in Rehabilitation Research and Development from the Department of Veterans Administration. The award is presented annually to a VA investigator who exemplifies the entrepreneurship, humanitarianism, and dedication to veterans and is the highest honor for VA rehabilitation research investigators. The award was presented by Patricia Dorn, Deputy Director of VA Rehabilitation Research and Development (RR&D) Service (shown above) and Lucille Beck, Director of Audiology and Speech Pathology Service for the VA (not shown in photo). The prestigious award consists of a one-time cash prize of $5,000 and $50,000 per year for up to 3 years to supplement ongoing peer-reviewed research. Fausti was honored for his work in founding the National Center for Rehabilitative Auditory Research in 1997 at the Portland VA Medical Center. The Center trains new scientists, disseminates information to clinicians, and informs the public about hearing conservation, rehabilitative options, and how to cope effectively with auditory impairments.

Catherine Palmer, Program Chair for the 2005 Washington, D.C. Academy Convention, March 30 - April 7 announced that online program submissions will be accepted from June 29 - July 27, 2004. The deadline for research posters will be December 3, 2004 (see call for papers on page ____ of this issue of AT).

Sharon Fujikawa (left) and Sharon Kujawa (right) often have their names and identities confused by Academy members. Fujikawa is an Academy Past-President while Kujawa is a current member of the Academy Board of Directors.
Life has never sounded so good!

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Are you looking for a change? AHAA’s Audiology Depot Website and its Human Resource services can help! Job seekers and employers, visit www.audiologydepot.com to obtain information about audiology and dispensing jobs! Or call Ellen Hagen at American Hearing Aid Associates, West Chester, PA (800) 984-3272 x 351.

For information about our employment website, HearCareers, visit www.audiology.org/hearcareers. For information or to place a classified ad in Audiology Today, please contact Patsy Meredith at 720-848-2828 or Fax 720-848-2811.
The American Academy of Audiology offers its members several benefits of membership. You may not even be aware of some of the advantages that come with being an Academy member. Not only are our members part of the world’s largest professional organization of, by and for audiologists, but they also benefit from discounts in a number of programs. Read on to find out more about the benefits of membership with the Academy.

For more information about these benefits, contact Brittany Voigt, Member Benefits Coordinator, at 703-790-8466 x1044 or bvoigt@audiology.org.

PUBLICATIONS:
- Audiology Today
- Journal of the American Academy of Audiology

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FRAMING SUCCESS:
Members receive discount prices on quality frames to display your membership certificate. Call 1-800-677-3726 today and proudly display your membership certificate or credentials.

ACADEMY CREDIT CARD
With the Academy Credit Card, MBNA “gives a little something back” to the Academy every time you make a purchase, and you can earn points toward travel and brand-name merchandise. Apply online at www.audiology.org/professional/members/benefits or call 866-227-1553. Please mention priority code QL6K.

CAR RENTAL DISCOUNTS:
Members can get up to 15% off with Hertz and Alamo. Additionally, coupons are available for one car-class upgrade and $10 off a weekly rental with Hertz, and one free day or $10 off with Alamo. For Hertz use Discount Code (CDP# 1299750) and/or call the Academy for member discount coupons. For Alamo be sure to request Rate Code BY and ID# 676435 and/or call the Academy for discount coupons.

COMPENSATION & BENEFITS SURVEY:
The American Academy of Audiology conducted its third annual Compensation and Benefits Survey in the Fall of 2002. A full report of the survey with detailed information is available for Academy members online at www.audiology.org/hearcareers.

DISCOUNTED CONFERENCE CALL SERVICES:
The American Academy of Audiology has recently entered into a partnership with Connect-Us Group Communications - which is now the fastest growing provider of audio conferencing in the country. As a member benefit, you can take advantage of their state-of-the-art conferencing technology and award-winning billing systems at special member-only discounted rates.

GEICO AUTO INSURANCE:
Academy members may qualify for an additional discount off GEICO’s already low rates. Call GEICO today for a free rate quote at 1-800-368-2734. Tell them you are a member.

HEARCAREERS:
Whether you’re seeking a job or filling a position, the American Academy of Audiology’s HearCareers site has everything you need to achieve your hearing career goals. This online employment service allows job seekers to post their resume and view job postings for free. HearCareers offers discounted rates to our members who post positions. Go to www.audiology.org/hearcareers to make your next career connection with HearCareers.

MEMBERSHIP CARD/CALLING CARD:
This dual-purpose card can be used as a GlobalPhone domestic or international calling card. It is also your permanent membership card for easy reference to your membership number. U.S. rates are 5.9 cents per minute with no surcharges. To activate your calling card, call 1-800-866-895-5714 or go to www.audiology.org/callingcard.

NEW

PROFESSIONAL LIABILITY INSURANCE:
The Academy has endorsed the professional liability insurance program offered through Healthcare Providers Service Organization (HPSO). We selected this program because of the plan’s many benefits, affordable rates, and their commitment to customer service. For more information, call 1-800-982-9491 or visit their website at www.hpso.com.

For more information about these benefits, contact Brittany Voigt, Member Benefits Coordinator, at 703-790-8466 x1044 or bvoigt@audiology.org.