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Audiology Today accepts contributed manuscripts dealing with the wide variety of topics of interest to audiologists, including clinical activities and hearing research, current events, news items, professional issues, individual-institution-organization announcements, entries for the calendar of events and materials from other areas within the scope of practice of audiology. All copy received by Audiology Today must be accompanied by a 100M Zip disk or CD clearly identified by author name, topic title, operating system, and word processing program (in WordPerfect or Microsoft Word, saved as Text). Submitted material will not necessarily be returned. Specific questions regarding Audiology Today should be addressed to Editor, Audiology Today, 11730 Plaza America Drive, Suite 300, Reston, VA 20190 or by e-mail to jnorth111@aol.com.
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With more seats per capita than any city outside of New York, Minneapolis is home to a thriving theater and music scene. This pre-convention issue of Audiology Today features a cover that reflects the theater theme with a playful take on the upcoming “premiere” of AudiologyNOW! — the biggest show in audiology... and the hottest ticket in town!
Audiologists have been discussing the good, the bad and the ugly aspects of supportive personnel since I entered this profession decades ago. During the early years of our Academy, we had a number of dialogues at our conventions concerning the use of supportive personnel in our practices. At that time (1990-1991), the topic was one of the most incendiary and divisive issues we faced. It seemed that about half of our 3,000 members in 1990 favored training our own assistants and the other half of our members were outspokenly against the idea and threatened to resign from the Academy if we pursued such a plan. The opposition voiced opinions that “…such a program would be another nail in the coffin of audiology,” and “…if there is anything that will sink the entire profession, it is something that would put low-paid under-trained technicians under the direction of physicians” (AT, 3:6, pg. 2, 1991).

I became familiar with the value of support personnel in the audiology clinic as a young Army officer in 1966. At that time, the military trained corpsmen to help medical officers provide care and treatment to patients with eye, ear, nose and throat problems. Part of that training included basic audiometry. Many of these corpsmen worked under the supervision of military audiologists (and, yes, some of them performed hearing tests for otolaryngologists in outlying clinics) and many became quite adept at basic hearing testing, screening and monitoring audiometry, basic hearing aid repairs and fitting hearing conservation earplugs. Not surprisingly, many of these assistants pursue academic degrees in audiology following their discharge from military service. The hearing needs of the vast number of military patients and their dependents, during those Viet Nam years, far exceeded the capabilities of a few audiology officers who depended upon these qualified corpsmen to provide services. The military continues to train and effectively use these corpsmen as audiology technicians.

It is now 35 years later and audiologists are still debating the pros and cons of using supportive personnel in our clinical settings. Granted, in 1997 our Academy joined with several other audiology organizations to develop a Consensus Statement and Guidelines on Support Personnel in Audiology — but the position statement was fairly neutral and simply provided definitions and duties (AT, 9:3, pg 21, 1997) and generally went unnoticed. However, as you are no doubt aware, audiology assistants have proliferated around us in growing numbers in nearly every type of audiology practice setting. As an example, many use support personnel in universal newborn hearing screening programs to meet the challenge of screening the hearing of some 4,000,000 infants per year. The need for hearing aids by our rapidly growing senior citizen population may require an expanded use of audiology assistants as the estimated manpower requirements needed far exceed our best estimates of the numbers of audiologists that will be available to meet these services. Actually, audiology assistants are now so widely used to provide services that 31 states currently have regulations regarding their utilization and duties. Of special interest is the Otologic Technicians’ program developed by the American Academy of Otolaryngology – Head and Neck (AAO-HNS) Foundation. Announced mid-year in 2003, the Certificate Program for Otolaryngology Personnel (CPOP) trains “oto techs” to perform examination of the outer ear canal, tuning fork tests, pure tone hearing tests including speech audiometry, masking and related functions (including ENG) under the supervision of an otolaryngologist. The two and one-half day didactic course includes independent study (text book and readings) with clinical practicum followed by supervised on-the-job clinical experience described as a “minimum of 60 cases of each type of test over a six-month period.” Some 175 technicians have gone through the CPOP program to date.

Each of us can no doubt recall at least one patient referred to us with inaccurate audiometrics performed by a “technician.” In most cases, however, these hearing tests were performed by people who had not been through a formal training course nor did they have adequate supervision of their efforts. Our focus topic in this issue of Audiology Today bring to your attention the use of audiology assistants in a private practice office, in a corporate dispensing network, in the Veterans Administration clinics and the unique audiologist’s assistant training program underway at Nova Southeastern University in Florida. In each of these circumstances, formal training and proper supervision of the support personnel result in expanded capabilities for the provision of hearing services. Look around and it is likely that you will find someone in your area using support personnel to do hearing testing, hearing aid work, or balance and dizziness testing.

So it is no longer questions of ‘should we or should we not’ have audiology assistants or technicians – they are here. We need to ensure that technicians and assistants are well-trained and that they understand the limitations of their duties and responsibilities. Perhaps we should go so far as to provide an organizational structure for them within our Academy so that the assistants will fully comprehend their roles within the audiology hierarchy. We can continue to complain or continue to stick our collective heads in the sand and pretend that these assistants and technicians will just disappear. However, a better solution is for audiologists as “the hearing professionals” to work toward appropriate training programs for these assistants and technicians and to ensure that they are properly supervised in the performance of their duties.
During the six months in which I have had the opportunity to serve as President of the Academy, I have learned much about “give and take,” achieving a balance among the needs of our Academy members, the needs of outside organizations with an interest in the profession of audiology, and other global issues related to the Academy. I have written and spoken previously about the Academy “coming of age.” The current Academy persona reflects many transitions that have occurred in the profession of audiology during the eighteen years since our inception. This evolution has allowed for a balance between the rights and responsibilities of the Academy and the demands of our profession.

As we have matured as an organization, we have built on our history to learn from past successes and mistakes, utilizing resources effectively, and incorporating models provided by other professions and professional organizations. The structure of an emergent organization sets the groundwork for where we are today and where we will be tomorrow, as the organization matures. An example of this is how the recent update of the Strategic Plan will help to both fortify the Academy’s foundation and to provide a solid and focused direction for our future growth.

The ability of the Academy to grow in strength and sophistication as the professional voice of audiology is crucial, particularly as we move to the “adulthood” of the Academy. This summer, I attended a service in my childhood church in Cleveland. The topic of the sermon was liminality. Liminality refers to the concept of being “betwixt and between,” in a state of neither this nor that, a world in between. Audiologists are familiar with the terms limen or liminal as they refer to a physiological or psychological threshold. In the more global concept of liminality, as part of an organizational perspective, refers to a unique place where there’s “no road back home,” but it may be difficult to move forward due to the discomfort that comes with uncertainty. The challenge is to move forward in order to create one’s future, to move past the netherworld. Organizations and relationships that are based on liminality are structurally inferior. In order to create a solid foundation for the future, moving out of the gap of uncertainty to a position of strength requires dedicated and thoughtful decision-making and planning.

The Strategic Plan, as integrated into the fabric of the Academy through mission, vision, and committee structure/charges, provides such a framework for moving forward. In addition to the Strategic Plan, I direct you to an article on governance in this issue of Audiology Today. This article is authored by the Academy’s Board of Directors and outlines by-law changes related to how the president of the Academy will be elected in the future. Governance is one of those areas of an organization that lacks the “sex appeal” of other topics, such as member benefits or marketing. However, it is among the most important aspects of setting the stage for future organizational success.

In addition to the comments offered by the Board in the article on governance, I understand that some members may perceive that the right to vote for the Academy President is being taken from them. As I have thought about this topic often, I see the by-laws change actually places more responsibility on the membership. There will be consistency within leadership and assurance that the President fulfills the direction of the Board, which is elected by membership. As the Academy has grown in organizational and fiscal complexity, the responsibilities to membership have also grown. The Board electing the President is another step in assuring accountability, particularly in understanding the financial implications of decision-making on behalf of the Board and the Academy.

The model adopted in the by-laws change is not unique to the Academy. In fact, many professional organizations utilize this type of presidential structure for the reasons mentioned here and in the Board article. As our Academy has matured, we have solicited input from association
management executives and consultants to understand the implications of governance decision-making. In addition, this model is used by the US Senate and House of Representatives.

After 20 years of the general membership electing the Academy President, the by-laws change will certainly be a transition. However, as stated in the governance article, it is time for a change—not just for the sake of change, but to address the realities of the current organization and to establish a foundation for future success. This issue of AT addresses a number of issues that highlight change and growth in our profession, including the concept of support personnel. Issues such as governance and use of support personnel may be viewed by some as controversial; however, these serve to highlight the “give and take” in the profession, while balancing rights and responsibilities.

In relation to the election, I challenge each of you to exercise your responsibility to vote for the Board of Directors from the slate of candidates highlighted in this issue. This is your opportunity to shape the future of the Board. Each candidate has presented a thoughtful and insightful assessment of his or her view of the future of our Academy. Each year, a relatively small percentage of Academy members actually participate in this process. As the by-laws change, participating in electing the Academy Board takes on increased importance since the Board is the vehicle for electing the President. Voting assures that member input is heard.

In conclusion, I commend the Academy Board for making a bold decision in order to move the Academy beyond our current position of liminality in governance to a position that will strengthen our foundation. As Albus Dumbledore, Headmaster of Hogwarts Academy, asserts in *Harry Potter and the Goblet of Fire*, “Now is the time that we must choose between what is right, and what is easy.” The status quo is an easy place to stay but does little to prepare us for what is ahead. This change in governance structure, in addition to contemplative strategic planning, establishes a position of strength for the American Academy of Audiology as we move ahead to represent the evolving profession of audiology. ☪

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THE WHITE HOUSE

WASHINGTON

November 16, 2005

American Academy of Audiology
Reston, Virginia

Dear Friends:

I learned about your contributions to help the victims of Hurricanes Katrina and Rita. Our Nation is grateful to all those who are helping their fellow citizens in need.

The scenes from the hurricanes have touched our hearts, and our Nation is again showing the world that the greatest challenges bring out the best in America. Together, we will continue to bring new hope to those affected by this tragedy, and the Gulf Coast will emerge better and stronger.

The good works of American Academy of Audiology demonstrate the character and great strength of our Nation. May God bless all those affected by these storms, and may God continue to bless America.

Sincerely,

George W. Bush
For the past seven years, there has been spirited and thorough debate within the Academy about the best governance structure needed to fulfill the Academy's vision, mission and strategic plan. As the Academy has matured, there is a need to balance rapid responsiveness to members' needs and concerns with the more long-term approach of setting a strategic and consistent course of action to support the vision and mission. In 1998, a task force comprised of Academy members was convened to review and make recommendations regarding the governance structure of the Academy. The task force recommended nomination and election of the President from and by the sitting and immediate past Board of Directors (BOD), rather than continuing the practice of electing the President by membership vote.

The model of electing from the BOD is not uncommon among professional membership organizations and societies similar in scope and function to our own membership association. The two primary reasons for election of the President by the BOD cited by the task force were the dual advantages of electing a person with known leadership skills based on demonstrated performance on the BOD, and avoiding rejection of good candidates during the election process, risking alienation of excellent candidates who are sometimes reluctant to run again in a future election. A number of other task forces have reconsidered this issue, and have consistently recommended this change. As the Academy's Strategic Plan has become more intricate and detailed and as functions at the Academy's national office have become more complex, it is clear that we must elect Presidents able to effectively carry out the mission and goals as the Academy continues to mature into a more expansive organization. Thus, demonstrated leadership skills and working knowledge of current Board activities and goals becomes critical in this election process.

As a result of the task force recommendations, which were based on deliberate and thoughtful research into governance structures within membership organizations, a vote was taken at the BOD meeting in January 2005 to change the election of the Academy President. The vote result was in favor of changing the by-laws to elect the President from the sitting or immediate past BOD membership. The members-at-large positions on the BOD are nominated and elected by the membership and from these positions, the President will be elected. The job of the President is to carry out the mission and goals set by the BOD based on the needs of the membership. The President, elected from the BOD and the members-at-large who sit on the BOD are accountable to the whole of the membership of the Academy.

The decision for this change in electing the President has thoughtfully evolved and represents the input from Academy members from all types of work settings. The time is here for the Academy to recognize the need for change and act in our best interests not only as a membership organization but for the profession as a whole. Given the confidence in our membership to elect an effective Board of Directors, the new process will ensure that the Academy continues to be successful in recruiting a competent, knowledgeable and productive President.

Implementation of this by-laws change will be effective at the time of the 2007 elections cycle. The current process for election of Board member-at-large seats will remain unchanged.

**Questions and Answers:**

**Q:** How do we currently nominate and elect the President and Board of Directors of the Academy?

**A:** Members of the Nominations Committee are elected by the Board of Directors. The Nominations Committee is chaired by the Past-President and consists of one (1) BOD member from each of the current three (3) terms, one (1) member from the past term, and two (2) Academy fellows.

Nominations can be made by any current fellow of the Academy. Nominations are screened by the Committee to ensure that the slate is representative of the membership of the Academy. A list of two to five candidates for each office is submitted to the BOD for approval prior to presentation to the general membership for election.

**Q:** How will we nominate and elect the President of the Academy in the future?

**A:** Members of the BOD may nominate themselves, or may be nominated by another member. Election of the President will occur by a ballot by the BOD.

**Q:** Why is this change in the Presidential election process good for the Academy?

**A:** The process is designed to elect a person with known leadership skills and a current, working knowledge base of the complex issues facing the Academy.

The process will hopefully reduce the risk of losing future candidates because they will not undergo a public election where unfortunately, someone always has to lose even though he or she could have been an outstanding President.

The process of becoming President progresses logically from member of AAA, to demonstrated commitment/involvement in Academy volunteer activities, to nomination as a BOD member, to member election to BOD, and finally to election as President after a period of education, training and performance as a BOD member.

**Q:** If we are going to choose a president from the current BOD, isn’t this a “good ole’ boy” situation?

**A:** No. The membership elects the BOD – so members will still very much have a say in determining the group from which the President will be elected. The reality is that to be effective, Presidents must have served on a BOD recently, and the BOD is in the best position to determine who among them is best able to take on the demands of being President. The new process acknowledges the fact that Presidents are not autonomous in making decisions – they are answerable to both the BOD and the membership.

**Q:** How does a person get nominated to be on the BOD?

**A:** A call for nominations goes out to membership via email and Audiology Today. Candidate selection by the Nominations Committee is based on demonstrated service to the Academy and leadership factors.

Once selected, candidates are asked to submit biographical sketches that are published in Audiology Today so that members can be informed about candidates before voting.
The Academy’s implementation of the Strategic Plan includes the budget development process and prudent financial management throughout the year. The leadership focuses on the budget to meet the critical needs of audiologists under the direction of the Board of Directors and through the work of various committees and staff. For the 2006 fiscal year,* the Board of Directors approved a budget with revenues of $6,072,138 and expenses totaling $6,009,488 for a positive change in net assets of $62,650. The positive change in net assets will enable the Academy to fill the positions that are essential to meeting the growing needs of Academy members, including hiring a Director of Reimbursement and a Marketing Manager during the upcoming year.

To operate within this budget, many difficult decisions have been made and will need to be made throughout the year. A follow-up to last year’s Leadership Financial Summit was held recently to discuss additional sources of revenue to fund the programs necessary to provide the quality services you have come to expect. As can be seen by the graphs, membership dues and convention are the Academy’s two main sources of revenue. A recent dues increase will provide a temporary solution to the need for additional revenue sources to fund quality programs that address member needs, however additional sources of non-dues revenue are also being addressed.

Staff and leadership review year-end projections on a monthly basis to ensure that the Academy is operating within the approved budget. In addition, the Academy annually conducts an independent audit to certify that all financial information is consistently prepared according to the highest level of financial integrity.

I thank the American Academy of Audiology’s Board of Directors, Finance Committee and staff for their leadership, support and hard work in developing and maintaining a balanced budget.

Helena Solodar, AuD
Treasurer, Board of Directors

*Fiscal year is July 1, 2005 - June 30, 2006
**Letters to the Editor**

**Audiology Support Needed for Dominican Republic**

I am an Australian audiologist who is now working with Medical Ministries International to develop hearing health education and develop audiological services in the Dominican Republic. My role includes the development of an audiology course in conjunction with a local university that meets the International Society of Audiology’s recommendations. I am also working to expand and update the clinic in this hospital so that we can provide clinical practice for the students here. To that end, I need donations of equipment and also used hearing aids. I am excited to be beginning this project, but these projects are initially not able to be totally self-sustaining. I am writing to request the support of the American Academy of Audiology members in donating any used equipment and used hearing aids to help our programs. I am also seeking volunteer guest lecturers for the course. Please contact me at carked@yahoo.com for additional information.

—Donna Carked, Audiologist, Dominican Republic

**ABA Responds to Metz’ AT Viewpoint**

The Board of Governors of the American Board of Audiology™ (ABA) was pleased to see Michael Metz’s recent viewpoint article “Continuing Education: What Were They Thinking?” As Metz points out, professional associations frequently and purposefully avoid clear specifications for continuing education to permit professionals to self-evaluate their areas of weakness which may require further study. I agree with Metz that it is unfortunate that this lack of specification has resulted in many audiologists meeting the intentions of continuing education requirements through the simple attendance of manufacturer’s product-specific software training.

It is this very concern that led the ABA to institute higher continuing education standards for its voluntary certification beginning January 1, 2008. At that time, the number of continuing education units (CEU) required during a three-year period will increase from 45 to 60, with 15 of these hours in a Tier 1 category. Tier 1 CEUs are defined as activities of a minimum of three hours duration with some form of outcome measure identified by the authors/presenters. In addition, a minimum of 3 CEUs in each certification cycle must be in the area of professional ethics. The ABA encourages all audiologists to challenge themselves to meet the true spirit of the Academy’s Code of Ethics requirement by addressing their continued learning needs within a wide range of areas of the profession.

—John Greer Clark, Past Chair, American Board of Audiology

**Clarification Re: Article on Hearing Loss & Tinnitus**

As committee chair, and on behalf of the entire study committee, I was pleased that our recent report for the Institute of Medicine, *Noise and Military Service: Implications for Hearing Loss and Tinnitus*, was brought to the attention of *Audiology Today* readers. However, we feel it is important to clarify our findings on certain points and distinguish them from observations offered by the author of the article. Although the author of the article was not identified, from the observations provided by the author we are certain it was not someone who was involved in the work of the study committee.

First, we must be clear that the study committee was not asked to address presumption of hearing loss or tinnitus in the review of claims filed with the Department of Veterans Affairs (VA). In fact, the committee was asked not to address this matter, which is in many ways a matter of policy rather than science. The discussions of “presumption” that appeared throughout the *Audiology Today* article are not an accurate reflection of the content of *Noise and Military Service*. Similarly, the committee was not asked to consider, and the report does not address, VA’s policies and practices for determining disability for hearing loss or tinnitus.

On two of the questions the committee was asked to address—whether noise-induced hearing loss can have a delayed onset and what risk factors can be identified for noise-induced hearing loss and tinnitus—the article in *Audiology Today* suggests that specific conclusions were reached. In fact, the committee determined that the scientific evidence was not sufficient to reach conclusions for or against any specific outcome or risk factor. Concerning the matter of delayed onset of noise-induced hearing loss, however, the committee did observe that indirect evidence suggests that such a process is unlikely.

In contrast to the implication in the article, the committee did not conclude that 15% of service members would experience “material hearing loss” at frequencies of 500, 1000 and 2000 Hz with exposure to noise levels in excess of an 8-hour time-weighted average of 85 dBA. The committee focused most of its attention on hearing losses at frequencies of 3000 Hz and higher, which is where the effects of noise exposure are typically seen. The committee also stated explicitly that while certain military personnel have had patterns of hearing loss that are consistent with the effects of noise exposure, the evidence is not sufficient to determine the number or proportion of service members who developed noise-induced hearing loss and tinnitus.
An Open Letter Regarding Hearing Aid Compatible Wireless Devices

In response to the September 16, 2005 FCC Hearing Aid Compatibility (HAC) deadline, the ATIS AISP.4 Hearing Aid Compatibility Incubator and CTIA-The Wireless Association® have teamed up with consumer groups, hearing aid manufacturers, and professional hearing health organizations to produce educational materials and information essential to consumers and those in the hearing health profession.

In meeting the FCC’s HAC requirements, wireless service providers and device manufacturers will provide hard of hearing consumers with tested products and labeled packaging. The new labels will reflect a wireless device rating for compatibility with hearing aids. The stakeholders involved with this process understand the unique position that you have in positively impacting your patients’ experience with cell phones and other handheld wireless devices.

We invite you to explore http://www.accesswireless.org/, a website devoted to listing accessible telecommunications products for persons with hearing, visual, mobility and cognitive disabilities. Hosted by CTIA-The Wireless Association®, the website contains the latest information about hearing aid compatibility with wireless devices, allows consumers to share information, and links to other important websites that provide information on telecommunications services and devices for persons with disabilities. Also visit the AISP.4 HAC Incubator online at http://www.atis.org/hac/ for more information on participating members and activities.

We look forward to continuing the important work of making wireless devices compatible with hearing aids as the industry works toward the next deadline of September 2006 for the “Telecoil” inductive coupling. With the support of hearing healthcare professionals and organizations, consumers with hearing loss can have a positive experience when using wireless devices.

—Susan Miller, President and CEO, Alliance for Telecommunications Industry Solutions; Steve Largent, President and CEO, CTIA–The Wireless Association®

Audiology Today welcomes letters from readers. The AT Editorial Advisory Board offers the following guidelines: All letters are subject to editing for brevity and clarity. Letters should be limited to one subject or theme. Letters should not exceed 175 words. Invective and derogatory comments will not be published. Send letters to the Editor by e-mail to jnorth1111@aol.com

What’s New in JAAA January 2006 (Vol. 17, No. 1)

EDITORIAL
Meniere’s Disease
Maurice Miller, Guest Editor

ARTICLES
Problems and Solutions for Fitting Amplification to Patients with Meniere’s Disease
Michael Valente, Karen Mispagel, L. Maureen Valente, and Timothy Hullar

Meniere’s Disease Review 2005
George A. Gates

Evaluating Treatments for Meniere’s Disease: Controversies Surrounding Placebo Control
Teri A. Hamill

An Update on the Surgical Treatment of Meniere’s Disease
Soha N. Ghossaini and Jack J. Wazen

Electrocochleography in the Evaluation of Patients with Meniere’s Disease/Endolymphatic Hydrops
John A. Ferraro and John D. Durrant

Differentiation of Meniere’s Disease and Migraine Associated Dizziness: A Review
Neil T. Shepard
A Fireside Chat on Reimbursement

There is increasing concern throughout the profession of audiology that our reimbursement is not keeping up with the cost of service delivery. Indeed, this is very true. The cost of service delivery is outpacing reimbursement in many areas. But this did not come about at the hands of any organization or any single factor. A myriad of factors have converged throughout recent years to bring us to where we are now. In the following discussion, I offer my version of a “fireside chat” to touch on some of the influences shaping our reimbursement landscape.

The key factors affecting our current reimbursement situation include the Center for Medicare and Medicaid Services (CMS), Congress, and the attitude of many private third party payers. Also, in most states, Medicaid is a major deterrent to appropriate reimbursement because, in general, Medicaid reimbursement has no relationship to the cost of service delivery.

REIMBURSEMENT HISTORY IN BRIEF. Throughout the 1960’s to the 1980’s, almost all medical/health care services were reimbursed on a fee for service basis. Insurance companies had few qualms regarding the service charges as long as the charges were in line with what was “usual and customary” for the same procedure within the community. A problem existed, however, in that there really was no standard for reimbursement, and the cost of health care was literally skyrocketing. Congress began to show great concern about the runaway Medicare costs in the mid-1980’s and asked the question, “How much does it really cost to practice medicine?” No one knew. In an effort to find out, Congress contracted with Harvard and, hence, the Hsiao study and the Medicare budget allocation could not vary from one year to the next by more than $20 million. That seems like a large amount until you compare that with overall Medicare expenditures of some $50 billion. But that was the foundation of where we are today. On top of that foundation one finds profound changes in the insurance industry including the advent of health maintenance organizations (HMOs) which established a foothold in the marketplace in the mid to late 1980s. The original idea behind HMOs was pre-paid care. The HMO assumed the risk on the basis that if the patient remained healthy, the HMO made money. But if the patient got sick, the HMO made less money and ran the risk of losing money. But what HMOs evolved into was a system of care rationing and service payments defined by many as “capricious and arbitrary.” In contrast to their original design, HMOs turned into a system of care denial and retention of premiums for increased profits. Then as a result of consumer backlash, a series of new products sprang forward such as Point of Service and Preferred Provider Organization plans, just to name two. Each came with restrictions although not as many as with the evolving HMOs. So with Congress, the issue was the percentage of the federal budget that would go to health care; with private payers, the focus centered on profit margins, especially when some HMOs became publicly traded on the stock market. Those who suffered were the patients, first and foremost, and providers secondly. The complaints of many audiologists regarding reimbursement are shared throughout every phase of health care, even among physicians. It is a constant battle to maintain reimbursement levels and lay the foundation for improvement. As one example, we have at the University of Miami a large office of individuals working to ensure that claims are “clean” with appropriate authorizations and referrals. But being reimbursed (and how much) is still somewhat akin to Russian roulette. One never knows until after the fact what will happen.

COOPERATION BETWEEN THE ACADEMY AND ASHA. Being a member of both the American Academy of Audiology (AAA) and the American Speech-Language-Hearing Association (ASHA), I am acutely aware that the two organizations do not see eye-to-eye on a number of issues. But in the area of reimbursement, the two organizations have worked hard at forging a compatible relationship for the benefit of the discipline of audiology. ASHA got over the “We are one profession” years ago and, especially in the area of reimbursement, has become very sensitive that the needs of audiologists and speech-language pathologists (SLPs) are quite different. On more than one occasion I have heard disgruntlement that “ASHA got the seat” at the American Medical Association (AMA) Committees. The AMA designated ASHA as the “umbrella organization” for both speech-language pathology and audiology many years ago. But that does not mean that audiology is represented by...
The major focus of our company covers APD testing. For that reason, it is essential to understand the best of circumstances, not every HMO or insurance reimbursement varies immensely from payer to payer. Even my practice, and what I have found is that coverage and reimbursement depends on the third party payer. APD testing is a big part of the evaluation is done. That would also offer the opportunity eventually to scale our services so that those which are more difficult (i.e., require more skill and physical/mental effort) can be of greater value than those services that do not require as much skill and effort. The time required to provide the service is the primary factor used for valuation of each code under the current reimbursement formula. According to the final rule of the Medicare Physician Fee Schedule for 2006, we will be in talks with CMS on this topic throughout the coming year.

I have received e-mails stating that insurances consistently deny claims or refuse to cover our services when we provide them. Again, this depends on the third party payer. My greatest frustration is with Blue Cross/Blue Shield. They will authorize the service with me as the provider but deny my claim because the service was not personally delivered by a physician. This and similar situations come under the heading of capricious and arbitrary. Bundling services (i.e., tympanogram and reflexes) is another example of the perverse reimbursement game played by some third party payers. Some of these battles we have won, others are ongoing.

CONSISTENCY AND DOCUMENTATION. Of utmost importance for gaining satisfactory reimbursement is that audiologists must use the codes consistently, even for self-pay individuals. Medicare has a regulation that basically says, “The most one can charge is the least that one charges.” If hearing tests are provided without charge (i.e., hearing aid dispensing), then, by regulation, audiologists cannot charge anyone in the third party payer system for a 92557. The charge for a procedure must be consistent for all patients, regardless of payer. What we get reimbursed is another story, but the charges must be consistent. And the documentation must be complete to match who we are, what we did, and what we found. I have seen many instances of incomplete documentation whereby I had no idea why the patient was there, only a vague idea of what was done, and little clinical interpretation, but the documentation had clear recommendations. Any recommendations must be justified by complete information regarding why the patient was present (history and chief complaints), what was done, what it means, and then from all of the above, what recommendations do we offer. This is a Medicare standard that has been adopted by most third party payers.

FUTURE DIRECTIONS. The major focus of our reimbursement efforts at the moment (both AAA and ASHA) is to change our reimbursement formula to first stabilize our reimbursement whereby it is much less susceptible to the factors that influence practice expense (which is how we are currently considered). Toward that effort, we have lobbied CMS to grant us the Professional Component of the reimbursement formula (also known as physician work) and move our reimbursement from practice expense to work. That would also offer the opportunity eventually to scale our services so that those which are more difficult (i.e., require more skill and physical/mental effort) can be of greater value than those services that do not require as much skill and effort. The time required to provide the service is the primary factor used for valuation of each code under the current reimbursement formula. According to the final rule of the Medicare Physician Fee Schedule for 2006, we will be in talks with CMS on this topic throughout the coming year.
It is essential to understand, however, that if we are successful in being granted “physician work,” this will have nothing to do with independence, autonomy, or the professional recognition of audiology. It will be strictly a means to stabilize and maintain overall reimbursement levels. To clear up a possible misconception, direct access legislation has nothing to do with reimbursement.

CONCLUSION. There is much more to the story, but I hope this helps at least a little to promote understanding of how we got to this point and what audiologists, through the combined efforts of the Academy and ASHA, are doing to improve the reimbursement situation. It is important to recognize, however, that we are not alone in our frustrations and woes. All medical specialties and health care disciplines share our situation. There is an abundance of equal opportunity discrimination and deprivation when it comes to reimbursement in the health care world.

The opinions expressed in this Viewpoint are those of the author and in no way should be construed as representative of the Editor, officers or staff of the American Academy of Audiology.
Presidential Address to the American Academy of Audiology

As President of the American Academy of Audiology, my overarching goal will be to continue the focus and impetus that our leaders have established during the Academy’s existence. Having served on the AA Board of Directors, the Board of the American Auditory Society and the California State Licensing Board, I will bring my experience in negotiations and teamwork to ensure that the Academy continues to be proactive in setting the direction for critical issues such as professional autonomy, encroachment of our scope of practice, shortage of pediatric audiologists, appropriate reimbursement for professional services, and support for research.

I will strive to represent all audiologists — members and non-members alike — to continue the growth of the organization and strengthen state academies and licensing boards. I will work with all stakeholders, as our professional strength and success depend on collaboration with colleagues in other fields. Finally, I will continue the progress that we have made in becoming a presence on Capitol Hill, as visibility to our legislators is of the utmost importance as laws and regulations impact the way we practice and are reimbursed on our scope of practice, shortage of pediatric audiologists, appropriate reimbursement for professional services, and support for research.

The importance of academic accreditation requirements for AuD programs is critical. I will work with the ACE and the CAA, to ensure rigorous accrediting standards for university AuD programs. Finally, recognition by the public — consumers, families and, most importantly, those individuals who need but do not choose to be served — will be one of my major emphases. Ethical, quality service to consumers is of great importance, and demands our sustained focus.

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CANDIDATES FOR THE AMERICAN ACADEMY OF AUDIOLGY BOARD OF DIRECTORS

MEMBERS-AT-LARGE

Bopanna Ballachanda, PhD
Associate Professor, Department of Speech and Hearing Sciences, University of New Mexico; Director of Audiology, Premier Hearing Centers, Albuquerque, NM

EDUCATION:
BS: Audiology and Speech Pathology, University of Mysore, 1973
MS: Audiology, University of Texas-Dallas, 1982
PhD: Auditory Neurosciences, University of Texas-Dallas, 1977

PROFESSIONAL ACTIVITIES: Audiologist, Mysore, India, 1973-1975; Audiologist, University of Mysore, 1973; Audiologist, California State University, 1974

HONORS: Teacher of the Year — Audiology, University of New Mexico, 1999 and 2000

AREAS OF SPECIAL INTEREST: Adult and geriatric amplification; coding/billing issues; research issues in temporal processing; state licensure issues/government affairs.

POSITION STATEMENT: I am honored to be considered a candidate to serve on the Board of Directors of the Academy. I have seen the Academy grow from a small organization to become a single voice for audiologists. The Academy consists of members who are clinicians, educators, and researchers. We must integrate the varied views of each member, whether it is a clinical issue, or research funding and addressing the shortage of academic researchers. It is the diversity that has made the Academy a strong organization and I will strive to preserve the diversity and work to address the needs of each individual. We must clearly demonstrate leadership and protect currently practicing audiologists while changes in state licensure laws are taking place. I have persevered to ensure that currently practicing audiologists in the State of New Mexico are protected while transitioning from masters level degree requirement to doctoral level. I strongly believe that our educational programs must be properly staffed and funded to ensure the best education for our AuD and PhD students. If I am your choice for the advancement of our profession, I will advocate that the Board support: 1) issues related to state licensure law changes 2) direct access to reimbursement 3) better funding for our educational programs and 4) positioning audiologists as the premiere hearing health care providers.

James A. Beauchamp, AuD
Audiologist, Tulare County Office of Education, Tulare, CA

EDUCATION:
BA: Communicative Disorders, California State University, 1973
MS: Communicative Disorders - Audiology, California State University, 1974
AuD: Central Michigan University, 2003


AREAS OF SPECIAL INTEREST: Pediatric and educational Audiology; amplification and rehab; professional education and ethics.

POSITION STATEMENT: I am honored to be a candidate for election to the Board of Directors of the American Academy of Audiology. I look to AAA as an organization of, by and for audiologists to provide the mechanisms for professional oversight and political advocacy, which are vital for our profession. Transitioning the profession to the doctoral level, and patient’s direct access to audiological care continue to be important issues for the profession of audiology. Evolution and refinement of best practices, professional autonomy and reimbursement issues are critical for the sustained strength and interests of the profession. Health care is increasingly big business and political. As individual practitioners we simply cannot successfully compete for professional autonomy and standing, or for fair and equitable reimbursement for services rendered in the health care business and political environment that exists today.

We must do our part individually; however, we must have strong group efforts at the state and national level to ensure the high visibility with legislators and public policy makers necessary to continue the growth and viability of the profession of audiology. As a member of the Board of Directors of the American Academy of Audiology, I will work diligently to advance these ideals and interests.
Richard W. Danielson, PhD  
National Space Biomedical Research Institute  
Baylor College of Medicine, Houston, TX  

Education:  
BS: North Dakota State University  
MS: Minot State University  
PhD: Univ. of Texas at Dallas, Callier Center  

Professional Activities:  

Honors:  
“A” Prefix for Professional Excellence, Office of the Army Surgeon General, 1995; Founder’s Award, Military Audiology Association, 2002; Presidential Award, American Academy of Audiology, 2004; Special Professional Achievement Award, NASA-Johnson Space Center, 2004.  

Areas of Special Interest:  
Hearing loss prevention; governmental affairs; audiology education.  

Position Statement:  
The American Academy of Audiology has successfully emerged to represent audiologists in critical strategic arenas, including several that are still evolving. Our position as the leading professional organization representing audiologists was born and cultivated by senior principals in our field who foresaw needs for a focused alliance. Now, our viability relies on cultivating future leadership among those ‘coming up’ in the field. The Academy, by stimulating communication and active member involvement in initiatives, must anticipate and develop programs that effectively respond to patient needs, research issues, and educational challenges. In addition, the Academy must stimulate membership growth to amplify its potential and execution even further. As we approach target dates for conversion to doctoral-level entry requirement, we must effectively demonstrate professional competencies and leadership that affirm our position as leaders in hearing and balance care. My first working experience, 50 years ago, firmly taught me to be an assertive audiology advocate. Today, I see an even greater need for drive and conviction among audiologists, as we face others who believe in externally restraining our scope of practice. I would like to offer my enthusiasm (now experienced with real-life management) to the Academy as a member of the Board of Directors.

Kris English, PhD  
Associate Professor, University of Pittsburgh, Pittsburgh, PA  

Education:  
BA: Communication Sciences, San Diego State University, 1983  
MA: Audiology, San Diego State University, 1986  
PhD: Education, San Diego State/Claremont Graduate University, 1993  

Professional Activities:  
Educational Audiologist, 1986-1991; Board Member, Educational Audiology Association, 1991-2001 (President, 1997); Project Coordinator, Child Language Intervention Program, University of Pittsburgh, 1991-1996; Assistant Professor, Central Michigan University, 1996-1998; Assistant Professor, Duquesne University, 1998-2002; Adjunct Faculty, Central Michigan/Vanderbilt University Distance AuD program, 1998-present; Editor, Journal of Educational Audiology, 1998-2000; Vice President of Programming, Southwestern Pennsylvania Speech-Language-Hearing Association, 1999-2000; Editorial Board Member, Seminars in Hearing Journal, 2001-present; Assistant Professor, University of Pittsburgh, 2003-2005; Chair, Professional Standards Subcommittee, Education Committee, AAA, 2004-present; Advisory Board Member, Audiology Awareness Campaign, 2004-present; Associate Professor, University of Pittsburgh, 2005-present.  

Honors:  
Outstanding Graduate Student Award, San Diego State University, 1986; Editor’s Award, ASHA Journal, 1986; University Scholar Award, San Diego State University, 1989; Provost’s Award for Outstanding Research and Creativity Award, Central Michigan University, 1998; Presidential Scholarship Award, Duquesne University, 2002; Frederick S. Berg Award, Educational Audiology Association, 2002; Noel Matkin Research and Creative Endeavors Awards, Educational Audiology Association, 2004; Honors of the Association, Southwestern Pennsylvania Speech-Language-Hearing Association, 2004.  

Areas of Special Interest:  
Audiologic counseling; management of hearing loss in children, including educational audiology and listening skills development training; teaching audiology.  

Position Statement:  
Most of my workday involves student training, and one of the best parts of my job is the “end-of-semester pay-off.” With every exam, project and demonstration, students show me what they know, and every term, my hopes soar for the future of audiology. It is gratifying to know that their professional development is not left to chance; graduate programs carefully identify intended learning outcomes and then design instruction to achieve those outcomes. When graduation arrives, students are prepared to function within our scope of practice. I consider it an honor to be part of that process, a part of that cycle. Similarly, the development of audiology itself has not been left to chance. Over the years, audiologists have identified goals for the profession, and worked tirelessly to meet those goals. Their efforts have resulted in remarkable achievements, including licensure in every state, recognition of audiology as the entry point to hearing care, and doctoral level training. With every achievement, more goals are added to the “to-do” list. I would consider it an honor to be part of this process too, to support audiology’s future and help with this important work, by serving as a Member-At-Large.
MEMBERS-AT-LARGE

Patrick Feeney, PhD
Associate Professor and Chief of Audiology
Department of Otolaryngology, Head and Neck Surgery, V. M. Bloedel Hearing Research Center
University of Washington, Seattle, WA
Education:
BA: English/Psychology, Kent State Univ., 1971
MA: Audiology, Washington State University, 1979
PhD: Audiology, University of Washington, 1993
Professional Activities: Clinical Audiologist, 1979-1987; Assistant Professor, Department of Otolaryngology, Head and Neck Surgery, University of Washington, 1994-1996; Assistant Professor, School of Hearing and Speech Sciences, Ohio University, 1996-2000; Membership Committee, American Academy of Audiology, 1997-2004; Assistant Professor, Department of Speech and Hearing Science, Ohio State University, 2000-2002; Member, Convention Program Subcommittee: Research Podium and Posters, American Academy of Audiology, 2001-2002; Associate Professor and Chief of Audiology, Department of Otolaryngology, Head and Neck Surgery and Adjunct Associate Professor Speech and Hearing Sciences, University of Washington, 2002-present; Member, Research Committee, American Academy of Audiology, 2002-2003; Assistant Editor, Journal of the American Academy of Audiology, 2002-2005; Chair, Research Podium and Posters, American Academy of Audiology, 2003; Chair, Instructional Courses, American Academy of Audiology, 2004; Chair Select, Convention Committee, American Academy of Audiology, 2004; Member, Committee on Round Tables, American Academy of Audiology, 2005; Program Chair, AudiologyNOW!, American Academy of Audiology, 2006.
Honors: Award for Excellence in Teaching and Clinical Supervision, Master’s Graduating Class in Audiology, University of Washington, 1996; Honorary Member Golden Key Honor Society, Ohio University, 2000.
Areas of Special Interest: Research in diagnostic audiology; professional autonomy; audiology research training.
Position Statement: I am honored to be selected as a candidate to serve on the Board. Over the last year, I have had the opportunity to attend several Board meetings as the 2006 Program Chair for AudiologyNOW! This allowed me to experience the scope of the Academy’s business addressed by the Board and to participate in two strategic planning sessions. Although I was in awe of the process, I am now excited to participate more fully in the Board’s mission to serve the various stakeholders of the Academy and impact the growth of our profession. I have also had an opportunity to work closely with the amazing Academy staff in my role as Program Chair, and look forward to future interactions as a Board member. As the director of a hospital-based audiology service, I see the need for professional autonomy as a key goal for Audiology. This is a goal that will not be achieved by simply demanding a seat at the table; rather it will be earned by the continued growth of the profession through evidence-based service to our patients, appropriate reimbursement, and research by audiologists on the diagnosis and treatment of hearing and balance disorders.

Lina R. Kubli, MA
Clinical Audiologist, Suburban Hospital Research Audiologist, Walter Reed Army Medical Center, Washington, DC
Education:
BA: Hearing and Speech Sciences, The University of Maryland, 1988
MA: Audiology, The University of Maryland, 1996
Professional Activities: Clinical Audiologist and Instructor, Walter Reed Army Medical Center, 1997-2000; Research Audiologist, Walter Reed Army Medical Center, 1999-present; Audiologist, Suburban Hospital, 2003-present; Trustee, American Academy of Audiology Foundation, 1998-present; Chair, American Academy of Audiology Foundation Convention Events, 2004, 2006; Member, State Leaders Network Committee, American Academy of Audiology, 2003-present; Member, International Committee, American Academy of Audiology, 2003-present; Member, Web Site Committee, American Academy of Audiology, 2000-2004; Member, International Events Sub-committee, American Academy of Audiology, 2002; Other service: Appearances on minority-oriented television programs-Guest host, Image-in-Asian Television (WNBC World View TV), 2001; DanShan TV, interview as guest expert on hearing loss, aired May 28, 2005; Volunteer, American Red Cross, Volunteer, Montgomery County Commission for Women.
Areas of Special Interest: Clinical research; serving minority and underserved populations; public policies affecting the audiology profession; marketing audiology domestically and internationally.
Position Statement: It is perplexing that although millions of individuals in the United States suffer from hearing loss, only a small percentage of them take advantage of professional audiology services. To address this disparity, we must take a number of important steps. First, we must streamline the public image of audiologists and project that image into underserved segments of the population through effective public relations and marketing. Second, and hand-in-hand with this effort, is the need to rectify unfair governmental and third-party payer reimbursement policies. Specifically, the profession must work in a coordinated manner with members of this Academy to update the statutory and regulatory reimbursement regimen, at both the federal and state levels. Finally, the autonomy of the audiologist must fully and finally be established — starting with the elimination of artificial eligibility requirements imposed by independent certification organizations. In addition, having worked in research, I believe the long-term importance of research to our profession and consumers cannot be overstated. It is vital that the Academy continue to support researchers. I am passionate about working with you to address these critical areas, and will bring a fresh perspective and energy towards achieving the goals that we have set for this profession and ourselves.
Moe Bergman is one of the most respected (and likeable) audiologists of our time. It is impossible to be in his presence without smiling and appreciating his many gentlemanly qualities. Added to his warm personal presence is the awareness that his professional career has stretched from the very beginnings of audiology. Even today, in his “retirement” years, he is still invited to present speeches at conferences around the world.

Bergman began his professional career as a Special Teacher of Speech and Hearing in his home town of Peekskill, NY. His strong interest in hearing started in those early days of 1939 as he lugged a 68-pound Western Electric Audiometer from school to school! Dr. Bergman honed his professional skills during the years following World War II when he was instrumental in the planning, development, and supervision of the US Army’s programs in aural rehabilitation – as described in his unique monograph, prepared for the American Academy of Audiology in 2002, entitled “The Origins of Audiology: American Wartime Military Audiology.” He earned his highest degree (EdD) from Columbia University in 1949. He has come a long way since those early days to establish a worldwide reputation as one of our foremost audiologists. As testament to his outstanding teaching career, he was conferred Professor Emeritus status from both Hunter College of the City University of New York and the Sackler School of Medicine in Tel-Aviv, Israel.

Moe Bergman’s contributions and service have been recognized by numerous professional societies including an Honors award from ASHA in 1982 and selection by the American Auditory Society as the Carhart Lecturer in 1994. I’ve had the pleasure of talking and working with Dr. Bergman over the years, including a most enjoyable luncheon with him recently in Portland to finalize this interview.

**AT:** How do you personally view your long successful career as an audiologist?

**BERGMAN:** In those beginning years, the earliest practitioners recognized the unmet clinical needs and simply fashioned methods to meet the problems presented. Most of us actually practiced without specific training since we had no academic degree programs available. In fact, I can now admit that I never had a course in audiology beyond an introductory lip reading course in 1938. Of course, it was after World War II that some of us initiated courses in academic settings in a field that had been named “audiology” in 1945.

**AT:** Those must have been demanding times during and after World War II when so many soldiers were returning home with significant hearing losses.

**BERGMAN:** Yes, indeed, we were busy! But it was a wonderful opportunity to plan, develop and implement treatment protocols at the various military hospitals. I was fortunate to work with so many creative and bright colleagues including Raymond Carhart, Grant Fairbanks, Ira Hirsh, Leo Doerfler, Bill Hardy, Miriam Pauls, Harriet Haskins and we were all inspired by the research that came from the Harvard Acoustics Laboratory group and from Dick Silverman at the Central Institute for the Deaf.

When I was stationed at the Pentagon to write the history of our military clinics in 1946, I knew that I would be responsible for activating the first pilot VA Audiology Clinic to be established in New York City. My wife, Hannah, and I still giggle over our memory of cutting up graph paper for planning the clinic spaces while sitting on the bed of the only room we could rent in Washington DC. In New York, I hired and worked
with colleagues such as Bernie Anderman, who later became the Head of the National VA Clinics, Roy Horne of the Navy program, and Jacques Penn, a specialist in speech pathology and lip reading. About that same time, I began teaching the first courses in audiology offered in New York at Columbia University.

**AT:** I recall your early publications with otologist Sam Rosen during the 1950s. Rosen had developed a new surgical approach for otosclerosis known as the stapes mobilization procedure. You provided the audiology support for his work with pre- and post-operative audiograms for his surgical patients.

**BERGMAN:** Dr. Rosen’s stapes mobilization operation was a vast improvement over the inner ear fenestration procedure being promoted at that time by Julius Lempert. The stapes mobilization was a simple corrective surgery for otosclerosis—a hearing disorder that created conductive hearing loss in thousands of people. You just can’t imagine how many patients with otosclerosis showed up in our audiology clinics in those days! I did all the audiometry for Sam Rosen and we published a dozen papers on our stapes mobilization experiences.

**AT:** As a young doctoral student, I was fascinated by your publications regarding the measurement of the hearing levels among the Mabaan tribe members.

**BERGMAN:** Sam Rosen and I traveled to the Sudan in 1960 to study the hearing of pre-Nilotic peoples who were minimally exposed to high level noises as part of an effort to understand presbycusis. It was quite an experience for us. We lived near the confluence of the Blue and Red Nile River for about 6 weeks to conduct our examinations and measurements. The absolute absence of noise in this population gave us a solid reference against which to compare the hearing of patients from developed (and noisy) countries who demonstrated what we called “socioacusis.” We tested over 500 tribe members, although we had to estimate their ages since they didn’t know their birth dates. We speculated about the effects of the inevitable coming of the trappings of “civilization” on these shy, dignified people. I would love to do the study again on this population now!

**AT:** Your “second career” has taken place in Israel. How did it happen that you ended up in Tel-Aviv, living there for the past 30 years?

**BERGMAN:** In 1950 I was invited to lecture at the First International Course in Audiology, held in Stockholm, along with my colleagues Carhart, Hardy, Hirsh, Doerfler and the new otology specialists, Julius Lempert, John Bordley, George Shambaugh and Aram Glorig. I was approached during the Stockholm course by several leading Israeli otolaryngologists. They invited me to come to Israel and teach audiology. Based on my early visits and lectures, they became interested in developing a degree program in audiology. So I drew up a curriculum, with helpful suggestions from Carhart, Hardy and others, for a specialty training program in audiology and speech and language pathology in the Sackler School of Medicine of the Tel-Aviv University. After repeated visits to Israel, I retired from Hunter College in 1975 and we re-located to Tel-Aviv. I was very excited about this unique opportunity to introduce audiology and speech pathology into a developing country, and all of a sudden I realized we had been there for 30 years!

**AT:** Looking back on such a distinguished career, what concluding thoughts do you have for today’s audiologists?

**BERGMAN:** I am aware how fortunate I am to have lived during the period of history when our field evolved from a pre-technical reliance on lip reading and auditory training in the 1930s and ’40s to today’s scientific and professional discipline and practice. One thing I now know for sure after all these years: Our profession can change very radically during one lifetime.
Customizable Marketing Materials are just a Few Clicks Away!

Ever wish you could quickly pull together a professional looking postcard campaign without dealing with designers, printers, mail-houses and list brokers that you need to get the job done? Now you can… in just five days.

Over the past year, the Academy’s marketing committee has been hard at work creating templates for marketing materials that you can customize with your practice’s contact information and your own unique message. The results of their efforts -- a series of brochures, postcards, flyers and posters with two distinct themes -- are very impressive.

Working with Steve Cuddy -- an advertising consultant whose work includes campaigns for Kohler, the Minnesota Academy of Audiology and the National Pork Board (“the other white meat”) -- the committee met regularly to discuss concepts, brochure copy and the best way to make these materials available to the membership. The final products are attractive, easy to customize, reasonably priced and readily available in quantities large and small.

The “Heart Checked?” brochure inserted in this issue of Audiology Today shows how you can customize your message to make your next direct mailing work for you. The “Sounds Familiar” theme found in the ad on the adjoining page demonstrates a subtler approach to good hearing health. Both are an effective way to promote better hearing and your practice, and both themes are available in poster, flyer, brochure and postcard formats.

The posters and flyers have small customizable areas where you can put your practice’s contact information, and the brochure allows full customization of the back panel, as does the post card. If you select the postcard template, the step-by-step purchasing process also allows you to rent a mailing list online or upload your own mailing list and have your postcard mailing printed and mailed in one easy step. An appointment reminder, refer-a-friend or Grand Opening announcement are just several options for how the postcard can be used. The sky is the limit. You’ll also view an instant PDF proof of your purchase before you finalize your order and pay online by credit card.

Best of all, you can order online 24 hours a day. And if you run into a problem or have a question, helpful customer service is just a phone call away.

These new materials are available through a link from our web site. Just visit the Academy Store at www.audiology.org/store and click on the link to “New! Customizable Marketing Tools.” You’ll be redirected to a secure site where you can select your design, type in your contact information and unique message, select a quantity and pay online with a credit card. Your customized marketing pieces will be printed and mailed in 3-5 days.
A distant train.

Crickets outside your window.

Wind through pines.

A dog barking in the distance.

Children laughing.

A light rain.

Sound familiar?
If not, talk to an audiologist today.

Your Name
Your Company Name
Your Address
City, ST 12345
111 555 7890

FELLOW
American Academy of Audiology
Support Personnel in VA Audiology

VA Audiology Faces Massive Increase in Demand

In 1996, Congress passed Public Law 104-262, The Veterans’ Health Care Reform Act. This law mandated sweeping changes in eligibility for health care services for veterans and required that VA establish special rules for eligibility for hearing aids. In 1997, VA published a federal regulation that greatly expanded eligibility for hearing aids. At the same time, VA was undergoing a system-wide organizational and quality transformation that encouraged thousands of veterans to use VA health care services. The immediate result was a massive increase in demand for audiology services resulting in long waiting times.

VA Audiology Re-engineers its Clinic Operations

These events required that VA audiologists take a hard look at how audiology was practiced and to incorporate efficiencies in the delivery of services to meet the demand of eligibility reform, an influx of new enrollees, and an aging veteran population.

VA identified eight high-profile clinics, including audiology, and established performance standards that required them to provide their services within 30 days. VA also implemented a system-wide re-engineering of clinical services based on concepts developed by Dr. Mark Murray and the Institute for Healthcare Improvement (IHI). This non-profit organization seeks to improve health care, improve clinical outcomes, lower costs, increase access, improve ease of use, and improve satisfaction using a set of proven strategies. Health care organizations such as Health Partners, Mayo Clinic, and Kaiser Permanente significantly decreased waiting times using these strategies. In VA, this process was called Advanced Clinic Access (ACA). The basic assumptions of ACA are (1) that health care should be improved from the patient’s perspective and (2) supply and demand for health care services is predictable and measurable. Using queuing theory (the study of how lines form and how people behave in lines), Murray and IHI developed a series of key strategies to improve clinic efficiency:

Advanced Clinical Access Key Strategies

• Work Down the Backlog
• Reduce Demand
• Understand Supply and Demand
• Reduce Appointment Types
• Plan for Contingencies
• Manage the Constraint
• Optimize the Care Team
• Synchronize Patient, Provider, and Information
• Predict and Anticipate Patient Needs
• Optimize Rooms and Equipment

An Audiology ACA Task Force was appointed and made recommendations to improve the efficiency of VA Audiology clinic operations. These strategies included:

• Eliminating automatic returns or routine re-assessments
• Encouraging continuity of care (same provider)
• Creating alternatives to face-to-face encounters (telehealth, websites, and self-care)
• Analyzing and tracking supply and demand trends
• Reducing the number of appointment types to minimize triage and standardizing appointment lengths
• Planning for contingencies by anticipating unusual but expected events (illness, leave, weather)
• Developing a flexible, multi-skilled workforce (health technicians)
• Managing constraints such as staff, equipment and space where backlogs are likely to develop
• Max-packing or doing as much work as possible at each visit to reduce the number of return visits and future appointments
• Building service agreements with referral sources to ensure the correct information is provided and the right patients are referred for the right reasons
• Optimizing the care team by using health technicians, clearly delineating care roles and using clinical protocols
• Ensuring that everything necessary for the encounter is ready before the appointment, predicting and anticipating patient needs by using clinic “huddles” or meetings at the beginning of the clinics day, Communicating, holding weekly staff meetings, optimizing rooms and equipment, and standardizing supplies.

VA Audiology Expands Use of Health Technicians

One of the principal strategies found successful in meeting...
the demand for services was the expanded use of support personnel. In the private sector, these individuals are called audiology assistants. In the military, they are called audiology/ENT technicians. In VA they are called health technicians.

VA Audiology clinics re-evaluated the range of duties an audiologist conducted throughout the normal business day and realized that a number of these activities could be accomplished by a well-trained technician. Audiologists were doing numerous non-patient care tasks such as scheduling patients, answering telephones, filing and searching files for reports. They were also doing a number of technician-level tasks such as boxing hearing aids and earmolds for shipment to the lab or to the patient, inspecting and certifying hearing aids and assistive listening devices, equipment maintenance, restocking expendable inventory, hearing aid troubleshooting, and hearing aid repair services for walk-in and scheduled patients.

While VA responded to the demand by adding staff audiologists, the most significant gains were made with the addition of health technicians. The number of VA clinical audiologists grew 83% from 1996 (317) to 2005 (580). However, the number of health technicians increased 720% during the same period, from 15 to 123. The average ratio of audiologists to health technicians decreased from 21:1 in 1996 to 5:1 in 2005. The ratio of health technicians to audiologists varies widely. Utilization ranges from sites that do not use technicians to sites that have a 1:1 ratio of health technicians to audiologists. The addition of these personnel along with other balance of supply and demand efficiency strategies allowed VA Audiology to respond to an unprecedented increase in demand (over 300% increase in the number of hearing aids issued) while keeping quality high and waiting times within established limits. In fiscal year 2005, audiology visits approached 885,000 and have been increasing 6-7% a year. Waiting times, however, were within performance limits. Eighty percent of new patients and 96% of established patients were seen within 30 days. The average waiting time for new patients and established patients was 25 days and 7 days, respectively.

The addition of health technicians to the clinic care team allowed VA audiologists to hand over a number of clerical and technician-level duties and enabled audiologists to focus on the professional tasks for which they are best trained, diagnostic hearing services, fitting of hearing aids, patient education, counseling, and aural rehabilitation.

In addition to their general support functions, the health technicians provide 18-20% of direct patient care services, primarily focusing on minor hearing aid repairs and troubleshooting, and the processing of hearing aid and assistive device orders. While VA Audiology still has many improvements to make in the efficient delivery of hearing health care services, it is now able to serve a greater number of veterans and to provide high quality, timely, patient-centered care when the veteran wants it. The hearing health technician has become an indispensable member of the VA hearing health care team.

**VA Health Technicians**

VA health technician candidates come from various backgrounds. Some are former military medical corpsmen with general or specialized (ENT) corpsmen training; some are former LPNs; and some are ward clerks who qualified because of general familiarity with the medical setting. There are no specialized training criteria; nor is there a specialized VA training curriculum. Most training consists of on-the-job training provided by the staff audiologists. Many are sent to the hearing aid manufacturer’s courses at the factories to be trained in hearing aid troubleshooting or repair techniques. Some are trained through the distance-learning Audiologist Assistant course offered by Nova Southeastern University. Generally, health technicians work under the direct supervision of an audiologist. With the rapid expansion of hearing health technicians, the need for a consistent approach to training and continuing education is planned to more fully utilize this important resource.

**Feature Article**

To find out more, or to speak to an Army Health Care Recruiter, call 800-206-0466 or visit healthcare.goarmy.com/hct/48
The Positive Impact of Using Audiologist’s Assistants

The use of support personnel in audiology practices has been discussed and advocated for more than 30 years. A review of audiology practices today indicates that support personnel are being used successfully in a variety of practice settings, including the military, the VA, educational institutions, hospitals, industrial settings and private practices. However, despite the long-term advocacy for the concept and evidence of current practice, a recent survey of American Academy of Audiology members revealed that only 28% of the 938 respondents currently use support personnel in their practices.

The advent of the AuD degree has once again brought the issue of using support personnel to the forefront. A writing group recently evolved from the Task Force on Supervision in Audiology and was given the charge to further explore the possible uses of support personnel in audiology, as well as to define the scope of practice for these individuals. The writing group determined that the appropriate title for support personnel used in audiology practices should be “audiologist’s assistants.” The writing group developed a new Position Statement which was subjected to widespread peer review over the past months, edited to incorporate comments from the membership when applicable, and awaits final approval by the Academy Board of Directors as an official Position Statement.

The Value of Audiologist’s Assistants

I began using technicians in my practice, Professional Hearing Services, Ltd. (PHS) in St. Joseph, MI, in 1988, and continue doing so today. The steady growth of the practice and the lack of audiologists in the small community forced me to hire support personnel to perform tasks that did not require the education and expertise of an audiologist. As the practice continued to grow, it became evident that the use of technicians improved productivity, service accessibility, quality of patient care, and patient satisfaction. The state of Michigan, which only recently began licensing audiologists, has no regulations regarding the use of technicians or assistants in audiology practices. Although many states do regulate the use of audiologic technicians, most of their laws do not specify which specific tasks technicians are qualified to perform.

At present, PHS employs three full-time audiologist’s assistants who staff designated walk-in hours devoted to providing on-the-spot service to patients. The audiology assistants also conduct annual hearing screenings, perform hearing aid warranty checks and complete the paperwork to order and repair hearing aids. Their role is to handle some of the routine, less technical activities at our clinic, thereby enabling the audiologists to devote more time to perform diagnostic, educational and rehabilitative activities with our patients. In addition, patients are able to receive immediate assistance with minor hearing aid problems, which emphasizes the importance that PHS places on customer service.

Specific time is set aside each day at PHS for “walk-in hours” when patients are encouraged to visit the office to receive immediate attention without a scheduled appointment. Among the types of problems determined to be appropriate for staffing by our audiologist’s assistants during walk-in visits are hearing aids that need cleaning, dead hearing aids, minor irritation in the ear from a hearing aid, a broken battery door, a crack in a hearing aid, wax in a hearing aid and patient difficulty in inserting or removing hearing aids. Walk-in procedures are explained in writing to patients at the time they pick up their new hearing aids. Patients are encouraged to call the office for an appointment if they feel they need to see an audiologist.

Daily records of walk-in visits are analyzed each month at PHS to insure that quality of patient care is not compromised through utilization of our audiologist’s assistants. In addition, PHS has established a policy that patients who have not had a hearing evaluation in the past 12 months must be scheduled to see an audiologist.

During the 12 months of 2004, the three audiologist’s assistants at PHS handled 4,780 walk-in visits, for an average of 19 walk-in visits each workday. A little more than half (53%) of these visits involved hearing aids that were covered under a manufacturer’s warranty. Since PHS does not charge
for service during the warranty period, it is likely that this large number of patient walk-in visits (N= 2,517) did not generate additional revenue for the practice.

Further analysis of these data show that 33% of the walk-in patients came in for routine hearing aid cleaning; an additional 7% of the walk-ins presented hearing aids that were “dead,” but were returned to normal function after cleaning by the audiology assistant; 8% of the walk-in patients had dead hearing aids that had to be sent to the manufacturer for repair. In addition, 13% of the patients complained of problems such as “hearing aid volume was too loud for everything” or “hearing aid volume was too soft to hear anything.” In these cases, the audiology assistants performed minor hearing aid programming adjustments, using the software tools provided by the manufacturer. Some 5% of the patients seen during walk-in visits during 2004 required minor modification of the hearing aid shell and in 5% of these cases, it was necessary for the audiometric assistants to make new ear mold impressions.

We noted that 15% of our walk-in patients came in for minor repair of hearing aids, which included replacing broken battery doors, replacing tubing in earmolds, repairing cracks in hearing aids, re-attaching receiver tubing, and replacing windscreens or hoods. Minor hearing aid adjustments were made for 2% of our patients who experienced feedback, and cerumen was removed from the ears of an additional 6% of patients who complained of feedback problems. The audiology assistants spent time working with the 7% of the walk-in patients who needed special assistance and additional instruction and practice in inserting or removing their hearing aids.

PHS sends a follow-up survey to measure patient satisfaction 3-months after hearing aids are fitted. We find that 84% of our patients who return the surveys indicate that they are “very satisfied” or “satisfied” with their hearing aids and 94% report that they would recommend a hearing aid to a friend or relative. Both figures are significantly higher than the average satisfaction scores reported in MarkeTrak studies.

Of importance to the focus of this article on utilization of audiology assistants personnel in the private practice office, our records show that 88% of the patients in 2004 who walked in for service support handled by our audiology assistants, left the office within a few minutes with their chief complaint resolved. Obviously, those patients who presented “dead” hearing aids that could not be repaired in the office and those who needed a hearing aid remake left our office without their chief complaint resolved. It is clear that our success in effectively managing this large pool of patients depends on the careful training and supervision of our audiometric assistants. The outcome measures obtained at our practice indicate that the use of audiology assistants is a tremendous asset to a busy audiology practice. The use of audiology assistants improve our efficiency in managing patients, expand our productivity by increasing the number of patient visits we can manage on a daily basis, resulting in increased overall profitability and patient satisfaction.

REFERENCES

<table>
<thead>
<tr>
<th>Patients</th>
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<tr>
<td>Aids in warranty</td>
<td>2517</td>
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<tr>
<td>Minor repair</td>
<td>729</td>
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<td>Minor adjustment</td>
<td>630</td>
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<tr>
<td>Clean aid</td>
<td>1578</td>
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<td>Dead aid/sent out</td>
<td>373</td>
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<td>Ear lavage</td>
<td>282</td>
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<td>Ear impressions</td>
<td>173</td>
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<tr>
<td>Feedback</td>
<td>97</td>
</tr>
<tr>
<td>Modify shell/mold</td>
<td>223</td>
</tr>
<tr>
<td>Counsel patient</td>
<td>346</td>
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</table>

Table 1. In 2004, 4780 “walk-in” visits were recorded. This table details the chief concern of those patients.
Evaluation of the Nova Southeastern University Audiologist’s Assistant Training Program

As audiology transitions to a doctoral profession and patients obtain improved access to audiologists for hearing and balance care, there will be increased demand on practitioners to provide quality cost-effective services. Licensed Doctors of Audiology must spend their time with patients with critical care needs and permit less complex services be provided by assistants who function under the supervision of the audiologist.

The 1997 AAA Position Statement on Support Personnel defined the roles and tasks for audiologist’s assistants and recognized that audiologists were using support personnel to “ensure both the accessibility and the highest quality of audiology care while addressing productivity and cost-benefit concerns” (Position Statement, 1997). Kasewurm and Byrne (2001) presented their experiences in private practice and in the military. They noted that assistants were successfully trained to perform routine clinical tasks ranging from troubleshooting hearing aids to pure tone screening. Hamill and Freeman (2001) surveyed audiologists about their opinions on the scope of responsibility of assistants in order to further define the tasks audiologists consider appropriate for an assistant. The results of that survey supported the need for audiologist’s assistants who are trained and supervised by audiologists to complete limited technical tasks. Audiologists favored assistants completing routine technical tasks, but did not support the use of assistants completing routine evaluations or hearing aid fittings. The survey respondents noted that support personnel could improve cost effectiveness as the demand for audiologic services continues to grow.

DEVELOPMENT OF AUDIOLIGIST’S ASSISTANT TRAINING PROGRAM

Based on the results of the Hamill and Freeman survey, the Nova Southeastern University (NSU) Audiology Department created two training modules for audiologist’s assistants. The diagnostics training module prepares assistants to help with pediatric testing, manage case history paperwork, and conduct pure-tone air-conduction reevaluation on patients with prior complete testing on file. It trains the assistant to conduct screenings, including tympanometry. The second module trains the assistant to guide patients in hearing aid use and care and to perform hearing aid troubleshooting and in-office repair. The programs are self-paced. Material is presented through CD slide shows. There is a workbook containing handouts. Tests and activities are web-based.

Each module has specific assignments for the assistant to complete under the supervision of the sponsoring audiologist. For example, in learning to conduct pure-tone testing, after viewing the informational presentation, the assistant is provided with audiometer simulation software and student accuracy is assessed. Then, the supervising audiologist assists the student in learning to use the equipment at their clinical facility. Completed assignments must be signed by the supervisor and sent to the Audiology Department at Nova Southeastern University. Supervisors may elect not to train assistants on tasks within the training module. Upon successful completion of a module, the assistant is provided with a certificate of completion.

<table>
<thead>
<tr>
<th>Module</th>
<th>Amplification</th>
<th>Diagnostics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed</td>
<td>70 (49%)</td>
<td>59 (42%)</td>
</tr>
<tr>
<td>Inactive</td>
<td>27 (19%)</td>
<td>18 (13%)</td>
</tr>
<tr>
<td>Active</td>
<td>46 (32%)</td>
<td>62 (45%)</td>
</tr>
<tr>
<td>Total</td>
<td>143</td>
<td>139</td>
</tr>
</tbody>
</table>

Table 1. Summary of assistants taking and completing modules.
RESULTS

Table 1 presents a summary of the number of assistants enrolling in the training module programs. Since the program’s inception in December 2002, 139 have ordered the diagnostics module and 143 the amplification module. Many students ordered both modules. Upon enrollment, students must agree to complete each program within six months or they will be placed in inactive status. To date, 59 and 70 assistants have completed the diagnostics and amplification modules, respectively.

Following completion of a module, assistants were invited to complete an on-line survey about the module. Fifty-three percent of students completing the amplification module and sixty-three percent of students who finished the diagnostics module completed the survey. The evaluations are strongly positive (95% or more of students agreeing or strongly agree with each of the 26 evaluation items). The only exception is that 4 of the 36 students (11%) completing the diagnostics module did not find the internet site easy to navigate nor the commercial WebCT course management software easy to use. Student comments included complementary remarks and suggestions for course improvement.

Recently, a survey was mailed to the audiologists supervising students who were enrolled in or had completed the training program. Twenty-three responses have been received; sixteen had sponsored training with both modules, five with the diagnostics module only and two, the amplification module only. Of those, two had assistants who did not complete training. One left employment at the facility and one was still in progress. Figure 1 reviews the evaluation results.

The respondents said they had seen either a great increase (56%) or some increase (39%) in efficiency (with 4% no response). The audiologists were asked why they hired an assistant, and were allowed to select all applicable choices. The most commonly cited reason (n=13/23) was to better serve walk-in patients. It was also noted that use of assistants was appropriate for completing non-professional tasks (n=11) and that assistants provided cost-effective service provision (n=10). Some (n=8) noted that the use of an assistant added prestige to the practice setting, as doing professions frequently use assistants. Only one respondent reported having hired an assistant because of difficulty in hiring an audiologist.

The scope of tasks appropriate for an assistant has not yet been fully defined (see accompanying Draft Scope of Practice Guidelines which note only that the assistant must be appropriately trained and supervised, but do not specify acceptable and unacceptable tasks). The audiologists who supervised the assistant’s training were surveyed on whether the primary tasks included or introduced in the training were considered appropriate. Tables 2 and 3 show the results. All of the tasks within the training modules were thought appropriate by at least 50% of the respondents. However, 39% disapproved of an assistant independently conducting pure tone and tympanometric screening, and 26% disapproved of an assistant conducting independent OAE screening. At least 75% of respondents approved of an assistant conducting otoscopic inspection and making earmold impressions, tasks that were more controversial in our initial survey of audiologists (Hamill & Freeman, 2002). The supervising audiologists were additionally asked if there were other tasks the assistant should be trained to complete. Two respondents thought cerumen management should be included. Three audiologists wanted the assistant to be more involved in using NOAH to reprogram hearing aids (e.g. after repair); one wanted the assistant to be able to modify the hearing aid programs as part of hearing aid troubleshooting. Other requests were for more training on public school screening protocols, more on assistive devices, and to include cochlear implant troubleshooting.

DISCUSSION

In an effort to respond to the increasing demand by audiologists for an assistant’s training program, two distance learning training modules were developed through the Audiology Department at Nova Southeastern University. The success of these programs is dependent on the commitment made by the assistant and, more importantly, the supervising audiologist. The supervising audiologist is ultimately responsible for all the work performed by the assistant, and it is the audiologist who ultimately decides upon the tasks the assistant will perform, within the confines
of state licensure laws.

The results of evaluation of the NSU Audiologist’s Assistant Training Modules revealed that the majority of assistants beginning the modules complete them with success. The assistants have found the training modules beneficial in preparing them for their new responsibilities. The supervising audiologists report that the training material is of good quality and accuracy.

There is divergence of opinion on which tasks an assistant should complete, as evidenced by a significant number disapproving of an assistant conducting OAE screenings, a task that is typically delegated to technicians within neonatal screening programs supervised by nurses. However, there appears to be general consensus on the types of tasks acceptable for assistants, which suggests that delineating the acceptable scope of practice for an assistant is feasible. The results of the survey suggest that the NSU modules provided direction to the supervisor about training the assistant with reliance on the supervising audiologist to assure that the assistant was performing their tasks appropriately.

The underlying motivation for using assistants is increased productivity and improved patient access to care. Those using assistants noted an increase in office efficiency, which Kyle Dennis (2005) also reported. Dennis (2005) compared the cost effectiveness of using assistants in two hospital audiology clinics. Each clinic employed 5 full-time audiologists but one clinic also employed 4 assistants. Dennis reported that the clinic with the assistants was able to provide services to three times more patients at 60% of the cost per patient as the site that did not use assistants. He reports that this was done without compromising the quality of patient services. As Dennis noted, “this is where productivity really counts. More patients also mean more revenue and higher resource allocations.”

**Table 2. Supervising audiologist’s opinions on the appropriateness of tasks included in the amplification module of the assistant’s training program.**

<table>
<thead>
<tr>
<th>Amplification Tasks</th>
<th>MY ASSISTANT CONDUCTS THIS TASK</th>
<th>ACCEPTABLE, Mine does not conduct</th>
<th>NOT A TASK FOR AN ASSISTANT</th>
<th>NOT ANSWERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conducts otoscopic inspection</td>
<td>83%</td>
<td>9%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Makes earmold impressions</td>
<td>61%</td>
<td>17%</td>
<td>17%</td>
<td>4%</td>
</tr>
<tr>
<td>Instructs patients in hearing aid insertion and use, how to change batteries, etc.</td>
<td>78%</td>
<td>13%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Completes sales forms with the patient</td>
<td>26%</td>
<td>39%</td>
<td>13%</td>
<td>22%</td>
</tr>
<tr>
<td>Administers self report assessments (e.g. APHAB, COSI)</td>
<td>9%</td>
<td>65%</td>
<td>9%</td>
<td>17%</td>
</tr>
<tr>
<td>Discusses assistive listening devices with patients</td>
<td>65%</td>
<td>17%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Evaluates hearing aids presented for repair</td>
<td>91%</td>
<td>4%</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>Cleans and makes in-office repairs of hearing aids, even when audiologist is not in the office.</td>
<td>87%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Uses hearing aid analyzer to conduct electroacoustic analysis</td>
<td>26%</td>
<td>39%</td>
<td>17%</td>
<td>17%</td>
</tr>
<tr>
<td>Determines when aids require manufacturer repair</td>
<td>83%</td>
<td>9%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Attaches hearing aids to NOAH and loads patient file</td>
<td>56%</td>
<td>26%</td>
<td>13%</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Table 3. Supervising audiologist’s opinions on the appropriateness of tasks included in the diagnosis module of the assistant’s training program.**

<table>
<thead>
<tr>
<th>Diagnostic Tasks</th>
<th>MY ASSISTANT CONDUCTS THIS TASK</th>
<th>ACCEPTABLE, Mine does not conduct</th>
<th>NOT A TASK FOR AN ASSISTANT</th>
<th>NOT ANSWERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily equipment calibration check</td>
<td>52%</td>
<td>44%</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>Provides patients with case history forms, clarifies questions as needed</td>
<td>48%</td>
<td>35%</td>
<td>13%</td>
<td>4%</td>
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<tr>
<td>Performs off-site pure-tone and tympanometric screenings independently</td>
<td>22%</td>
<td>30%</td>
<td>39%</td>
<td>9%</td>
</tr>
<tr>
<td>Performs in-office tympanometry</td>
<td>39%</td>
<td>35%</td>
<td>22%</td>
<td>4%</td>
</tr>
<tr>
<td>Conducts pure tone air-conduction retesting on patients who have previously had a complete evaluation</td>
<td>44%</td>
<td>44%</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>Assists with pediatric testing (VRA, play, etc.)</td>
<td>30%</td>
<td>56%</td>
<td>4%</td>
<td>9%</td>
</tr>
<tr>
<td>Performs otoacoustic emissions screenings independently.</td>
<td>26%</td>
<td>44%</td>
<td>26%</td>
<td>4%</td>
</tr>
<tr>
<td>Prepares patients for ABR/ENG (e.g. electrode application)</td>
<td>9%</td>
<td>70%</td>
<td>13%</td>
<td>9%</td>
</tr>
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</table>

**References**

The Use of Supportive Audiology Personnel in the Corporate Network

As the profession of audiology continues to pledge its commitment to expanding its reach of service and increasing market penetration, we are faced with the undeniable fact that there is a significant shortage of audiologists available to provide the needed services. Compounding this challenge is the current and future increased demand resulting from the aging demographics in America. This leads us to face an increasingly harsh reality: How do we meet the consumer’s growing need for Audiology and hearing services? If we are able to reach out to the 80% of the hearing-impaired population that is underserved, who will take care of them?

HearUSA, Inc. is a hearing services corporation that owns and operates 140 hearing clinics in 8 states and employs over 150 audiologists. At any given time, the company has openings for 8-10 audiologists, and recruitment of new and replacement staff is an on-going endeavor. The national pool of graduating audiologists each year is small and not nearly sufficient to meet the shortage caused by increased demand of consumers and attrition of practicing audiologists. It is anticipated that an increasing percentage of practitioners will be retiring within the next 10 years, further expanding the critical void that already exists in our service delivery system. Private practices and corporations alike will be challenged to find professional personnel to address these concerns. One immediate and effective approach is to increase audiology efficiency through the use of support personnel working under the direct supervision of the licensed audiologists.

HearUSA has developed technical staff positions that are sanctioned or registered by certain states to provide supervised support in the delivery of routine hearing and hearing aid care. Some states have responded to the need for additional hearing care personnel by providing registration of audiology aides or assistants, such as California and Florida. Both states have outlined certain pre-requisites for registration of supportive personnel, including approved training programs and designated audiology supervisors. In HearUSA clinics, the incorporation of a technical support system helps to ensure that our patients receive a timely response to their needs. The technicians have proven to be very effective in resolving issues and problems related to the care and operation of patient’s hearing aids.

The training program and individual technician educational plans developed and implemented by HearUSA cover everything from infection control and clinical documentation to otoscopy, hearing aids, assistive listening devices and aural rehabilitation. The classes are instructed by experienced and licensed audiologists, and are consistent with the company’s overall standardized clinical programs. The technicians are taught to align themselves with the practice patterns of their supervising clinician, so that the overall care is coordinated and the patient perceives continuity.

The decision to utilize technical support staff is dependent upon a number of variables, including patient traffic, staffing, and the revenue base in a particular office. Working under the direct supervision of their audiologist sponsor, registered technicians assist in repair and servicing of hearing aids, counseling and orientation, and even conduct aural rehabilitation courses following a pre-designed curriculum. In Florida, audiology assistants can perform routine audiometric testing, which helps to keep up with 6-month and annual hearing checks, as well as initial hearing screenings. In California, audiology assistants are not permitted to perform hearing testing, but they are instrumental in providing hearing aid orientation and counseling services, and in providing on-the-spot troubleshooting of hearing aids to unscheduled patients that walk in seeking assistance.

On the subject of customer service, a hard question is: how will we set the standard for consumers’ expectations for hearing care and service? Although often mistakenly viewed as a product industry by outsiders to the profession, the reality is that hearing aid dispensing and related hearing services require multiple visits over extended time periods and are highly service intensive. Today’s increasingly savvy consumer expects not only a high quality of product and care, but excellent customer service as well. A look into HearUSA’s computerized scheduling system on any given day validates this fact: at least 75% of an audiologist’s scheduled time is spent servicing the needs of new and existing hearing aid patients. That leaves precious little time available for diagnosing new patients and initiating new hearing aid orders.

In a short survey completed by HearUSA licensed
audiologists, those offices that have audiology technicians support, truly appreciate their assistance and are note the savings in time and money that technicians provide. Just as important, the ability to service patients in a timely and responsive manner goes a long way toward customer satisfaction. A recent poll indicated that close to 100% of the audiologists responding (40) approved of the use of technical support staff, as long as the technicians were fully trained and sanctioned by the state to administer services. HearUSA Audiologists who use assistants or technicians view them as a tremendous asset and feel strongly that they make a significant contribution to our patients and the goals of the company.

Over the years, HearUSA has sponsored more than a dozen hearing aid specialists and technician aides, who started out in office or administrative roles but came to enjoy the rewards of providing care and attention to a needy and grateful clientele. By working closely with these individual employees, we learned to appreciate their work ethic, their ability to relate to the patients, and their commitment to professional growth and development. Through carefully selected trainees and responsible supervisors, many of these employees have developed career paths that they find very rewarding.

From our experience, there are many pros and very few cons in the use of technical support staff. The most important factor in delivering care is access, and if our schedules are full, we can not be available to new patients. Hearing aid technology changes and improvements over the past decade require an increase level of patient contact, such as troubleshooting and wax related issues. Couple those issues with hearing aids that are designed to last longer, and you have an exponentially increased demand by the consumer for re-programming, minor cleaning and repair, and routine follow-up. The use of support staff to work alongside with the licensed audiologist expedites the resolution of these cases, and allows the audiologist to focus more on the identification and treatment of new patients. Our patients are happy to have their immediate needs addressed by audiology assistants, and our staff feels more productive all around.

On the other hand, we need to be responsible and ensure that our technical staff remain within their defined scope of practice and resist the urge to venture into areas where they do not have the training or expertise that is required. And supervising audiologists need to take their responsibilities seriously, keeping a close eye on the patients as they move through the system. This has not been proven to be problematic, but remains a caveat worthy of mention because it can lead to misperceptions on the part of colleagues, consumers and the medical field if boundaries are not clearly defined and respected.

The use of support staff is a growing practice in the field of healthcare, as nurse practitioners, physician assistants, and pharmacy aides have stepped up to handle the more routine aspects of their respective professions, allowing licensed practitioners to focus in areas that require more clinical expertise. Given the increased demand for our services and the shortage of audiologists that is already here, we would do well to embrace support personnel in our quest to deliver a high level of quality and customer service, while reaching out to grow the market.

For more information on the use of support staff, consult your state’s Audiology and hearing aid dispensing regulatory requirements.

“In my office, a technician is absolutely necessary in the provision of minor services, handles patient questions, coordinates paperwork and contributes to the overall care of the patient; I strongly recommend using audiology technicians to support a high volume office.”
—HearUSA Audiologist, CA
ABA’s Mentoring Program:  
A Unique Way To Curtail Professional Burnout

Erin L. Miller, AuD

When the American Board of Audiology™ first decided to develop a mentoring program at the American Academy of Audiology’s Convention 2004 in Salt Lake City, Utah, I was both excited and supportive. I believed this would be a perfect opportunity to meet students and help them as they embark on their careers in audiology. At that time, I was like many professionals; I had very little contact with students entering our profession. The mentoring program was a perfect opportunity for me and other board certified audiologists to meet students entering the field.

When the program was initiated in 2004, we actually had more students who applied for mentors than professionals offering to mentor. Because of this, members of the board were asked to take on two (or more) students and I gladly did so with enthusiasm. I am pleased to report that in 2005 we had more professionals offering to mentor than students requesting mentors! I had the pleasure of being paired with two young women from Florida AuD programs. Jamie Angus, a second year student from Nova Southeastern University and Emily Roescher a second year student from the University of Florida. Our first meeting was the beginning of a friendship that has grown over the past two years. I have been in contact with Jamie and Emily via email over the past two years, and of course we meet at convention. I have enjoyed listening to their excitement over their third-year rotations and fourth-year externships. I have shared some wisdom and provided them with advice when requested, but I truly have gained more than either of these young women.

As professionals we often get caught up in our day-to-day routines, and although we enjoy our patients and what we do, our lives and practices can become somewhat routine. It was enlightening to hear about Jamie’s and Emily’s experiences; their excitement over entering the field often reminded me about why I first entered the field of audiology. I have seen both of these young women become involved as officers in their local NAFDA chapters. I had the opportunity to see Jamie present part of a session on Ethics at the AAA’s Convention 2005 in Washington, DC. These are two women that I believe will become leaders in our profession, and for which I will be very proud.

I believe as professionals you can make this mentoring program as much as you want it to be. I am hopeful that I will continue to develop my relationships with these young professionals as they embark on their first employment, learn to manage family and professional lives and become involved in state and national issues. I look forward to mentoring other students and gaining strength from their enthusiasm. On a personal note, Jamie and Emily helped me realize that I needed to take my career in a different direction. I realized that I wanted to work with students and help them take the theory they have learned in their classrooms, to clinical skills that they will use throughout their professional lives. I am now working with the Northeast Ohio Au.D. Consortium (at the University of Akron) and have the pleasure of working with students in this program on a daily basis.

I encourage each of you to become a mentor. This has been an experience I would not trade for anything and one which I believe became the impetus for me to change my own career path. For further information about the ABA Mentoring Program and how you can become a mentor, please contact Sara Blair Lake, Director of Certification, at slake@audiology.org.
EarPopper™ Restores Hearing, Resolves Middle Ear Fluid

Middle ear fluid is one of the most common reasons U.S. children visit the doctor, second only to the common cold, resulting in more than 30 million doctor visits each year and adding $4 billion in medical costs to the health care system. Although increasing concerns about the risks of resistance to antibiotics recently led doctors to recommend “watchful waiting” as the first line of treatment,* more than 10 million antibiotic prescriptions are written annually to treat middle ear fluid or Otitis Media with Effusion (OME). Persistent OME is often treated with surgical insertion of ear ventilation tubes. More than 700,000 children undergo this procedure each year. In many cases both antibiotics and surgery have proven problematic and often unsuccessful.

A new device, known as the EarPopper™ may eliminate the need for antibiotic treatment or placement of surgical tubes as treatments for otitis media. According to Shlomo Silman, professor of Hearing Sciences and Audiology at Brooklyn College and co-inventor of the EarPopper™ patients now have available by prescription, a simple, non-invasive device that offers a safe and clinically-proven treatment for middle ear fluid. The hand-held, battery-operated EarPopper™ delivers a constant, controlled stream of air pressure and flow into the nasal cavity, diverting air up the Eustachian tube when the patient swallows. This action clears and ventilates the middle ear and restores hearing immediately. The device, which can be used at home, will help families avoid recurring visits to the doctor for treatment.

In a four-year study sponsored by the National Institutes of Health (NIH) and directed by otologist Daniel Arick and audiologist Shlomo Silman, 74% of children diagnosed with hearing loss from persistent OME were restored to normal hearing after seven weeks of treatment with the EarPopper™ compared to only 24 percent of the control group. After extending the treatment for four weeks in patients who did not recover within the first seven weeks, the total recovery for the study group was 85%. The results were published in two parts in the Ear, Nose and Throat Journal in September and October 2005. In addition to OME, the EarPopper™ treats Eustachian Tube Dysfunction, Aerotitis and Barotitis. Eustachian tube dysfunction can cause development of negative pressure in the middle ear due to a lack of ventilation and lead to an uncomfortable, “blocked” feeling in one or both ears. Aerotitis/Barotitis is a result of negative pressure in the ear caused by rapid ascent or descent (as in an airplane or during scuba diving).

If used early enough, the EarPopper could avoid antibiotic or surgical treatments in many patients suffering from these ear-related issues. In recent years, concerns have increased that frequent use of antibiotics for common ear conditions could raise the possibility that children will harbor drug-resistant bacteria during subsequent, unrelated illnesses. At the same time, many doctors and parents want to avoid the risks of surgery. Each year more than 700,000 children undergo surgery to insert tubes in their ears at an estimated cost of $2,000 per procedure. Complications reduce the effectiveness of ear tubes as they commonly fall out within four to seven months. After the tubes fall out, 40% of patients experience a recurrence of OME, and more than half of them must undergo repeat surgery to replace the tubes. The EarPopper™ is manufactured and marketed by Micromedics, Inc. of St. Paul, MN.
The nation has gone makeover crazy. They will make over your face, body, wardrobe, bedroom, house and anything else you can think of that would look better with the help of a personal trainer, a stylist or a coat of paint. Rather than revolt against this unstoppable trend, the Academy has embraced it. HearCareers is now better equipped and in fighting shape. We have taken our employment service to the gym and it’s coming out swinging.

HearCareers has a brand new look. It is easier to maneuver with a lively display that is designed to be more like what you are used to on the web. This isn’t just a cosmetic transformation; we have new features to make advertising and finding a job an easier process overall.

To celebrate these new features and the upcoming event AudiologyNOW!, we will be offering the “30 for 90” deal on job postings from January 9th until April 8, 2006. When you purchase a 30-day posting at the 30-day rate within this time frame, your listing will stay on our web site until April 8th. Basically, we are giving away two free months of job posting time. Don’t worry, if you buy a 30-day posting on April 6th it will not go away on the 8th, we will give you the full 30 days.

This deal is especially enticing this year because of our recent improvements. Employers will now have the option to post their position as a “featured job.” For an additional $125 (member price) employers can have their jobs featured separately on the job seekers sign-in page in conjunction with the normal job-posting site. Featured jobs will also be highlighted with bold print and a star logo to increase the prominence of the listing.

Job seekers also have new benefits. Applicants who register on HearCareers have the option of saving up to 100 jobs for viewing at anytime; also, our new searching capabilities will help potential employees find jobs by giving them a wider variety of search criteria.

We hope you like the new look, better navigation and additional features as much as we do. Look out Monster and HotJobs, we are ready to contend with the heavyweights...float like a butterfly, sting like a bee. Give our new career services a try at www.audiology.org/hearcareers.
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The Board of Trustees of the American Academy of Audiology Foundation is grateful for the generous gifts of its supporters!

Thank you!

HURRICANE KATRINA MEMBER ASSISTANCE PROGRAM
The American Academy of Audiology Foundation is pleased to announce that it is working with the American Academy of Audiology to create and fund a Member Assistance Program. In 2006, this program will provide AudiologyNOW! registration relief to Academy members whose homes and/or businesses were damaged or destroyed during Hurricane Katrina. The AAA Foundation hopes to offer complimentary registration to 40-50 Gulf coast audiologists who might not otherwise have the resources to attend AudiologyNOW! But we’ll need your help to make this possible!!!

We are looking for Academy members, and corporate and industry partners to help us as we work to raise $20,000 to fund this initiative. We’ve already received generous support from these Academy members and friends: Eticon, Inc.; Fred Bess; Sheila Dalzell; Patrick Feeney; Richard Gans; Deborah Hayes; Linda Hood; Francis Kuk; Robert Margolis; Catherine Palmer; Therese Walden

All donations to the Member Assistance Program are tax deductible, but most importantly, donors will receive the satisfaction of knowing they provided a helping hand to their professional colleagues. Let’s show our friends in need that we care! Call Cheryl Kreider Carey (703.226.1050) or Kathleen Devlin Culver (703.226.1049) to make your pledge or gift today.

Thank you in advance for your support of this worthwhile effort!
The auditory steady state response (ASSR) is an objective electrophysiological response generated by the brain. It can be evoked by presenting the ear with clicks or tone-bursts, as well as with amplitude modulated (change in intensity) and/or frequency modulated (change in frequency) tones. It can also be elicited by two stimuli with dissimilar frequencies (e.g., F1 = 2000 Hz and F2 = 2029 Hz) which produce a difference tone (DT = 29 Hz), similar to those used in measuring distortion product otoacoustic emissions (DPOAEs). The ASSR is important clinically because it shows promise as a tool for hearing screening and threshold estimation in infants and young children. This response, like the tone-burst auditory brainstem response (ABR), allows for frequency-specific estimation of hearing; however, there are several advantages to using the ASSR. For example, responses to several frequencies can be recorded simultaneously, which can reduce the amount of time it takes to test a patient.

Many aspects of the ASSR are under investigation. Previous studies have shown that the amplitude of the response varies with changes in state of arousal, such as with the onset of sleep or with the administration of anesthesia (Gilron et al., 1998). These arousal/anesthesia effects are important from a clinical perspective, because the ASSR is often collected during sleep or sedation, specifically when testing young children. From a neuroscience standpoint, investigating these effects may lead to discovering the specific areas of the brain which generate this response.

Scientists are currently studying the ASSR in chinchillas by recording evoked potentials from electrodes implanted in the inferior colliculus (IC) and auditory cortex (AC) (Szalda & Burkard, 2005). This method/model allows the researchers to observe near-field responses from different anatomical sites. One goal of the present study was to examine the ASSR amplitude across stimulus frequency, which provided information regarding the optimal stimulation parameters and the relative contributions of the IC and AC to ASSR responses. Another objective was to determine the effects of anesthesia (Nembutal, also known as Pentobarbital) on the amplitude of the ASSR in the IC and AC, which also provided information regarding the neural generators of the response.

Recordings were made from the right IC and AC simultaneously, while two tones (F1 and F2) were presented to the left ear. F1 remained constant at 2000 Hz, while F2 varied from 2029 to 2249 Hz in ~ 20 Hz steps. The stimuli decreased from 80 to 30 dB pSPL in 10 dB steps. Recordings were made both with and without anesthesia.

In the IC, ASSR amplitude was essentially unchanged, or in some cases enhanced, at DT frequencies below 90 Hz, while response amplitude decreased at DT frequencies above 90 Hz with anesthesia compared to without. In contrast, ASSR amplitudes from the AC decreased, regardless of DT frequency or stimulus level, with anesthesia as compared to without. These results suggest that both the AC and IC may contribute to the scalp-recorded ASSR in the awake state. However, in the Nembutal-anesthetized state, the response recorded from the AC was significantly reduced, whereas the IC response was relatively unaffected, specifically at low DT frequencies. Therefore, it seems likely that the IC is the primary neural generator in the scalp-recorded responses under Nembutal anesthesia.

**References**

THE YEAR IN EARS

15-MONTH DESK CALENDAR

You’ll find interesting ears for every month of the year in the Academy’s provocative new “The Year in Ears” 15-month desk calendar. The full-color Year in Ears calendar was cleverly designed to fit into a plastic CD jewel case so it can sit smartly on your desk. Innovative ear ideas are showcased each and every month taking you from January 2006 through March 2007. Perfect for the audiologist or ear enthusiast on your holiday shopping list! $15 for members; $20 for non-members. Shipping is extra.

Order today at www.audiology.org/store or call 1-800-222-2336, ext. 1039.

IT’S EAR-ESISTIBLE!
There are many new and exciting things to tell you about Audiology NOW! 2006, but here I will concentrate on several items of the program that feature Science & Research. We are particularly excited about the Featured Sessions for Audiology NOW! 2006 developed by Bob Margolis and the Featured Session Subcommittee.

WOW!Session

There are several types of Featured Session in the program. The first type is a special symposium we call the WOW!Session, on Friday morning, April 7, which is a journey from our roots in auditory science to a vision of the future entitled Legends of Auditory Science. We have invited four of the most prominent auditory scientists in the world—William Brownell, PhD; Peter Dallos, PhD; Robert Galambos, MD, PhD and Jozef Zwislocki, ScD— to discuss the impact of hearing research on our profession in this three-hour session. Drs. Zwislocki and Galambos have made landmark advances in diagnostic methods in audiology. Drs. Dallos and Brownell have made the most significant discoveries of the function of the inner ear that have led to our current understanding of normal and impaired hearing. This will be a historic session — Plan to be there.

Symposia

Another new type of Featured Session is the Symposium. These are invited sessions on topics of special interest presented by top audiologists, hearing scientists and physicians. This year we have three Symposia. The first, on Thursday morning, April 6, is a Symposium on Stem Cell Research with presenters Barbara Alving, MD, Jeffrey Kahn, PhD and Allen Ryan, PhD. Stem cell research holds great promise for treatment of many chronic and fatal diseases, but ethical concerns have significantly impacted progress in this area. Rapid advances in stem cell biology suggest that replacement of many different types of damaged cells, including inner ear cells, may be possible. These distinguished experts in the science and ethics of stem cell research will review the science, public policy and the ethical considerations of this potentially lifesaving technology.

NOW!Sessions

The remainder of the Featured Sessions are called NOW!Sessions. These are 90-minute sessions on contemporary topics presented by the experts. Foremost among the NOW!Sessions is the Marion Downs Lecture in Pediatric Audiology funded by the AAA Foundation, with a grant from the Oticon Foundation. This year’s invited lecture is presented by Albert Mehl, MD, a pediatrician from Boulder, Colorado who is the appointee from the American Academy of Pediatrics in Newborn Hearing Screening. His presentation on Thursday, April 6, is titled: Beyond Newborn Hearing Screening.
LEARNING MODULES

- A Clinical Comparison Between Two ASSR Stimuli
- All About Nystagmus
- Electroneuronography: Diagnosing Facial Nerve Disorders
- Infant Speech Discrimination & Hearing Loss
- VEMP101: Intro to Vestibular Evoked Myogenic Potentials
- Auditory Brainstem Response to Speech: What Can We Learn?
- Auditory Neuropathy/dys-Synchrony: Diagnosis & Management
- Current Applications of the Hearing in Noise Test (HINT)
- Neurologic History & Physical Exam of the Dizzy Patient
- New ABT Tools for Retrocochlear & Cochlear Assessment
- Recording ABR in Harsh Environments & Non-Relaxed Patients
- Help—There’s a Baby in My Waiting Room!
- Temporal Processing: From Science to Practice
- Three Common Technical Errors in Clinical Audiology
- A Battery of Auditory Speech Tests for Infants & Toddlers.
- Audibility & Cortical Evoked Responses in Infants
- Didactic & Hands-on with VEMP
- Grand Rounds-Infant Assessment & Amplification
- Optimizing Tone Burst ABRs w/ Clinically Available Equipment
- VEMPS & Vestibular Diagnosis: Mayo Jacksonville Experience
- WHEN AUDIOMETRY WAS FUN (at least for us)
- Superior Canal Dehiscence: A 3rd Window to the World
- Definition, Dx, & Tx of (C)APD: Current Perspectives
- NF2: Audiological Findings & Medical Management
- Dangerous Decibels: Prevent NIHL in Kids of All Ages
- Infronics: The Very Low Frequency (10 to 200Hz) Health Issue
- Musicians & the Prevention of Hearing Loss
- Cognitive Issues with Hearing Aids, or Why the Brain Matters
- Advisernt Practices & Access to Hearing Technology
- Launching Your Research Career: Navigating the NIH/NIDCD
- The Amazing Efficiency of Sound Through the Middle Ear
- The A to Z of a Successful Hearing Aid Open House
- The Audiologist’s Guide to EHI Di Data
- The Preceptors’ Ethical Tightrope: Walking the Straight Line
- How Audiologists Can Advocate for Children with Hearing Loss
- Managing Your Practice: A Step-by-Step Blueprint for Success
- Surgical Neuropathology: A Career Horizon
- The Baha System in the Medical/Audiology Practice
- The Marion Downs Legacy: From Vision to Practice
- Assessing Student Competence Via Clinical Comprehensive Exam
- Ethical Decision Making in Audiology
- Using ICD-9 Codes to Advantage in an Audiology Practice
- Audiologists as Experts & Litigation Consultants
- Effective Precepting: The Supervisory Process
- Ethics, Infants & Their Families
- Foundations of an Efficient, Profitable Audiology Practice
- Assessing the Effectiveness of Feedback Cancellation Systems
- Auto-steering: Adaptive Parameter Control in Hearing Aids
- Best Practices for Audiologists in Early Intervention
- Designing a Hearing Aid: The Sequel
- Efficacy of Open Ear Fittings: For Whom? & How Much?
- The Nucleus System 4 Adult Clinical Trial Summary
- Use of Sound in Treatment of Tinnitus & Hyperacusis
- A Practical Course in Tinnitus Management
- Automatic Behavior in Advanced DSP Systems—Friend or Foe?
- Cochlear Implant Candidacy, Device, & Management Update
- Involving the Family in Geriatric Aural Rehabilitation
- Moving from “Acoustic” to “Auditory” Scene Analysis in HAs
- Musicians & Hearing Aids
- Nonlinear Fitting Rationales for Special Populations
- Patient Counseling: Questioning, Retention & Social Style
- Preliminary Results of PMA Trial of an IMED
- Solving the Hollow Voice Dilemma
- Tales of Two Ears: Experiences with Bilateral Implantation
- Contemplating the Status Quo in Pediatric Amplification
- DSL® v5.0: The New DSL Method for Hearing Instrument Fitting
- Evaluating Manufacturer Claims
- Predicting Aided Thresholds for Infants & Toddlers
- This Child has a Hearing Loss! What Comes Next?
- Use of Objective Measures with Cochlear-Implant Recipients
- Virtual Education & Systems Change in EHDI Service Delivery
- “Real Ear” meets “Real World”
- ALDs/FM with Nucleus Cochlear Implants & The Baha System
- AR for Elders with Cognitive/Processing Listening Challenges
- Do You Want to Verify Nonlinear Hearing Aids Accurately?
- Issues & Applications for Real Open Fittings
- Management of Bilateral Technology for the CI Audiologist
- Selecting, Verifying & Validating Hearing Aid Performance
- Technology & Speech Perception in Naturalistic Conditions

Over 50 one- and two-hour Learning Modules will also be offered this year. Erika Zettner and the Learning Module Subcommittee chose the cream of the crop from sessions submitted in the Call for Innovative Proposals. One-hour introductory and two-hour advanced modules will be offered Thursday, Friday and Saturday, April 6–8.
RESEARCH PROGRAMS

The deadline for Research Proposals was extended to allow for the latest findings to be presented at AudiologyNOW! Sherri Jones and the Research Pods and Poster Subcommittee will be selecting the finest Research Podium proposals and grouping them into four 15-minute Research Pods based on the Learning Cores. The top Research Poster proposals will be selected to be hung in the poster room where attendees will receive up to 0.2 CEUs for attending the poster session. There will also be an AAA Foundation Research Awards presentation at the Poster Presentations on Friday afternoon April 7 from 5:00 to 6:30pm. Masters and doctoral-level students and recent audiology graduates were invited to submit proposals for presentation of their original research completed while a graduate student in audiology at the Student Research Forum. This is an award competition funded by the AAA Foundation. Vishakha Rawool and the Student Research Forum Subcommittee will be selecting this year’s winners based on expanded review criteria. This sub-committee will also review poster submissions for the James Jerger Award for Excellence in Student Research (funded by the AAA Foundation) to be presented at the Poster Session Reception.

The abstracts for the Research Sessions (Research Pods, Research Posters and Student Research Forum) will be available using the online Itinerary Planner (www.audiology.org), beginning January 15, 2006.

I am excited about the strong science and research focus of AudiologyNOW! 2006. I hope to see you there!

—Patrick Feeney, 2006 Program Chair

ADDITIONAL LEARNING OPPORTUNITIES:

There are many other educational sessions planned for AudiologyNOW! such as the hands-on half- or full-day Learning Labs, Discussion Groups and Focus Groups.

LEARNING LABS - Wednesday, April 5 (Additional Fee)
- Vestibular Evoked Myogenic Potentials (VEMP)
- Clinical Application of Auditory Evoked Response in Children
- Utilization of Middle & Late Auditory Evoked Potentials
- Cerumen Management
- Cracking the Reimbursement & Practice Management Code
- Marketing for Audiologists in All Practice Settings
- Audiologic Tinnitus Management: What To Do & How To Do It

FOCUS GROUPS - Wednesday, April 5
- (C)APD: For Clinicians, By Clinicians, With Clinicians
- AuD Education: Meeting Challenges of the 4th Year Externship
- Mild & Unilateral Hearing Loss in Children

DISCUSSION GROUPS - Saturday, April 8
- How Do We Verify That Amplification Sounds “Good”?
- Middle & Late Evoked Potentials—Their Role in APD
- How Do You Identify an Auditory Processing Disorder?
- Audiology Practice & Education: A Global Perspective
- Audiology: The Parent Perspective
- Developing Future Leadership in Audiology
- Hard-Of-Hearing Audiologists: Joining Forces III
- Integrating EHDI Training Into AuD Academic Programs
- Licensure & the AuD
- New Perspectives: Clinical Supervision of the AuD Student
- Roundtable: Forensic/Investigative Audiology
- Specialty Recognition in Audiologic Rehabilitation?
- Digital Hearing Aids & Children: Sharing Clinical Experience
- Educational Audiologists & Implant Centers: Bridging the Gap

I am excited about the strong science and research focus of AudiologyNOW! 2006. I hope to see you there!

—Patrick Feeney, 2006 Program Chair
• 30 Featured Sessions including:
  • The WOW! Session with the Legends of Auditory Science • Dr. William Brownell, PhD • Dr. Robert Galambos, MD, PhD • Dr. Peter Dallos, PhD • Dr. Jozef Zwislocki, ScD
  – Symposia on Stem Cell Research, Gene Therapy, & Physiological Assessment of Infants

NOW! Sessions featuring the state-of-the-art in Audiology presented by top audiologists, hearing scientists and physicians.

• 7 Interactive Learning Labs: Full Day or Half Day Sessions. Learning Labs are designed to be interactive and to create a learning rich environment with hands-on experiences. (Wednesday, April 5; additional fee)

• Over 50 Learning Modules: 1-hour introductory and 2-hour advanced. Learner-focused courses on topics of current interest incorporating interactive learning styles.

• Over 25 Exhibitor Courses: 1-hour courses presented by exhibitors illustrating product performance, benefit and /or satisfaction.

• Research Rich! 1-hour Research Pods, 1.5 Hour Student Research Forum and Research Poster Presentations highlighting the cutting edge of hearing and balance research.

• Focus Groups: 2-hour in-depth discussions on hot topics in Audiology.

• Discussion Groups: 1-hour informal discussions on a variety of current interest topics.

• New Learning Cores for targeted learning: Diagnostics (100s) • Disorders (200s) Hearing Conservation (300s) Hearing and Balance Sciences (400s) Professional Issues and Practice Management (500s) Treatment (600s)

Audiology Solutions (Expo)

At AudiologyNOW! 2006 you’ll discover Audiology Solutions! Over 200 companies and organizations will be standing ready to help you with your patients’ needs and your professional development. We’ve scheduled time each day so that you can experience Audiology Solutions free from competing events. Take time to explore new technology and discover new services to nurture your career.

• Interactive Learning at selected NOW! Sessions and Learning Modules using Audience Response Systems.

• Manufacturer Tours: Reserve the afternoon of April 5th for this opportunity to tour a manufacturing facility. (Tour is included in your registration.) Advanced sign-up required.

• CEUs will be offered for Research Posters (up to .2 CEUs) and Focus Groups (.2 CEUs).

• AAA Foundation Silent Auction: Going Once, Going Twice, GONE!!

• Selected Featured Sessions and Learning Modules will feature Audience Response Systems.

Want to create your own AudiologyNOW! experience? Use the innovative Itinerary Planner at audiologyNOW.org

• Innovative training course for presenters to improve the learning experience.

• ProgramNOW!, distributed at AudiologyNOW! will include abstracts and presenters for all sessions.

• Look for the Research Symbol to help you locate sessions that are “Research Rich!” in content.

• The Schedule of Events has changed as well! AudiologyNOW! will offer more CEU sessions on Thursday and the exhibit hall will have dedicated time distributed throughout the program schedule (previously only on Thursday).
The Association of VA Audiologists (AVAA) is pleased to announce its 6th Annual Meeting in conjunction with AudiologyNOW! 2006. We look forward to another outstanding meeting including continuing education offerings, presentations from VA and national organization leaders and time to network with your colleagues from around the country. Please make plans to join us. For more information, email Judy.Schafer@med.va.gov.

**National Association of Special Equipment Distributors (NASED)**

NASED holds its annual meeting on the eve before the opening of Audiology Solutions. Attended by the country’s hearing and balance health care equipment distributor members, as well as many of the principal equipment manufacturers, this reception’s highlight is the presentation of NASED’s annual Lifetime Achievement Award. For more information, e-mail mail@hcinstruments.com.

**The Professional Supervisor of the Audiometric Monitoring Component of the Hearing Conservation Program**

Presented by the Council for Accreditation in Occupational Hearing Conservation (CAOHC)

This workshop offers a comprehensive tutorial for audiologists seeking instruction in their role and scope of practice in hearing conservation programs. Presenters will explain how to establish audiometric monitoring programs, review problem audio-grams, determine work-relatedness (including OSHA reports), manage databases and integrate with other hearing conservation team players. Case presentations will illuminate details of regulatory requirements and successful supervision of these programs. Attendees will receive copies of CAOHC’s Hearing Conservation Manual and several noise standards. CEU’s pending. Instructional Level: Basic/Intermediate. For more information visit www.caohc.org.

**National Association of Future Doctors of Audiology (NAFDA)**

The National Association of Future Doctors of Audiology (NAFDA) will hold its 7th Annual Convention in conjunction with AudiologyNOW! 2006. NAFDA welcomes Doctor of Audiology (AuD) and research PhD students a day prior to the Academy’s Convention, on April 5, 2006. All NAFDA members and Academy attendees are welcome to join NAFDA at an open meeting at 6:00pm on Thursday April 6th to hear exciting speakers and discuss the exciting future of NAFDA and Audiology. For more information visit www.nafda.org.

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Fax: 1.800.521.6017 (US/Canada) — Hotel Reservation form can be found at audiologyNOW.org

Phone: 1.800.974.9833 (US/Canada, 8:00am-5:00pm CST) +1.847.282.2529 (International)

Mail: AUD/I.T.S. • 108 Wilmont Road, Suite 400 • Deerfield, IL 60015

(Do not call the hotels directly as the official rate will not be offered)

**regEXPRESS**

Pre-registered attendees only! Register by March 15, 2006 and save time by redeeming your ticket at regEXPRESS locations to receive your badge holder, convention bag and materials.

- Hyatt Regency Minneapolis - Wednesday, April 5 (Only!) 11:00 am-5:00 pm
- Hilton Minneapolis - Wednesday, April 5 (Only!) 11:00 am-5:00 pm
- Minneapolis Convention Center - open during Full Service Registration.
Resumes are a great way to get an idea of the qualifications of an applicant, but no matter how detailed, you can’t get a true impression of a person until they come in for a face-to-face interview. Setting up a face-to-face interview can be quite a time consuming process. First you post an expensive ad with a popular job search web site or a local newspaper. Next, you wait for resumes to slowly trickle in. Then you set up appointments according to everyone else’s schedule.

There is a better way. A way that gives you access to a large number of audiologists in one area so you can meet them in three days instead of three weeks. We are referring to the American Academy of Audiology’s Employment Service Center, which will be available at AudiologyNOW! The Employment Service Center provides an area where employers can reserve interview space to meet applicants one after another. Using the Employment Service Center is not only a more efficient way to find an employee, but it is also a more frugal way.

In January, we began the “30 for 90” special. This means that starting January 9th if you pay for a 30-day job post at the 30-day rate it will remain on HearCareers, the Academy’s year round job posting career center site, for up to 90 days. This offer ends on April 8th so hurry and get your job up before all of those free days of web visibility are gone. If you post a job and there are less than 30 days left until the April 8th deadline, you will still receive the full 30 days you paid for.

Let’s say you have decided to take advantage of the time and cost efficiency that interviewing applicants at Employment Service Center provides. How do you let people know you will be attending? To identify yourself as a person who is attending AudiologyNOW!, you simply need to flag your job posting with the Academy logo. This option will be made available when you post your open position on HearCareers. Through the HearCareers site you can set up interviews before convention, or job seekers can contact you to request a spot on your busy interviewing schedule.

Our event is the largest in the world of audiology, with over 6,700 attendees at last year’s AudiologyNOW! Chances are good that with such a high concentration of qualified audiologists at least one of them is the perfect person for your opening.

Among the pool of potential employees attending are about 500 student volunteers. Many of these future audiologists will be actively seeking job and networking opportunities with respected names in the industry. Maybe one of them will be a perfect fit for you.

Our employee services don’t stop after AudiologyNOW! is over. HearCareers job services are available all year-round. Our rates are the lowest in the field. Target your job posting by placing it where people in the industry are looking. With HearCareers you get to advertise positions, feature jobs, search resumes, get instant email notifications of submissions and the ability to contact potential employees. You can make your job description as long as you like.

For more information on our Employee Service Center benefits, visit our web site at http://www.audiology.org/hearcareers/.
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## COMPANY | BOOTH NO.
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ADVANCE Newsmagazines | 1900
Advanced Bionics | 521
All American Mold Laboratories | 905
Ally & Bacon | 801
American Hearing Aid Associates | 2543
American Overseas Trading Corp. | 1803
American Speech-Language-Hearing Association | 1201
Amplivox Ltd | 1209
Arizona School of Health Sciences | 1801
Association Health Programs | 802
Audient | 2247
Audifen - USA, Inc. | 317
Audigy Group LLC | 1647
Audina Hearing Instruments | 617
Audio Energy | 1318
Audio Enhancement | 901
Audiology Awareness Campaign | 2421
Audiology Foundation of America | 924
Audioscan | 1417
AudNet, Inc | 1101
Audire Ink Publishers | 1908
Australian Hearing | 2048
Balanceback | 2401
Beltone Electronics | 2331
Bernafon LLC | 2341
Bio-logic Systems Corp. | 1023
Brul & Kjaer/Listen, Inc | 1317
CareCredit | 1501
Central Michigan University | 1805
Citi Health Card | 821
Cochlear Americas | 2217
ComCare International | 2443

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## COMPANY | BOOTH NO.
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Computers Unlimited | 2423
COMTEK | 2516
COSELI S.P.A. | 343
Demo Theater | 1517
Discovery Hearing Aid Warranties & Repair | 517
Doc’s Proplugs, Inc. | 1549
Drew Otoplastik GmbH | 1047
Duracell/The Gillette Co | 2023
E-A-R Auditory Systems | 942
Ear Technology/ Dry & Store | 1709
Earmold Design Inc. | 2417
Eckel Industries of Canada Ltd. | 1348
Educational Audiology Association | 2815
Egger Corp. | 1522
Elextron Inc. | 1217
ELT Group | 2520
Emtech Laboratories, Inc. | 1905
Energizer Battery Co. | 443
Ent News | 1449
Envisiontec, Inc. | 849
Envoy Medical Corporation | 1304
EPIC Early Professionals Int. Corp | 2248
ESCO - Ear Service Corp | 425
Ethyomic Research | 2001
EYE Dynamics, Inc. | 747
Fairview Audiology Clinic | 700
Frey Electronics, Inc. | 1601
G.R.A.S. Sound & Vibration | 909
Gallaudet University | 1149
Gennum Corporation | 321
GlaxoSmithKline Consumer Healthcare | 1906
GN Otometrics | 642
GN ReSound | 430
Hagemeier North America | 916
Hal Hen Company Inc. | 823
Hansaton Hearing Systems | 606
HARC Mercantile, Ltd. | 1308
Harris Communications | 902
Hearcare Providers Service Organization | 1848
HEAR USA | 1917
Hearing Components | 1323
Hearing HealthCare News | 1908
Hearing Products Report | 1707
Hearing Review, The | 1806
HEI, Inc. | 243
Hermatic Switch, Inc. | 1247
HMSA. Inc | 707
HITEC Group/Clear Sounds Communications | 2123
dCellTech Corp | 1507
Industrial Acoustics Co. | 1717
Insta-Mold Products, Inc. | 2323
Institute for Persons Who are Hard of Hearing or Deaf | 1008
InTech Industries Inc. | 449
Interaudios | 421
Interon | 917
JEDMED | 2108
Kaiser Permanente/ The Permanente Medical Group | 1709
Knowles Electronics | 131
Larson Davis | 900
Lawrence Erlbaum Associates | 1202
Lifesline Amplification Systems | 2406
Lightspeed Technologies, Inc. | 1608
Lippincott Williams & Wilkins | 2400
Lisound Hearing Aid Systems | 1909
Longworth Laboratories | 1305
Lotus Technology, Inc. | 1001
Magnadone | 2117
Marcon Hearing Instruments, Inc. | 2149
McKeon Products Inc. | 2524
MED-EL Corporation | 2301
MedRx Inc. | 2317
Micro Audiotronics Corp. | 1817
Micro-DSP Technology Co., Ltd. | 2508
Micromedical Technologies Inc. | 1223
Micromedics | 2407
Micropower Battery Company | 2525
Microsonic Inc. | 1117
Mid-State Laboratories | 922
Midwest Hearing Industries, Inc. | 1017
MiraCell | 1809
Montclair State University | 1200
National Association Special Equipment Distributors (NASED) | 843
National Hearing Conservation Assn. | 903
Natus Medical Inc. | 1004
NeuroTone, Inc. | 2100
NeuroCom International Inc. | 2349
Newport Audiology Centers | 322
Oaktree Products, Inc. | 1125
Oral Deaf Education * | 1300
Oticon, Inc. | 1930
Otodynamics LTD | 1418
OTOVATION | 217
PCO School of Audiology | 800
Perfect Seal Labs | 1916
Phonak Hearing Systems | 2130
Phonic Ear | 1923
Plural Publishing | 1000
Precision Laboratories | 2009
Rayovac Corporation | 1623
Renata | 1423
Resistance Technology Inc. (RTI) | 2517
Rexton, Inc. | 717
Sahara Dry Ear | 1708
Sebotech Hearing Systems | 2101
Sennheiser Electronic Corp. | 1700
Siemens Hearing Instruments | 1531
SonaMed Corporation | 1800
SONIC Innovations | 1543
Sonion US Inc. | 1043
Sonovation, Inc. | 1802
SONUS USA | 2617
SoundID | 2507
Starkey Laboratories | 1230
SYCLE.NET | 807
Teltex, Inc. | 703
The Ear Q Group, Inc. | 1902
Thieme Medical Publishers | 1509
Thomson Delmar Learning | 1007
Tympnny Inc. (formerly Hearing Health Network) | 1947
United Hearing Systems | 2307
Unihtron Hearing | 230
University of Florida/EMS | 2409
University of Texas Medical Branch | 920
US Army Medical Recruiting | 817
VA RR&D National Center for Rehabilitative Auditory Research | 1605
Varta Microbattery Inc. (POWER ONE) | 2531
VIAYS Healthcare | 1723
Vivatone Hearing Systems | 1301
Vivosonic Inc. | 1516
Warner Tech Care | 943
Western Systems Research Inc. | 1249
Westone Laboratories Inc. | 2431
Wide Dispensing Audiology | 831
Williams Sound Corp. | 803
Zeni Power, Zhi Li Battery Co., Ltd. | 2008

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THE STAGE IS SET FOR Audiology Solutions

AS OF DECEMBER 1, 2005

VOLUME 18, NUMBER 1

AUDIOLGY TODAY 47
HIGH IMPACT GRASSROOTS:
You Can Make a Difference

The Academy continues to urge members to make their voices heard and to advocate on behalf of the autonomy of the profession. The state leaders and grassroots advocates involved in the Academy’s State Leader Network have been instrumental in leading this charge and the Academy would like to build upon these efforts and encourage further outreach. More needs to be done to educate policymakers about who audiologists are and the value of the hearing and balance services they provide.

Academy members are the grassroots of the profession of audiology. The profession’s goals cannot be achieved without individual advocacy efforts. Over 150,000 associations are trying to lobby Congress and state legislatures, yet 95% of the bills introduced in Congress do not pass. It requires a sustained effort to hold the attention of policymakers at both the federal and state levels. Therefore, winning the legislative war requires fighting many little battles. This means maximizing the visibility of audiology and driving home the importance of quality hearing and balance care.

Audiologists have a strong case to make. The prevalence of hearing loss is increasing dramatically (see Newsweek July, 2005). It is up to the Academy and its members to explain the role of audiologists in alleviating this public health concern. To elevate the profile of the profession and advance its goals, most notably direct access, audiologist must share their story. The Academy has provided sample letters to Congress as a tool for members to contact their legislators. The Academy encourages audiologists to personalize these sample letters on their own professional letterhead and to include statements about why a specific initiative is important to providing the necessary services to individuals with a hearing impairment or balance disorders.

SHARE PERSONAL STORIES

In a recent letter to the editor published in the October 2005 issue of The Hearing Journal, an audiologist wrote about why Medicare patients need direct access. The audiologist included a real-life situation where the process of obtaining a physician referral delayed an elderly patient with vertigo in seeing the audiologist and in the meantime, the patient had fallen and broken her hip. Following this incident, the referring MD told the audiologist to just see her patients in the future and that she would send the referral. The audiologist concludes by saying, “We need to focus on the people we are here to help. That should be what guides our decision regarding direct access.”

It is these patient stories that bring the merit of policy to life. The above example serves as a valuable message to support the Hearing Health Accessibility Act (HR 415/S 277). This legislation seeks to remove the physician referral requirement for Medicare beneficiaries. Personal testimonies are essential in bringing the message home and making a greater impact with legislators who strive to respond to constituent needs and concerns. Take a moment to document one or two patient stories or examples and share them with your Member of Congress. The Academy’s national office would also like to collect these personal stories to use when staff advocate on your behalf. Please e-mail your examples of patient cases where direct access to audiologists would have improved the delivery of hearing and balance care to Medicare beneficiaries at jchappell@audiology.org.

“As influence agents, we must learn to think in story, talk in story, and present our arguments in a narrative form. Because story can persuade and inspire where reason and logic and argument fall flat.”

-- Kelton Rhoads, PhD
(Amyism #47, The Showalter Group)

LETTERS TO THE EDITOR

Another powerful tool in advocating for the profession and educating the public and policymakers about the importance of seeing an audiologist for hearing and balance care is submitting Letters to the Editor in your local newspaper. These letters also serve as a marketing tool for the services you provide in your communities. Please include support for legislative measures such as direct access and call on your Representative and Senators to support direct access in your letters. Members of Congress and their staff monitor and clip articles in local papers specifically referencing legislation and policy issues for the legislator’s
The Academy has successfully positioned itself in Washington as the experts in hearing and balance care. The road to autonomy goes through Washington and it is every audiologists professional responsibility to educate patients, health care providers, communities, state and national health care agencies, and state and federal legislators. The future of the profession depends on these individual efforts. Advocacy and marketing your skills and role in providing quality hearing and balance care isn’t rocket science…its fun!! So get the word out!

FREQUENTLY ASKED ADVOCACY QUESTIONS

Q: I wrote a letter to my Member of Congress and received a response informing me of the bill’s status and indicating support for ensuring access to quality health care. The Member simply stated that he would keep my concerns in mind if and when Congress considers the legislation. What should I do next?

A: Every Member of Congress has his/her own policy for responding to constituent mail. Most offices respond through written correspondence that is usually drafted by the Legislative Correspondent and is usually quite generic in nature. The response you received is a typical response. Often offices think that this response is enough, but the Academy encourages members to follow up with the Health Care Legislative Assistant in the relevant Congressional office to inquire about the Member’s specific position on this legislation and to provide any new or additional information that might not have been included in your first letter/e-mail to the Member. Additional information might include the recent direct access white paper, cost analysis study, or a personal testimony about a patient who would have benefited if the policy were already in place.

Q: I have heard that there are specific Members that should be targeted for advocacy efforts. How are these targets determined? When I contacted one of the recent targets, I was informed that because the Member was on a certain committee, she would not sign on as a cosponsor but would consider my views if the legislation came before the committee.

A: There are four authorizing committees that have jurisdiction over health care issues:

- Senate Finance Committee, Subcommittee on Health – Its jurisdiction includes: health programs under the Social Security Act and health programs financed by a specific tax or trust fund (e.g., Medicare and Medicaid).
- Senate Health, Education, Labor and Pensions Committee – Its jurisdiction includes: measures relating to education, labor, health, and public welfare; aging; biomedical research and development; Gallaudet College, Howard University and Saint Elizabeth’s Hospital; handicapped individuals; labor standards and labor statistics; occupational safety and health; and public health among other areas.
- House Energy and Commerce Committee, Subcommittee on Health – Its jurisdiction includes:  public health and quarantine; hospital construction; mental health and research; biomedical programs and health protection in general, including Medicaid and national health insurance; food and drugs; drug abuse; and homeland security-related aspects of the foregoing.
- House Ways and Means Committee, Subcommittee on Health – Its jurisdiction includes: bills and matters that relate to programs providing payments (from any source) for health care, health delivery systems, or health research. More specifically, the jurisdiction of the Subcommittee on Health includes bills and matters that relate to the health care programs of the Social Security Act (including titles V, XI (Part B), XVIII, and XIX thereof) and, concurrent with the full Committee, tax credit and deduction provisions of the Internal Revenue Code dealing with health insurance premiums and health care costs.

When a bill is introduced, it is assigned to a Committee for consideration. A bill must move through the committee process before the bill can be brought to the floor for a vote. Bills must pass in both the House and the Senate in order to be forwarded to the President for signature into law. The Hearing Health Accessibility Act (direct access), HR 415/S277 has been assigned to the Senate Finance, the House Energy and Commerce Committee and the House Ways and Means Committees. Members serving on these committees are perceived as targets to focus outreach and educational efforts since they are in position to move the bill to the floor for a vote.

Activate to Advocate for Audiology
Audiology advocacy materials at your fingertips…
www.audiology.org/professional/gov
AdvocateNOW!
Some people believe that marketing is only necessary for audiologists who work in or own a private practice. However, audiologists in all practice settings may experience a lack of patient traffic because consumers and referral sources lack awareness of audiology and knowledge of the valuable services that audiologists provide. If we don’t tell them, who will? How many times has someone said to you, “Audiology? What’s that?” Thanks to much effort from the Academy and our members, the word “audiology” is spreading, but it is still not a household word and the average hearing impaired consumer doesn’t know who audiologists are and what we do. It is the responsibility of each one of us to spread the message, “How’s your hearing? Ask an Audiologist!”

With this in mind, the Marketing Committee will host a half-day Learning Lab on Wednesday, April 6, from 1-5pm. The seminar, “Marketing for Audiologists in all Practice Settings,” will be taught by Bob Negen, President of WhizBang Training in Grand Haven, Michigan. Negen has first hand experience with marketing and has been presenting seminars for many years. He knows the challenges and opportunities that face audiologists and will relate how to deal with them first hand.

Negen’s hard-hitting and often hilarious stories come from over two decades building his own business from a negligible $17,000 in annual sales to a multi-store, multi-million dollar operation. Negen discovered his entrepreneurial spirit at the young age of 23 and opened one of the world’s first kite stores. In 20 years, he helped change the public’s perception of the kite from a child’s toy to an ‘eco-friendly’ hobby for families and people of all ages. A natural marketer, Negen consistently created very successful promotions while in business. While attempting to stimulate a national yo-yo craze, Negen’s company created an innovative concept by developing and opening, “Yo-Yo Universe” kiosks in over a dozen malls. While promoting this concept, Negen hired and trained over 150 employees using his unique training system, and sold over two million dollars worth of yo-yos. The amazing part of this unconventional idea is that Negen accomplished all of this in just over six months!

His yo-yo adventure forced Negen to boil down twenty years of hard-earned experience about life as an entrepreneur into a fun, but no-nonsense, only-if-it-works outlook on business that applies to audiologists in all practice settings. This ‘make it fun, but get it done’ attitude has given Negen an expert edge not only in marketing, but also in practical, proven customer service practices; solid, common sense employee management; super efficient business operations; and focus on the entrepreneurial spirit.

While Negen’s background began in the retail side of business, for the past ten years, he has expanded his focus to working with small businesses helping them to expand the share of their target market. Negen’s innovative and inspiring message will teach participants how to most effectively spend their marketing dollars and will show them how to increase sales, create new customers, increase current customer loyalty, and generate excitement in the community.

This outstanding seminar will teach attendees how to create a fresh and inspiring marketing plan that is sure to maximize marketing dollars.

Start your Convention experience with a “bang” and plan to attend the Learning Lab, “Marketing for Audiologists in All Practice Settings.” You are sure to come away with outstanding ideas for increasing the awareness of audiology and innovative ways to improve consumer’s knowledge of your business or organization.
As we all know, the "teen years" can be a challenge for parents and for their teenagers. The teens can also be a challenge for an organization. It is sometimes difficult to gauge your own development as so much seems to be happening at once. Perhaps, therefore, it would be useful to pause, step back, and take a look at the bigger picture of the Academy's development towards our long-term goals.

**These are some of the issues and, yes, victories of the past few years on our way to professional and political independence and autonomy.**

But, much remains to be done!

In my personal opinion, the most important long-term goal for the American Academy of Audiology is autonomy: professional autonomy for each of you and political autonomy for the Academy. There is no single silver bullet out there that will accomplish the autonomy goal. Rather, autonomy will be achieved by winning on a number of various fronts.

**Let's take a look back!**

Our first major Congressional victory was to amend the statute that governs the Federal Health Benefit Programs to allow direct access for audiology. This allowed (but did not require) the various federal health care plans to provide direct access, similar to the Department of Veterans Affairs.

We worked with the Office of Management and Budget to change the Standard Occupational Classification (SOC) for audiology. We achieved one of our two objectives specifically, we succeeded in having audiology classified separately from speech-language pathology. Our other objective was to have audiology placed in a standalone category under the main heading iHealth Diagnosing and Treating Practitioners.i rather than being classified under the subheading iTherapists.i We will seek to have this change made during the next major review of the SOC, which is scheduled to begin this year, and likely will be underway in full force in 2006.

We successfully lobbied Centers for Medicare and Medicaid Services (CMS) to change its Medicaid rules to defer to state licensure in determining who is a qualified audiologist. This, as you may recall, was a lengthy battle that took five full years. Legislation was introduced, the Appropriations Committees "urged" CMS to make the change and eventually they did so without a change in the statute. This battle was extremely important to the political growth of the Academy. Power in Washington is about winning and once you identify a goal, you must stay the course.

Creating and expanding our Political Action Committee (PAC) was also important to our political development, both as an end in itself and as a means to an end. Our PAC has allowed us to raise our visibility and visibility leads to credibility. When I first started attending PAC events, I would often hear that "the audiologists" were just here, or we just met with the audiologists. That does not happen any more. The Academy is on the map and Capitol Hill now understands that ASHA and AAA are two different organizations.

Congressman Ed Whitfield (R-KY) was our first Member of Congress to attend a national convention of the American Academy of Audiology, followed by HHS Secretary Tommy Thompson and Senator Tom Harkin (D-IA). We are now interacting with senior governmental officials on a regular basis.

The recent Medicare Physician Fee Schedule proposed rule threatened a steep drop in audiology reimbursement because of proposed changes to the way CMS would determine the practice expense Relative Value System (RVU). While we are not out of the woods, yet, it is interesting to note that in the Final Rule published by CMS that issued a one-year moratorium, the document referred to the comments of the "two" audiology organizations and the Congressional letters asking CMS to work with the American Academy of Audiology.

These are some of the issues and, yes, victories of the past few years on our way to professional and political independence and autonomy. But, much remains to be done:

**Let's take a look forward!**

We are currently seeking direct access in the Medicare program. Congressman Jim Ryun (R-KS) and Senator Tim Johnson (D-SD) have introduced legislation to make this change. The Appropriations Committees have again urged CMS to...
respond. At the moment, however, CMS does not feel they have the authority to do so. Time is on our side. It is projected that by 2030, 78 million Americans will have some degree of hearing loss. Direct access is essential if these Americans are going to be served properly. It will not take until 2030 to accomplish this change, but it is important that the Academy stay the course until the goal is accomplished.

The Medicare Physician Fee Schedule is facing a major challenge, whether it comes to a head in 2006, or in a few years. But it is a key issue because direct access will be a hollow victory if audiologists are not being paid a fair amount for services.

We need to continue our work with key consumer organizations such as the Hearing Loss Association of America (formerly known as SHHH). When we seek letters to Congress, it would be helpful if the Congress also heard from the ultimate consumer of hearing care services.

Our PAC remains an important part of doing business in Washington. Even the regulatory process has a political dimension that can benefit from Congressional supervision and the PAC is a part of the game. We must continue growing the Academy PAC.

In short, the political process is just that, an ongoing process. Like freedom, protecting our interests requires constant vigilance. Peer relationships are important to teenagers. In some ways, the Academy is the younger sibling and the rest of the professional hearing care family needs to adjust to the fact that the kid is about to become an adult. On the other hand, we need to mature, settle in and watch our elbows.

The Academy has come very far, very fast: From a volunteer run organization, to being managed by an association management company, to a full time excellent professional team at a new headquarters office. The larger goal of professional and political autonomy for audiology has also taken major strides forward. With the great leadership provided by a series of Boards and Presidents, The Academy is continuing to mature as an organization. You have every right to be proud of your professional political progress as you approach the end of your teens.
A Question of Ethics

Ethical Practices Board Case Findings: 2005

The following is a summary of cases and their disposition as reviewed by the Ethical Practices Board during the year 2005. Members of the Ethical Practices Board include Jane Kakula, (Chair), Patricia Gans, Gloria Garner, Steven Gonzenbach, David Hawkins, Marilyn Larkin, Michael Metz, Georgine Ray, Thomas Tedeschi, Laura Wilber and Karen Jacobs (Board of Directors Liaison.)

A member was accused of violation of Rule 2a for harming a patient while making an ear impression, Rule 4a for selling used hearing aids as new, Rule 6a for misrepresenting his credentials and Rule 8b for insurance fraud. The alleged violation of Rule 6a was proven to be untrue. The alleged violations of the other rules were unsubstantiated. The EPB case was closed.

It was alleged that a member harassed and wrongfully terminated an employee in the member’s practice. The information provided to the EPB did not support the allegations. The EPB case was closed.

At the time of membership renewal, a member reported agreeing to a reprimand by a state licensure board for inadvertently including inaccurate information in the application for renewal of a state license. The circumstances surrounding the reporting of the inaccurate information were reviewed. The EPB determined there was no ethical violation. The EPB case was closed.

The EPB received a copy of a Settlement Agreement between a member and a state licensure board, suggesting incompetent practice by the audiologist. Upon further investigation the EBP discovered that the state later withdrew the Settlement because the charges were unsubstantiated and the member was cleared. The EPB case was closed.

It was reported that a member was using the title “AuD Candidate” while completing a Doctor of Audiology degree. The member was sent a Cease and Desist Request and the member complied with the request.

The EPB received a copy of a Settlement Agreement between a member and a state licensure board. In the agreement the member admitted to not having completed the appropriate number of continuing education hours for license renewal. At one time the state board issued one license for the practice of speech pathology and audiology. Several years later the board separated the professions and issued a separate licenses for audiology and speech pathology. The board gave the member a license to practice both professions and the member notified the board that only a license to practice audiology was necessary. The state did not update the file. When audited for continuing education the member was cited for not having the appropriate number of hours in speech pathology. The EPB determined there was no ethical violation and closed the case.

An individual who was a former member of the Academy reapplied to the American Academy of Audiology for renewal of membership. The applicant’s file included a notice that the member relinquished a state license to practice audiology. Circumstances surrounding the surrender of the license were unusual. The applicant practiced in a state requiring a mandatory return period for hearing aids. The applicant’s employer failed to refund returned hearing aids fit by the applicant. The state found that the applicant was legally bound to refund returned hearing aids, not the employer. The member paid the refunds out of pocket, relinquished the audiology license in that state and moved to another state. The EPB determined there was no ethical violation, closed the case and recommended approval of the applicant’s request for renewal of membership in the Academy.

The EPB received a complaint from an adult community with a copy of a letter from a member to residents of the community. It appeared that the administration of the facility changed a policy to no longer provide on-site space to healthcare practitioners. The member’s letter notified his patients that he would no longer be able to see them at the facility and provided his office address for their personal appointments. Though the letter conveyed a negative attitude toward the administration of the facility, EPB did not find an ethical violation. The case was closed.

A former American Academy of Audiology Fellow was found in violation of Rules 2d, 4a, 6a, 5b, 5c and 6b while that individual was an active member of the Academy.

MEDICARE ALLOWS COVERAGE OF OSSEOINTEGRATED AND BRAINSTEM IMPLANT AUDITORY DEVICES FROM HEARING AID CATEGORY

The Centers for Medicare & Medicaid Services (CMS) released a change request effective December 12, 2005 (see www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM4038.pdf) that will allow auditory osseointegrated devices and auditory brainstem devices to be eligible for Medicare payment as prosthetic devices. Medicare contractors will pay for osseointegrated auditory and brainstem auditory devices as prosthetic devices only when hearing aids are deemed medically inappropriate or cannot be used due to congenital malformations, chronic disease, severe sensorineural hearing loss or surgery. Medicare maintains its policy that it will not pay for any Part A or Part B expenses incurred for items or services related to “hearing aids or examination for the purpose of prescribing, fitting or changing hearing aids” (42 CFR 411.15(d)).
The 2006 CPT coding manual has been published with some changes to existing codes as well as the introduction of new codes that are of interest to audiologists. All changes become effective January 1, 2006.

**ADDITIONS:** The following are four new CPT codes for auditory rehabilitation:

- **92626** Evaluation of auditory rehabilitation status, first hour
- **92627** Each additional 15 minutes
- **92630** Auditory rehabilitation: pre-lingual hearing loss
- **92633** Auditory rehabilitation: post-lingual hearing loss

Audiologists may bill Medicare and other third party payers for 92626 and 92627 as evaluation procedures. On the other hand, while audiologists may bill codes 92630 and 92633 to some third party payors, they may not bill Medicare for them because these services are considered treatment, not diagnostic codes. Medicare policy only provides for the payment to audiologists for diagnostic services. Note that the reimbursement for both 92626 and 92627 are undervalued in the 2006 Medicare Physician Fee Schedule. The Academy and ASHA are seeking a correction from CMS to reflect a more appropriate reimbursement of these services.

**REVISIONS:** CPT Codes 92568 and 92569 have been editorially revised in order to clarify that 92568 is intended to report the threshold portion of the acoustic reflex testing. This change was a response to members’ concerns regarding confusion among third party payors about which procedures were included in these services. This change in definition helps to differentiate these two procedures, thereby disallowing third party insurers from bundling the acoustic reflex threshold and the acoustic reflex decay codes as they are and always were two separate procedures.

**DELETIONS:** CPT code 92510 has been deleted.

A detailed analysis of these changes and the clinical vignettes that accompanied the new codes reflected above are published in the AMA’s *CPT Changes 2006: An Insider’s View* that is available for purchase at [www.amabookstore.com](http://www.amabookstore.com).
The Academy of Audiology of Puerto Rico (AAPR) celebrated its 10th anniversary during 2005. Gail Whitelaw, Academy president, joined the group in the anniversary celebration and convention at the Wyndham Condado Plaza and Resort in San Juan. Whitelaw followed in the footsteps of many other leading audiologists who have graced past conventions including James and Susan Jerger, Charles Berlin, Richard Gans, Barry Freeman, Dave Fabry, Patricia McCarthy, Bob Keith, Noel Matkin, Brad Stach, Judy Gravel, Robert Glaser, William Martin, Gail Chernak, James Thelin, Craig Johnson, Angela Loavenbruck, Carol Flexer, Chaslow Pavlovic, Michael Raffin, Ian Windmill, Lee Van Middlesworth and others. This long-term relationship between AAPR and the American Academy of Audiology has helped to fortify the AAPR at all levels and to advance the profession of audiology in Puerto Rico.

In 1995, Puerto Rican audiologists met and voted overwhelmingly to become a proud state chapter member of AAA. During the last ten years, AAPR has been busy working to ensure our ability to serve our hearing impaired patients with the highest standard of care possible. We have seen the fruition of our efforts: in Puerto Rico, now only audiologists can evaluate, recommend and place hearing aids and most medical insurance plans now cover audiological services and, in some cases, part of the cost of the hearing aids. Our most recent achievement was the enactment of the Universal Newborn Screening Law, requiring either otoacoustic emissions or auditory brainstem response evaluations on all newborns prior to hospital discharge with appropriate follow-up for all infant hearing failures. We have completely revised the AAPR Scope of Practice to reflect all of the new changes in the way we practice audiology while abiding by a strong Code of Ethics. At the present time we are working with the AAA Director of Health Care Policy and CMS to determine if Medicare Advantage programs can discriminate against audiologists by denying us provider status. We encourage all state associations to join us in this endeavor and appreciate the assistance we are receiving from the National Office staff of the AAA.

The next annual convention is February 3 - 4, 2006 in the great Puerto Rican city of Ponce at the Ponce Hilton and Golf Resort. All audiologists, students, hearing industry representatives and medical professionals are invited to fly (or sail) down and enjoy a professional experience while relaxing in the turquoise waters of the Caribbean. More information is available in both English and Spanish on our new website: www.academia-audiologiapr.org

—Submitted by Mark McDowal
**News & Announcements...**

**Name Change for SHHH**

The Board of Trustees of Self Help for Hard of Hearing People (SHHH) voted to change the name of the organization to the Hearing Loss Association of America on November 6, 2005 during their fall meeting. Terry D. Portis, Executive Director of SHHH states, “SHHH needs to position itself to meet the needs of a new generation of people with hearing loss while continuing to serve the constituents who rely on us today. I believe that by updating our name and image we will be better able to communicate our message and fulfill our mission. SHHH expects to complete the transition to the Hearing Loss Association of America in March 2006.” The population of people in the United States with hearing loss has grown from an estimated 28 million in 1989 to over 31 million in 2004, and is anticipated to grow by a third in less than a generation, to 40 million people. SHHH’s mission is to open the world of communication to people with hearing loss through information, education, advocacy and support.

The Hearing Loss Association of America (formerly Self Help for Hard of Hearing People (SHHH)) is the nation’s largest membership and advocacy organization for people with hearing loss. Founded in 1979 by Howard E. “Rocky” Stone, the Hearing Loss Association of America opens the world of communication to people with hearing loss through information, education, advocacy and support. It publishes a bimonthly magazine, Hearing Loss and its website is www.hearingloss.org. The national support network includes the Washington, DC, area office, 13 state organizations, and 250 local chapters. The Hearing Loss Association of America’s straightforward message has changed the lives of thousands of people: Hearing loss is a daily challenge you can overcome. You do not have to hide your hearing loss. You do not have to face hearing loss alone.

**California Academy of Audiology Meets in Anaheim**

The California Academy of Audiology (CAA) held their 6th annual conference in Anaheim, CA September 15-17, 2005. American Academy of Audiology President, Gail Whitelaw, provided the welcoming address, as well as an informative presentation on Auditory Processing Disorders in children. Whitelaw outlined ways in which the national American Academy of Audiology organization can work cooperatively and effectively with state academy organizations. She specifically described various cooperative programs that could result in the betterment of audiology in the state of California. The CAA conference featured speakers highlighting research in hereditary hearing loss, cochlear implants and auditory neuroscience, cortical plasticity with electrical stimulation, hearing aid manufacturers’ updates, fitting strategies and improved treatment outcomes, hearing conservation, communicating the value of our profession, and an educational audiologist forum. The CAA educational committee continues to provide an interesting and balanced opportunity for continuing education. The 7th annual CAA conference will be held in San Jose, California, September 14-16, 2006. For information concerning next year’s conference, contact Larry Eng at larryaud@gghs.com.

**PASSES**

Candace A. Kamm, PhD, died November 4, 2005 at her home in Mountain View, CA after a valiant battle with lung cancer. Dr. Kamm received a Master’s Degree in Speech Pathology and Audiology from California State University, Los Angeles in 1974 and a PhD in Psychology from UCLA in 1980 and served as a research audiologist at the UCLA School of Medicine, Division of Head and Neck Surgery. Kamm affiliated with Bell Labs, Bellcore, AT&T Labs in NJ and FXPAL in Palo Alto, CA, where she continued research on speech recognition and related technologies. She co-created the ParaDiSE framework for modeling performance of spoken dialog systems, a groundbreaking project in her field. Dr. Kamm held patents on several methods and systems for delivering pre-recorded voice messages to both live recipients and recording systems.

On December 17, 2005, O.T. Kenworthy, passed away at age 56 following a courageous battle with colon and liver cancer. Dr. Kenworthy received his BA and MA in Audiology at the University of Washington, and his PhD at University of Wisconsin-Madison in 1984 in the area of Child Language. O. T.’s passion was the early identification of hearing loss and the development of deaf and hearing impaired children. He served as an Assistant Professor at Vanderbilt University/Bill Wilkerson Center, the Executive Director of Providence Speech and Hearing Center in Orange, CA, and as Associate Professor in the Dept. of Communicative Disorders at California State University, Long Beach. Dr. Kenworthy was active in many local, state and national endeavors in audiology and the American Youth Soccer Association. His life will be celebrated well by all who knew, respected and loved him.

Carl C. Crandell, PhD, Associate Professor at the University of Florida (Gainesville) in the Department of Communication Sciences and Disorders, passed away suddenly at age 47 on December 6, 2005. Dr. Crandell was nationally recognized for his numerous presentations and publications in the areas of classroom acoustics and the use of FM amplification systems for students with hearing impairment. Crandell earned his BA and Master’s degrees from Florida State University and his PhD degree from Vanderbilt University. He previously held a faculty position at the University of Texas, Callier Center from 1989-1994 and then joined the faculty at the University of Florida in 1994 where he was an instructor in the on-campus and distance learning AuD programs, and a mentor for PhD students.
The International Binaural Symposium held in Manchester (UK) 2005 (29–31 Oct) was organized and sponsored by the Medical Research Council’s Hearing and Communications Group of the UK. The event marked the 25th anniversary of the release of the influential report, “Binaural Hearing and Amplification,” edited by Cy Libby, and published by Zenetron of Chicago in 1980. The Binaural Symposium attracted some 200 delegates from Asia, Africa, Australia, North America and Europe, demonstrating the importance of binaural issues around the globe. There are an estimated 560 million people with bilateral hearing impairment in the world, a number that is expected to grow to around 703 million by the year 2015. The symposium highlighted the need for improved scientific methods to evaluate the benefit of bilateral amplification and advanced signal processing features in hearing aids. Traditional, laboratory-based evaluations methods often do not adequately reflect the challenging environments of today’s work places and social life. Further research is urgently needed to show the benefits of personalized binaural hearing support from the exciting new generation of hearing aids that are being made possible by miniaturization, and by new approaches to making aids more comfortable and demonstrating the benefits of hearing instrument technology in the clinic. The Symposium papers will be published in 2006. More information on the event is available by e-mail at naomi.stocks@mrchear.man.ac.uk.

Hugh Knowles Scholarships Awarded at Northwestern University

Cara DePalma, a Summa Cum Laude graduate of The Ohio University, and Renee Banakis, a Summa Cum Laude graduate of Miami University of Ohio, are the first Hugh Knowles AuD Scholars at The Department of Communication Sciences and Disorders at Northwestern University. These scholarships are available to outstanding applicants to the AuD program and are awarded in addition to a departmental scholarship by The Hugh Knowles Center for Clinical and Basic Science in Hearing and its Disorders. The Hugh Knowles Center was established in the Department of Communication Sciences and Disorders at Northwestern University in 1988 through a gift from Knowles Electronics in honor of its founder, Hugh S. Knowles. The Center is dedicated to pioneering research directed not only toward bringing the joy of hearing to those denied its pleasure, but also toward preventing others from suffering its loss. Its mission is to promote excellence in hearing research, teaching, training, and clinical service. For more information about these scholarships and the AuD program at Northwestern University contact AuD@northwestern.edu.
International Society of Audiology Offers Conference Scholarships

Four $1000 Student Scholarships are available for students to attend and participate in the International Congress of Audiology in Innsbruck, Austria, September 3 –7, 2006. The Executive Committee of the International Society of Audiology (ISA) because of the generosity of the A. Charles Holland Foundation is pleased to be able to offer the second biannual scholarships for undergraduate or graduate students to attend and present a research poster at the XXVIIIth International Congress of Audiology. The $1000 scholarships will be awarded to four scholars to help support travel and housing as well as registration fees.

Applicants for the 2006 scholarships must be full-time students in a program leading to a degree in Audiology or Hearing Science or related discipline. An effort will be made to select scholars representing the diverse countries represented in the ISA membership. Awardees will be selected by the Scientific Committee of ISA based on the application reviews. The deadline for submission is February 15, 2005 with notification of award by March 15, 2006. For more information and an application form please contact Sharon Fujikawa Brooks at sfujikaw@uci.edu or visit the ISA website at www.isa-audiology.org.

NIH Director’s Pioneer Award

The National Institutes of Health announces the 2006 NIH Director’s Pioneer Awards. A key component of the NIH Roadmap for Medical Research, the NIH Director’s Pioneer Award supports exceptionally creative scientists who propose pioneering approaches to major challenges in biomedical research.

In September 2006, NIH expects to make 5 to 10 new awards of up to $500,000 in direct costs per year for 5 years. Women, members of groups that are underrepresented in biomedical research, and individuals in the early to middle stages of their careers are especially encouraged to apply.

Open to Scientists Who Are

U.S. citizens, non-citizen nationals, or permanent residents
Currently engaged in any field of research
Interested in exploring biomedically relevant topics
Willing to commit at least 51% of their research effort to the Pioneer Award project

Apply Online

Streamlined application includes 3- to 5-page essay and 3 letters of reference
Apply between January 15 and February 27, 2006

More Information

See the Pioneer Award Web site, http://nihroadmap.nih.gov/pioneer
E-mail questions to pioneer@nih.gov

NHS 2006 Conference

The theme of the 2006 NHS Conference is “Beyond Newborn Hearing Screening: Infant and Childhood Hearing in Science and Clinical Practice.” The NHS Conference will be held May 31 - June 3, 2006 at the Villa Erba Congress Center in Cernobbio, Italy. Conference co-directors are Ferdi Grandori and Deborah Hayes. The conference will include Round Table discussions, Special Sessions, Keynote presentations, free papers, poster sessions as well as satellite events. Abstracts may be submitted on line at www.nhs2006.polimi.it. Important dates for the 2006 NHS Conference are the deadline for abstract submission (Jan. 18); notification of acceptance and format (poster/oral presentations (Feb. 20); and the deadline for Early registration and hotel reservations (Mar 15). For more information, contact Sharon Scagnetti, Institute of Biomedical Engineering CNR, piazza Leonardo da Vinci, 32 20133 Milan, Italy, nhs@polimi.it.
AFA REPORTS ACTIVITIES

- The Audiology Foundation of America (AFA) kicked off its annual fundraiser with an emphasis on supporting state licensure efforts and enhancing professional autonomy for audiologists. Donations can also now be accepted online at www.audfound.org.
- AFA raised over $35,000 at the recent Academy of Dispensing Audiologists (ADA) convention in Savannah, GA, through combined efforts in both an art auction and golf tournament. The AFA Art Auction featured Deborah Price as this year’s auctioneer. The AFA Golf Tournament raised $18,000 with over 80 golfers playing the Club at Savannah Harbor.
- The AFA recognized the Arizona School of Health Sciences’ entry-level and advanced (ASHS) AuD degree programs at A.T. Still University (ATSU) with an Award for Excellence in Education at the Academy of Dispensing Audiologists Convention. The ASHS program for established practitioners has graduated 993 doctors of audiology with an additional 600 audiologists currently in the degree program.
- The first annual “David P. Goldstein: Outstanding Audiologist Award” was presented at the October 2005 ADA Banquet by the AFA to David Cieliczka. The award recognizes the accomplishments of an audiologist who has made significant contributions to the profession by promoting the transformation of audiology to a doctoral profession with the AuD as its distinctive designator. The award honors David Goldstein, founding chair of the AFA. Goldstein is professor emeritus at Purdue University in West Lafayette, IN.
- Scholarships for $1,000 are now available on a first-come, first-served basis for school-based practitioners who are not currently enrolled in a distance education AuD program, but who plan to do so by June 30, 2006. The AFA received a $12,000 donation from Phonak in support of scholarships for school-based practitioners who plan to earn an AuD degree. Rules and an application form are now available online at the AFA website (www.audfound.org).

AUDITORY SOCIETY MEETING 2006

The American Auditory Society (AAS) will hold their annual meeting in Scottsdale, AZ at the Chaparral Suites Resort, March 5-7, 2006. The AAS is a multidisciplinary organization composed of individuals whose professional work is dedicated to the ear, hearing and balance. The mission of the Society is to foster the dissemination of knowledge and exchange of information among those professionals. Michael Gorga is the 2006 AAS Meeting Program Chair. Additional information, as well as the complete program and registration for the meeting may be found online at www.amauditorysoc.org. The conference will feature the following events:

- Carhart Memorial Lecture: Joseph B. Nadol Jr., MD
- Translational Research Presentations: John Rosowski, PhD; Ruth Litovsky, PhD
- Douglas Cotanche, PhD; Steve Armstrong, BSEE
- Special Session: Hearing Aids: Todd Ricketts, PhD; Ruth Bentler, PhD; Jim Kates, PhD
- Life Achievement Award Recipient: Marion Downs, MS, DHS
- Introduction to NIH Research: Fred Bess, PhD
- Podium Presentations: 52+ submitted papers
- Technology Update Sessions: 16, 30-minute sessions
- NIH Mentored Student Posters: 15 General Posters
- NIH Research Forum: Daniel Sklare, PhD
The American Academy of Audiology offers its members many benefits. Some members report that they are not 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. Here they are!

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

**CONTINUING EDUCATION:**
The Academy’s CE Registry provides a transcript of your CEUs at a discounted member rate. www.audiology.org/professionals/ce

**PROFESSIONAL SUPPORT MATERIALS:**
The Academy offers discounted prices to members on a wide variety of:
- Educational Publications
- Marketing Tools
- The Front Line
- Office Training Kit
- Audiograms
- Ear Anatomy Posters
- Interactive CD’s
- Tapes and more

**FIND AN AUDIOLOGIST/LINKUP:**
LINKUP advertises your website for an annual subscription fee. E-mail ssebastian@audiology.org to order. This web feature helps consumers find you and enables you to network with other audiologists.

**RESEARCH DOME:**
The Dome online research subscription is the premier information service developed for clinicians, educators, researchers and students in the field of Audiology and Communication Sciences and Disorders. Save 47% off the regular price ($119.95) of an annual Dome subscription.

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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# 706768 and/or call the Academy for discount coupons.

**COMPENSATION & BENEFITS SURVEY:**
The American Academy of Audiology conducted its fourth annual Compensation and Benefits Survey in the Fall of 2004. A full report of the survey with detailed information is available for Academy members online at www.audiology.org/hearcareers.

**HEARCAREERS:**
Whether you are seeking a job or advertising 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.

**HEALTH INSURANCE:**
Association Health Programs at (888)450-3040 or www.associationpros.com provides health, long-term care, life, disability, dental and vision plans (and more!) to meet members needs. Call today.

**WORLDWIDE 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 from 3.9 cents per minute with no surcharges. To activate your calling card, call 1-866-895-5714 or go to www.audiology.org/calling card.

**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 the Member Benefits Coordinator, at 703-790-8466 x1044 or vscherstrom@audiology.org.