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Sincerely,
Bob Oliveira, Ph.D., Pres.
This is my first chance to thank the membership for the opportunity to serve as your President. Carol Flexer and I have worked together during the past year making the July 1 transition a smooth one. I also welcome our new Board members. The AAA Board of Directors is a representation of all aspects of audiology practice, i.e., private practice (5 members), university teaching and research (2), government (1), public schools (1), hospitals (3).

Anything that is worthy of achievement can be obtained if you follow what Bryce Courtney describes in his novel, The Power of One: "one idea, one heart, one mind, one plan, and one determination." We, as the Power of One Profession, can achieve autonomy or any other goal that we may have once felt was beyond our grasp.

The Board of Directors is united in its commitment to make audiology an autonomous profession. Decisions by the Board, although at times controversial, are made based upon what is in the best interests of all of us, as the Power of One Profession—audiology. Perhaps, as indicated by our recent Needs Assessment Survey, the Board needs to improve our communication. A good start is our new AAA Web Page (www.audiology.com) with frequent updates provided by our Committees and Board. Our new Web Editor, Roy Sullivan, assures us that we will have "the most up-to-date and state-of-the-art page on the Web."

Our success lies within each of you. You are the Academy and you are the Profession. If we are to continue being the Voice of Audiology and to make audiology autonomous, then we must have your participation and support. How could we have come so far without the vision of audiologists like James Jerger and the original Board to create this Academy eight years ago? Our success is represented by the hard work of audiologists like Kristen Kaufman, first President of the South Dakota Academy of Audiology, who got out of a sick bed to fax a letter on behalf of the Academy to Senator Tom Daschle, who was meeting with our lobbyists in Washington later that day; or audiologists like Jerry Church, who went out on a limb to convince his administration at Central Michigan University that the AuD is the future of our profession—only, by the way, to see the applicant pool more than double this year with outstanding AuD candidates, and to see his faculty expand to become the largest full time tenure track audiology department in the country.

While these people are a part of our power, the fact that 5,200 persons attended the recent convention in Salt Lake City, and that so many audiologists are involved in state and local activities, demonstrates commitment. Each of you is part of the force driving this profession and our organization to be the Voice of Audiology.

During my year as AAA President, I would like to see:

- Open dialogue among all national audiology organizations on professional issues. The American Academy of Audiology has initiated meetings with the national audiology, consumer and related professional associations to discuss shared interests.
- More entry level and distance learning AuD programs in universities. To facilitate these efforts, the AAA Board coordinated a meeting in Salt Lake City of university training program directors to discuss ways of bringing programs on-line and provide a mechanism for current practitioners to earn the AuD.
- Recognition of Audiology by third parties as an independent profession and a gatekeeper of hearing care. That is, implementing a system to provide patients direct access and reimbursement for our professional services. The Board and our lobbying firm are communicating closely with the Department of Labor, HCFA, Office of Personnel Management, and other regulatory bodies to assure that Audiology is clearly and correctly defined.
- Licensure in every state that clearly defines the scope of audiological practice and recognizes the AuD as the entry level degree.
- An independent accrediting body for audiology training programs. The AAA has taken the lead by working closely with all other national audiology organizations to establish a joint audiology accrediting commission.
- Our Continuing Education programs continue to expand and attract members from throughout the world. The Education Committee has reviewed suggestions from the Needs Assessment Survey. They are developing courses and unique methods for program delivery to facilitate the acquisition of continuing education by the membership.

We, as the Power of One Profession, can achieve each of these goals as well as the many additional ones that may be on your personal list. We will succeed, but we must be in control of our own future and stay involved...

We will succeed, but we must be in control of our own future and stay involved...

Barry Freeman, AAA President, Center for Audiology, Clarksville, TN
Certification vs. Licensure

I was surprised at the Salt Lake City Convention opening session by AAA’s determination to replace certification with licensure. At best this is ill-advised considering the tenuous nature of licensure in today’s health care climate. Those of us who have been in the trenches working with licensure realize that it can be wiped out at the whim of a governor, sunsetted by a legislature, and privatized into a self-serving professional group. Licensure is under attack by the Pew Health Commission who recommended in December 1995 that mergers of unrelated boards occur, and that scopes of practice allow for many practitioners to perform the same duties. Furthermore, licensure of audiologists is not universally available across the states.

Further, I am deeply concerned about AAA’s apparent animosity towards ASHA. At a time when health care delivery is shifting under our feet a unified front is needed more than ever. I had previously held the belief that there is value for me in membership in both organizations, but now I’m not sure. There is no mechanism in AAA for me to have a voice in actions that the organization is undertaking. I can’t support an anti-trust suit of ASHA, and may be forced to vote by withdrawing my membership, an action I would take reluctantly.

It is my sincere hope that AAA will drop its adolescent posturing and develop a mature attitude of cooperation with ASHA for the good of the audiology profession. Power and control issues become moot if the profession no longer exists.

—Gay Vekovias, Shreveport, LA

CCC-A & State License NOT Equivalent

I read with horror in the recent Audiology Express (Vol 2:1, April 5, 1996) that AAA endorses substituting State License for the ASHA CCC-A as the credential for professional practice in audiology. Academy officers have shown extreme shortsightedness in adopting this position. The CCC-A and state license are not equivalent.

The CCC-A has long stood as the national standard for the competence of professionals practicing as audiologists. This standard has been developed and implemented by peer professionals. In contrast, state licenses, although often modeled after the CCC-A, represent a minimum standard of preparation that individuals must attain prior to practicing in a specific state. State specific standards are typically monitored and updated (if at all) by area professionals, state bureaucrats and consumers. Moreover, some states currently have no licenses for audiologists!

By attempting to equate CCC-A and licensure, AAA shows a willingness to lead the profession in a risky direction. AAA needs to reassess its position in light of the trends to reduce regulatory actions by the government, to reduce costs within many states and third party providers and to “sunset” regulatory boards. Abandoning the CCC-A means that we are willing to accept a different standard for the profession in each state. A worse case situation would be that non-audiologists could successfully lobby for changes in the licensure laws that will weaken the profession. We could be moving towards a time when hearing aid dispensers, with no formal education beyond high school, can obtain a State license. Without a national standard, imperfect though it may be, each State Licensure Board would be free to respond only to local interests and not have an accepted measure of competence upon which to gauge their own set of regulations.

I understand that many audiologists question the relevance of ASHA Certification. Specifics of the content and structure, as well as the fees for the CCC-A, are not acceptable to many audiologists. Although some individuals have chosen not to continue holding the CCC-A and are providing services under State License, this does not justify eliminating the CCC-A. To equate the function of the CCC-A and that of state licensure is simply silly.

We need to be careful not to throw out the baby with the bath-water in our enthusiasm to change the CCC-A. As much as we may chafe under the rigidity of the CCC-A, it is the only national standard in which we can now participate, albeit with varying effectiveness. While we are fighting for increased professional autonomy and a broadened scope of practice, the need for a national standard is critical. Abandoning a national standard will only serve to divide the profession into regional or state areas, many of which will abdicate their responsibilities. Since the inception of the certification process, the standard has evolved with the profession, and there is no reason to assume that it cannot continue to evolve and meet contemporary needs of audiologists. We need our AAA leaders to work to insure that the CCC-A continues to evolve with the profession.

I strongly urge AAA to re-consider and endorse a national standard which will not fractionalize the profession. At this time, the only existing national standard is the CCC-A provided by ASHA.

—Elizabeth Kennedy, Barrington, NJ

AAO-HNS Fact Sheet

Editor’s Note: The following letter was sent to Neil O. Ward, MD, President, American Academy of Otolaryngology - Head and Neck Surgery, in response to the recent Fact Sheet sent to all AAO-HNS members:

Dear Dr. Ward:

The American Academy of Audiology (AAA) strongly objects to the AAO-HNS document entitled “Audiologists and Mandates for Direct Access and Reimbursement Under the Federal Employee Health Benefits Program (FEHBP) — Fact Sheet/ Talking Points.” We believe that this “fact sheet” is a disservice to the 28 million Americans with hearing loss, to whom our two academies share a common commitment.

The fact sheet misrepresents the training, skills, and scope of practice of audiologists, and also mischaracterizes the pending FEHBP legislation. For the record —

Audiologists complete a rigorous graduate-level training program that emphasizes basic and applied sciences related to auditory disorders, including their causes and characteristics, assessment and rehabilitation. Currently, 46 states have licensure or other regulation of the practice of audiology. We assume that you are familiar with the training and
LETTERS TO THE EDITOR

qualifications of audiologists, however, we would be pleased to provide specific information if it would be helpful to you.

AAA strongly objects to the AAO-HNS statement: "Audiologists are not qualified by education, training, or experience to diagnose or treat the extent and causes of hearing impairment." On the contrary, audiologists are fully qualified to determine the type and extent of a hearing impairment, to assess the effects of hearing impairment on social/vocational function, and to provide non-medical management for the habilitation/rehabilitation of communicative function. AAA recognizes that otolaryngologists have a distinct and important role for determining the etiology of hearing impairment and for providing medical and surgical treatment. However, this does not in any way diminish the expertise and ability of audiologists to provide a broad range of non-medical diagnostic and rehabilitative audiologic services.

AAA takes special exception to AAO-HNS' characterization of audiologists as "technicians' trained to administer hearing tests which can aid the physician in rendering a medical diagnosis." In the health care field, the term "technician" is used to denote an individual who receives minimum training (usually not culminating in a degree) and performs specific technical tasks, the results of which are interpreted and communicated to patients through another professional. Technicians typically are not educated in the principles that underlie the procedures they conduct; they do not engage in scholarship; they do not direct patient care. By contrast, audiologists are highly trained, autonomous health care professionals, who — like physicians — perform certain "technical" evaluations in the course of examining patients; however, they also interpret and explain the results of those evaluations to their patients, and make health care treatment judgment based upon their professional training and experience.

> The AAO-HNS fact sheet mischaracterizes the effect of HR 1057 and S 800. This legislation would not mandate new coverage of services. Rather, it simply would permit FEHBP beneficiaries to choose between direct access to an audiologist and indirect access through a physician for already-covered audiology care. Furthermore, the legislation would not be harmful to patients. The AAO-HNS' assertion that individuals with hearing loss should see a physician to have their condition diagnosed and treated. This is in the best interest of the patient and remains the most cost-effective method of delivering hearing health care...simply is not true in the modern health care system. Approximately eighty percent of patients with hearing loss cannot benefit from medical or surgical treatment. Therefore, in the majority of cases, audiologists can provide the full range of effective diagnostic and rehabilitative services to people with hearing loss. In the remaining cases, AAA notes that audiologists are trained to — and do routinely — make appropriate referrals to physicians. There is no evidence that direct access to audiologists will increase the cost, or decrease the quality, of hearing health care. Indeed, AAA believes that direct access will increase the quality of care, by facilitating early and appropriate treatment (including physician referral when indicated).

Together, our academies can achieve more cost-effective treatment of hearing loss including earlier physician referral of medically and surgically treatable ear disease. AAA is committed to the principle that professional autonomy for audiologists is in the best interests of our hearing-impaired patients. AAO-HNS should not distort or minimize the training and competencies of audiologists or attempt to control our profession.

We were heartened by the 1994 address of AAO-HNS President, Dr. Mansfield Smith, when he said that this is an important time for colleagues in audiology and otolaryngology to work more closely together and hold all of our efforts to a higher standard to increase the well-being of our patients. If our academies can share that vision, we can begin a dialogue that will foster a collegial interdisciplinary relationship that will benefit our patients.

—Bruce Wardle, Executive Director, American Academy of Audiology

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FREQUENTLY ASKED QUESTIONS

ACADEMY REPORT ON CERTIFICATION & LICENSURE

Recently, members of the American Academy of Audiology (AAA) Board of Directors requested a meeting with members of the American Speech-Language-Hearing Association (ASHA) Executive Board to discuss issues of critical importance to audiologists. On March 14, 1996, AAA President Carol Flexer, President-Elect Barry Freeman, and AAA Executive Director Bruce Wardle met with ASHA Vice President for Professional Practice in Audiology Larry Higdon and ASHA Executive Director Fred Spahr to discuss the relationship between ASHA certification, ASHA accreditation, and state licensure.

This Fact Sheet was developed by the AAA Board of Directors in response to AAA member questions about that meeting. Additional information about certification, accreditation, and licensure will be published in Audiology Today and on the AAA Web Page (http://www.audiology.com).

WHAT WAS THE PURPOSE OF THE MEETING INITIATED BY AAA WITH ASHA?

The AAA Board of Directors requested a meeting with the ASHA Executive Board to discuss recognition of the state license in audiology as the practice credential for audiologists. Prior to state licensure laws, the ASHA Certificate of Clinical Competence in Audiology (CCC-A) defined the minimal entry credential in the profession. Today, licensure in audiology is present in 44 states; it is the credential that legally defines the practice of audiology in those states. Regardless of certification status, an audiologist cannot practice in those states without a license except in exempted employment settings (e.g., public schools). However, ASHA does not recognize licensure as equivalent to the CCC-A. ASHA requires licensed audiologists in ASHA-accredited training programs and clinical programs to maintain the current CCC-A even though their legal right to practice is described by their state license. The only requirement for current certification by ASHA is the payment of an annual fee. AAA initiated a meeting with ASHA to discuss recognition of the state license in audiology as equivalent to the CCC-A.

WHAT IS THE AAA REALLY ASKING ASHA TO DO?

AAA is asking ASHA to reconsider its position and to recognize that a state license in audiology is equivalent to current certification for the purposes of ASHA-accredited university training programs (ASHA Council on Academic Accreditation [CAA]) and clinical programs (ASHA Professional Services Board [PSB]). Audiologists employed in these settings should not be required to pay the annual certification fee in addition to their state license in order to be employed. AAA does not believe that an audiologist should be tied to a voluntary credential such as the CCC-A in order to secure employment in ASHA-accredited programs. This is an unnecessary coupling.

What AAA is asking ASHA to do is recognize the license as equivalent to the CCC-A only for ESB and PSB programs and not for other employment or practice settings.

Through the accreditation mechanism, ASHA controls employment requirements in ASHA-CAA and ASHA-PSB settings—in order to work in those settings, an audiologist MUST maintain the CCC-A. By recognizing state licensure as equivalent to the CCC-A, ASHA could immediately grant audiologists in those practice settings freedom-of-choice regarding certification, and thereby significantly influence employment requirements in other practice settings.

WHY IS AAA EMPHASIZING THE IMPORTANCE OF THE LICENSE RATHER THAN CERTIFICATION?

AAA emphasizes the importance of the license because, in the vast majority of states, the license defines the legal right to practice audiology. Licensing laws generally follow the same requirements as those required to be a Fellow in AAA (FAAA), that is, earning at least a master’s degree in audiology from an accredited university, passing a national examination, and completing nine months of supervised, professional experience. AAA does not believe that an audiologist’s right to practice should be tied to maintaining a voluntary, entry level credential. Perpetuating the vagaries of the CCC-A has created an artificial need to maintain CCC’s by many audiologists.

IS IT EASIER TO GET MY STATE LICENSE IF I HAVE MY CCC-A? DO I HAVE TO MAINTAIN THE CCC-A IN ORDER TO MAINTAIN STATE LICENSURE?

Many state licensure boards accept proof of certification for licensure. Any acceptable, verifiable proof of academic and clinical practicum documentation will be accepted by licensure boards as evidence of having completed the minimum requirements described in their respective laws. Each state has established procedures to document necessary licensure requirements without obtaining ASHA CCC-A. None require ASHA certification for licensure. No state licensure board requires an applicant to pay membership dues or a certification fee to any voluntary professional organization as a condition of licensure—you do NOT have to maintain your CCC-A to keep your state license.

IN STATES WITHOUT LICENSURE, WHAT DEFINES ME AS AN AUDIOLIGIST?

Those states with registration will have a legal description to define those eligible for registration. In states without licensure, the scope of practice of an audiologist is usually controlled by the specifics of the practice setting. Academic and clinical credentials will help define the scope of practice; however, definitions will ultimately rest with the position description. To the extent that it is permissible by state law, any person can claim to be an audiologist regardless of that person’s educational background, training or certification status. For this reason, state licensure is a critically important component...
of professional identity and practice and consumer protection. Though any legislation is subject to change, consumer protection issues such as licensure are in a relatively safe position. Changes in licensing laws will more likely be geared toward increasing those aspects that protect the consumer rather than decreasing regulations.

**DO I NEED MY CCC-A TO KEEP MY JOB OR TO GET ANOTHER?**

That depends on your practice setting. As currently defined, audiologists in ASHA-CAA and ASHA-PSB accredited programs must maintain their CCC-A for employment. Some other accrediting agencies may also require the CCC-A. If ASHA would recognize the state license as equivalent to the CCC-A for purposes of employment in ASHA-CAA and ASHA-PSB programs, most audiologists could practice with the sole credential that is legally required to practice—the state license.

**SHOULD STUDENTS BE ADVISED TO GET THEIR CCC-A?**

Students should understand that the state license or registration represents the legal credential to practice. They should also understand that no state licensure board requires the CCC-A, although some boards accept proof of certification for licensure. At the present time, if the student wishes to become employed in an ASHA-CAA or ASHA-PSB accredited program, or to supervise audiology graduate practicum training, the student must obtain the CCC-A.

**IS AAA ADVISING AUDIOLOGISTS TO DROP THEIR CCC-A?**

AAA believes that audiologists should have the right to choose whether to maintain the CCC-A. AAA further believes that employment status should not be tied to any voluntary credential. Audiologists should understand the advantages and limitations of certification in their individual work settings, and decide to maintain or drop their CCC-A based on personal priorities and objectives.

**IS THE AAA TRYING TO DESTROY ASHA CCC-A'S AND ASHA'S ACCREDITATION PROGRAMS?**

It has never been the intention of the AAA to destroy ASHA's certification or accreditation programs. The issue has been—and remains today—that a "decoupling" of the two would be in the immediate and long-term interests of the profession of audiology. There simply is no truth to the allegations that AAA is trying to destroy certification. Indeed, nothing could be farther from the truth.

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Editor's Note: AT interviewed James Jerger in the fall of 1994 (AT 6:6, pg. 13) at the completion of the initial year of the Baylor College of Medicine's inaugural AuD Program. Following Jerger's recent announcement (AT 8:1, pg. 13, 1995) that the Baylor AuD Program had revised the requirements for admission (resulting in no new students being admitted without adequate undergraduate preparation) it seemed timely to revisit Dr. Jerger for an update on his thoughts — specifically concerning AuD education and the future of audiology in general.

AT

There seems to be some confusion about the current status of the Baylor AuD program. Can you bring us up to date on your current situation?

JFJ

We have learned the important lesson that an AuD training program cannot be started from scratch without considering a number of interrelated factors. Since our program is organized within a medical school framework, certain basic science knowledge is expected of our AuD students. We discovered that without tutorial help our AuD students could not pass course work requiring basic knowledge of chemistry, physics and biology. Accordingly, we had to arrange special courses to give students the science background that they should have had in their undergraduate educational programs.

These issues may not affect AuD programs in non-medical settings. However, if we are serious about strong educational programs for our AuDs, then we must be serious about upgrading the undergraduate prerequisites. Our current AuD students now have this knowledge, but it has not come without a struggle. We concluded, therefore, that it was important to re-evaluate our entrance requirements and to accept only new students with an appropriate undergraduate background.

AT

Does this mean the Baylor College of Medicine AuD Program has been canceled?

JFJ

By no means. We still have an active Advanced Standing program for AuD candidates with a master's degree. It is the case, however, that we are taking a harder look at their applications and background to assure that they have had sufficiently rigorous training in the basic sciences to profit from the in-depth clinical training that we provide during the two year advanced AuD program. We plan to continue our full complement of Advanced Standing students each year. We intend to concentrate our recruitment of regular students on those recent graduates who have had the appropriate course work and background to be successful in our AuD program. We believe that qualified students do exist, but must be recruited from a different pool than we have been addressing.

We are graduating our first three students on May 22, 1996. The nation's first qualified AuDs are Tabitha Parent, Amy Wilson and Kimberly Gallagher.

Now that you have had three years of experience, how do you feel about the future of the AuD?

JFJ

I have two grave concerns about the future of the AuD.

First, I am concerned about the inadequate undergraduate preparation that audiology majors appear to receive. Students who major at the undergraduate level in traditional speech and hearing professions appear to be weak in the basic sciences necessary to enter the health care professions. If we do not correct this academic training deficit and agree to strengthen undergraduate preparation, the AuD will continue to have the same inherent weaknesses that plague many of our current master's degree programs.

My second concern is the ill-advised move toward entitlement of the AuD. This entitlement issue is having a very detrimental effect among the major university programs. To make the AuD successful we must, ultimately, have the wholehearted support and cooperation of the mainstream academic programs. Our academic people are key players, and they have been dragging their feet about getting on the AuD bandwagon. Until the entitlement issues came up we were making good progress; resistance to change was crumbling and I could feel a positive change in attitudes as we all rallied behind the AuD. However, within the last few months, with the announcement of the AFA entitlement plans to be undertaken this summer, I am seeing colleagues draw back, turn off, and demonstrate a wait-and-see attitude about initiating new AuD programs. Why should a university administration seriously consider a new AuD degree program when, in fact, a cheapened version of the AuD will be available?

As audiologists we have not developed a united stance in which everyone understands and agrees to ultimate common goals. Everyone is going to have to give in a little for the common good of the profession. The big picture is still not fully developed - we are trying to redefine the profession of audiology, and this cannot be developed by simply making everyone a "doctor". Our professional redefinition will require a more unified, coherent approach than we have seen thus far. Too many individuals and organizations are still influenced by their own private agendas. There are an outspoken few who want to foster entitlement at any cost. We must not permit this.

On the other hand we have many audiologists who want to preserve the status quo at any cost and are unwilling to be inconvenienced or to work toward a better profession. We have to find the middle group between these two extremes.

AT

There seems to be widespread concern about the shrinking job market for audiologists!

JFJ

The concern for availability of future jobs seems to exist in many professions these days. This concern is, I think, a reflection of the times and the rapidly changing patterns in...
health care. But I believe that the long-term future of our profession is strong; in fact, I am more optimistic about the profession of audiology now than ever before. We are key players in the health care professions and our role can only grow in the future. Preferably, audiologists should be trained in medical settings with large and diversified clinical populations of hearing-impaired children and adults. As I stated in the last AT interview, we would benefit greatly as a profession from fewer programs with more students and stronger faculties. That is where our leadership, and the Academy, must take a more active role to identify and acknowledge quality programs that feature outstanding teacher/clinicians working among large, diverse clinical populations. We have an immediate need to weed out weak programs where little or no clinical material is available to our students. The AAA needs to establish a blue-ribbon academic commission to review and appraise all of the present training programs and to make recommendations for effective educational reform.

In terms of educational reform, what is your recommendation for the Clinical Fellowship Year (CFY)?

The CFY is another example of the flawed educational model in which we are currently operating. The CFY experience should be built in, and concurrent with, the educational program rather than being tacked on at the end as an afterthought to make up for weak clinical preparation. The goal of a reformed educational program should be to turn out a finished professional product, not a student who still needs to develop marketable clinical skills.

If we pursue the AuD as a clinical doctorate, where does the PhD research degree fit in?

Even as we move to the AuD as the entry level degree for the profession, the PhD will continue to be essential for the training of individuals dedicated to expanding the knowledge base of the profession. My personal hope is that PhD students will get more exposure to the clinical issues driving the profession, but a cadre of training scientists is critical to our future development. Research must continue to play an important role in the training of every audiologist, AuD or PhD. Without such training we may be able to run in place, but we will not move forward.

Any concluding thoughts you would like to add?

Individuals representing particular agendas can be expected to speak out against, and oppose, almost every proposed educational and professional change. But I believe that, as a group, audiologists have reached the point where we must plan for the future of the profession as a whole, and not just settle for positions that are presently convenient for a particular interest group.

New Lead Generator Is Huge Success

"The Consumer's Guide to Hearing Aids has generated over 1,400 leads and the phone is still ringing..."

—Ray Jones, Jones Audiology & Hearing Aid Center, Fort Worth, TX

The public has come to depend on product guides for buying new cars, stereo systems, TVs and more. Now comes the Consumer's Guide to Hearing Aids, a full-color pro-audiology compendium of information on hearing aids from 28 major hearing aid manufacturers, including model numbers and circuits. The Guide does not rank or rate one brand as better than another.

Full-page full-color photographs of video otoscopy, real ear measurement and hearing testing show the scientific approach to hearing care, establishing your image on par with any medical specialist. Plus, sections that answer the questions consumers ask most. Like what to expect from hearing aids, why binaural listening is better, and definitions in layman's terms explaining what the various circuits do. The 24-page glossy Consumer's Guide is annual report quality and is customized for your practice in quantities as low as 500. Use it as a practice brochure to land referring physicians, HMOs and PPOs. Send it to prospects who inquire about your hearing aid prices. And as a lead generator, place a small ad in your local newspaper offering the Consumer's Guide to anyone considering the purchase of hearing aids. The Consumer's Guide will establish you as the top audiologist in the area, giving you the credibility you deserve. And because the 28 major multi-line brands and models are organized alphabetically, you'll solidify your image as the best organized and most knowledgeable source for hearing aids in your area.

Researched and written by Wilson & Co., the Consumer's Guide to Hearing Aids is in stock now for immediate shipment. For a sample copy, including the details of how the Consumer's Guide will be personalized for you, a sample of the lead-generating newspaper ad, and ordering information, send $6 to

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INTRODUCTION
Vital to the success of any professional association is the active participation of its membership. AAA is pleased to support the almost 6,000 member audiologists who have demonstrated their commitment to the advancement of the association through their involvement.

The true value of AAA to its membership and the profession of audiology as a whole, lies in its ability to act as a united front, espousing those goals and objectives common to the membership. As such, AAA can more effectively educate the general public, convey the interests and concerns of the entire profession to legislators and regulators, and provide the education, products and services necessary to keep our members at the forefront of their profession. AAA continues to work on the many goals and objectives which were outlined in the September/October, 1995 issue of Audiology Today.

During the 1995/1996 year, AAA has been especially proactive on the issues, such as autonomy, which are affecting the audiology profession, while expanding and improving its member services. Following is an overview of some of the many activities of the Association this past year.

COMMITTEE REPORTS
Allied Organization Liaison Committee
Chair: John Greer Clark
The goal of the AOLC is to foster unity and build relationships with other organizations which share our common goal. The State Affiliate subcommittee falls under the AOLC.

An information exchange has been established between AAA and affiliated organizations representing an audiologic constituency. Within this exchange a quarterly summary of pertinent AAA activities has been forwarded to contacts within affiliated organizations. More recently, this summary has also been directed to State Affiliate contacts and the AAA network of Legislative contacts. A separate information exchange is maintained for these latter two groups.

In a further effort to help foster awareness of audiologists as a primary entry point for hearing care, the AOLC is working to establish a mechanism to enable speakers from the AAA faculty roster to be placed on convention programs of organizations of non-audiology professionals who share our patient base. A separate Task Force under AOLC is investigating the development of audiology marketing materials aimed at primary care physicians.

Education Committee
Chair: Sharon Fujikawa

In 1995, the American Academy of Audiology began granting AAA CEUs to individuals enrolled in the AAA CEU Registry. These CEUs are recognized by most licensing boards with final recognition by a few boards still pending. A system is in place for awarding special recognition for AAA Scholars who have accumulated 5.0 CEUs in a span of two years. With recognition of the AAA CEUs, the administration of ASHA CEUs by AAA will be discontinued after the Salt Lake convention. Excellent continuing education programs were produced in 1995 in Ft. Lauderdale, Dallas, at the MidWest conference, and in Newport Beach. The 1996 program was described in an annual catalog that was distributed to the membership in the fall of 1995 so that plans could be made early.

In addition to AAA programs, a Faculty Roster has been established that will allow members, state affiliates and other program planners to obtain the names of individuals who have developed presentations and courses in a variety of audiology related topics. Requests for faculty and other details are available through the AAA office.

Distance learning with AAA CEUs will be initiated with the marketing of an interactive CD-ROM developed by the Veteran's Administration. This CD-ROM with case studies of audiologic and otologic patients will be introduced in conjunction with the American Academy of Otolaryngology, Head and Neck Surgery, and will be available through the AAA office. Many journals are interested in providing AAA CEUs and will be reviewed by the Distance Learning Task Force. Our goal is to provide broad spectrum of vehicles by which AAA members can acquire CEUs.

Government Affairs
Chair: Barry Freeman
For a complete list of Legislative and Regulatory Issues addressed in 1995/1996, please contact the AAA National office.

Membership Committee
Chair: Judith Gravel
Membership in the Academy hit an all time high of 5,694 in 1995, with a net increase of 677 members.

The membership retention rate has remained a steady 95% and despite the membership dues increase to $110 in 1996, the retention rate is tracking the same as in 1995.

Over 460 students have joined the Academy under the new membership category “Candidate Member” for current graduate students and recent graduates completing their Supervised Experience Year.

A new 1996 Membership Directory will be published and distributed in June of 1996.

Professional Practices Committee
Chair: Deborah Hayes
The Professional Practices Committee is comprised of three Task Forces, each of which addresses specific issues related to the clinical practice of Audiology.

The Task Force on Early Identification (Tom Mahoney, Chair) successfully completed a revision of the brochure, “Hearing Loss in Neonates and Infants - Hearing Screening,” which was published in late Fall, 1995. This brochure is available for member use and distribution to physicians, administrators, and health policy personnel. The Task Force is currently developing a resource directory of model newborn hearing screening programs to assist members in reviewing program models, geographies, follow-up strategies, reimbursement, and other pertinent information. Other Task Force projects include a provider exhibit/education display and development of guidelines regarding use of support personnel in newborn hearing screening programs.

The Task Force on Screening Guidelines (Jackson Roush, Chair) is nearing completion of their guidelines on screening. Draft guidelines will be reviewed by all Task Force members, the AAA Board of Directors, and the AAA Publication Committee prior to finalization in Summer, 1996. Screening guidelines will be pub-
How Does 78dB Gain Sound?  
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The Mega Power is your advantage for fitting severe to profound hearing losses. Loaded with an amazing 78dB full on gain, maximum 137dB SSPL90 and Class B output compression, this compact unit provides powerful, yet undistorted and clear amplification. The four adjustable trimmers (power, high & low frequency and gain control) and optional audio input offer additional acoustic flexibility.

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Join the Sennheiser team today. You'll be glad you did!

The Task Force on Practice Standards (Kathleen Campbell, Chair) has collected all relevant clinical practice standards for review. Following review, the Task Force will recommend adoption and/or development of specific practice standards by AAA.

**Research Committee**
Chair: Linda Hood
Promoting research among Academy members is part of the long-range plan of the Academy. The Board of Directors approved an ongoing Research Awards Program including two categories of research awards for new investigators.

Two awards of $5000 each will be given to Young Investigators who have recently completed a degree in audiology and do not have significant sources of research funding.

Two awards of $2500 each will be given to Student Investigators working towards a degree in audiology who wish to complete a research project as a part of their course of study.

The report from the Task Force on Evaluating New Hearing Aid Technologies has been completed and the final draft is being typed. Chas Pavlovic and Robyn Cox chaired this activity.

AAA will be a voting member organization on the ANSI S3 Committee on Bioacoustics. Dave Fabry has agreed to be the AAA representative.

AAA member Larry Shotland and the AAA lobbying firm are monitoring activities related to the development of a National Research Agenda by NIOSH. In March, 1996, AAA submitted documentation to NIOSH regarding the importance of the inclusion of hearing conservation and hearing-related topics on the research agenda.

The Research Committee is working with the Hereditary Hearing Information Resource Registry to provide information in Audiology Today, support the HHIIRR's presence at the Convention, and disseminate information to AAA members.

A Research Network to disseminate information and facilitate development of the research programs is being developed. Persons interested in being included on the Network mailing list should contact the Academy Office.

**Public Relations Committee**
Chair: Gretchen Syfert
The Public Relations Committee was pleased to release the new brochure “How’s Your Hearing? Ask An Audiologist” this year for our members’ use. This brochure reviews the training of an audiologist and discusses the autonomous role an audiologist has in hearing health care. It also reviews types and causes of hearing loss and suggestions for assistance.

AAA exhibited at four allied organization’s conventions this past year, including: Self Help for the Hard of Hearing (SHHH), American Academy of Pediatrics, American Academy of Family Practitioners and American Academy of Otolaryngology.

**CONCLUSION**
Since its inception, the American Academy of Audiology has fought to protect and preserve the interests of audiologists, while providing our members with the tools and information they need to remain at the forefront of the increasingly competitive marketplace. The common interests of our members not only provide the impetus for the actions of the Association, but also the power to act as a united body. With the continuing support of our growing membership, AAA will remain proactive in its legislative and regulatory efforts and continue to provide the products and services that increase the success of our members.
The Bill Wilkerson Center
and
The Division of Hearing and Speech Sciences
Vanderbilt University School of Medicine
present the
Fourth International Symposium
on Childhood Deafness
Serving All Children With Hearing Loss

Kiawah Island, South Carolina
October 9 - 13, 1996

featuring keynote speaker
Bob Keeshan
Best known for his children's show, "Captain Kangaroo", Keeshan is an author and advocate for children's rights and healthcare. Keeshan is in great demand at academic and medical conventions as a speaker on the benefits of early intervention; his interest in childhood hearing loss was sparked by his own nephew's deafness.

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SESSIONS:
• Early Identification of Hearing Loss in Newborns
• Assessment Approaches/Issues
• Special Issues in Auditory Processing
• Update on Otitis Media
• Amplification Selection in Infants
• Efficacy of Early Intervention
• Working with Families: A Tribute to Noel D. Matkin
• Rediscovering Habilitation
• Professional/Legal Issues

For further information and a registration packet, contact:
Shelia Lewis, Bill Wilkerson Center, 1114 19th Avenue South
Nashville, Tennessee 37212 • (615) 320-5353
CALL FOR INSTRUCTIONAL COURSES
DEADLINE FOR SUBMISSION: SEPTEMBER 16, 1996

The American Academy of Audiology is pleased to announce the call for instructional courses for the 9th Annual Convention program. Course proposals should be instructional in nature, and profile an aspect of clinical audiology, basic science, or related area.

All members of the Academy or related professionals are invited to submit instructional course proposals for the 1997 convention program.

Courses should be limited to one hour in length and may be co-instructed. A limited number of two-hour courses will be considered.

Presentation proposals must be received no later than September 16, 1996. Submissions must include a completed copy of the Instructional Course Proposal Form, an original of the proposal, plus 11 copies. Failure to provide any of these items may result in disqualification of your proposal.

Send the original proposal, the proposal form and 11 copies to: Michael Dennis, Ph.D.
Chairman, AAA Instructional Course Committee
800 N.E. 13th Street, 6NP522
Oklahoma City, OK 73104
Telephone: (405)271-8046; FAX: (405)271-6436

THE EVALUATION PROCESS
Members of the AAA Instructional Course Committee will evaluate the instructional course abstracts based on the following four criteria:

- Overall quality
- Educational objectives
- Well-defined focus
- Timeliness of topic

Committee members: Christopher Bauch, Ruth Bentler, Roger Ruth, Kathleen Campbell, Michael Cevette, Luann Van Campen, Michael Gorga, Thomas Littman, Dawn Nelson, and Terrey Oliver Penn.

AUDIOVISUAL SUPPORT
The following audiovisual equipment will be available to all instructional courses:

- Overhead Projector
- Projection Screen
- Electric pointer
- Lavalier microphone
- Head Table
- Lectern
- 35mm Slide Projector w/remote control & one slide carousel
- A computer classroom equipped with 20-25 networked Pentium® PCs with Windows95® and internet access will be available for courses needing this type of support.

Any additional audiovisual equipment requests will be reviewed for appropriateness by the Instructional Course Committee.
INSTRUCTIONAL COURSE PROPOSAL FORM (MUST BE TYPED)

DEADLINE FOR SUBMISSIONS: SEPTEMBER 16, 1996

Lead Instructor #1

Name: ____________________________
Academy Member ☐ Yes ☐ No
Affiliation: ________________________
Mailing Address: ___________________
City: __________________ State: ______ Zip: ______
Telephone: (_____) ___________ FAX: (_____) ______

*For additional instructors, please attach a separate sheet with the above information.
☐ Check here if you have presented this course previously at a AAA convention.

Educational Objectives
After the course is completed, participants will be able to:
1. ________________________________
2. ________________________________

Education Program Track (Please check the one track which best represents your course content.)
☐ Rehabilitation/Cochlear Implants ☐ Hearing Conservation ☐ Amplification ☐ Practice Management
☐ Vestibular Assessment & Management ☐ Hearing Science ☐ Professional Issues ☐ Diagnostics
Instructional Level: ☐ Introductory ☐ Intermediate ☐ Advanced
Submit up to a 200-word Instructional Course summary in the space provided below. Do not send supplementary material.

Course Title: _______________________
(No more than 60 characters, including spaces and punctuation)

Summary:

Is there a maximum number of participants in the course? ☐ No ☐ Yes
If yes, what is the maximum number of attendees? ______
What audiovisual equipment* is needed to present your course? (Please list any equipment not included in the standard course audiovisual package, such as high intensity overhead projector, video or computer projection, audiocassette player, etc.)

☐ Check box if computer classroom needed.

*Note: Late requests for additional audiovisual equipment will not be considered.
As the lead instructor of this proposed instructional course, I agree to present the course up to two times on the assigned dates between April 17-19, 1997, if accepted. I, and the additional instructors listed with this course proposal, hereby give the American Academy of Audiology permission to professionally record and sell this presentation on audiocassette.

Signature, Lead Instructor ____________________________ Date ____________

1997 CONVENTION PROGRAM ANNOUNCEMENTS

AUDIOLOGY TODAY JULY/AUGUST 1996
CALL FOR POSTER PRESENTATIONS

Members are invited to submit proposals for poster presentations at the 1997 Annual Convention of the American Academy of Audiology. Posters may be submitted in two categories: Scientific or Informational. Posters submitted in the Scientific category should be based on original research and will be subject to a peer review process. Reviewers will evaluate the submission for originality, soundness of design, and techniques and relevance. Posters that are designed to instruct or inform should be submitted in the Informational category. Submissions in this category will also be subject to peer review, but will be evaluated for clinical relevance, organization and content. Posters will be displayed during assigned times during the 1997 convention in a prominent public area. Authors will be assigned times to be present at their posters to discuss their work.

Please complete the Poster Presentation Cover Form at the bottom of the page. Include only the corresponding author on the cover form. Submit a typewritten double-spaced abstract not to exceed 75 words. Include all authors’ names and affiliations at the top of the abstract. For posters submitted in the Scientific category, submit a typewritten double-spaced summary of up to 250 words including a brief statement of the purpose of the study, methods, results, and conclusions. For proposals submitted in the Informational category, submit a 250 word typewritten, double-spaced summary that describes the content of the poster and its relevance to Academy members. Inclusion of up to two tables or figures is encouraged for both categories. Poster title, authors’ names and affiliations should be included at the top of the summary page.

Submissions must be received by November 1, 1996. Materials received after this date or those that do not conform to these instructions will be returned to the corresponding author without review. Faxed submissions will not be accepted. The corresponding author will be notified of the results of the review by December 20, 1996. Detailed instructions for presentation of accepted submissions will be sent with the notification.

POSTER PRESENTATION COVER FORM

Please indicate the type of poster:  □ Scientific  □ Informational

Title: ____________________________________________

Corresponding Author (Name/Degree): ____________________________________________

Affiliation: ____________________________________________

Address: ____________________________________________

City: ____________________________ State: ____________ Zip: ____________

Telephone - Work: ____________________________ Home: ____________________________ Fax: ____________________________

American Academy of Audiology Member:  □ Yes  □ No

Topical Area:

□ Rehabilitation  □ Cochlear Implants  □ Hearing Conservation  □ Amplification

□ Practice Management  □ Diagnostics  □ Hearing Science

□ Professional Issues  □ Vestibular Assessment and Management

Send six (6) copies of the cover form, abstract and summary to: Ian M. Windmill, PhD,
c/o American Academy of Audiology, 8201 Greensboro Drive, Suite 300, McLean, VA 22102

DEADLINE FOR SUBMISSION: NOVEMBER 1, 1996
Audiology / Speech-Language Pathology

Two positions

(1) A-CCC, staff position, 12 months, minimum MA with three years experience, eligible for MS license. Responsibilities include comprehensive community-based services, teaching, and supervision.

(2) SLP-CCC, assistant professor, tenure-track position, 9 months, PhD required, eligible for MS license. Responsibilities include teaching, supervision, and advising. Interest in adult disorders preferred.

Competitive salary and benefits. Applications accepted until position filled. Applicant should send a letter of application, vita, transcripts, and three recent letters of recommendation to MUW Personnel, W-Box 1609, Columbus, MS 39701; phone inquiries to (601) 329-7175. MUW is an EO/AA Employer.

Academic Audiologist

The Department of Otolaryngology at Wayne State University is seeking an audiologist to head clinical and investigative programs of a large academic medical center. The individual must demonstrate experience and capability in supervising and performing clinical audiological and vestibular services. Academic appointment and compensation will be related to training and experience.

Letters of inquiry and curriculum vitae should be sent to: Robert H. Mathog, M.D., Professor and Chairman, Dept. of Otolaryngology, Wayne State University School of Medicine, 540 East Canfield, 5 E UHC, Detroit, MI 48201. Wayne State University is an equal opportunity/affirmative action employer. All buildings, structures and vehicles at WSU are smoke-free. Wayne State University—people working together to provide quality service.
**VIEWPOINT**

**PEDIATRIC COCHLEAR IMPLANTS
A Word of Caution**

Cochlear implants offer an option that has never before been available for children with profound hearing losses. Improvements in speech perception and production that have occurred for children using cochlear implants have been clearly documented (Miyamoto et al., 1993; Geers and Moog, 1994; Waltzman et al., 1994; Tye-Murray and Woodworth, 1995). However, those of us who are excited about this technology should carefully assess how we present this information to the families we serve, and we must strive to increase our sensitivity to each family’s needs and perceptions.

Parents who have just been told that their child has a significant hearing loss vary in their ability to receive and process information. Family members typically leave from the initial diagnostic appointments in a stage of grief—shock, denial, guilt, anger—or experiencing some combination of these emotions. These feelings tend to occur even when the diagnosis serves to confirm suspicions they have had for some time. Family members’ feelings can easily color or limit their ability to hear or understand what is being said. This can have a lasting effect on the assimilation of information given during and immediately following the child’s diagnosis.

As a colleague recently said, parents come to us with a different set of filters than our audiological background provides for us. By nature, parents want only to make things better for their children, and to stop or fix anything that hurts. Our culture has trained us to seek cures from medical and clinical professionals. When presented with information on cochlear implants as an option, parents may only retain “surgery” and “hearing,” no matter how carefully we may try to discuss eligibility, potential risks and benefits, and the fact that a cochlear implant is another type of amplification device. In addition, most parents tend not to want options initially—they would prefer to have a professional give them direction or a specific recommendation concerning how to improve their child’s hearing. Under these circumstances, it is easy for families to leave with a confusing jumble of technical information, or a decision made by someone else.

The NIH Consensus Statement on Cochlear Implants in Adults and Children (1995) states that parents should be able to give informed consent when deciding to pursue a cochlear implant for their child. As a part of this process, audiologists must be aware of their own biases which can unintentionally skew information that is provided or omitted. As cochlear implants become more widely available, and as children are identified at younger ages, the pressure increases for parents and professionals to make decisions more quickly. As audiologists, we must help parents understand the need for accurate and complete audiological information, as well as the necessity for an appropriate trial with alternative amplification, combined with habilitation, prior to making a decision for or against a cochlear implant.

Use of a cochlear implant may increase a child’s opportunity to benefit from auditory-oral input, but auditory and speech outcomes continue to be highly variable within the pediatric population. Use of a cochlear implant is not a prerequisite for choosing any specific communication methodology, and audiologists must be knowledgeable about issues other than hearing that may affect choice of methodology. When information concerning communication methodologies and amplification options are presented at the same time, it can become difficult to separate one decision from another. As children with hearing losses are identified earlier, we must attempt to assist families in keeping these choices separate.

Audiologists, by profession or personality, are prone to be “turned on” by technological advances. The excitement generated by reports of successful research with new devices can be very contagious. This positive reaction undoubtedly has contributed to advancements in devices, such as cochlear implants, that can now be offered to our clients, and there is no reason to doubt that future technology will only improve. But we should also be aware that our excitement can color the information we provide, and therefore, attempt to increase our sensitivity to the emotions, experiences and predispositions that families bring to the decision-making process concerning amplification for their child.

**REFERENCES**


Submitted by Jane Seaton, Seaton Consultants, Athens, GA
At the American Academy of Audiology’s annual convention in Salt Lake City, AAA President Carol Flexer stated in her keynote address that the Academy has petitioned the Bureau of Labor Statistics (BLS), within the U.S. Department of Labor, to establish a new, independent category for audiologists within the “Standard Occupational Classification (SOC) Manual.” The SOC Manual provides a framework for data collection by federal, state, and local governments, as well as by private research bodies. This framework can be quite important, as occupational data often provide the basis for specific public and private policy decisions.

The SOC purports to classify occupations according to similarities in work performed. However, the BLS is undertaking a review of the classification system to ensure it is up-to-date, and to better take into account similarities in professional skills, as well as the type of work performed.

Currently, within the SOC, audiologists are classified in the category “Speech Pathologists and Audiologists.” However, this categorization fails to give proper recognition to the very distinct nature of the professions of audiology and speech-language pathology in terms of training, skills, licensure, and type of work performed.

Furthermore, the current SOC classification “Speech Pathologists and Audiologists” is a subgroup of the broader occupational group entitled “Pharmacists, Dietitians, Therapists, and Physician’s Assistants.” This categorization clearly fails to reflect the autonomous role that audiologists play in the modern health care system.

In its recommendations for SOC code revision, AAA explained to the BLS that audiologists are as distinct from speech-language pathologists as they are from any other health professional. Indeed, AAA advised that, among the professionals listed in the SOC, audiologists are most like optometrists in terms of overall skills and the type of work performed. Both audiologists and optometrists serve as principal health care providers for diagnosing the type and degree of a specific sensory impairment (i.e., hearing or vision loss) and for providing non-medical or non-surgical management and rehabilitation. By virtue of their training and licensure, both audiologists and optometrists generally may provide hearing or eye care without physician oversight. Both professions work closely with physicians, including referring patients for medical or surgical treatment when indicated, i.e., when ear or eye disease symptoms are present. (Physicians also refer patients to audiologists for audiological assessments and diagnostic interpretations in lieu of, or in connection with, medical evaluations.) However, in most cases, audiologists and optometrists operate as “full-service” providers of diagnostic and rehabilitative hearing/vision care. AAA specifically noted that an estimated 80 to 90 percent of hearing loss is sensory, rather than disease-based; therefore, it is not amenable to medical or surgical treatment.

Consequently, for most people with hearing loss, an audiologist is the health care practitioner who is most appropriate to provide diagnostic and rehabilitative care.

AAA asked that a new occupational category entitled “Audiologists” be created within the “Health Diagnosing and Treating Practitioners” major grouping. This category encompasses physicians, dentists, veterinarians, optometrists, podiatrists, chiropractors, naturopathic doctors, hypnotherapists, and acupuncturists. According to the SOC, “Health Diagnosing and Treating Practitioners”:

“Generally work independently of other medical specialists rather than under supervision. However, they may consult with other workers in this group.”

By contrast, “Therapists” (where audiologists currently are classified) function more in a support capacity, following up on the determinations and treatment plans of diagnosing practitioners.

AAA provided BLS with information supporting the requested SOC classification change. The Academy explained in detail that, since 1975, when audiologists first appeared in the SOC:

- There have been extraordinary improvements in the range and sophistication of audiologic diagnostic and rehabilitative procedures and technologies.
- There also have been significant advances in the training and regulation of audiologists. Currently, audiologists are subject to regulation (licensure/registration/certification) in 46 states, with continuing education requirements in 29 states. Furthermore, efforts are underway to establish audiology as a fully doctoral level profession.

Audiology-specific data will be critical for public and private policymaking over the next 10 to 15 years, as the “Baby Boomer” generation ages and the incidence of hearing loss increases rapidly. It will be important to be able to assess accurately the availability of hearing care, and to project costs and needs. Data about audiologists also will be important for federal, state, and local planning, funding, and evaluation of services provided to children with disabilities under the Individuals with Disabilities Education Act, which guarantees educationally related audiology services to eligible children with hearing loss.

SOC classification impacts directly on career counseling and decision making. The Occupational Outlook Handbook, for example, largely mirrors the SOC structure. AAA expressed concerns to BLS that the current classification of audiology in the SOC, and the resulting classification in the Occupational Outlook Handbook, masks the true nature and the visibility of the profession, and fails to inform people about the requirements of -- and opportunities in -- the profession, including its significant potential for growth in the coming years.

Finally, from a professional standpoint, it would be extremely useful for AAA and other parties interested in the profession of audiology to be able to track trends and plan for the continued development of the profession, using well-defined and directly relevant statistics.
JARGON I WISH I HAD LEARNED IN GRADUATE SCHOOL

When we graduate from accredited Audiology programs we feel that we are prepared to enter the medical arena. Little do we know that there is a whole other language spoken by physicians, nurses, therapists, hospital administrators and others who cross our path. What follows is a compendium of some of the jargon I have come across in my years of practicing audiology. Some of these have two (or more?) meanings. Some may mean entirely different things to an Audiologist than other medical personnel, e.g. HA can be a hearing aid or a headache. FB may be feedback or a foreign body. Some may mean entirely different things to an Audiologist than other medical personnel, e.g. HA can be a hearing aid or a headache. FB may be feedback or a foreign body and SOB... well this may have two entirely different meanings altogether. This list is by no means complete but may serve as a helpful guide for the novice entering this "brave new world". For the initiated, test your knowledge and cover up the "answers" and see how much you know.

TESTS

- ABR—auditory brainstem response
- AEP—auditory evoked potential
- BAER—brainstem auditory evoked response
- BSE—brainstem evoked response
- CAT—computerized axial tomography
- CBC—complete blood count
- CT—computed axial tomography
- EKG & ECG—electrocardiogram
- EEG—electroencephalography
- EMG—electromyography
- ENG—electronystagmography
- EP—evoked potential
- FBS—fasting blood sugar
- FTA—blood test for syphilis
- IACs—internal auditory canals
- MRI—magnetic resonance imaging
- SER—somatosensory evoked response, serology (blood test)
- T3, T4—blood tests for thyroid function
- T7—T3 & T4 thyroid tests
- UA—urinalysis
- VDRL—blood test for syphilis
- VER—visual evoked response
- WBC—white blood count

DIAGNOSIS & SURGERY

- ASNLH—asymmetrical sensorineural hearing loss
- BMIs—bilateral myringotomy tubes
- PE tubes—pressure equalization tubes
- SNHL—sensorineural hearing loss
- Stage I Tympanomastoidectomy—removal of cholesteatoma
- Stage II Tympanomastoidectomy—reconstruction of TM, ossicles

Submitted by Linda Lupton, Saint John's Medical Center, Anderson, IN

FOR YOUR INFORMATION

AUDIOLOGY SOUP!

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
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<tbody>
<tr>
<td>S/P, s/p</td>
<td>status post, post op (after surgery)</td>
</tr>
<tr>
<td>SOM</td>
<td>serous otitis media</td>
</tr>
<tr>
<td>OM</td>
<td>otitis media</td>
</tr>
<tr>
<td>T &amp; A</td>
<td>tonsillectomy &amp; adenoidectomy</td>
</tr>
<tr>
<td>URI</td>
<td>upper respiratory infection</td>
</tr>
<tr>
<td>UTR</td>
<td>urinary tract infection</td>
</tr>
<tr>
<td>SGA</td>
<td>small for gestational age</td>
</tr>
<tr>
<td>FEVD</td>
<td>fever of undetermined etiology</td>
</tr>
<tr>
<td>MI</td>
<td>myocardial infarction (heart attack)</td>
</tr>
<tr>
<td>SOB</td>
<td>shortness of breath</td>
</tr>
<tr>
<td>HBP</td>
<td>high blood pressure</td>
</tr>
<tr>
<td>TMJ</td>
<td>temporomandibular joint</td>
</tr>
<tr>
<td>TMD</td>
<td>temporomandibular disease</td>
</tr>
<tr>
<td>TIA</td>
<td>transient ischemic attack (mini-stroke)</td>
</tr>
<tr>
<td>CVA</td>
<td>cardiovascular accident (stroke)</td>
</tr>
<tr>
<td>CA</td>
<td>cancer</td>
</tr>
<tr>
<td>CHF</td>
<td>congestive heart failure</td>
</tr>
<tr>
<td>ETG</td>
<td>eustachian tube dysfunction</td>
</tr>
<tr>
<td>otopgia</td>
<td>ear pain</td>
</tr>
<tr>
<td>gathered ear</td>
<td>ear infection, mastoiditis</td>
</tr>
<tr>
<td>catarh</td>
<td>runny nose</td>
</tr>
<tr>
<td>diploia</td>
<td>double vision</td>
</tr>
<tr>
<td>sensorium</td>
<td>disturbance of the senses</td>
</tr>
<tr>
<td>hemiparesis</td>
<td>weakness of half of the body</td>
</tr>
<tr>
<td>hemiplegia</td>
<td>paralysis of half of the body</td>
</tr>
<tr>
<td>hemianopsia</td>
<td>unable to see half of the visual field</td>
</tr>
</tbody>
</table>

DOCTOR & NURSE TALK

- ASAP | as soon as possible |
- BP | blood pressure |
- Bx | biopsy |
- H & P | history & physical |
- FH | family history |
- O | female |
- M | male |
- FB | foreign body |
- c/with | with |
- $ | without |
- f | after or post |
- a | before |
- p | after meals |
- e | and |
- c/o | complains of |
- fu | follow up |
- cc | chief complaint |
- QH | every four hours |
- BID | twice a day |
- TID | three times a day |
- QID | four times a day |
- BRP | bed rails partial or bathroom |
- priv | privileges |
- ad lib | at liberty, as much as required |
- PRN | as needed |
- MOM | milk of magnesia |
- ASA | aspirin |
- ETOH | alcohol |
- OD | right eye |
- OS | left eye |
- OU | both eyes |
- VO | voice order |
- PO | phone order or by mouth |
- NPO | nothing by mouth |
- post | after |
- HA | headache |
- LMP | last menstrual period

N & V | nausea & vomiting |
- PMI | past medical history |
- BUOC | bring up old charts |
- ICU | intensive care unit |
- CCU | critical care unit |
- NICU | neonatal intensive care unit |
- PCCU | pediatric intensive care unit |
- STAT | immediately |

THERAPIST TALK

pt | patient |
- PT | physical therapy |
- OT | occupational therapy |
- SLP | speech-language pathologist |
- ST | speech therapist |
- ROM | range of motion |
- ADLs | activities of daily living |
- Fx | fracture |
- Tx | therapy |
- Rx | diagnosis |
- Rx | treatment |
- Hx | history |
- W/C | wheelchair |
- Rx | prescription or treatment |
- MVA | motor vehicle accident |
- AMA | against medical advice |
- y/o | year old (e.g. 41 yo female) |
- R | right |
- L | left |
- WFL | within functional limits |
- WNL | within normal limits |
- 2° | secondary (i.e. hearing loss 2° to...) |
- ↑ | improve or increase |
- ↓ | worsen or decrease |

ADMINISTRATOR TALK

JCAHO | Joint Commission on Accreditation of Healthcare Organizations |
- QA | quality assurance |
- CQL | continuous quality improvement |
- TQM | total quality management |

AUDIOLOGY TALK

- HL | hearing level |
- SL | sensation level |
- PTA | pure tone average |
- VRA | visual reinforcement audiometry |
- CPA | conditioned play audiometry |
- COR | conditioned orienting reflex |
- AD | right ear |
- AS | left ear |
- AU | both ears |
- WNL | within normal limits |
- TTY | teletypewriter (accepted abbreviation) |
- TDD | telecommunication device for the deaf |
- ALDs | assistive listening devices |
- CNT | could not test |
- PYL | pulling your leg |
- HPC | high porcelain content (a "crock") |
- HA | hearing aid |
- ET | eustachian tube |
- CAP | central auditory processing |
- CAPD | central auditory processing disorders |
- ADD | attention deficit disorder |
- ADHD | attention deficit hyperactivity |
Editor's Note: Measures of treatment outcome are being demanded of the entire managed care industry, and all medical specialties are struggling with how to objectively prove efficacy and benefit of treatments. As audiologists grapple with the seemingly myriad requirements of managed care plans that involve diagnostic audiology and hearing aid services, we are also caught up in the requirement to prove that we actually accomplish what we promise to accomplish, particularly when we bill and accept payment for doing such. This is the essence of why we must concern ourselves with the assessment of treatment outcomes. We are greatly appreciative to Lucille Beck for providing this important and timely perspective on Outcomes Assessment.

1. Add New Words to Your Managed Care Vocabulary.

Words like capitation, fee for service, co-payment and outcomes are part of the new vocabulary to learn as we negotiate our way through the managed care maze. It is important that your managed care company knows what benefit your patients receive as a result of your service or treatment. Managed care companies, indeed all referral sources, want to know if the treatment you provided made a difference to your patients. Managed care companies want to know the outcome of your treatment. An outcome is something that happens as a result or consequence. In other words, what happened to the patient as a result of your treatment? Was your treatment effective? How do you know?

2. What is Your Treatment?

What treatment was provided to the patient? This question assumes that you did an assessment of the problem and developed a treatment plan. For us, a typical case would be an assessment which identified the need for amplification and associated professional services. A reasonable treatment plan would be provision of a hearing aid and associated professional services, such as counseling, auditory rehabilitation, etc.

3. What is the Result of Your Treatment?

What is the result or outcome of the treatment you provided to the patient? Your list of results would probably include things like: the quality of life has improved, fewer difficult communication problems, hearing is better, better communication in background noise, and improved speech understanding, to name a few. What you have done is describe the outcome(s) of your treatment.

4. Was it Effective? Can You Prove It?

Once you have determined the result of your treatment, the next step is to document the result or outcome of the treatment. In other words, you must be able to demonstrate in an objective manner that the treatment was effective. The managed care company wants data from you to support the outcome(s) you reported on your list. In fact, all health care decisions are being guided by the availability of data which can substantiate the report that the treatment was effective.

An example would be as follows: If you say that the patient experienced an improved quality of life, can you provide data, (e.g., the results obtained on a questionnaire), which show that the person's quality of life has improved? Of course, the questionnaire must have psychometric validity.

Do you document the outcome(s) of your treatment? In other words, how do you communicate to managed care companies that your treatment was effective? There are many ways to describe the results of your treatment and provide the necessary documentation. What you need is data that document in a systematic manner, with appropriate methodology, the effects of your treatment.

5. Measure Outcomes

The clinical outcome is defined as something that follows as a result or consequence. To compete effectively in the managed care environment, you will need hard data to document the beneficial effects of your services. It will be up to you to demonstrate that your clinical services deliver beneficial results. Your destiny will be determined in some measure by your ability to provide data about the effects of treatment. Are you ready?
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- $100
- $500
- Other

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RHODE ISLAND

The officers of the Rhode Island Academy of Audiology (RIA) are President Lisa Carty, President-Elect James Healy, Secretary/Treasurer Laurie Duffy, and Members-at-Large Steve Kasden and Margo Chiappinelli. A major goal of the new officers is to recruit at least 50% of the audiologists in Rhode Island to become members of RIAA. After the initial two months of the organization, this goal has nearly been achieved! RIAA held its first formal meeting during February of 1996 sponsored, in part, by Unitron Industries, as well as a state-wide local pediatric audiology seminar on the RI Hearing Assessment Program. Kent Loy served as CEU coordinator for these meetings. Currently the RIAA is revising the state licensure law to include a mandatory continuing education requirement.—Submitted by Lisa Carty, Providence, RI

CALIFORNIA

The California Academy of Audiology (CAA) and CASH held a full day program on “An Overview of the Human Central Nervous System with Brain Dissection” in Monterey. The workshop was organized by Jeff Danhauer and included a faculty of Kenneth Kratz, S. Parker Haberly, Michael Wynne and Harold Clumcek. The program was attended by 112 professionals.—Submitted by Jeffrey Danhauer, Santa Barbara, CA

MISSOURI

The Missouri Academy of Audiology has an active continuing education program for 1996. Carol Flexer was featured at a January meeting in Saint Charles and spoke on “Audiology in America: 1996”. Robert Foster, a consumer advocate for the hearing-impaired, presented a lecture on “ALDs and Access for the Hearing Impaired” in May. Also scheduled for May is a lecture on “Genetics of Hearing Loss”. Barbara Roe Beck has been appointed by the MAA Board of Directors to serve as Education Coordinator, and will oversee the development of the MAA Audiology Graduate Student of the Year program. The annual MAA-St Louis University “Audiology-The Scope of Practice” meeting is scheduled for September 20-21, and will feature Lucille Beck of the Veterans Administration in Washington, D.C.—Submitted by Douglas Beck, St. Louis, MO

PUERTO RICO

The newly established Puerto Rico Academy of Audiology (PRAA) held their first convention in February. Speakers included Michael Raffin, Charles Pavlovic, Jorge Rocafort, Soami Santiago de Snyder, Mark MacDowall, Nydia Santiago, Elaine Kolodziej, and Charles Harney. The keynote address was delivered by James Jerger.—Submitted by Soami Santiago de Snyder and Charles Harney, San Juan, PR

INDIANA

The Indiana Academy of Audiology held its seventh annual luncheon meeting in April. Suzanne O’Connor is the current IAA President, Roger Paul is Vice President and Mary Mungovan serves as Treasurer. IAA Board Members are Richard Dubrowski, Suzanne Foley, Tom Hemeyer, Gregory Lowe and Mary Mungovan. David Goldstein was the featured luncheon speaker who spoke on “Earned Entitlement and Equivalency-An Update.” Mary Caccavo has been appointed by Governor Bayh to the Indiana Speech-Language Pathology and Audiology Board.—Submitted by Suzanne O’Connor, Indianapolis, IN

NEW JERSEY

The New Jersey Academy of Audiology (NJAA) sponsored the third annual state conference during December of 1995. Carol Flexer spoke to a group of approximately 70 audiologists on the technical advances for treating hearing loss and facilitating hearing in the classroom using personal and sound-field FM systems. The NJAA has introduced two bills to the New Jersey State Assembly and Senate, in cooperation with NJSLH Association, to combine the Audiology and Speech Language Pathology Advisory Committee with the Hearing Aid Dispensers Examining Committee to form a Joint Board.—Submitted by Jennifer Schual, Fords, NJ

From left to right: Mary Mungovan, Treasurer; Suzanne O’Connor, President; David Goldstein, presenter & member

Members of the Colorado Academy of Audiology traveled by Amtrak from Denver to attend the AAA Convention in Salt Lake City. Delays caused the scheduled 12 hour trip to take nearly 21 hours! Weary CAA travelers included Deanne Meinke, Jay Tinglum, Paula Dyrikopp, Vickie Thomson, Kristin Rankin, Karen Carpenter, Gus Hernandez and Sandy Gabbard.
MILITARY AUDIOLOGY SHORT COURSE

Approximately 120 audiologists and hearing researchers from the Department of Defense (DOD) met in Virginia Beach to attend more than 30 sessions covering topics of hearing conservation, diagnostic audiology, hearing aids and applications of auditory research to Military missions. Sessions were presented by the Working Group on Auditory Initiatives for Federal Audiologyists, the Consensus Panel on Audiology Support Personnel and the DOD Working Group on Hearing Conservation. Clinical Topics included ototoxic monitoring, pediatric audiology and comparison of military hearing profiles with articulation indices.

Naval audiologist LTCR Nancy Hight, from Camp Pendleton Naval Hospital, received the Charles S. Stephenson Award for Excellence in Preventive Medicine in the U.S. Navy Medical Department (first for military audiology). Other awards included the Elizabeth Guild Award for Excellence in Hearing Conservation to MAJ Therese Schultz of Brooks Air Force Base, and the Founder’s Award for Member of the Year to MAJ Lynn Henselman of Walter Reed Army Medical Center. Brian Walden, also of Walter Reed Army Medical Center, was designated a Fellow of the Military Audiology Association for his life-long contributions to Army Audiology. Submitted by LTC Richard Danielson, Washington, DC.
HEALTH CARE FINANCE ADMINISTRATION

In February, 1995 the AAA responded to a Health Care Finance Administration (HCFA) request for comments on "Medicare Program: 5 year Refinement of Relative Value Units (RVUs)" published in the Federal Register. The Academy recommended that HCFA add work unit RVUs for audiology services to properly compensate audiologists for their "training, effort, and time necessary to perform and interpret test results".

The May 3, 1996 Federal Register (Vol. 61, No. 87), commented that "the American Academy of Audiology believed that work RVUs of greater than zero should be assigned to certain audiology function tests that now have zero work RVUs."

Unfortunately, the response from HCFA was a simple, "We disagree." They commented that the fee for these services are included in the "practice expense component [of the RVU]... and are included in the wages of personnel who perform... the services."

Although we were not successful with our profession's first attempt to be recognized for our expertise and training, we continue to pursue professional recognition. In addition to our petition to HCFA, we have written and recently met with the Health Care Professions Advisory Committee (HCPAC) which makes reimbursement recommendations to HCFA.

The AAA Committee on Government Affairs and our Washington Lobbyists are continuing to pursue better reimbursement and recognition for audiologists.

CLASSIFIED ADS

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Full time CCC - A position now available in Division of Audiology of the Johns Hopkins Medical Institutions. Responsibilities include both pediatric and adult populations for diagnostic audiology, ABR, ECOG and AID's. Strong hearing aid experience preferred. Please send CV to Karin Young, Johns Hopkins Medical Institutions, P.O. Box 41402; Baltimore, MD 21203-6402 or fax (410) 955-6526.

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Sharon Fujikawa, Chair of the AAA Education Committee, in a letter to Nancy Huffman, Chair of the Continuing Education Board of the American Speech-Language-Hearing Association, has proposed a unique educational liaison between AAA and ASHA that would be of benefit to individuals who belong to both organizations. AAA, as part of the development of the AAA continuing education program, has established CEUs under the auspices of the International Association for Continuing Education and Training (IACET). ASHA is also a CEU sponsor under IACET. Since many members belong to both AAA and ASHA, and since both organizations are sponsors adhering to the IACET criteria for continuing education units, AAA proposes that a mechanism be developed by which members of the ASHA CEU Registry and the AAA CEU Registry can record CEUs on both. For example, we are proposing that if an AAA member goes through the CEU process at the ASHA convention and obtains ASHA CEUs and wants those CEUs also recorded on the AAA CEU Registry, he/she can do so with minimal paperwork and difficulty. Such a process will encourage the educational objectives of both organizations and make life easier for members. The ASHA Continuing Education Board is currently considering this proposal.

**CONTINUING EDUCATION CALENDAR**

**Bernafon-Maico Training Program**
- July 12, 1996, Tampa, FL: Contact Brad Wallace, Bernafon-Maico (612) 941-4200
- August 16, 1996, Chicago, IL: August 23, 1996, Kansas City, MO

**Vestibular Rehabilitation Workshop**
- July 24-25, 1996
  - Contact Richard Gun, American Institute of Balance (813) 347-9147

**Foundations of the Auditory-Verbal Approach: An Introductory Course**
- July 30-August 4, 1996
  - Northampton, MA: Contact Fran Price, Auditory-Verbal International (703) 739-1049

**Management of Infants & Children with Hearing Loss**
- August 2-3, 1996
  - Cleveland, OH: Contact Craig Newman, The Cleveland Clinic Foundation (216) 445-8520

**A Practical Workshop on ABR & OAE**
- August 16-17, 1996
  - St. Louis, MO: Contact Barbara Roe Beck, Missouri Academy of Audiology (314) 977-2944

**Vanderbilt Hearing Aid Selection & Fitting Hands-On Workshop**
- August 22-25, 1996
  - Contact James Hall III, Vanderbilt Balance & Hearing Center (615) 322-6389

**Hearing Aid Fitting "96"**
- August 23-24, 1996, Chicago, IL: Contact Michael Rosenblatt, Dahlberg, Inc. (800) 234-7714 x 686

**Jackson Hole Rendezvous**
- September 7-11, 1996
  - Jackson Hole, WY: Contact Michael Marion (805) 882-3667

**Audiology Update: Testing, Technology & Trends**
- September 20-21, 1996
  - State College, PA: Contact Jeane Violin Singer, Pennsylvania Academy of Audiology (814) 946-0721

**AAA Chicago Fall Program**
- September 27-28, 1996
  - Chicago, IL: Contact Valerie Taylor, American Academy of Audiology (800) AAA-2336, ext. 213

**Fourth International Symposium on Childhood Deafness**
- October 9-13, 1996
  - Kiawah Island, SC: Contact Fred Bess, Bill Willersen Center (615) 340-8290
- ENG 1996: October 18-20, 1996
  - Chicago, IL: Contact Judy Goodwin, ICS Medical Corp., 2227 Hammond Drive, Schaumburg, IL 60173 (708) 397-2150
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