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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 jnorth1111@aol.com.

Audiology Today welcomes feature articles, essays of professional opinion, special reports and letters to the editor. Submissions may be subject to editorial review and alteration for clarity and brevity. Closing date for all copy is the 1st day of the month preceding issue date.
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ON THE COVER
This issue cover of Audiology Today shows one of the most valuable uses of the ubiquitous pinea – a unique pencil holder. And, just in time for the fall season and back-to-school month. This photo, borrowed from the Academy’s popular “The Year in Ears” 15-month desktop calendar, is one of many clever and seasonal views of the pinea available on CD. Check out the Academy Store to order your calendar at: www.audiology.org/academy store.
I hope this finds you all well and rested from the summer. The pace of life seems to slow down in the summer, allowing me to reflect on the past and organize some goals for the future. With that said, I would like to report on the “State of the Academy” and then share some of my desired outcomes for this year.

**DUES INCREASE PERMITS NEW MEMBER BENEFITS.**

I am pleased by the incredible support of the membership for the dues increase for this year. The Board of Directors thought long and hard before approving the change in dues. We ascertain from the membership surveys what our colleagues feel are priorities and desired membership benefits. To be responsive and implement these goals, an increase in dues was essential. The Board appreciates the commitment of the Academy membership and your understanding of the financial intricacies of running an organization of this size. The Academy continues to grow in scope and visibility, enabling us to represent the profession more effectively.

The additional revenue is already being put to good use. This year the Academy has expanded its staff to include some new key positions. As an organization that relies on volunteers in leadership roles, we draw upon the knowledge and guidance of association professionals in areas key to the goals of the Academy. Our new staff members include Lisa Miller, Director of Reimbursement, and Phil Bongiorno, Director of Government Relations. In the past, one staff person handled these two responsibilities; however, the scope of these jobs was overwhelming for a single position. We now have two people dedicated to focusing on their areas of expertise. In the short time they have been with the Academy, we have benefited from their guidance; they have already positively influenced our decision-making in these areas. Additionally, we have hired Kate Thomas, Health Care Policy Coordinator, to assist Lisa and Phil and to triage member questions and concerns.

**EDUCATION AND PROFESSIONAL STANDARDS.**

Education and professional standards are key areas of focus for the Academy, especially in view of the completion of the transition to a doctoral profession in 2007. Creating, implementing, and revising professional standards is a complicated process that challenges the profession. Cornelia Gallow, Education and Standards Manager, has been hired to help the Academy with this ongoing daunting task. The Board of Directors hope to further expand staff in this area as we fully develop education and professional standards. Additionally, trained staff will interface with the agency or agencies accrediting training programs to ensure that appropriate outcome measures are in place to assess that the standards are being met.

**THE NATIONAL OFFICE.**

AudiologyNOW!, our new branded name for our annual convention, continues to be a huge success. I am proud to report that our past meeting in Minneapolis attracted 7,065 attendees, the second highest attendance over the past five years. This was under the incredible leadership of Cheryl Kreider Carey, Deputy Executive Director, Convention, Exposition, and Education. To be this successful, though, Cheryl has increased her staff to help her with the multi-complexities of running a convention that is state-of-the-art and is setting the standard for other professional organizations. In addition to providing a setting for an incredible learning experience, AudiologyNOW! provides the Academy with non-dues revenue, another source for supporting
the demands of a dynamic Academy. Thank you to everyone who helped make AudiologyNOW! 2006 a resounding success. For those of you who were unable to be in Minneapolis, please join us in Denver, Colorado, April 18-21, 2007. This year’s AudiologyNOW! Program Committee is well on its way to creating a spectacular learning experience by incorporating many of the member suggestions obtained from your prior convention evaluation forms.

To be fiscally responsible, we must have sound financial accounting and guidance. We are fortunate to have Sandy Bishop, Director of Finance, who is relentless in finding ways to save us money without sacrificing quality of services. Additionally, we have hired Leza Owens, Staff Accountant, to join Sandy. Their joint efforts and creativity have already effected financial savings for the Academy.

Bishop, Director of Finance, who is relentless in finding ways to save us money without sacrificing quality of services. We are fortunate to have Sandy. Their joint efforts and creativity have already effected financial savings for the Academy.

Putting audiology on the “map” is not an easy task. Sydney Hawthorne Davis and her Communications Coordinator, Elizabeth Lowman, are hard at work spreading the word. Last year, we enjoyed being listed in many of the major magazines such as Newsweek, Men’s Health, and U.S. News and World Report, as well as endless local and regional television and radio broadcasts, and publications. Expanding staff allows for the man-hours requisite for promoting our profession and educating the consumers of our services.

Our benefits department, under the leadership of Vanessa Scherstrom, is always hard at work expanding membership benefits. I recommend checking the “Membership Benefits” area of the website periodically to note the “perks” that the Academy is providing to save you money and/or to satisfy your personal and professional needs.

**MEDICARE REIMBURSEMENT.**

This year Medicare proposed the elimination of the Non-Physician Work-Pool, the category under which Audiology is listed within the Medicare system. This was an unexpected change that, if implemented, would have drastically reduced reimbursement for audiology codes. Significant Academy expenditures were required in order to undertake the costs for expert counsel specific to this issue. This financial outlay was/is mandatory for securing our autonomy and establishing fair and equitable reimbursement for our services. The Medicare reimbursement structure is the template or “gold standard” used by other third party payers. Significant Academy expenditure was/is mandatory for securing our autonomy and establishing fair and equitable reimbursement for our services. The Medicare reimbursement structure is the template or “gold standard” used by other third party payers. We literally could not afford to ignore this important and potentially profession-changing event.

**WEBSITE FACELIFT.**

An old adage states that one has to spend money to make money. It takes money to impact change. Future hires will include a web manager who will help make our website stronger and better. I hope you have all noticed that our website has undergone a facelift. Please take the time to visit the new website (it still resides at www.audiology.org) driven by innovative, state-of-the-art software; it is just the beginning of things to come. Current changes allow for easier navigation by being more user-friendly. We will begin developing a consumer section which will allow the public to access our website and obtain links to valuable information. The Academy needs to be recognized as the conduit for obtaining and disseminating hearing and balance health care information.

One of my major desires is to see increased student involvement. Students are the future of our profession. We all play a role in making students feel a “part of the family.” We have to be good role models; students carry the torch into the future. Please agree to be a preceptor for a student. The success of the clinical year is predicated on strong clinical placements. We have to promote professionalism. Being an audiologist is more than having the title “doctor.” It means raising our standards to exceed what the public expects from a doctor of a profession. Universities must offer education and training on how to be an effective preceptor. Audiologists must give of themselves to foster a legacy of caring. Contact the University programs that are placing students and enroll in a class that guides you in how to be an effective and responsive preceptor.

A strong profession is comprised of practitioners who never stop learning. The Academy strives to expand the opportunity for distance learning. Beginning this fall, we will be offering distance learning opportunities taught by distinguished faculty from within our own membership presenting on topics critical to you. We will start this process slowly with the goal of ultimately expanding to multiple courses covering a broad spectrum of subjects. It will give you a chance to learn with your peers and obtain continuing education without having to leave your home and/or business.

My goals for this year are manifold and after reading the above, you will be pleased that some of them don’t need money to see them come to fruition. I want to see good communication among the Board members and the membership and to see staff responsive to membership needs. Please fill out member surveys, contact Board members with your opinions, and/or contact Laura Fleming Doyle, our Executive Director. We want and need to hear what you are thinking and we need to know how we are doing as an Academy and ultimately as a profession.

Running the Academy is no different than running a business. The success of this business is multi-faceted and cash flow is a key component for achieving our vision. The yearly funds we have at our disposal are limited, so this means having patience when your priority is not on this year’s list of “things to accomplish.” The Board of Directors and I thank you for exercising tolerance when you have to wait for “next year.” We’ve got the message; big things are coming.
My name... Carmen Brewer

childhood ambition... I wanted to be a "doctor"

first job... newspaper delivery on my bike

inspiration... the many who have believed in me

fondest memory... the day my daughter was born

favorite movie or book... Benny & Joon - and yes... I have made grilled cheese with an iron

indulgence... travel, cookbooks, shoes

proudest moment... earning my Ph.D., a "doctor" at last

perfect day... exploring a new city, museum, lunch at an outdoor cafe, and of course, shopping with family or friends

My life... frequently on overload, but that's the way... I like it

My profession... Audiology!

Carmen Brewer
My name is Kris English.

Childhood ambition: To be... Hayley Mills' best friend.

First job: Donut Shop, Marina del Rey, CA. Customers included Crosby, Stills, and Nash.

Inspiration: Abraham Lincoln!

Fondest memory: Attending a Notre Dame football game. Oh, USC won, but still.

Favorite movie or book: "Introvert Advantage: How to Thrive in an Extrovert World." This explains everything.

Indulgence: Self-truth: None. I'm the poster child for moderation.

Proudest moment: My kids graduating from college.

Perfect day: Any day with my husband.

My life... Just keeps getting better and better.

My profession: Audiologist.

Kris English
As we all know, one of the rules that we learned in kindergarten that is still applicable today is “to play well with others.” When the Academy Board drafted the 2002 Strategic Plan they were very purposeful in including a section of the plan related to “other organizations.” The Academy Board designated that the Academy should find ways to foster collegial relations with allied organizations. During the 2005 update of the strategic plan, this section remained an important part of the Academy’s strategies.

In keeping with this initiative, when the Deafness Research Foundation (DRF) approached the Academy in 2002, and again in 2006, to provide a complimentary copy of their magazine Healthy Hearing to all Academy members, the Academy leadership agreed that this might be something of interest to our members and their patients.

Most of you received this magazine along with a cover letter from me suggesting you might wish to keep this magazine in your waiting rooms for your patients. Unfortunately, we were unaware of two problems that would arise from this mailing. First, the magazine included a fund-raising envelope for the DRF. We did not intend to promote the fund-raising efforts of the DRF, thereby deterring from the AAA Foundation. The AAA Foundation works very hard to raise funds to support education, research and public awareness in audiology and is the single foundation that we endorse.

In agreeing to provide this magazine to Academy members, we were not provided any right of editorship, and were not privy to the content. We made our decision to distribute this magazine based on the quality of articles in past issues. This resulted in the second problem. The magazine contained an advertisement for the internet sale of hearing aids, a topic that we weren’t expecting to be advertised within the DRF magazine. Historically, the DRF publication has contained professional articles with educational value.

We heard from two very unhappy members. We would not be surprised if there are more of you who are disappointed but have not had the time to share your thoughts. I want to let each of you know that we have communicated to the DRF the valid concerns expressed by our membership.

In this instance, our efforts to participate in a collaborative experience differed greatly from that of 2002 when we initially provided the complimentary issue of DRF’s Healthy Hearing magazine. Please allow me to take this opportunity to both alert you to what we have learned as an Academy and to apologize for any inconvenience this magazine may have caused. We will continue to look for ways to have cooperative relationships with other organizations in order to be collegial, as it is an integral part of our strategic plan. We have ascertained that “playing well with others” isn’t always as easy as it seems.
On Thursday, July 13th, the Academy’s Board of Directors visited Capitol Hill to meet with lawmakers to advocate on behalf of audiology. The morning began with a fundraising breakfast for Representative Jim Walsh (NY-25”), a true champion of hearing health issues. Rep. Walsh is well known to audiologists as the legislator responsible for passing the universal infant hearing screening bill. Rep. Walsh is currently the Chair of the Veterans Affairs Appropriations Subcommittee of the House Committee on Appropriations and is considered a frontrunner for the Chairmanship of the full committee in the next Congress. This breakfast event to honor Rep. Walsh was made possible through the Academy’s Political Action Committee (PAC), and is a prime example of how funds raised by the PAC enable the Academy to support leaders in Congress who have taken the lead on audiology issues. The breakfast provided a unique opportunity for the Academy Board Members to sit down with Rep. Walsh and thank him for his continued support for Direct Access legislation (HR 415) and for his sponsorship of the EHDI Reauthorization legislation (HR 5250). Nicole Henning and Melissa Clark represented the Academy of Dispensing Audiologists at the PAC breakfast. The event provided an informal forum to discuss the future of audiology and our role in providing hearing health services to the nation’s hearing impaired population.

Following the breakfast meeting with Rep. Walsh, the members of the Board of Directors set out on an extensive campaign to some 25 scheduled meetings with their respective Senators and Representatives and other congressional leaders, seeking additional support for audiology services. The legislative meetings provided powerful outlets for the Board members to speak out, as both constituents and audiologists, and many of the meetings yielded positive feedback regarding support for Direct Access and the EHDI legislation. As a result of Therese Walden’s visit to his office, Congressman Al Wynn (MD- 4th) signed on to HR 415 as the 54th cosponsor on the bill. As demonstrated by the success of the Board members’ Hill visits, it is imperative for audiologists to speak out as both constituents and professionals to ensure that the issues are making it to the desks of their elected officials!

Academy Sponsors Hearing Testing, Hearing Health Awareness at House Health Fair

A special thank-you to Therese Walden and Holly Burrows from the Walter Reed Army Medical Center in Washington, DC for contributing to the tremendous success of the House of Representatives Annual Health Fair held on Thursday, July 27th at the Rayburn House Office Building. The Health Fair was designed to provide health screenings and educational information to House Members and staff. The Academy featured a booth with information on a wide variety of hearing health issues, including hearing loss, hearing conservation, infant hearing screenings, and materials on finding an audiologist. It was estimated that over 500 people attended the Health Fair, and thanks to the hardwork of both Therese and Holly, a record 85 people received hearing screenings at the Academy’s booth. Many of the people who received hearing screenings were young people concerned about the effects of exposure to loud music and the prolonged use of headphones and personal music devices, a reflection of the growing awareness of hearing health issues and the immense value of hearing conservation to younger generations.
The article “Risky Business: What You Need to Know About Hearing Aid Commissions” in this issue of Audiology Today is very important. We urge all members to take a moment and read it carefully. It deals with certain business practices that may violate federal and/or state anti-kickback laws.

Unlike other types of fraud, business arrangements that violate the anti-kickback laws are not always obviously illegal. They may be presented in ways that do not set off internal alarm bells. For example, a hearing aid manufacturer may offer an audiologist points towards the purchase of equipment and software based on the number of hearing aids the audiologist purchases from the manufacturer. The equipment and software offered may indirectly benefit the audiologist’s patients. The manufacturer may assure the audiologist that the arrangement has been reviewed and approved by the manufacturer’s legal counsel. Yet, this arrangement is a potential violation of the federal Anti-Kickback Statute.

Because such business arrangements may appear at first glance to be innocuous, there is a danger that audiologists and other health care practitioners may inadvertently violate anti-kickback laws. For that reason, it is important that all audiologists have a basic familiarity with the federal Anti-Kickback Statute as
Ethical and Legal Issues & Hearing Aid Commissioners

well as their state anti-kickback law. The federal Anti-Kickback Statute prohibits any person from offering, paying, soliciting, or receiving remuneration (i.e., anything of value) in return for referrals of items or services payable under a federal health care program. Both parties to the transaction are liable. (Most states have their own anti-kickback statute that may differ from the federal statute.)

Because the federal statute is so broad, the Department of Health and Human Services’ Office of Inspector General (OIG), the agency that enforces the Anti-Kickback Statute, has created a number of “safe harbors.” If a transaction meets all of the requirements for a safe harbor, the parties to the transaction are protected from liability. For example, the employee safe harbor protects any amount paid by an employer to a bona fide employee.

We expect to see increasing efforts to attack fraud in federal health care programs. Everyone knows that the Medicare program is looking for ways to cut costs. In Washington, attacking fraud and abuse is a perennially popular way to cut costs and trim budgets. Who can argue with reducing fraud?

Last year, the Deficit Reduction Act of 2005 (Public Law 109-171) included big increases in funding for Medicare and Medicaid “program integrity” efforts. It requires CMS to create a new Medicaid Integrity Program to match the existing Medicare Integrity Program. Funding for the Medicaid anti-fraud program starts at $5 million in fiscal year 2006, then jumps to $50 million in FY 2007 and 2008 and $75 million each fiscal year thereafter. The Deficit Reduction Act also requires that, effective January 1, 2007, state Medicaid plans must require that any entity (e.g., a hospital, nursing home, or group practice) that receives or makes annual Medicaid payments of at least $5 million must have written policies on fraud and abuse for its employees and contractors. The Medicare and Medicaid programs are clearly getting more serious about fraudulent practices that cost them money.

If a business arrangement is proposed to you that appears questionable, do an “anti-kickback analysis.” Is someone being offered remuneration in return for referrals or purchases of items or services that are reimbursable under a federal health care program? If so, does the transaction qualify for a safe harbor?
Think of some of the tools and methods of diagnosis and treatment that we use daily in our audiology practices that have been developed by researchers in audiology and hearing science. A host of acronyms comes to mind, such as ABR, ASSR, DPOAE, APHAB, HINT, DHI, NU-6, VEMP, SSW, REAR, NAL-R. We could add to this list *ad infinitum* thanks to the researchers in our field who have advanced the profession of audiology.

We have enjoyed an era of dramatic advancement in our understanding of basic processes of hearing and balance in health and in disease. However, to improve human health and treatment options, such basic scientific discoveries must be translated into practical, clinical applications that improve patient outcomes. With the right training and support, audiologists are in an excellent position to contribute materially to these efforts. As noted by the NIDCD (http://grants.nih.gov/grants_guide/notice-files/NOT-DC-05-002.html): ‘Research on the measurement of hearing, the clinical assessment of hearing disorders and the nonmedical habilitation/rehabilitation of hearing are uniquely within the province of the discipline of audiology.’ These and other areas of research in the hearing and balance sciences clearly can benefit from the background and clinical insights of audiologists.

However, we are now entering an era of a dramatic shortage of audiologist clinician-scientists. If the profession of audiology is to remain vital, if its knowledge base is to keep pace with and utilize advancements from other fields of study, if it is to become truly autonomous, then audiologists must continue to actively participate in and support a strong research base. How do we foster this home-grown research? We do it by providing the necessary training and support to our doctoral students who wish to integrate research into their career path. We also do it by continuing to encourage, mentor and support new investigators who show promise as productive researchers.

Enclosed in this issue of *Audiology Today*, you will find a brochure describing the AAA Research Awards program, which provides funds for the support of research by new investigators and students. The New Investigator Award provides a $10,000 grant to support pilot/feasibility studies of new doctoral-level investigators that will allow them to compete successfully for major funding support. Just as students are the life-blood of our profession, they are also our future researchers and teachers. The Academy offers the Student Research Award of $5000 for research by graduate students in audiology programs, and the Summer Fellowship Award of $2500 to undergraduate or graduate students to help kindle an interest in a research career through a summer research experience. For more information and award application procedures, please go to http://www.audiology.org/academiaresearch/Research/Awardprograms/.

The overall goal of the Academy’s Research Awards program is to increase the body of knowledge in audiology and hearing and balance sciences through a process that will allow researchers, teachers, clinicians and students to exchange information, resources, and expertise. The Research Award program is made possible through your generous donations to the American Academy of Audiology Foundation and provides the seeds for vital audiology research endeavors. We encourage you to support this effort with a donation to the AAA Foundation Research Award program. Who knows, your donation may support the next major advancement in audiology.
Do you know graduate students or postdoctoral investigators interested in conducting progressive research in the hearing sciences? Give them a Research Awards brochure and let them know we want to hear from them!

In our efforts to support a quality audiology Research Awards program, the AAA Foundation has partnered with the American Academy of Audiology to create a new brochure containing the most up-to-date information on the awards program. These brochures are available free of charge for display and distribution in academic and university settings, and for use at state and local association meetings. Contact the AAA Foundation office (kculver@audiology.org or 703.226.1049) to request your supply.

And don’t forget the AAA Foundation relies on the support of the Academy membership in order to continue funding the Research Awards on an annual basis. You can make your tax-deductible gift at www.audiologyfoundation.org. Thank you in advance for helping us ensure that research in audiology and the hearing sciences receives the funding it deserves.
Audiologists are guided and governed by two sets of principles: legal and ethical. The mark of a professional is that practice is guided not only by the law, but also by a code of ethics.

As Academy members, we agree to abide by our Code of Ethics, which includes, among other things, Rule 4c: “Individuals shall not participate in activities that constitute a conflict of professional interest.”

Conflicts of interest (COI) may pose legal, as well as ethical, risks. For example, if an audiologist accepts payments or other benefits from a hearing aid manufacturer in return for prescribing that manufacturer’s products, and if the products in question are reimbursable under a federal health care program, the arrangement is a violation of the federal Anti-Kickback Statute (the “AKS”). Health care providers, including audiologists, are prohibited from offering, giving, soliciting, or accepting payments for referrals of items (e.g., hearing aids) or services that are reimbursable by a federal health care program. Federal health care programs include Medicare, Medicaid, and TRICARE. Violation of the federal AKS is a felony that carries both civil and criminal penalties.

This article focuses on the legal issues involved in conflicts of interest. Specifically, it looks at commissions or other gifts of value for the sale of hearing aids and how paying or accepting such commissions may violate the AKS.

**RISKY BUSINESS**

Audiologists are sometimes offered commissions, bonuses, or other rewards based on the number of hearing aids they prescribe. These payments may be in the form of money, gifts, gift certificates, trips, or credits to accounts. Accepting such commissions may violate the law. Consider these four scenarios:

**Scenario #1:** An ENT practice that employs two audiologists pays the audiologists productivity bonuses based on the number of hearing aids they sell each month.

**Scenario #2:** An ENT hires an audiologist as an independent contractor to come into the ENT’s office twice a week to perform hearing tests and fit hearing aids; the ENT pays the audiologist according to a formula that takes into account the number of hearing aids prescribed.

**Scenario #3:** A hearing aid manufacturer offers audiologists points for each hearing aid they purchase from the manufacturer, which can be “cashed in” to purchase additional hearing aids, software, or free training sessions.

**Scenario #4:** A hearing aid manufacturer offers audiologists points for each hearing aid they purchase from the manufacturer, which can be “cashed in” for gifts or trips (which may be identified as “continuing education” but which occur in the Caribbean or the Orient and contain minimal hours of education).

Have any of the audiologists in the above scenarios broken the law? When is a commission a productivity bonus used to reward hard work, and when is it a “kickback” that encourages audiologists to over-prescribe hearing aids at taxpayer expense?

To answer these questions, we must learn a little law. Specifically, we must acquaint ourselves with a federal law called the Anti-Kickback Statute.

**THE ANTI-KICKBACK STATUTE**

The Federal Anti-Kickback Statute (the “AKS”) prohibits any person from knowingly and willfully soliciting, receiving, offering, or paying remuneration to induce or reward referrals of items or services reimbursable under a federal health care program. Thus, if remuneration is paid purposefully to induce the recipient to purchase, order, or prescribe hearing aids that are reimbursable, in whole or in part, under a federal health care program, the statute is violated.

“Remuneration” is defined broadly to include anything of value.

So, let’s say an ENT offers to refer patients to you in return for a share of the revenue from any hearing aid sales. Suppose further that some of the patients referred by the ENT are beneficiaries of Medicare, Medicaid, or other federal health care programs. This arrangement would potentially violate the AKS, because you would be paying remuneration to the ENT (i.e., a
About Hearing Aid Commissions

share of the revenue from hearing aid sales) in return for referrals of patients who are to be provided items (e.g., hearing aids) or services (e.g., diagnostic tests) reimbursed by a federal health care program. Another variation on this theme is where the ENT offers to refer hearing aid patients to an audiologist in return for free diagnostic testing of the ENT’s patients.

Both parties to the transaction, the giver and receiver of the remuneration, are liable. The AKS is a criminal statute. Violation is a felony punishable by a maximum fine of $250,000 for individuals and $500,000 for corporations, imprisonment up to five years, or both. In addition, the Department of Health and Human Services’ Office of Inspector General (OIG) may bring a civil administrative action to exclude a violator from federal and state health care programs or to impose civil monetary penalties for an anti-kickback violation.

The purpose of the AKS is to prohibit arrangements that are likely to result in over-utilization of items or services, increase costs to federal health care programs, affect professional judgment, and/or promote unfair competition.

“SAFE HARBORS”

To avoid criminalizing innocent conduct, Congress and OIG have created a number of “safe harbors” from liability under the AKS. If a transaction satisfies all of the conditions specified in an OIG safe harbor regulation, the parties to the transaction are protected from liability. If an arrangement does not qualify for safe harbor protection, OIG will analyze the totality of the facts and circumstances to determine whether the arrangement as a whole poses an unreasonable risk of fraud and abuse. However, OIG strongly recommends, and we agree, that whenever a transaction implicates the AKS, every effort should be made to qualify for safe harbor protection.

The following are several safe harbors that may be relevant to audiologists:

Employee Safe Harbor

This safe harbor protects any amount paid by an employer to an employee for employment in the furnishing of items and services reimbursable under a federal health care program, provided a bona fide employment relationship exists between the parties. Thus, commissions or bonuses paid by an ENT to an audiologist employee for the prescribing of hearing aids do not violate the AKS, even if the payments are based on the volume or value of hearing aids sold by the employee.

Personal Services and Management Contracts Safe Harbor

This safe harbor protects payments by a principal to an agent as compensation for the agent’s services, provided the following seven conditions are satisfied:

• The agency agreement is in writing and signed by the parties;
• The term of the agreement is not less than one year;
• The agreement covers all of the services the agent provides to the principal for the term of the agreement and specifies those services;
• If the agent’s services are to be provided on a periodic, sporadic, or part-time basis, the agreement specifies the exact schedule of such intervals, their precise length, and the exact charge for such intervals;
• The compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions, and is not determined in a manner that takes into account the volume or value of business generated between the parties for which payment may be made, in whole or in part, under a federal health care program;
• The agent’s services performed under the agreement do not involve counseling or promotion of activities or arrangements that violate any state or federal law; and
• The aggregate services contracted for do not exceed those reasonably necessary to accomplish the commercially reasonable business purpose of such services.

An “agent” is any person, other than a bona fide employee, who has an agreement to perform services for or on behalf of a principal.
Space Rental Safe Harbor
This safe harbor protects any payment made by a lessee to a lessor for the use of premises, provided the following six conditions are satisfied:
• The lease agreement is in writing and signed by the parties;
• The term of the lease is for not less than one year;
• The lease covers all of the premises leased between the parties for the term of the lease and specifies those premises;
• If the lease is for periodic intervals of time, the lease specifies exactly the schedule of intervals, their precise length, and the exact rent for such intervals;
• The aggregate rental charge is set in advance, consistent with fair market value in arms-length transactions, and is not determined in a manner that takes into account the volume or value of referrals or other business generated between the parties for which payment may be made under a federal health care program; and
• The aggregate space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

Equipment Rental Safe Harbor
This safe harbor is virtually identical to the space rental safe harbor, but applies to rentals of equipment.

Discount Safe Harbor
This safe harbor protects a discount on an item or service payable under a federal health care program, provided the discount is properly disclosed and accurately reflected in the charges billed to the federal health care program. Essentially, the discount must be passed along to the federal health care program. A “discount” is “a reduction in the amount a buyer is charged for an item or service based on an arms-length transaction.” To be protected by this safe harbor, a discount must be made at the time of the purchase sale of the item or service.

The definition of “discount” does not include any of the following:
• A payment of cash or cash equivalents (except rebates in the form of a check where the terms are fixed and disclosed to the buyer at the time of the initial purchase);
• Supplying one good or service without charge or at a reduced charge to induce purchase of a different good or service, unless the goods and services are reimbursed by the same federal health care program using the same methodology and the reduced charge is fully disclosed to the federal health care program and accurately reflected in the reimbursement;
• A reduction in price applicable to one payor but not to Medicare or a state health care program;
• A routine reduction or waiver of any coinsurance or deductible owed by a program beneficiary;
• A warranty;
• Services provided under a personal or management services contract; or
• Other remuneration not explicitly described in the definition of “discount” (such as signing bonuses or “up-front rebates”).

Applying the AKS to Hearing Aid Commissions
What does all of this mean to the practicing audiologist? When Party A pays Party B a commission to reward B for prescribing hearing aids, which are reimbursable under a federal health care program (e.g., Medicaid), the AKS is implicated. As previously stated, when an arrangement implicates the AKS, we strongly recommend that the parties look around for a safe harbor, or change the arrangement.

Let’s revisit the the four scenarios at the beginning of this article:

Scenario #1: A physician practice pays an audiologist employee a commission or bonus based on hearing aid sales, and some of the hearing aids are covered by the state Medicaid program. If there is a bona fide employment relationship, this arrangement is protected by the employee safe harbor.

Scenario #2: A physician practice pays an audiologist a commission based on hearing aid sales where the audiologist is not an employee but an independent contractor. Some of the hearing aids are covered by the state Medicaid program. The employee safe harbor is unavailable. The personal services and management contracts safe harbor also is unavailable, because the remuneration takes into account the volume or value of items or services payable under a federal health care program. The arrangement appears to violate the AKS. In this case, we would recommend that the arrangement be modified so that it qualifies for either the personal services safe harbor (i.e., the compensation of the audiologist may not take into account the volume of value of hearing aid sales) or another safe harbor (e.g., the audiologist may rent space and/or equipment in the ENT practice’s office pursuant to the space rental and/or equipment rental safe harbors).

Scenario #3: A hearing aid manufacturer offers audiologists points for hearing aids purchased, which can be cashed in for additional hearing aids, software, or other benefits. If any of the hearing aids are payable
under a federal health care program, this is a clear violation of the AKS and is not protected by any safe harbor. (However, if the manufacturer instead offers audiologists a discount that is properly reported and passed on to the audiologist's' patients and federal health care programs, it would be protected by the discount safe harbor.)

Scenario #4: A hearing aid manufacturer offers audiologists points for each hearing aid purchased from the manufacturer, which can be "cashed in" for gifts or trips. The trips may be represented as “continuing education” but are held at resorts or other desirable destinations and involve minimal educational content. Again, if any of the hearing aids are payable under a federal health care program, this is a clear violation of the AKS and is not protected by any safe harbor.

**Conclusion**

All audiologists need to be aware of the Anti-Kickback Statute. All audiologists need to be on their guard against proposed compensation arrangements that include a built-in incentive to run up large bills for Medicare, Medicaid, and other government programs. When presented with a business arrangement that involves such incentives (e.g., commissions based on hearing aid sales), a red warning light should go off and you should consult legal counsel familiar with both federal and state anti-kickback laws. Even if the commissions have completely innocent intent and no real impact on the prescribing of hearing aids, the risks and disruption associated with an anti-kickback investigation far outweigh any economic benefit to be derived from the commissions.

Not only should you be conversant with the legal implications of business relationships, but the ethical implications as well. Avoidance of COI, and avoidance of even the appearance of COI, is necessary and important. It’s been referred to as the “Mike Wallace Test”—if 60 Minutes came into YOUR office to disclose your business relationships and arrangements, how would it appear to your patients?

**References**

For a discussion of ethical considerations, please see the Academy’s Code of Ethics and its Ethical Practice Guidelines on Financial Incentives from Hearing Instrument Manufacturers.

1. Most states have their own state anti-kickback laws, which may differ from the federal statute. State anti-kickback laws are beyond the scope of this article, but audiologists should be aware of the state anti-kickback law in their state.
2. Most states have their own state anti-kickback laws, which may differ from the federal statute. State anti-kickback laws are beyond the scope of this article, but audiologists should be aware of the state anti-kickback law in their state.
3. The AKS provides: Whoever knowingly and willfully offers or pays (or solicits or receives) any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person... to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony. 42 U.S.C. § 1320a-7b(b).
4. Even though one of the purposes of the AKS is to protect patients enrolled in federal health care programs, an AKS violation is not cured by disclosing the remuneration to the patient. That’s because disclosing the business arrangement to the patient does not protect the federal health care program.
5. 42 U.S.C. § 1320a-7b(b)(3); 42 C.F.R. § 1001.952(i).
6. 42 U.S.C. § 1320a-7b(b)(3); 42 C.F.R. § 1001.952(d).
7. 42 C.F.R. § 1001.952(c).
8. 42 C.F.R. § 1001.952(d).
11. No information for this reference given.
AudiologyNOW! 2006 brought many changes. We saw new names for the courses. Pre-convention workshops became Learning Labs. Instructional Courses became Learning Modules. The educational tracks were streamlined into 6 Learning Cores: Diagnostics, Disorders, Hearing and Balance Sciences, Hearing Loss Prevention, Professional Issues & Practice Management and Treatment. There was a greater emphasis placed on engaging the learner in the learning experience.

AudiologyNOW! 2007 promises to bring even more changes. Wednesday will become Day 1 of the event with the offerings of Learning Labs. Most exciting, however, is the introduction of Super Tracks!

Super Tracks are dedicated tracks of learning. Based on your feedback from AudiologyNOW! 2006 four tracks have been designated as Super Tracks. They are: Hearing Loss Prevention (also the theme of AudiologyNOW! 2007), Vestibular, Pediatrics, and Sensory Aids (including hearing aids, cochlear implants, other implantable devices and assistive listening devices). Learning in the Super Tracks begins on Day 1 with Learning Labs, proceeds to Featured Sessions with additional courses provided by your colleagues through submissions to Learning Modules & Posters and finally incorporating more hands-on activities with the cooperation of the manufacturers through their offering of Demo Programs. Super Tracks allow a participant to come to AudiologyNOW! with minimal knowledge in a designated Super Track topic and leave with a working knowledge of that area. Super Tracks are thematic mini conferences within AudiologyNOW!

The Program Committee has been hard at work weaving the thread of each Super Track through the Learning Labs and Featured Sessions. And they will continue by threading submitted courses through the Super Tracks of:

- **Pediatrics** – including but not limited to newborn hearing screening, diagnostic evaluation, early intervention (including amplification and therapy options), causes of hearing loss, prevention of hearing loss in children, and program development.
- **Vestibular** – including but not limited to anatomy and physiology, state-of-the art diagnostic testing, medical, psychologic, and audiologic aspects of the dizzy patient, vestibular rehabilitation, advances in vestibular science, and programmatic development.
- **Sensory Aids** – including but not limited to any aspect of hearing aids, cochlear implants, other implantable devices, and assistive listening devices.
- **Hearing Loss Prevention** – including but not limited to prevention of hearing loss through pharmacology, effects of environmental toxins, interactions of drugs, noise, and genetics, development of hearing loss prevention programs for musicians, industry, children, users of personal listening devices, and marketing of such a program to the community.

As Program Chair, I invite you to take part in an opportunity to awaken your senses, achieve new heights, and attain new dimensions in the Mile High City by being an active participant in AudiologyNOW! 2007

AudiologyNOW! • April 18-21, 2007 • Denver, Colorado

Sharon Sandridge, PhD
2007 Program Chair
FEATURED SESSIONS (FS)
Featured Sessions are contemporary topics presented by top audiologists, hearing scientists and physicians. Presenters for these sessions are invited by the Program Committee to speak based upon their expertise in a given topic. (1.5 hours, 0.15 CEUs)

FOCUS GROUPS (FG)
Focus Groups generally come from previous Discussion Groups. Focus Groups have a clearly defined issue that will be presented and discussed by interested members. The outcome of a focus group may be a recommendation to the American Academy of Audiology Board of Directors or may result in the identification of the need for ongoing discussion that could be supported via on-line mechanisms and future meetings. (2-hours, 0.2 CEUs)

LEARNING LABS (LL)
Learning Labs are held on day one of AudiologyNOW! They offer in-depth, cutting-edge information in “hot” topic areas. The topic areas require half- or full-day sessions to enable sufficient coverage of the information. Learning Labs are designed to be interactive and to afford opportunities for hands-on exercises with appropriate clinical practices. (3.5 to 7-hours, 0.35-0.7 CEUs) Additional Registration Fee required.

SUBMITTED SESSIONS

LEARNING MODULES (LM)
Learning Modules are learner-focused, interactive courses on topics of current interest that provide participants with information they can use in their clinical practices. These may cover a wide variety of topics including clinical audiology, treatment, basic science, practice management or a related field. (1 or 2-hour, 0.1 or 0.2 CEUs)

EXHIBITOR COURSE (EC)
The Exhibitor Courses are designed to provide attendees with access to clinical research that illustrates users’ performance, benefit and/or satisfaction related to products or services. (1-hour, 0.1 CEUs)

DISCUSSION GROUP (DG)
Discussion groups are opportunities to get together with colleagues to share experiences, discuss innovative topics/approaches and/or debate current issues. (1-hour, no CEUs)

RESEARCH PODS (RP)
The Research Pod format provides the opportunity for individuals to present current clinically directed research in the core learning areas (Treatment, Diagnostics, Disorders, Hearing & Balance Sciences, Professional Issues, Hearing Loss Prevention). Each pod will consist of four (4) 15-minute presentations in a related core area. (15 minutes each, including a 3-minute question period, four presented in a 1-hour session, 0.1 CEUs)

RESEARCH POSTER (PP)
The Research Poster Presentation format provides the opportunity to visually present clinically-directed research in the core learning areas (Treatment, Diagnostics, Disorders, Hearing & Balance Sciences, Professional Issues and Hearing Loss Prevention) on an individual basis during a 90-minute session. A wine and cheese reception (cash bar) will be dedicated to the poster presentations. The posters will remain available for review throughout the duration of AudiologyNOW! (up to 0.2 CEUs)

STUDENT RESEARCH FORUM (SR)
Masters and doctoral-level students and recent audiology graduates are selected for presentation of their original research completed while a graduate student in audiology. (15 minutes each, five presented in a 1.5 hour session, 0.1 CEUs)
WEBSITE – The AudiologyNOW .org website has been redesigned to help you find the information you need quickly and easily! The website is updated regularly so check back often for the latest happenings for AudiologyNOW!

REGISTER AND RELAX! – Academy members who register in November will receive a $10 Starbucks card to heighten their AudiologyNOW! 2007 experience. Registration and housing opens November 1, 2006 for members, December 1, 2006 for all others. To better manage the number of hotel rooms being reserved, registration and hotel bookings will be linked sequentially. Upon successful completion of registration, attendees will then be directed to a hotel reservation web site.

CEUS FOR POSTERS – It started with AudiologyNOW! 2006 and will continue for 2007. CEUs will be offered for Research Posters (up to 0.2 CEUs) and these CEUs may be earned at anytime, on any day.

PREVIEW NOW! – The preliminary program and registration book will be mailed in late October. It will provide concise, user-friendly information on registration, housing, the program of events and abstract information for Featured Sessions, Learning Labs and Focus Groups.

NOTE: Abstracts for Learning Modules, Exhibitor Courses and Discussion Groups will be available online November 1, Research Sessions by January 31, 2007. Start planning your AudiologyNOW! experience by either downloading a daily schedule of events to print and read at your leisure or by logging into the online Itinerary Planner to map out your experience.

HOST AN INDEPENDENT SATELLITE EVENT!

The American Academy of Audiology offers related organizations the opportunity to hold an Independent Satellite Event in conjunction with AudiologyNOW! 2007. These events will be held on Wednesday, April 18, 2007.

To obtain information, contact Lisa Yonkers at lyonkers@audiology.org, 703.226.1038, by November 1, 2006.

CALL FOR INNOVATIVE PROPOSALS

Research Deadline: November 1, 2006
Go to audiologyNOW.org to submit.

OPEN HOUSES!

Have a great ending to your AudiologyNOW! experience by attending (or throwing) a party sponsored by your alma mater or organization and enjoy the company of your current and former colleagues. Rooms are offered free of charge. For further information on hosting an open house, contact Lisa Yonkers at lyonkers@audiology.org, 703.226.1038.
It’s a city with attitude and altitude! Poised at an elevation of exactly 5,280 feet, it is no wonder that visitors enjoy a Rocky Mountain high! Travelers agree that Denver, CO is one of the most popular destination cities in our nation with something of interest for everyone to enjoy! During its neophyte years, the American Academy of Audiology held its third annual convention in Denver, and now enthusiastically returns after 16 years to do it again! All audiologists should mark their calendars and begin making plans to join us at AudiologyNOW! 2007 on April 17-21, 2007 in Denver, the “Mile High” city.

Founded in 1858 as a gold mining camp, Denver is located at the base of the majestic Rocky Mountains, 5,280 feet above sea level – exactly one mile high. When gold was discovered, Denver became a boomtown filled with fortune seekers, wagon trains and cowboys. Today, Denver is one of America’s fastest growing cities – and one of the most exciting. Denver is an energetic young city with 300 days of annual sunshine, brilliant blue skies and stunning mountain scenery. Getting out and exploring it all is easy, with an extremely walkable downtown centered around the 16th Street Mall – a mile-long pedestrian promenade lined with outdoor cafes, entertainment centers and shops. Free shuttles leave either end of the mall as often as every 90 seconds, allowing visitors to catch a free shuttle ride to various downtown attractions.

As the scientific program and audiology presentations finish for the day and the sun goes down, Denver’s nightlife heats up – Big Time! The city resonates with live music and dance clubs and has more than 2,000 restaurants. Visiting audiologists can savor innovative cuisine prepared by nationally recognized chefs or delve into authentic Southwestern and Mexican recipes passed down through generations. Buffalo and beef are traditional Western fare and pair well with a pint of handcrafted beer – which Denver just happens to brew more of than any city in the world, with more than 80 different beers brewed here daily.

The ghosts of the red light district from Denver’s gold rush days may still haunt the streets of Lower Downtown, but they are not alone anymore. A very special area, termed LoDo by locals, was virtually empty 10 years ago. But since the opening of Coors Field, home to baseball’s Colorado Rockies, this 20-block district of 19th-century brick buildings has come alive with energy and entertainment. The original commercial core of Denver underwent a major renovation and now sports a seemingly endless variety of trendy pubs, restaurants, nightclubs, shops and luxurious loft apartments. Larimer Square, at the southern end of LoDo, occupies a portion of Denver’s oldest street and radiates Victorian charm and bustles with dining and
dancing delights. The buildings, now occupied by upscale chains, including Morton’s of Chicago, and Denver originals like the Wynkoop Brewing Company, have long histories as former brothels, saloons and old-time general stores. Check out LODO at http://www.lodo.org.

For families or when you need a break from an intense AudiologyNOW! 2007 schedule, a new light rail system connects downtown to a series of nearby attractions including the Downtown Aquarium, a world-class interactive aquarium featuring more than 15,000 fish and even Sumatran tigers. Close by is Six Flags Elitch Gardens, one of the only downtown amusement parks in the country. Denver is the largest shopping destination in a 600-mile radius. Just three miles from downtown, the Cherry Creek Shopping District tempts locals and visitors alike with hundreds of boutiques, galleries, stores and restaurants. Right next to the Convention Center is Denver’s thriving arts and cultural scene, from neighborhood arts districts and innovative public art displays throughout downtown, to the Denver Performing Arts Complex – the second largest in the country – offering 10 performance venues seating 10,000 people for symphony, opera, ballet and Tony Award-winning theatre. The Denver Art Museum features the world’s premier collection of Native American art, while its astonishing new Hamilton Building, designed by renowned architect Daniel Libeskind, has changed the architectural landscape of Denver with its striking modern design.

It is worth considering adding a pre- or post- ski experience or a day trip to the mountains; April is noted for sunshine on the slopes and famous spring skiing in the Rockies. Vail is only an hour and a half away and there are many other great destinations within a 1-2 hour drive, where you can experience crisp mountain air and invigorating scenery while skiing at world class resorts, hiking, horseback riding, fly fishing, and mountain climbing and still be back in time to hit the town’s nightlife scene.

For more information on Denver and where to find that great place in the city, check out http://maps.mapnetwork.com/denver/index.asp for an interactive map of the area.
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COMPENSATION & BENEFITS SURVEY:
The American Academy of Audiology conducted its fifth annual Compensation and Benefits Survey in the Fall of 2005. A full report of the survey with detailed information is available for Academy members online at www.audiology.org/membership/careers.

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 employment goals. This online employment service allows job seekers to post their résumé and view job postings for free. HearCareers also offers discounted rates to members advertising positions. Go to www.audiology.org/membership/careers to make your next career connection with HearCareers.

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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 web site at www.hpsso.com.

For more information about these benefits, contact Vanessa Scherstrom, Member Benefits Coordinator, at 703-790-8466 x1044 or vscherstrom@audiology.org.
HEALTH-RELATED QUALITY OF LIFE BENEFITS OF AMPLIFICATION IN ADULTS

An executive summary of the American Academy of Audiology’s Task Force on Health-Related Quality of Life Benefits of Amplification in Adults is presented on the following pages. Carole Johnson and Jeffrey Danhauer prepared this summary on behalf of the Task Force. The Task Force members were Theresa Chisolm (co-chair), Craig Newman (co-chair), Carole Johnson, Jeffrey Danhauer, Harvey Abrams, Sharon Lesner, Patricia McCarthy, and Laural Portz (public member). The entire final report will be published in a future issue of the Journal of the American Academy of Audiology and will be posted on the Academy web site.
Although sensorineural hearing loss (SNHL) can have a substantial negative impact on the lives of numerous patients and their families, many individuals are uncertain about the potential benefits that might be derived from hearing aid use. In the spirit of evidenced-based practice (EBP), audiologists, their patients, and other interested parties deserve to know whether research is available to support the premise that hearing aids can have positive effects on the lives of those with SNHL.

Most hearing aid research has focused on the acoustic benefits of amplification that are verified through audiologic testing and/or self-report instruments which assess users’ improved audibility in various listening situations. However, Health-Related Quality of Life (HRQoL) benefits are measured by examining individuals’ perceived changes in the psychosocial problems associated with hearing loss that they experience as a result of using hearing aids compared to their unaided condition. Documenting the effects of hearing aid use as a major component of the rehabilitative context as a whole on HRQoL of adults with acquired SNHL is important for EBP and securing reimbursement for audiologic services including hearing prostheses.

EBP involves integrating current, high-quality research findings with practitioner expertise and patient preferences and values into the process of making the best possible clinical decisions (American Speech-Language-Hearing Association, 2005). The evaluation of available scientific evidence assessing the efficacy of rehabilitative interventions is best accomplished through a systematic review process. This quantitative systematic review described the findings of specific studies relevant to the topic and included a meta-analyses that combined the results of several studies, which by averaging, increased the accuracy and efficiency in estimating the population parameter of the individual investigations and resulted in an aggregate indication of the effectiveness of hearing aid use in adults. This review involved establishing criteria for: (1) including studies, (2) searching/retrieving relevant studies, (3) assessing the quality of included studies, and (4) qualitatively and quantitatively analyzing the results, which are briefly summarized here.

**Establishing Criteria for Included Studies**

We included only information from studies published in refereed journals in order to enhance our chances of gleaning evidence at the highest levels. Studies accepted for inclusion in this quantitative systematic review involved: Level 1 – randomized, controlled trials (RCTs); Level 2 – quasi-experimental controlled trials that used non-randomized, parallel group, or crossover designs; and Level 3 – well-designed non-experimental studies, particularly those using pre-test/post-test designs with adequate descriptions.

The participants in the included studies had to be at least 18 years of age and have SNHL with unaided severity ranging from mild to profound, normal cognitive function, and independent or assisted living accommodations, and be new or previous hearing aid users. The criteria for amplification used was broad and did not account for differences in hearing aid style, signal processing circuitry, microphone technology, or fitting strategy.

Included studies were required to use validated generic (applicable across diseases and disorders) and/or disease-specific (designed for use with a particular patient population) HRQoL outcome measures that assess the degree to which participants’ health status affects their self-perception of daily functioning and well being. The Medical Outcome Study 36-item Short-Form Health Survey (MOS SF-36: Ware and Sherbourne, 1992) is an example of a generic HRQoL outcome measure, while audiologists are probably more familiar with disease-specific self-report instruments like the Hearing Handicap Inventory for the Elderly (HHIE: Ventry and Weinstein, 1982) which measure the effects of hearing loss in psychological, social, and emotional domains.

**Search and Retrieval of Relevant Studies**

A full search strategy was used to identify studies to include in this systematic review. Over 50 search strings were created and submitted to several databases, which identified 171 relevant abstracts, of which 97 were duplicates. Thus, 74 studies were acquired for full-article retrieval and were scrutinized to ensure that they met the a priori inclusion criteria. Only 16 articles met the criteria; the remaining 58 failed to do so and were excluded from further consideration.

Readers can find the entire list of references for the studies in the upcoming detailed article in JAAA.

**Characteristics of Included Studies**

The 16 included studies were fairly heterogeneous regarding level of evidence, participant characteristics, and outcome measures. Only two of the
studies used RCTs, while five employed quasi-experimental and nine involved pre-test/post-test designs. The studies used males and females (28 to 95 years of age) with mild to profound SNHLs, who were both new and experienced hearing aid users obtained from different delivery systems (e.g., private pay, national health care systems, Department of Veterans Affairs National Hearing Aid Program). Five generic and four disease-specific HRQoL outcome measures were used across the 16 studies.

**QUALITY ASSESSMENT OF INCLUDED STUDIES**

The quality of the evidence provided by each of the 16 studies was examined according to: level of evidence (two at Level 1; one at Level 2; 13 at Level 3), use of a power analysis to ensure appropriate sample size (only one did), assignment of participants to experimental and control groups and assurance of equivalence of the groups at baseline (only three did), adequate detail of participant inclusion and exclusion criteria allowing for generalization and study replication (12 did), well-described hearing aid fitting and verification protocols (nine did), application and reporting of statistical analyses (all 16 did), and accounting for any dropout of participants from the studies (10 did, but only five provided sufficient reasons for their participants’ failure to complete the protocols).

**QUALITATIVE AND QUANTITATIVE ANALYSES**

Comparing pre-test/post-test results for generic HRQoL measures revealed that some studies revealed significantly improved health states for participants following hearing aid use, while others showed no difference or even a significant reduction in health functioning post-hearing aid fitting. However, most of the results for the disease-specific HRQoL outcome measures (e.g., the HHIE) showed strong reductions in emotional and social impacts of hearing loss for participants as a result of hearing aid use. All but one of the studies provided sufficient data for inclusion in the meta-analysis. Effect sizes and confidence intervals indicated that the overall between-subjects effects data supported the effectiveness of hearing aid use for improving the HRQoL for adults with acquired hearing loss.

Assigning a grade to a systematic review of the literature is a way of indicating the extent to which the evidence supports a particular healthcare recommendation from the evidence. A high grade suggests that more confidence can be given to the evidence for a particular procedure (in this case, the use of hearing aids), while a low grade means that a recommendation must be made with great caution. Overall, the findings of this quantitative systematic review suggest that a grade of “B” seems warranted for the use of hearing aids to improve adults’ HRQoL concerning the levels of evidence and quality of the included studies. Improvement in HRQoL is the most likely outcome, particularly when hearing related effects are directly assessed.

Unlike other chronic health conditions that may have multiple treatment alternatives, the only viable option for most cases of SNHL is indeed the use of hearing aids, which relegates clinical decision-making to one of whether to pursue amplification. In doing so, patients and their health care professionals must weigh the risks and benefits of pursuing amplification, a comparatively non-invasive, low-risk treatment with considerable potential benefits. Most states now require trial periods for hearing aids so that patients face little financial risk if they are not completely satisfied with the results of their purchase. Therefore, the modest evidence of benefits in HRQoL provided by this systematic review become quite powerful when considering that hearing aid use is the only viable treatment for SNHL, a condition with insidious and potentially devastating effects when left untreated.

**CONCLUSIONS**

The results of this systematic review support the notion that hearing aid use (a comparatively non-invasive, low-risk option with considerable potential benefits, which is the only viable treatment for SNHL) improves adults’ HRQoL by reducing psychological, social, and emotional effects of SNHL, an insidious, potentially devastating chronic health condition if left unmanaged.

The quantitative systematic review process provided a powerful method for assessing the HRQoL benefits of amplification; however, its conclusions are only as robust as the studies that are included in the review, and it is a time-sensitive endeavor that needs to be updated periodically in order to reveal the best and most current evidence for particular treatments.

Although the field of audiology appears to have a sufficient battery of disease-specific tools, it should strive to use, adapt, or develop generic instruments that are sensitive to and appropriate for assessing changes in hearing aid users’ and their families’ HRQoL as a result of amplification.
In the future, researchers should exercise great care in designing, conducting, and reporting their studies in order to maximize their contributions to EBP.

Future research in this area should strive to use RCT designs and generic HRQoL measures that are sensitive to the effects of and treatments for hearing loss. Investigators should conduct power analyses, employ both experimental and control groups, use double blinding, adequately describe participant inclusion/exclusion criteria, provide intention-to-treat analyses, discuss dropouts, and compute effect sizes and confidence intervals for statistically significant results whenever possible.

The audiolgic community, patients with hearing loss and their families, physicians and other health-care providers, and third-party entities should be encouraged that hearing aids can provide considerable HRQoL benefits for the increasing numbers of the adult population having SNHL.

The task force cautions readers that the conclusions presented here relate to the particular patient population and treatments investigated in this review, and they may not necessarily apply to other groups such as children or different forms of amplification such as cochlear implants. While separate systematic reviews are warranted for other populations and treatments, and we hope that future investigations will justify similar conclusions for them, audiologists and their adult patients can now be more confident that there is evidence to support what many of them have known all along - hearing aid use does provide HRQoL benefits for adult users.

REFERENCES


An executive summary of the American Academy of Audiology’s Task Force on Audiologic Management of the Adult Patient and Adult Hearing Impairment is presented on the following pages. Michael Valente served as chair of the Task Force and prepared this summary on behalf of the Task Force. The Task Force members were Harvey Abrams, Darcy Benson, Theresa Chisolm, David Citron, Dennis Hampton, Angela Loavenbruck, Todd Ricketts, Helenda Solodar and Robert Sweetow. The entire final report is available for review and downloads on the Academy web site at www.audiology.org/publications/documents/positions/adultrehab/.
WHY A NEW GUIDELINE?

The most recent guidelines for hearing aid fittings in adults were published in 1998 (Valente, et al., 1998) and, obviously since that time, there have been significant advances in hearing aid technology and methods to verify and validate fittings. There was concern that current clinical practices may do little to differentiate how hearing aids are dispensed by audiologists. The current Task Force felt that this important topic deserved analysis using evidence-based principles (EBP) in developing new guidelines, and that the guidelines must be patient-centered by incorporating a section on auditory and non-auditory needs-assessment. Finally, it was felt that if the “spirit” of the guidelines were followed then implementation by audiologists would:

• Promote uniformity of care,
• Decrease variability of outcomes,
• Promote better fitting practices,
• Elevate the clinical care to our patients as well as elevate our profession,
• Provide greater patient satisfaction, and,
• Reduce the hearing aid return rate.

The Task Force divided the guidelines into five major divisions: (1) Introduction; (2) Assessment; (3) Technical Aspects of Intervention; (4) Audiologic Rehabilitation including Instruction, Orientation, Counseling and Follow-Up; (5) Assessing Outcomes. These divisions follow the sequence patients typically follow when pursuing amplification. The five divisions were divided into the nine sections and the numbers appearing below in parenthesis indicate the number of key recommendations developed for each section. The specific recommendations for each section ranged between none and 13. Overall, the guideline contains 43 specific recommendations.

• **Assessment**: auditory assessment (0), auditory needs assessment (3), and non-auditory needs assessment (6).

• **Technical Aspects of Intervention**: hearing aid evaluation (13), quality control (2), fitting and verification (7), and hearing assistive technology (4).

• **Instruction, Orientation, Counseling and Follow-Up**

• **Audiologic Rehabilitation**: hearing aid orientation (2), and counseling and follow-up audiologic rehabilitation (6).

• **Assessing Outcomes** (0)

A systematic search of the literature was conducted using EBP for each of the 43 recommendations. The search focused on the best available evidence to address each recommendation and ensured maximum coverage of studies at the top of the hierarchy of study types (Levels 1-2). The search extended to studies or reports of lower quality (Levels 3-6) only if higher quality studies could not be found. However, for most recommendations within the guidelines, less than 1/3 were judged as Level 1-2. This finding should be of concern as it points to the need for research to justify how audiologists provide services relative to the sections covered in these guidelines.

ORGANIZATION OF THE GUIDELINES

Each section of the guidelines begins with an objective stating the purpose for the section, followed by a background detailing how the section fits within the guideline. Specific Recommendations then follow and each section ends with the Table of Evidence and References.

INTRODUCTION TO THE GUIDELINES

Within the Introduction section, the guidelines provide several statements outlining some of the essential components. First, a licensed audiologist must provide services. Second, the combined efforts of the audiologist, patient, significant others, and/or caregivers are essential. Third, assessment must be viewed as a multi-faceted process that includes assessment of auditory function to determine the extent of impairment and assessment of activity limitations and participation restrictions through self-report of communication need and performance. Fourth, consideration should be given to assess the typical listening environments using such tools as data logging. Also, there should be consideration of how these levels of assessment interact and reinforce each other to improve quality of life (QOL). It was felt that as a result of the multi-faceted assessment, clear and realistic individualized goals for intervention could be set.

ASSESSMENT

**Auditory Assessment.** This section details the various components of the auditory assessment of the patient. Some of the specific components may include:

• Comprehensive case history,
• Identifying type and magnitude of hearing loss via pure-tone and speech audiometry as well as immittance,
• Measuring loudness discomfort levels (LDLs)
• Otoscopic inspection and cerumen management,
• Determine need for treatment/referral to physician or need for further tests (ABR; vestibular, etc),
• Counsel patient, family, caregiver on the results and recommendations,
• Assess candidacy and motivation toward amplification,
• Determine medical clearance as determined by FDA (1977).
**Audiologic Management of Adult Hearing Impairment**

**SUMMARY GUIDELINES**

**Audiology Needs Assessment.** This section details procedures to develop patient-specific communication needs. This includes providing realistic expectations and creating patient-specific fitting goals as the initial stage of the “validation” process. Also involved in this process is determining which hearing aid “features” may be appropriate for the patient. These features may include:

- Directional microphones
- Direct auditory input (DAI)
- Noise management
- Frequency Modulation (FM) devices

As part of the Auditory Needs Assessment, the patient may respond to a variety of questionnaires which might include any of the following:

- **Abbreviated Profile of Hearing Aid Benefit (APHAB)** (Cox and Alexander, 1995).
- **Client Oriented Scale of Improvement (COSI)** (Dillon et al., 1997).
- **Hearing Handicap Inventory for the Elderly (HHIE)** (Ventry and Weinstein, 1982).
- **Expected Consequence of Hearing Aid Ownership (ECHO)** (Cox and Alexander, 2000)
- **Glasgow Hearing Aid Benefit Profile (GHABP)** (Gatehouse, 2000)
- **International Outcome Inventory-Hearing** (Cox et al., 2003)

**Non-Auditory Needs Assessment.** This section deals with the non-auditory needs of the patient and recognizes that these needs may interact with auditory needs to determine success with amplification. These non-auditory needs may include cognition, patient expectations, motivation, willingness to take risks, assertiveness, manual dexterity, visual acuity, prior experience with amplification, general health, tinnitus, occupational demands, and the presence of support systems.

**TECHNICAL ASPECTS OF INTERVENTION**

**Hearing Aid Selection.** This section relates to the decisions needed to select the appropriate hearing aid(s) and hearing assistive technology (HAT) based on the results of the hearing, auditory and non-auditory needs assessment. The outcome of this process is an attempt to match the appropriate style and features to the patient. These decisions may include:

- Style (CIC, ITE, ITC, BTE)
- Occlusion management
- Volume control
- Bilateral versus monaural
- Direct auditory input (DAI); telecoil (programmable)
- Type of signal processing
- Capacity for frequency shaping (number of bands)
- Selection of output and SSPL90
- Number of memories
- Number of channels of compression and feedback management
- Digital noise reduction
- Switchable or adaptive directional/omnidirectional microphones
- Frequency compression or transposition
- Bone anchored devices
- CROS/BICROS/Transcranial CROS

**Quality Control.** The objective of this section is to ensure hearing aids meet reasonable and expected quality standards prior to scheduling for hearing aid fitting and verification. A small percentage of instruments and earmolds may be defective on receipt. In addition, hearing aids and earmolds may arrive in good working order, but with the incorrect configuration/features. Quality control (QC) measures are necessary to limit patient and clinician frustration and inconvenience. Examples of QC may be:

- Verify directional microphones performance,
- Electroacoustic analysis of new and repaired aids to assure compliance to standards and repairs are completed to clinician satisfaction,
- Electroacoustic analysis at final fit to provide base for measures at semi-annual or annual checks,
- Verify features to include confirmation of earmold/shell style, vent, color, type, processing (memories, automatic switches, etc.) and mechanical (directional microphones, t-coil, integrated FM, etc) features,
- Features not verifiable through physical examination or electroacoustic verification should be verified through a listening check. These may include operation of the VC, directional microphones, FM, t-coil, etc.

**Fitting and Verification.** The objective of this section is to assure the fitting and verification procedure is viewed as a process that culminates in the optimal fitting. Verification procedures also serve as a benchmark against which future hearing aid changes can be compared. Verification procedures should be based on validated hearing aid fitting rationales and are expected to yield a comfortable fit of hearing aids including all desired features. In the fitting and verification process a signal must be presented to the hearing aid whether in the test chamber or with a probe microphone in the real ear. The
Audiologic Management of Adult Hearing Impairment
SUMMARY GUIDELINES

American Academy of Audiology

The clinician must select signals ensuring accurate verification of prescriptive methods for which the targets are based on speech inputs and therefore a speech-like signal should be used. Examples of aspects of the fitting requiring verification may include:

- The physical fit should be comfortable
- Verify gain/output using validated fitting rationales
- Correction for monaural/bilateral
- Correction for type of HL
- Verifying that the measured RESR90 to below the individual LDL, when possible
- Aided sound-field thresholds for audibility of soft sounds.
- Verify function of features such as telecoil and directional microphone
- Verify that the occlusion effect is absent or minimal

Hearing Assistive Technology (HAT). The objective of this section is to promote the use of Hearing Assistive Technology (HAT) to ensure communication needs are met because hearing aids alone may not address all the needs of the patient. HATs can either be used alone or combined with hearing aids to supplement performance in difficult listening conditions. HATs can address four communication needs:

1. Face-to-face communication
2. Broadcast and other electronic media
3. Telephone conversation
4. Sensitivity to alerting signals and environmental stimuli.

HAT is available as personal systems or large area listening systems. The most common HATs are:

a. Personal FM
b. Infrared
c. Induction loop
d. Hardwired systems
e. Telephone amplifier, telecoil, TDD (telecommunication device for the deaf)
f. Situation specific devices (e.g., television)
g. Alerting devices
Hearing Aid Orientation. The objective of this section is to ensure patients obtain the desired benefits from amplification as easily and efficiently as possible. The hearing aid orientation process begins with the initial hearing aid fitting and may continue over several visits. Hearing aid orientation is complete only when all appropriate information has been provided and the patient (or family member/caregiver) is competent to continue the process. Hearing aid orientation is conducted as easily and efficiently as possible. The hearing aid orientation process comprises three main components:

1. **Orientation Information**
   - Device-related: Specific to the use and care of hearing devices. This includes information on device features, insertion/removal, battery use, and comfort.
   - Patient-related: Focuses on helping patients understand their hearing loss, adapt to amplification, and take advantage of other assistance sources. This may include communication strategies, HATs, and speechreading.
   - Community resources: Provides information on community resources that can support patients.

2. **Counseling**
   - Audio-related: Specific to the usage of hearing aids, including feedback management, use with the telephone, and warranty.
   - Device-related: Focuses on care and use of hearing devices, including fitting, maintenance, and troubleshooting.

3. **Follow-Up Audiologic Rehabilitation**
   - Successful management necessitates comprehensive counseling to help patients adjust to their hearing aids and instruct them on communication strategies to maximize their benefit. Counseling is often required to help patients learn new strategies to ensure success. In addition, emotional factors concerning hearing loss must be addressed in a comprehensive rehabilitation program. Counseling can be provided on an individual basis, but is often delivered in small group settings.

   - Topics addressed in these sessions should include:
     - Anatomy and physiology of hearing process
     - Understanding the audiogram
     - Problems associated with understanding speech in noise
     - Appropriate/inappropriate communication behaviors
     - Communication strategies
     - Listening and repair strategies
     - Ways in which to control the environment
     - Assertiveness training

Assessing Outcomes. This part of the patient management process assesses how well intervention reduced activity limitations, decreased participation restrictions, and improved quality of life and is referred to as validation. Validating the choices made as part of the assessment, selection, and fitting processes, to the extent that the patient’s needs have been met, is accomplished through the administration of outcome measures. Many outcome measures, described in the audiologic and non-auditory needs assessment section, have been developed to assess the impact of a hearing impairment on the individual in the areas of communication functioning, activity limitation, and participation restrictions.

As critical as it is to measure the benefits of hearing aid intervention at the level of the patient, the measurement of treatment outcomes is assuming greater importance on the national health care stage. Through the routine use of clinically applied outcome measures and carefully controlled clinical trials, audiologists can build a foundation for evidence-based clinical practice guidelines. Clinical practice guidelines, in turn, minimize variability in outcome, maximize treatment efficacy, reduce risks, decrease waste, improve patient satisfaction, and should elevate the profession of Audiology among third party payers, other health care providers, and, most importantly, current and future patients. As audiologists continue to compete in the health care marketplace, they must demonstrate that treatments reduce activity limitations, decrease participation restrictions, and improve health-related quality of life. Only by measuring the outcomes of treatment can audiologists be assured that interventions make a difference and patients have benefited from their care.

**References**


The Academy Honors Committee encourages all Academy Fellows to identify those colleagues they believe have made significant contributions to the audiology profession. If you know someone who should be recognized for his or her efforts, please take the time to submit a nomination packet to the committee for review. All nominations must be received by October 27, 2006.

**Nomination Process**
To nominate an individual, a nomination packet that includes a letter of nomination addressed to the Committee Chair and an up-to-date resume of the nominated individual should be submitted by the deadline. Self-nominations will not be accepted. The nomination packet should include sufficient documentation as to how the nominee meets the specified criteria for the selected category. Additional letters in support of the nomination and any other documentation that will assist the Honors Committee in their decision are strongly suggested. All materials should be mailed to the Academy headquarters.

**Award Categories**

**Jerger Career Award for Research in Audiology**
This award is given to a senior level audiologist with a distinguished career in audiology. Candidates must have at least 20 years of research productivity in audiology (not in related field), as well as have made significant contributions to the practice and/or teaching of audiology.

**Samuel F. Lybarger Award for Achievements in Industry**
This award is given for significant pioneering activity (research, engineering, or teaching) within the field of hearing. This award is restricted to individuals whose achievements occurred while employed by a company or corporation in the hearing healthcare fields but whose contributions extended beyond their contributions to their company’s services or product and served to have a significant impact on the understanding of normal or disordered auditory systems.

**International Award in Hearing**
The American Academy of Audiology has established an annual International award to honor and recognize achievements of international significance in audiology by an audiologist, hearing scientist or audiological physician. Nominees should be nonresidents of the US who have provided outstanding service to the profession of audiology in a clinical, academic, research or professional capacity, and be in good standing in their country.

**Humanitarian Award**
This award is given to an individual who has made a direct humanitarian contribution to society in the realm of hearing. This award could fit a broad category of significant service oriented activities. Candidates should have demonstrated direct and outstanding service to humanity in some way related to hearing, hearing disability, or deafness. Candidates should have demonstrated significant and consistent humanitarian contributions, preferably in matters related to hearing.

**Distinguished Achievement Award**
Recipients of this new award may include audiologists who are or have been exceptional educators in the classroom or clinic, have been innovative in program development, pioneering in areas of clinical service delivery, teaching, or research, or any combination of these areas. The contributions made by the recipients of the Distinguished Achievement Award must have an impact on the profession of audiology as a whole and not just at a state or local level. More than one Distinguished Achievement Award may be awarded per year.

**Selection of Honorees**
The Committee will consider all nominations, and awards will be made to qualified candidates who receive a majority vote of the voting members of the Committee pending final approval of the Academy Board of Directors. Not all awards may be given each year. Selected recipients will be presented at AudiologyNOW! in Denver, CO April 18-21, 2007.

**Guidelines**
Nominations should be made in a letter format with the resume of the candidate enclosed. The nomination and all supporting materials must be received at Academy Headquarters by October 27, 2006.

Address the nomination package to:
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Katrina Agung, Suzanne C Purdy, Catherine M McMahon, and Philip Newall

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Marlene P. Bagatto, Richard C. Seewald, Susan D. Scollie, and Anne Marie Tharpe

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E.D. Leigh-Paffenroth and C.G. Fowler

Efficacy of a New Treatment Maneuver for Posterior Canal Benign Paroxysmal Positional Vertigo
Richard A. Roberts, Richard E. Gans, and Renee L. Montaudo

Frequency Modulation (FM) Technology as a Method for Improving Speech Perception in Noise for Individuals with Multiple Sclerosis
M. Samantha Lewis, Michele Hutter, David J. Lilly, Dennis Bourdette, Julie Saunders, Stephen A. Fausti
A distant train.

Crickets outside your window.

Wind through pines.

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Children laughing.

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

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new report shows that consumers are exposed to roughly four thousand marketing messages a day (Lenderman, 2006). Many consumers are tired of dealing with the burgeoning amount of clutter in today’s multi-medium society. Making your message stand out is becoming increasingly difficult. Therefore, it may be time to take a new approach by making outrageous customer service your claim to fame. From small-town chicken outlets to suburban furniture stores to corporate giants like Southwest Airlines, extraordinary customer service is fast becoming the key to business success.

Spearheading the trend is T. Scott Gross, a confirmed believer in outrageous customer service and a popular speaker on the topic. Gross believes that great service is what customers respond to best, and making great customer service a priority can be the greatest tool that a small business has in its arsenal when it comes to winning over customers (Gross, 2004). By creating a winning family of employees and an enthusiastic work environment, and truly catering to your patients, word of mouth advertising can spread your message faster than any other form of marketing.

Have you ever shopped in a store where the clerks are glum and don’t seem anxious to serve you? Do you feel inclined to buy from them? Of course not. But go into a store where they seem glad to see you and will- ing to help you and you are far more likely to buy their products. The same applies to audiology practices. Audiologists in all practice settings should never lose sight of the importance of going the extra mile to delight the patients we serve. Few businesses can survive and certainly won’t thrive by serving patients only once. You want them to return to your business or organization and recommend it to everyone they know.

What is outrageous service or POS as Gross calls its? It’s above-and-beyond service that attracts customers with a touch of creativity and personality. It can take many different forms, but it always follows a few simple rules:

**POS IS RANDOM AND UNEXPECTED:** The element of surprise is part of its power.

**POS IS OUT OF PROPORTION:** It’s an extravagant gesture that catches attention.

**POS INVOLVES THE CUSTOMER PERSONALLY:** It’s an invitation to play that personalizes the service.

**POS CREATES POSITIVE WORD OF MOUTH:** More powerful than advertising, POS generates its own buzz. (Gross, 2004)

POS becomes a way of life, business will grow and audiology will become more fun.

If you can’t get your arms around the concept of POS, consider the following:

- Treat patients the way you treat friends when you see them. Be waiting at the door when a patient arrives, greet them by name and have their favorite cookies fresh from the oven. If a receptionist is your greater, train him or her to acknowledge the patient’s arrival within seconds of entering the office and try not to make the patient wait for their appointment. Waiting is not conducive to outrageous customer service.

- When dealing with patients over the telephone, never put them on hold. If you expect to be tied up for more than a minute, tell the patient when you will call back. If a patient needs information, take the message and respond as soon as possible. Have a real person answer your phone. It may be less expensive to have a machine, but it isn’t very patient friendly, especially for people who have hearing problems.

- Win over customers when mistakes happen, no matter who is at fault. This is the best way to turn unhappy patients into raving fans of your business or organization. If there is a scheduling error, admit to the patient that you made a mistake, ask them when they would like to come back and then have a limo pick them up for that appointment.

- Offer service that is the “fastest in town.” When a patient brings in a broken hearing aid, repair it while the patient waits and tell them lunch is on you. When a patient refers a friend or relative, send them a hand written thank you note and flowers. Better yet, deliver the flowers and the note in person.

- Go (well) beyond what is expected. POS is about doing the unexpected. When you give patients more than they expect, business will increase. People remember the outrageous. I still remember when Ozzy Osbourne bit the head off a bat! While you might not want to go to that extreme, delivering outrageous customer service may be just what the doctor ordered for your business or organization.

**References:**


New ABA Recertification Requirements Take Effect January 1, 2008

Steven D. Sederholm, AuD, ABA Board of Governors

One of the tenets of the American Board of Audiology™ (ABA) certification program is a “quest for excellence through lifelong learning.” State-licensed audiologists are generally required to upgrade their knowledge base and remain current by keeping up with recent developments in the field. ABA Board Certified audiologists accept the greater challenge of complying with the more stringent continuing education requirements as set forth by the Board.

The American Board of Audiology™ is not a continuing education provider. Rather, the ABA requires continuing education hours as part of its recertification program. In its continuing effort to encourage Board Certified audiologists to seek high level educational opportunities, effective January 1, 2008, the Board shall implement more rigorous and intensive requirements for recertification.

All ABA certificants applying for recertification must have obtained 6.0 continuing education hours (or 60 clock hours) during a three year certification period. Additionally, 1.5 hours (or 15 clock hours) must be Tier 1 continuing education hours, defined as educational activities of minimum three hours’ duration with some form of outcome measurement. The remaining 4.5 hours may be the “Tier 2” variety, or typical continuing education hours. Finally, three hours, in either Tier 1 or 2, must be in professional ethics.

Board Certified audiologists seeking recertification who also have been awarded ABA’s specialty certification in cochlear implants must earn 30 of their required 60 clock hours in activities pertaining to cochlear implants. These hours may be Tier 1 or Tier 2.

It is important to understand that the new requirements will apply to each certificant depending upon his or her renewal date. If your renewal date falls before 1/1/2008, you will only be required to fulfill the previous requirements. However, certificants with renewal dates after 1/1/2008 will be required to meet the new and more rigorous requirements.

The Board wishes to assure its certificants that adequate opportunities for Tier 1 activities will be readily available. Currently the ABA is communicating with CE providers to encourage them to make Tier 1 hours widely available. Tier 1 hours were available at AudiologyNOW! 2006 and will also be offered during the upcoming AudiologyNOW! 2007 in Denver. Additionally, Tier 1 hours will be available through the Academy’s distance education offerings. The Academy plans to offer one distance education opportunity per quarter commencing in late 2006.

In addition to state and national meetings, Tier 1 hours can also be earned through two publications, Seminars in Hearing and Ethics in Audiology, or the “Green Book,” published by the American Academy of Audiology. Audiologists may earn up to 1.1 Tier 1 CEUs through participation in the “Green Book CEU program” (this represents most of the Tier 1 requirements needed for the three-year certification period!). Seminars in Hearing is another good option for earning Tier 1 continuing education. Each issue shall count as approximately 10 hours, and may be applied towards the Tier 1 15 hour continuing education requirement. To count these hours towards ABA certification requirements, an ABA certificant should take advantage of the Academy’s CE registry.

The American Board of Audiology is working hard with state academies of audiology, hearing instrument manufacturers, and independent CE providers to ensure that a wide variety of Tier 1 courses will be available. The ABA will constantly announce new Tier 1 offerings in both this publication as well as our website, www.americanboardofaudiology.org.

Deadline for Transition to the Doctorate Rapidly Approaching!

For all applications for Board Certification in Audiology filed after January 1, 2007, an applicant must hold a doctoral level degree, either an AuD or PhD. Please make your colleagues who have expressed interest in the ABA credential aware of this rapidly approaching deadline!
Cochlear implants (CIs) have become a widely used treatment option for patients with severe to profound sensorineural hearing loss and who receive little to no benefit from hearing aids. A recent article by Middlebrooks et al. (2005) reviews some of the basic biological principles underlying implantation as well as new perspectives on signal processing. Audiologists and hearing scientists interested in learning more about current theories fundamental to signal processing and the biological representation of sound will find a wealth of information in this paper. Recent advances in signal processing, how sound is coded in the brain, and the effects of brain plasticity, are all reviewed. Here we highlight a few of these advances.

The neural representation of spectral (frequency) and temporal (timing) information (contained in speech) is being studied at various levels in the brain, including the inferior colliculus and auditory cortex, in hopes that CIs can be designed to improve the neural representation of this information and in turn improve perception. For example, in the normal auditory system, a frequency-place relationship exists in the cochlea. The frequency of the incoming signal provides maximal stimulation of the hair cells located at a corresponding frequency region in the cochlea, also referred to as tonotopy. This tonotopic organization begins at the level of the cochlea and is maintained throughout the central auditory system right up to the cortex. When the CI electrode array is inserted into the cochlea it employs a similar frequency-place assignment using up to 22 electrodes equally spaced along the length of the array designed to stimulate corresponding frequency areas. Each electrode represents a set range of frequencies with the lower frequencies near the apex and higher frequencies at the base.

CI stimulation requires current flow between an active intra-cochlear electrode and intra- or extra-cochlear return electrode(s); the path of current flow is termed configuration. Current CI configurations include monopolar (MP), bipolar (MP) and tripolar (TP). MP stimulation utilizes an extra-cochlear return electrode. In BP stimulation, the return is an adjacent intra-cochlear electrode, while with TP stimulation it consists of two adjacent and flanking intra-cochlear electrodes.

In the normal auditory system, a pure tone will excite a localized population of neurons “tuned” to that particular frequency while CI stimulation generally excites a larger neural population and has less fine-tuning. This spread of excitation may shift the maximum place of excitation more basally, resulting in an inaccurate representation of the incoming signal’s frequency content. The authors describe a new way to analyze this phenomenon with multi-site recording probes to record neural spike activity in the inferior colliculus and the auditory cortex of guinea pigs (Bierer and Middlebrooks, 2002; Snyder et al, 2004). Altering the electrode configuration (MP, BP or TP) and place of stimulation (basal to apical) creates different patterns of excitation within the auditory cortex. Results show less overall spread of excitation from MP to BP to TP and that BP and TP configurations provide more precise spectral representation than MP. Although the findings argue that MP may not be the best way to accurately represent frequency, studies have shown that CI listeners are able to discriminate cochlear place fairly accurately with MP. While CI listeners with MP stimulation show high performance for speech in quiet, perhaps advanced processing strategies utilizing BP or TP stimulation would improve performance in music appreciation and speech perception in noise.

Interesting findings involving temporal information and long term deafness with CI stimulation have also been reported. The temporal information contained in speech signals (place, manner, voicing, etc) is represented in the amplitude envelope of the acoustic signal. Animals deafened from birth show reduced sensitivity to temporal distinctions and loss of distinct tonotopy. Remarkably, studies have shown that long-term CI stimulation has a protective effect on both temporal resolution and tonotopy (Leake et al, 2000). In addition, if CI stimulation is introduced prior to five months of age in cats, it can partially restore higher level auditory cortical activity (Kral et al, 2002).

Although many pediatric and adult CI listeners achieve a high level of speech understanding, there are those who don’t. Also, in more challenging listening situations such as in the presence of background noise or while listening to music, CI listener performance is less than optimal. Some ways to enhance their speech understanding are to improve the way temporal and spectral information is coded in the periphery, and represented in the central auditory system.

REFERENCES


The first-ever national conference on noise-induced hearing loss in children will be held October 19-20, 2006 at the Embassy Suites River Center, Covington, Kentucky (just across the Ohio River from Cincinnati). All interested persons are invited to attend this important inaugural event.

**Topics Include:**
- How great is the risk of noise-induced hearing loss for our children?
- Are the underlying physiological mechanisms of noise-induced hearing loss (NIHL) the same in children vs. adults?
- Is early hearing loss prevention education and intervention successful at changing knowledge, attitudes and behaviors of children and young adults?
- What responsibilities do parents, schools, employers and public health systems have in preventing NIHL?
- What are the resources, programs and research agendas needed to successfully prevent noise-induced hearing loss in children and adolescents, both at work and at play?

**Sponsors:**
- National Institute for Occupational Safety and Health (NIOSH)
- National Institute on Deafness and Other Communicative Disorders (NIDCD)
- National Hearing Conservation Association (NHCA)
- Marion Downs Hearing Center
- Oregon Health & Science University of Northern Colorado

**Contributors:**
- Deafness Research Foundation (DRF)
- American Academy of Audiology (AAA)
- American Speech-Language Hearing Association (ASHA)

The Conference will bring together a diverse group of basic and applied science researchers with expertise and interests related to the prevention of noise-induced hearing loss (NIHL). The purpose of the Conference is to explore and discuss the most recent theoretical and experimental work in the relevant fields in an effort to expand the practical applications of knowledge shared. The Conference will focus on the issue of NIHL in children in occupational and recreational settings.

For additional information, contact Linda Howarth by telephone at 503-494-0670 or by Email: howarthl@ohsu.edu or visit the conference web site at www.hearingconservation.org/conf_childrenconf.html

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**B.E.S.T. Committee Holds Inaugural Meeting in Chicago**

Several members of the B.E.S.T. Committee met in Chicago in August. Standing from left, Bettie Borton, Stephanie McVicar, Karen Jacobs, Paul Pessis, Soriya Estes; seated from left, Tracey Irene, Gyl Kasewurm (Chair) and Robin Donham.

The new Business Enhancement Strategies and Techniques (B.E.S.T.) Committee, Chaired by Gyl Kasewurm, met in Chicago on August 4 and 5 to develop short term and long-term strategies for the coming year. The B.E.S.T. Committee is charged with developing ways to assist audiologists in obtaining the information and resources required to manage all aspects of practice management for all audiology practice settings. The Committee is working on strategies to “best” provide those resources to Academy members. Paul Pessis, Academy president, and local Chicagoan, attended the committee meeting and relayed the enthusiasm that the Board of Directors has for B.E.S.T. Pessis encouraged committee members to come forward with any and all ideas for creating and improving practice management resources for Academy members. Committee members attending the meeting in Chicago were Robin Donham, Bettie Borton, Soriya Estes, Tracey Irene, Stephanie McVicar. Committee members unable to attend the meeting include Granville Brady, Jana Brown, Kamal Elliot, Sally Jessee, Wendy Shiau, Ed Szumowski, Lynda Colligion-Wayne and Haley Nobel (Student Member). Ex-Officio attendees included Karen Jacobs (Board Liaison,) Sydney Davis (Staff Liaison) and Jerry Northern (Publicity). Watch for exciting developments in the near future.

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**15th Annual Colorado Academy of Audiology Conference**

The Colorado Academy of Audiology (CAA) will hold its 15th annual convention in the beautiful mountain resort of Breckenridge, CO, Sept. 28-30, 2006. Robert Sweetow will be the keynote speaker and other faculty presenters include Steve Ackley, Sandra Gabbard, Kristin Uhler, Erin Luckett, Dave Fabry, Cris Schweitzer, Robert Traynor, Robert Glaser, David Kelsall and John Christiansen. More information may be obtained from Michael Iliff, VP of Education for CAA at miliff@hicmail.com.
Next Academy President to Be Elected from Board of Directors
Nominations Committee Developing 2007 Slate of Candidates

The Nominations Committee is underway with the task to prepare a slate of nominees for the initial election of the Academy President to be selected from current or previous Boards of Directors. This will be the first election cycle in which the Academy President is elected from the Board of Directors as directed by a by-laws change approved in 2005 (see “Message from the Board: Presidential Elections – An Evolution, AT, 18:1, pg 9, 2006). The Academy Nominations Committee, chaired by the past-president of the Academy, Gail Whitelaw, will also recommend the process that the Board of Directors will follow for the election of the President. The Nominations Committee issued an open Call for Nominations on July 31, 2006 for candidates to fill three Board of Directors Member-at-Large positions to be elected by the general membership during February of 2007.

As required by the Academy bylaws, the Nominations Committee is comprised of the Academy’s immediate past-President as chair, a representative selected from each year’s Board of Director’s class — including the immediate past class of Board members, and two Academy members at large. The membership of the Nominations Committee is approved by vote of the Academy Board. The 2006 Nominations Committee is: Bopanna Ballachanda, Carmen Brewer, Paul Dybala, Ted Glattke, Melanie Herzfeld, Helena Solodar, Gail Whitelaw (Chair), and Ed Sullivan (Academy staff liaison).

The main charge of the Nominations Committee is to present a slate of candidates for Members-at-Large to the Board of Directors that is representative of the profession of audiology, subsequently to be voted on by the Academy membership. The Call for Nominations was open until late August and candidates were considered based on nomination of others or by self-nomination. An important part of the nominations process includes helping nominees to the Board of Directors to understand more effectively the roles and responsibilities of the Member-at-Large positions and to recognize that if elected to the Academy Board, they may ultimately be elected to serve as the Academy’s President.

Watch for announcements of the final slate of candidates for the Board of Directors and be sure to vote during February 2007. The electronic on-line voting process is quick and easy and has a significant impact on the future of the Academy. Your vote will be more important than ever, recognizing that each elected candidate might someday serve as Academy President.

AFA Outstanding Student Scholars

The Audiology Foundation of America (AFA) is proud to announce the winners of its Outstanding AuD Student Scholarships for the 2006-2007 academic year. Second-year AuD students Jessica Gordon, from the Graduate Center of City University, New York, and David Stewart, from the joint San Diego State University/University of California at San Diego AuD program, will each receive a $4,500 scholarship. In addition, third-year AuD student winners Cassie Effert, from the University of Florida, and Marissa Mendrygal, from the University of Texas at Dallas, will receive $4,500 scholarships for the upcoming academic year. The Outstanding AuD Student Scholarships were established to recognize and support the “best and brightest” AuD students. Scholarship winners will be honored at events held at their universities. These scholarships are funded by a grant from the William Demant and Wife Ida Emilie Foundation.
**MESSAGE**

**from Mongolia**

Jill Howe has been involved with the Torgood tribe community for 7 years, living there for four. There are no other foreigners in the area and even with the mass of foreign aid pouring into Mongolia at this point in history, very little reaches her community. The Soum’s population is 8,000. There is no electricity, no running water and little infrastructure. The great Altai Mountains and poor roads isolate the Torgood community, but there is an aeroplane that flies in every Saturday, all things pending! The community hospital has inadequate staff and equipment, services a very large area and people can travel up to 5 days by camel or horse to get to it. There are no basic specialist services at all which means children and adults never have their eyes or hearing tested. Just because the community is isolated and a long distance from anything doesn’t make the need any less. Jill’s life is often a bridge to the outside world for ‘good stuff’ to happen for the local people. Last year two 40-foot containers arrived, the contents outfitting the hospital and much of school Number 2 and much more about the town. Jill’s work involves managing an English Study Centre and visiting nomadic families who have children and adults with special needs. This brings her in touch with the hidden-away hearing impaired of the community.

Jill needs help. Hearing tests and hearing aids are required for many. Interested in making a journey of a life time and to do ‘good stuff’? Optometrist colleagues may be interested in joining you for a team effort. Any professionals who can visit and help will be welcomed and greatly appreciated by the community. You don’t have to ride a horse but you do have to be a good traveller over bumpy roads that forget they are roads a lot of the time. Don’t let that put you off…..just think how a little girl like Zolzaya could be helped.

Zolzaya is 10 years old. She lives in a loving and caring herds-family. She is also partially deaf and because of this she has not been allowed to attend either of the town’s two schools. She would be a problem for the teacher, Jill was told. Her mother came to Jill begging for help for her beautiful and bright little girl. Negotiations with school number 2 mean that now Zolzaya can begin classes in September. She will also need to live in the school dormitory. Life will be very challenging for this precious child as she travels her life journey in a harsh environment. Zolzaya’s character and determination will hopefully see her through…..And a hearing aid will make the whispers of life sweet for the whole family.

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**University of Pittsburgh Plans 2nd Annual “Teaching Audiology” Conference**

The University of Pittsburgh will host a second conference on teaching audiology next summer (June 14-16, 2007). The featured topic is “Teaching Audiolologic Management (aka Aural Rehab),” to be facilitated by a panel of nationally recognized educators in audiology. Jill Elfenbein will be the keynote speaker, and Gus Mueller will serve as moderator. The conference is open to all interested in the educational and clinical preparation of audiologists. A poster session will provide participants the opportunity to share teaching strategies and learning outcomes. For information about the conference or on submitting a poster, contact Barb Vento (barbv@pitt.edu).
CALIFORNIA

CLINICAL AUDIOLOGIST ñ Busy private practice has full time position in Apple Valley, California. We are 90 minutes from beaches and 60 minutes from mountain skiing. Benefits include medical, dental, 3-day weekends and year-end bonus in a $60K plus salary package. Send resume to: Desert Knolls Hearing Center, 15995 Tuscola Road, Apple Valley, CA 92307 or fax to: (760) 242-2312.

For information about our employment website, HearCareers, visit www.audiology.org/ hearcareers. For information or to place a classified ad in Audiology Today, please contact Elizabeth Lowman at elowman@audiology.org or 1.800.AAA.2336 ext. 1039.
There are many benefits to being a member of the American Academy of Audiology. There are the obvious ones, such as our annual convention, AudiologyNOW!, Audiology Today and the Journal of the American Academy of Audiology, access to other colleagues, advocacy for the profession...to name a few. There are so many advantages, in fact, that sometimes it is easy to overlook some of the services you are eligible for when you become a member.

Did you know that you could get insurance through Academy-endorsed programs? Not impractical Lloyds of London insurance, but the type of insurance that is needed if you are a practicing audiologist. For your professional liability insurance, we endorse Healthcare Providers Service Organization (HPSO). When you are looking for health/life/disability/property (amongst others) insurance for yourself or those working in your practice, we recommend that you contact Association Health Programs. If you are in need of auto insurance, GEICO has you covered.

The definition of insurance is “protection against future loss.” If our members find themselves in a situation where there is potential for loss, it is our job as the largest organization devoted strictly to the practice of audiology, to provide a means of protection. With the carefully chosen insurance programs we provide as benefits of membership, we believe that we have done just this. For more information about these and other member benefits, visit the Membership and Benefits section of the Academy’s website. Find out if you could be getting better service by using your Academy membership. Chances are that you could.

New benefits! Improved benefits! New and Improved benefits! Why are all of these sentences emphasized with an exclamation mark? Because the Academy is about to make your professional life a whole lot easier, and we are pretty excited about it. So what are all these wonderful benefits, meant to dazzle and delight, anyway? First, we have a new benefit that provides discounts on payment processing fees for Academy members. Recently, a few of our members let us know that they would consider this particular service helpful in their practice. We did the research, and a new Academy benefit was born.

We have partnered with Global Electronic Technology, Inc. (GET) to offer our members Discounted Payment Processing fees for credit cards. As a premier payment processor, GET offers a suite of products tailored specifically for Academy members. In addition to acceptance of all credit card and debit card payments, GET offers Automated Clearing House (ACH) and recurring billing capabilities, enhancing and streamlining cash collections and receivables. This should be especially good news for our members in practices where patients pay with a credit or debit card, and which means there are inherent transaction fees. A member of the Academy can save up to 20% annual savings off of their current rate when they use GET. GET has also generously agreed to make a donation to the American Academy of Audiology Foundation for each transaction processed.

Now let’s take a closer look at improved benefits. MBNA, the previous provider of our Academy credit card, is now a part of Bank of America. Bank of America has nearly 5,800 retail banking centers. Because of the resources available through Bank of America, Academy members who use their credit cards will have access to more ATMs. More ATMs means they are easier to find and you are less likely to pay service charges.

What changes should members expect from Bank of America? Except for a logo change on your statements, items like your PIN and Login number, NetAccess online banking capabilities, payment and deposit methods, and basically all card usage will remain the same.

There are also new and exciting developments to our conference calling service. ReadyConference® Plus allows you to conduct convenient and cost-effective meetings with both audio and Web features. Not only can you be on a call with colleagues, but you can have them view a PowerPoint presentation as well. Be able to communicate your ideas as if you were there in person.

We hope you will use these new and improved benefits. We appreciate your membership, and we will continue to find new and better ways to serve the profession. Check out the Membership and Benefits portion of the website to learn more about these and other Academy benefits.