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AUDIOLOGY TODAY

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AUDIOLOGY TODAY

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The American Academy of Audiology is presenting an interactive virtual seminar, Update of Meningitis and Cochlear Implants, on Friday December 6, 2002 from 11:00 am - 1:00 pm Eastern time. This Virtual Seminar is designed to give audiologists and other hearing professionals timely information regarding the diagnosis and treatment of meningitis in patients with cochlear implants as well as updates on recommended protocols for cochlear implant candidacy. This live, interactive seminar can be viewed at your desk or in a larger setting with your colleagues. If you haven't already signed up, you can do so by accessing our website at www.audiology.org/seminars.

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PRESIDENT'S MESSAGE

ACCREDITING COMMISSION ON AUDIOLOGY EDUCATION — NEW LETTERS ON THE BLOCK

ANGELA LOAVENBRUCK

One of the most important privileges of a profession is self-regulation, both in terms of its Code of Ethics, and in terms of the development of standards of practice and standards for academic programs. Virtually all professions have mechanisms for developing educational and practice standards, and methods for accrediting academic programs that prepare students for entry into the profession. At the present time, ASHA's Council on Academic Accreditation accredits audiology programs. Although the standards of this accreditation agency were developed for master's degree programs in audiology, they are now being used to accredit AuD and other doctoral level audiology programs. The standards have not been changed in any substantive way to acknowledge the unique characteristics of professional doctoral level education in audiology, or the role of distance education programs in the profession's transition to a doctoral entry level.

Over the past several years, the American Academy of Audiology has participated in a number of joint committees to explore the development of an independent accrediting body specifically and uniquely designed to accredit AuD programs. As a result of these initial explorations, the American Academy of Audiology, the Academy of Dispensing Audiologists (ADA), and the Organization of AuD Program Directors (OAPD) met in January, 2002 and formed the Accreditation Council on Audiology Education (ACAE). The initial steering committee began the tasks necessary to achieve recognition of a new accrediting body by the Department of Education's Office of Post-Secondary Education. Thus far, the ACAE has filed incorporation papers, and developed the initial drafts of bylaws, policies and procedures, and both academic and professional practice standards. The Steering Committee is in the process of interviewing candidates for an Accreditation Director as well as determining the funding needs and sources for this new accreditation body.

It is not surprising that this joint professional audiology initiative is not without controversy. The Council of Academic Programs in Communication Sciences and Disorders has stated its opposition to the creation of a second accrediting body. Among the concerns cited in a position paper by CAPSD (unpublished, 2001) are the potential expense and redundancy of having two accrediting bodies for audiology programs. It is important then to discuss why The Academy Board of Directors has voted to enthusiastically support and provide leadership for the ACAE.

First and foremost, the profession must have an accrediting body "of, by and for audiology." It is not in the best interest of the profession to have accreditation standards, professional practice standards, and the administration of its accreditation program funded and controlled by a single professional organization whose membership is overwhelmingly from another profession. Nor is it appropriate for accreditation standards to be inextricably tied to the purchase of a certificate sold by the controlling professional organization. In 1994 the Ad Hoc Joint Committee on Academic Accreditation Issues, consisting of representatives from ASHA and the CGPCDS, identified a number of difficulties inherent in the existing audiology accreditation program. Among these were the tying of certification requirements to accreditation, the lack of independence of the accrediting body from the politics of its sponsoring organization, and the inclusion of accreditation of two distinct professions in a single organization. As a result of the recommendations of this ad hoc committee, several changes were made in the ASHA accrediting body. In our analysis, however, none of the recommendations resulted in the kind of substantive changes needed to ensure that the audiology profession autonomously determines its own future and that the accrediting function is supported by, but separate from, any single professional organization.

More importantly, our goal for the new accrediting body is that the academic and professional standards represent not the minimum entry-level requirements, but rather set a new level of excellence in audiology education. In keeping with The Academy's long support of the AuD degree as the single designator for the profession, ACAE's standards should be specific to professional doctoral preparation as opposed to academic and research degrees like the PhD. Our support of this degree designator is not based on just the "letters" used, but on the philosophy that professional education has unique and critical differences from preparation for scholarly or academic pursuits, and that those differences must be reflected in both the degree designator and the educational and practice standards for our AuD programs. Further, during our transition to doctoral level entry, and for future preparation of four-year students, distance education is likely to play an important part. Standards must be developed which incorporate and define the role of distance education. It is also important to remember that with doctoral level entry requirements, accreditation of an academic program will mean, *by definition*, that its students have completed all academic and practicum requirements under the supervision of the academic program itself. Therefore, to be eligible for licensure, students need only produce proof of graduation from the accredited program and pass a national exam. There will no longer be any need whatsoever to document completion of practicum requirements separately from documentation of completion of degree requirements.

The process of attaining recognition of a new accrediting body by the Department of Education (DOE) (which allows students to be eligible for certain federal funding) is a vigorous and challenging effort. DOE requirements do not limit recognition to only one accrediting body per profession. Among other requirements, they do require that the accrediting body document that it has a unique role to play in the accrediting arena. The new Accrediting Commission for Audiology Education will more than meet these requirements.

Executive UPdate

LAURA FLEMING DOYLE, CAE
EXECUTIVE DIRECTOR OF THE AMERICAN ACADEMY OF AUDIOLOGY

Your National Office: Achieving The Best In Member Services

As of September 30, 2002 The Academy had 8,063 members. This is an increase of 5% since January 1st. Along with this growth in membership, we have added several staff positions to keep up with the escalating demand for services.

Since January, we have added a Director of Health Care Policy, Exposition Coordinator, Continuing Education/Convention Coordinator, Foundation Coordinator, and went from a part-time to full-time Director of Certification.

As the Director of Health Care Policy, **Jodi Chappell** has done a tremendous amount of work in a very short time to assist our members with issues related to reimbursement and health care policy. As staff liaison to the recently enhanced Reimbursement Committee, Jodi assists with answering coding inquiries of members. She manages and coordinates grassroots advocacy efforts in conjunction with The Academy's lobbyists, Marshall Matz and Robert Hahn. Jodi has been instrumental in quickly educating and providing The Academy with simplified information on HIPAA privacy rules. You can follow all of these activities on the Coding and Reimbursement, HIPAA and Government Affairs web pages on The Academy's web site at www.audiology.org.

We have a new and vibrant Expositions Department under the Direction of **Sabina Timlin**. In addition to Sabina, **Tina Mercardo** joined our staff as the new Expositions Coordinator. Sabina and Tina are doing an excellent job working to ensure that our members have the opportunity during the Annual Convention & Expo to learn about all of the new products available to audiologists and their patients.

Philecia Latham has joined us as the new Director of the Foundation for the Advancement of Audiology and Hearing Science. This foundation was formed as the result of a merger between the AAA Foundation and The Academy's Foundation.

Meggan Olek, Director of Education, along with **Glorymae Martin**, Education Coordinator, continues to manage the growing CE program. In addition, Leticia Hall has joined our team as the Continuing Education/ Convention Coordinator. The Education Department manages Pre-Convention Workshop development, program approval for continuing education sessions and recently, the development of virtual seminars (see www. audiology.org for information on the December 6th virtual seminar on Cochlear Implants and Meningitis).

Ed Sullivan, Director of Membership, continues to oversee our Membership Department to include customer services and benefits programs. These programs continue to expand to meet our members' needs (i.e., professional liability insurance, long distance calling card discounts, auto rental discounts, online career center). Ed is assisted by Sarah Sebastian, Membership Coordinator, and Laura Franchi, Membership Benefits Coordinator.

Cheryl Kreider Carey, Deputy Executive Director, manages our Convention, Exposition, and Education departments. She is assisted by **Annette Williams**, Convention Manager. It is under their direction that the multitude of details are handled each year to offer our members a great experience at Convention.

Sydney Hawthorne Davis, Director of Communications, utilizes her marketing and PR skills to get the word out about audiology and The Academy's many accomplishments. Her creativity shines through on everything from AAAlerts and news on our web site to Convention postcards and Academy brochures.

In addition to The Academy's recent growth, we have seen the American Board of Audiology grow by 55% since January. **Phil Darrin** joined The Academy in July as the new Director of Certification. Phil has been working with the ABA Board of Governors in developing specialty certification programs for audiologists. The first such program, in Cochlear Implant Services, is expected to be unveiled in 2003.

I am extremely fortunate to have **Marilyn Weissman** as my Executive Assistant. Marilyn provided invaluable assistance as The Academy staff went through the recent pains associated with our move to Reston, Virginia. In addition, Academy administrative support includes **Daryl Glasgow**, Director of Finance, **Nina Sims**, Bookkeeper, **Alice Wynkoop**, The Academy's receptionist and **Bill Kana**, information technology.

With a staff of only 20, The Academy is working to maintain the highest quality of service to our growing membership while continuing to develop many new opportunities for audiologists. Under the direction of your Board of Directors, staff is working daily to ensure that the goals and directions established by your Board are providing you with the best in member services.

As we grow so shall we prosper for the ultimate benefit of the hearing health care patient.

The Academy Staff: Seated, from left: Daryl Glasgow, Cheryl Kreider Carey, Laura Fleming Doyle, Ed Sullivan and Laura Franchi. Standing, from left: Sydney Hawthorne Davis, Jodi Chappell, Leticia Hall, Annette Williams (front), Sarah Sebastian, Phil Darrin, Sabina Timlin, Nina Sims, Glorymae Martin, Philecia Latham and Tina Mercardo. Not pictured: Marilyn Weissman, Meggan Olek, Alice Wynkoop and Bill Kana.

Hear Ye...Hear Ye

LETTERS TO THE EDITOR

CORAL Center Needs Your Help

The Oaxacan Center for the Rehabilitation of Hearing and Speech (CORAL, A.C.) offers hearing-impaired children and adults living in extreme poverty the gift of a brighter future by providing the full range of low-cost hearing rehabilitative services and programs in Oaxaca, Mexico.

In Oaxaca—the second poorest state in the Mexican union—there are an estimated 200,000 deaf and hard-of-hearing individuals in need of low-cost audiology services. With the average Oaxacan family earning less than $5,000 (US) per year, many individuals with hearing loss have no other choice than to go without sorely needed treatment.

CORAL is the only full-service hearing and language rehabilitation center in Southern Mexico. The organization consists of three general program areas: the Harry Press Clinic, offering hearing aids and related services; the Ralph S. Millhone Memorial School for the Deaf, providing intensive oral language therapy to children ages two to 14; and the social work and outreach program, working in poor communities to identify those in need of CORAL services, conduct hearing tests in the field, and monitor existing patients.

Help us help others! To meet demand, we are looking for donations or to purchase low-cost used hearing aids. All donations are tax-deductible. Please contact Catie Coman, Project Director, Child Aid: catiecoman@hotmail.com. For more information on CORAL go to: www.coraloaxaca.org. Thank you for your generosity.

—Catie Coman, Child Aid/Centro Oaxaqueño de Rehabilitación de Audición y Lenguaje, A.C.

Lack of APD Audiology Codes

I read with interest that The Academy is actively working to revise and update CPT codes (*AT*, 14:5, pg 9) I am concerned about the significant under-representation of codes for Auditory Processing Disorder (APD) tests. Recently I joined as a participating provider with several insurance companies. Much to my surprise and dismay, only one code, 92589, can be used for the majority of APD tests recommended for use in the 2000 APD Consensus Recommendations (Jerger and Musiek, *JAAA*, 11, 467-474, 2000). This forces audiologists to either not be compliant with recommended guidelines for doing the minimum test battery for APD, as these tests are, for the most part, not reimbursed, or to do them "free."

While I am aware that reimbursement for audiological services to cochlear implant users has been poor, I know that, by comparison, a far larger number of children and adults are referred for APD testing. Because reimbursement for APD tests is lacking, many audiologists will not conduct the tests.

The following tests have no CPT codes: HINT, Single and Double Dichotic Digits Test, Dichotic Sentences, SPIN, Articulation roll over, MLD, Pitch Pattern, Duration Pattern, Time Compressed Speech, PSSI, Selective Auditory Attention, Auditory Continuous Performance Test, Auditory Fusion Test-Revised, and Random Gap Detection Test, Functional Listening Test, Binaural Fusion, Rapidly Alternating Speech, to name only some of the tests used for diagnostic and screening APD evaluations. Reimbursement for tests that do have CPT Codes, such as Filtered Words and SSI, is so extremely low that it is not worth the time required to conduct the tests. This puts the audiologist in an ethical dilemma, as these tests are recommended by the 2000 APD Consensus Recommendations as being "the minimal test battery."

As a strong supporter of The Academy, I would like to see action reflecting the needs of those of us in private practice doing diagnostic audiologic studies. I spend hours on the phone with insurance companies advocating for APD test reimbursement. I might add that, as a private practitioner for 15 years, I have spent almost as much time seeking reimbursement as providing clinical services. For the past few years, I have noted an emphasis of Academy continuing education to improve the APD test battery. However, this effort will be for naught unless, at the same time, we seek improvement for reimbursement for these tests.

—Maxine Young, Private Practice, Broomall, PA

Audiology Today welcomes letters from readers. The *AT* Editorial Advisory Board offers the following guidelines: All letters are subject to editing for brevity and clarity. Letters should be limited to one subject or theme. Letters should not exceed 175 words. Invective and derogatory comments will not be published.

Send letters to the Editor by email at jnorth1111@aol.com.

Of, By and For Audiology: Realization of The Academy Mission

Larry Engel, Oklahoma City, OK

Editor's Note: Hear Me Out! is a new guest editorial feature of Audiology Today *that will be published periodically to stimulate discussion among our readers. We would hope that members of The Academy will read these editorials with consideration and respond with commentary regarding the topic. The opinions expressed in Hear Me Out! are those of the author(s) and in no way should be construed as representative of the Editor or Editor's Advisory Board, The Academy Board of Directors, or the National Office staff of the American Academy of Audiology.*

Audiology and speech-language pathology share a familial history. In its quest for independence audiology must move beyond its history and realize its potential for tomorrow. While talking about the American Speech-Language-Hearing Association (ASHA), Angela Loavenbruck[1] asked the question, "Can any association reasonably represent two different professions where the disparity is that great?" Her response was a resounding, "No."

ASHA's effort to continue representing audiology is a major obstacle that prevents audiology from speaking as one unified voice. ASHA's opposition to changes in Medicaid language and their embarrassing venture with the American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS) as the "audiology representatives" on the "Hearing Healthcare Team" reflect recent failures to adequately represent our profession. I believe that audiology's transition toward professional autonomy will remain impaired while ASHA is in the audiology business. It is time for change. Professional societies and organizations have restructured, dissolved, consolidated, and merged for centuries. Examples of these organizational changes are seen in ophthalmology, otolaryngology, and even with our colleagues from speech-language pathology (SLP).

SLPs Establish Precedence for Change

ASHA's history supports separating professions because of divergent interests and growth of affiliated groups. Paden[2] explained that as early as 1920, the National Association of Teachers of Speech (NATS) grew so large that their conventions had to be divided into different sections, i.e., dramatics, defective speech, and debate. Following a meeting in 1925, a group of speech correctionists formed the American Academy of Speech Correction (AASC). In 1926, NATS endorsed AASC as a daughter organization and the AASC ultimately evolved into today's ASHA. After holding conventions with NATS for 25 years AASC went through a series of name changes and became the American Speech and Hearing Association (ASHA) in 1947.

Audiology began to emerge as a communications disorder specialty field following World War II in 1945. According to Harford[3], "At that time, it would have been a monumental task to establish an independent Department of Audiology in any university...so, our forefathers decided to move in with their relatives, the speech correctionists. Not only did we move in at the universities, but also into their professional society." Audiology has been part of ASHA conventions for 55 years. Recently, ASHA's 2001 convention convened in New Orleans and was promoted to its members as "two conventions in one" - a separate conference for SLPs and a separate conference for audiologists. Kirkwood[4] reported that 748 audiologists attended the 2001 ASHA convention. This meager participation of audiologists at their annual convention, in view of ASHA's report of 14,000 audiologists in its membership[5], speaks loudly for a change in course.

Ophthalmology and Otolaryngology

Another example of a professional separation involves the former American Academy of Ophthalmology and Otolaryngology (AAOO) that was founded in 1896. Because of diverging interests, talk of separation of Ophthalmology and Otolaryngology began in the 1950s. According to Bryan[6], in 1962 Jerome Hilger's motion to separate the organizations included the following: "If properly directed, otolaryngology can certainly attain its objective in the broad field which our specialty over the years has developed. This, however, requires identity and competence. Identity we cannot possess so long as our major parent organization at the American Academy level persists in the impossible task of representing two unrelated specialties. The "double" ENT (Eye, Ear, Nose, and Throat) concept which is nurtured by this unnatural association is a handicap to both specialties in that it misrepresents the realities of present-day academic and practicing otolaryngology and ophthalmology." In 1978, an orderly separation of the Association was carried out with the formation of two new organizations - the American Academy of Ophthalmology (AAO) and the American Academy of Otolaryngology (AAO). In 1980, the American Academy of Otolaryngology added Head and Neck Surgery to its name to become the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS).

Hybrid Restructure and Merger

The task of separating audiology from ASHA in a planned and orderly fashion may indeed be a complicated venture. I suggest that ASHA restructure itself as the representative organization of Speech-Language Pathologists and activate a "merger" that would move the audiologists who belong only to ASHA to align their professional membership with the American Academy of Audiology (AAA). The non-AAA - ASHA audiologists would then be dissolved from ASHA and would be free to transfer to the AAA. More than 8000 audiologists are already members of AAA. Clearly, audiology is in a far better position to separate from ASHA today than was ASHA when it separated from NATS in 1951. At that time, ASHA had only 1070 members and 789 associate members.

Of, By and For Audiology...

Conclusion

Speech correctionists wanted their professional freedom and independence in 1925 and audiologists want their professional independence in 2002. The symbiotic relationship between audiology and SLP was mutually beneficial in the early years, but with audiology's and speech-language pathology's increasingly diverging interests, it would appear that for audiologists to separate completely from ASHA and merge into The American Academy of Audiology would be an act of reason and a natural evolution.

The Academy taking the helm for all audiologists would clear the way for us to have an independent accrediting body for graduate training in audiology and our own Audiology Board Certification could be firmly established. The process of phasing out audiology master's degree programs would accelerate. The CCC-A certificate would be eliminated to the financial relief of many audiologists.

This vision for audiology independence from ASHA should be approached professionally, respectfully, cooperatively and collegially. It can be accomplished now just as it was completed between the speech correctionists and speech teachers in 1925 and between the ophthalmologists and otolaryngologists in the late 1970s. Developing the initial framework to negotiate with ASHA would, of course, need to come from The Academy Board of Directors. This venture is not something that could be completed overnight and it would require committed leadership, a long-range strategic plan, and full membership support. I encourage and request The Academy Board of Directors to consider this plan of action during the next strategic planning session. Helen Keller once said that, "Optimism is the faith that leads to achievement." I am optimistic that The Academy is capable of making this vision a reality. The outcome would result in major steps toward freeing audiology to re-engineer itself into a true doctoring profession.

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AUDIOLOGICOECONOMICS:

APPLICATION OF HEALTH ECONOMIC PRINCIPLES TO THE PRACTICE OF AUDIOLOGY

RACHEL MCARDLE, BAY PINES, FLORIDA, **KENNETH PUGH,** UNIVERSITY OF HAWAII (MANOA CAMPUS),
HARVEY B. ABRAMS, BAY PINES, FLORIDA, **THERESA HNATH-CHISOLM,** BAY PINES, FLORIDA

The past decade has seen many changes in the delivery of audiology services. Factors influencing these include cost containment, consumer protection, competitive services by other professions, and profound changes in business management (Whelan, 2001). Each of these factors provides a means of market-based quality control. That is, only those providers who can demonstrate obtaining the most efficacious intervention outcomes in the most cost-effective manner will achieve market-place survival and growth.

There are several economic evaluation methods commonly used in the health care arena which can be utilized, not only to determine which services provide the best value for the money, but also the most efficient means of resource allocation. By becoming familiar with basic concepts in health care economics, audiologists may be able to successfully engage in the economic evaluation of their services. To this end, the application of several health care economic methods to the practice of audiology — or to coin a term, "Audiologico-economics" – are described.

Economic evaluation of audiology programs and services involves the comparative analysis of alternative courses of action in terms of both their costs and their outcomes (Drummond, et al., 1997). The use of economic evaluation techniques that can be applied to audiology are pervasive throughout the health care literature (see Warner & Luce, 1982; Sloan, 1995; Nas, 1996 for reviews). Indeed, many of the techniques that we will describe can be found in audiology literature examining the efficacy of hearing aid intervention (e.g., Alberti, 1977; Mulrow, et al., 1990; Ridge, 1997; Newman & Sandridge, 1998), acoustic neuroma surgery (e.g., Fitzgerald & Mark, 1999; Robinette et. al., 2000), and quality-of-life improvements among cochlear implant recipients (e.g., Wyatt, Niparko, Rothman, & deLissovoy, 1995; Summerfield, Marshall, & Archbold, 1997). Some of the more common economic evaluation methods and their descriptions are shown in Table 1. As can be seen in the table, each technique differs according to how costs and outcomes are measured and valued.

TABLE 1
A COMPARISON OF COST ANALYSIS PROCEDURES

This economic measure answers this question as measured by cost analysis.
How much does it cost me to deliver my service?
Measured in dollars.

COST-BENEFIT ANALYSIS
Will the generated revenue or cost avoidance associated with delivering my service, exceed my expenditures?
Measured in dollars vs. dollars.

COST-EFFECTIVENESS ANALYSIS
Which service option, among several, offers the best clinical results for each clinical improvement?
Measured in %, dB, etc. per dollars spent.

COST-UTILITY ANALYSIS
Which service option, among several, offers the largest improvement in quality of life, as determined by the patient, for each dollar spent?
Measured in dollars per quality adjusted life years.

From *Audiology Practice Management* (p. 81), by H. B. Abrams and T. Hnath- Chisolm, 2000, New York, NY: Thieme. ©2000 by Thieme Medical Publishers, Inc. Reprinted with permission.

COST ANALYSIS

Regardless of the economic evaluation method utilized, the first step is to complete a cost analysis to determine the absolute dollar amount of delivering a particular service. To complete this analysis, direct costs (such as labor and materials) and indirect costs (such as equipment and space) associated with the delivery of a service are calculated. Labor costs are needed for all personnel involved, including support staff such as a receptionist or file clerk, and are calculated for the amount of time an employee devotes to the specified service. If provided, fringe benefits (e.g., paid vacation, health insurance, and retirement plans) should also be included in the hourly wages.

To calculate labor costs the amount of minutes needed for each procedure and the hourly wage of the provider(s) are utilized to determine a cost per provider. Let's assume that the receptionist spends an average of five minutes on each patient who comes in for an audiological assessment. The five minutes includes checking the patient in, pulling charts, scheduling all follow-up appointments, and billing. Sixty (minutes in an hour) divided by five (minutes needed to complete the task) is 12. If the receptionists' hourly wage is $12.10, then the receptionists' labor cost for this patient is $12.10 divided by 12 or $1.01. This calculation is completed for all service personnel involved with the procedure of interest.

The direct costs associated with materials are much more straightforward. These should include all disposable products that are necessary for providing a particular service to a patient. When dispensing hearing aids, materials used may include insert phones, impression materials, and probe tubes.

Indirect costs associated with equipment and space that is owned must be depreciated over their life expectancy. The most common approach used to calculate depreciation is the straight-line formula, which equals the current cost of capital (e.g., furnishings, equipment, goods, etc.) divided by the total number of years each capital component is likely to last. If a 3 year-old audiometer was purchased at $10,000 and is estimated to last 7 additional years, the current depreciated value would be $7,000 dollars. Once the depreciated value is calculated that amount is divided by the number of procedures completed per year using that piece of equipment—in this case the audiometer. If the depreciated value of the audiometer is $7,000 and it is estimated that 1,800 procedures are completed each year using the audiometer, then the cost per procedure for the audiometer is $3.89. These calculations should be completed for all equipment used to perform the specified service. Other indirect costs that may be incurred in a hospital or medical center facility are administrative, engineering, and building management support.

Thorough cost analysis calculations are critical to economic evaluation. All of the economic evaluation methods discussed in the next section are based on the amount of absolute dollars required for providing a specific health service.

ECONOMIC EVALUATION METHODS

All economic evaluation methods have cost analysis in common, yet they differ widely in the questions they answer and the outcome measures they employ. Comparing percentage correct scores on a speech perception measure between a moderately priced hearing aid

TABLE 2
AN EXAMPLE OF A HEARING AID COST-EFFECTIVENESS ANALYSIS

Hearing Aid (half-concha) Cost (retail)	Cost(Improvement on CUNY--NST test) (%) (cost-effectiveness)	($) Outcome Score Cost per % Increase	
$1,104.42	24%	$46.02	#1 single-channel, single-program, dual microphone, analog.
$1,357.74	16%	$84.86	#2 dual-channel, multiple programs, single microphone. digitally programmable.
$3,472.64	18%	$192.92	#3 multi-channel, multiple programs, single microphone, fully digital.

From Audiology Practice Management (p. 91), by H. B. Abrams and T. Hnath- Chisolm, 2000, New York, NY: Thieme. ©2000 by Thieme Medical Publishers, Inc. Reprinted with permission.

and a high priced hearing aid would be a method of cost-effectiveness analysis (CEA). In this type of analysis you are looking at clinical improvement per dollar spent. Table 2 shows an example of a CEA.

Although CEA among different hearing aid technologies is an effective tool to compare treatment options within the field of audiology, it does not allow for economic evaluation of treatment options across various health disciplines. For this type of evaluation a cost-utility analysis (CUA) is used, which measures the costs of treatment in dollars, standardizes these costs by life expectancy and adjusts the costs for changes in quality of life. A CUA determines which service option, among several, offers the largest improvement in quality of life, as determined by the patient, for each dollar spent. Results of a CUA are reported in Quality Adjusted Life Years (QALY), which is a single index of monetary value that combines a qualitative and quantitative measure of treatment (Abrams & Hnath-Chisolm, 1999). The formula for calculating a QALY is the cost of service divided by benefit multiplied by life expectancy. Various examples of QALY calculations can be seen in Table 3.

TABLE 3
FOUR EXAMPLES OF QUALITY ADJUSTED LIFE YEAR CALCULATIONS

QALY example #1
Age of patient – 70 Cost of hearing aids - $2,000/pair
Benefit obtained – 25% Life expectancy – 5 years
Cost per QALY = $2,000 = $1,600.00

25 X 5 QALY example #3
Age of patient – 5 Cost of implant - $50,000
Benefit obtained – 30% Life expectancy – 70 years
Cost per QALY = $50,000 = $2,380.95

.30 X 70 QALY example #2
Age of patient – 70 Cost of hearing aids - $4,000/pair
Benefit obtained – 60% Life expectancy – 5 years
Cost per QALY = $4,000 = $1,333.33

.60 X 5 QALY example #4
Age of patient – 65 Cost of implant - $50,000
Benefit obtained – 70% Life expectancy – 10 years

Cost per QALY = $50,000 = $7,142.86
.70 X 10

Note. From Audiology Practice Management (p. 92), by H. B. Abrams and T. Hnath- Chisolm, 2000, New York, NY: Thieme. ©2000 by Thieme Medical Publishers, Inc. Reprinted with permission

A CUA uses outcome measures that target an individual's self-perceived quality of life regarding a specific disease or generically. Generic outcome measures (e.g., Sickness Impact Profile (SIP; Bergner et al., 1981), Medical Outcomes Study 36-Item Short Form Health Survey (SF-36; Ware & Sherbourne, 1992), and Health Utilities Index (HUI; Torrance & Feeny, 1989; Furlong et al., 2001), can be used with most diseases and disorders, which allows for cost comparison across health care domains. Wyatt et. al. (1995) completed a CUA using the Health Utilities Index (Mark III) to calculate the cost per QALY of cochlear implants compared to neonatal intensive care, coronary artery bypass, and coronary angioplasty. Results showed that cochlear implants cost $9,325 per QALY, which were more expensive than neonatal intensive care ($7,968) but less expensive than coronary artery bypass ($11,255) and coronary angioplasty ($11,485). One reason the neonatal intensive care was less expensive per QALY than cochlear implants is that life expectancy is part of the equation. The longer an individual is expected to live with improved quality of life after receiving the treatment, the more it reduces the cost of providing the service for each year of remaining life.

When comparing costs of service within a specific health field, disease-specific measures instead of generic measures can be used. (Mulrow et al.,1990) used the Hearing Handicap for the Elderly (HHIE; Ventry & Weinstein, 1982) as a disease specific outcome measure to evaluate the effect of hearing aids on quality of life. Results showed that three months of monaural hearing aid use was effective in improving the social, emotional and communication dysfunctions that accompany sensorineural hearing impairment. In addition, monaural hearing aid intervention was found to be cost-effective. Utilizing outcome data from the administration of the HHIE pre- and post-intervention and an estimated total cost of $1000 for providing one hearing aid, Mulrow et al. (1990) projected the cost of intervention to be equivalent to $200 for each quality adjusted life year gained.

In our clinic we examined whether providing short-term group aural rehabilitation classes (AR) in addition to hearing aids were less expensive per QALY than providing hearing aids alone (Abrams, et al., 2002). The cost analysis data showed an additional $62.70 per person was required for the hearing aids plus AR group to cover the costs of additional treatment. Thus, hearing aids plus AR would be considered more expensive treatment in absolute dollars. Health economics, however, considers treatment effects to remain over the individual's life span, thus the cost in absolute dollars can be standardized by life expectancy and adjusted for changes in quality of life. Results of a CUA, utilizing data obtained pre-and post - intervention from the SF-36V (Veteran's version, Kazis et al., 1999), showed that providing hearing aids plus AR was more cost effective ($31.91 per QALY) than providing hearing aids alone ($60.00 per QALY). Based on these CUA data, inclusion of a group aural

rehabilitation program as part of hearing aid dispensing is more cost-effective than providing hearing aids alone.

In short, CUA is an important tool as the concept of measuring the cost of improving one's quality of life becomes increasingly utilized in health care research. It is also likely to be more meaningful than many clinical measures to patients and third party payers (NIH, 1997). The data generated can also be used as pecuniary evidence for continuance of selected treatment approaches.

The final type of economic evaluation described in this paper is the cost-benefit analysis (CBA). This type of analysis compares the costs and health consequences of two or more programs, with each component expressed in monetary values. Comparisons may also be performed by calculating the ratio of the costs (resources consumed) to the ratio of the benefits created (health outcomes) in each program. By subtracting the money spent from the money gained or saved, CBA creates a method for calculating a program's net benefit as well as provides the decision maker(s) a single measure that facilitates decisions to either support or not support a particular program (Helfer, Shields, & Gates, 2000).

An example of applying this method to audiology would be to determine the comparative cost versus benefits of implementing an in-house versus contracted hearing conservation program. Suppose that Hearing Conservation Program A (contracted) has a cost of $2000 and a benefit of $3000 and can help 1000 employees since it improves health-related consequences (e.g., reduced exposure to hazardous noise levels in the workplace, decreased number of employee accidents, decreased number of worker's compensation claims). The benefit-to-cost ratio is 3:2 and the net benefit of this intervention is $3,000,000 – $2,000,000 = $1,000,000. Hearing Conservation Program B (in-house) has a cost of $1000 and a benefit of $3000 and can help 1000 employees. The benefit-to-cost ratio in this circumstance is 3:1, better than for Program A, and the net benefit of this intervention is $3,000,000 – $1,000,000 = $2,000,000. From a business point of view, the decision maker(s) may opt to choose Program B since its net benefit is larger. However, this evaluative approach represents an important caveat with CBA. The level of concern with this method of economic evaluation results from the nature of the beast itself (i.e., net benefit expressed in strictly bound monetary units), which has numerous social, medical, educational, and political implications.

In hearing health care, increasing interest exists in accountability for outcomes, proof of quality care, and reduced costs, yet rational choices cannot be made until an entity decides what it really would do with the money saved by implementing a particular program. In the above CBA example of hearing conservation, Program B demonstrates a larger net benefit in monetary units; however, Program A may be favored more by the union and its employees and could possibly lead to further improvements in worker productivity. In this condition, willingness-to-pay (WTP), a subset of the CBA concept, can be utilized to determine how much an individual (or community) is willing to pay for the benefits associated with an intervention. A WTP approach was utilized by Hnath-Chisolm & Abrams (2001) to examine what hearing aid users were willing to pay for their hearing aids. Results of 79 veterans showed a significant positive relation between benefit, as measured by the APHAB (Cox & Alexander, 1995) and WTP. Specifically, individuals were willing to pay $203.30 with no measurable APHAB global benefit score and an additional $22.06 for each point increase in global benefit. These data access the monetary value of hearing aid intervention within the health care arena.

SUMMARY

This brief tutorial was designed to help audiologists and other hearing health care professionals understand terminology, concepts and methods involved in basic economic evaluations. In order to provide more efficient hearing health care, it is essential to establish the relationship between costs and health-related consequences of the services provided. Economic evaluation has emerged as a basic tool in the evaluation of health care practices. In this era of shrinking health care resources and increased accountability, it is important to demonstrate that any service provided is economically, as well as clinically, sound.

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PINs Ensure Medicare Recognition for Audiologists

What is a PIN and how is it different from a UPIN?

The Provider Identification Number (PIN) is the Medicare carrier-assigned provider number, also known as the Medicare billing number. The seven-digit number is the individual's provider number; only one PIN is assigned to a provider throughout Medicare affiliation in any state.

The Unique Physician Identification Number (UPIN) is a six-digit alpha numeric number that identifies a physician who provides services for which payment is made under Medicare [42 U.S.C. § 1395u(r)]. In October 1994, the UPIN registry was expanded to include non-physician practitioners and medical group practices, however, only physicians defined by Medicare statute are required to have a UPIN.

Audiologists are not defined as a physician in Medicare statute and therefore would not be required to attain a UPIN. However, all claims for services ordered or referred by physicians must include the names and UPINs of the ordering/referring physician. Since audiologists are currently required to provide services based on a physician referral, an audiologist who bills Medicare for a service or item must show the name and UPIN of the ordering/referring physician on the claim form. The UPIN directory is available at www.cms.hhs.gov/providers/enrollment/upin/upintoc.asp.

Currently, the performing provider's PIN must be included on the CMS-1500. While providers use their locally assigned PIN on the CMS-1500, CMS has instructed carriers to cross-refer UPINs to the locally assigned provider numbers, to perform prepayment and post payment review of Medicare providers. Under the "administrative simplification" guidelines contained in the new Health Insurance Portability and Accountability Act (HIPAA) regulations; both the PIN and the UPIN will be replaced. A new system, the National Provider Identifier (NPI) will identify all providers. Once the NPI goes into effect, there will be an automatic issuance of this number to all providers to replace their PIN numbers. The NPI will be a ten digit numeric identifier. For more information on the NPI, see http://aspe.os.dhhs.gov/admnsimp/faqnpi.htm.

Under HIPAA, both the PIN and the UPIN will be replaced. A new system, the National Provider Identifier (NPI) will identify all providers. Once the NPI goes into effect, there will be an automatic issuance of this number to all providers to replace their PIN numbers. However, it is still imperative that audiologists apply for a PIN/NPI to ensure that the profession is recognized for the services it provides.

Why Do Audiologists need PIN numbers?

Medicare determines the fees it pays for services rendered. Unless an audiologist has a PIN number, he/she is not identified as a provider for that given service. According to Medicare, "specialty-specific practice relative value units (RVUs) are weight-averaged based on the frequency of services performed by any given specialty." [67 Fed. Reg. 43555, June 28, 2002]. So, if a specialty is identified as only providing a small portion of the services for a given procedure, it will have little effect on the procedure's final value. ***For audiologists to have any impact on the fees for any code, they must be identified as performing the bulk of that code.***

How do I apply for a PIN number?

CMS hires Medicare contractors to process enrollment applications and enroll audiologists in the Medicare program. At this time, an audiologist should contact the Medicare carriers serving his or her area to obtain information about enrollment. The carrier will provide the audiologist with information concerning the application(s) that needs to be completed and other supporting documents that need to be attached to obtain a Medicare billing number. Once an audiologist completes the application and has obtained the necessary supporting documentation (license, etc.), the audiologist should submit the information to the carrier. The carrier should process the application within 60 days, absent extenuating circumstances. If you have already submitted an application and have a problem with the carrier, you should contact the CMS Regional Office. The regional office has responsibility for monitoring the carrier's performance. Enrollment forms are also available online at www.cms.hhs.gov/ providers.

For more information, please contact Jodi Chappell, Director of Health Care Policy, at jchappell@audiology.org.

Olé San Antonio!
CONVENTION 2003

The sights and sounds of "Old San Antonio" will be the highlight of the Opening Night Reception at Convention 2003. The colossal festivities will kick-off in first class Texas style at the charming village of La Villita. Spanish for "little town," La Vallita is alive with artists and craftsmen, shops and restaurants.

La Villita began in the mid- to late 18th century as a settlement on the banks of the San Antonio River, adjacent to Mission San Antonio de Valero (better known as the Alamo). Located between an old military garrison to the south and the Alamo to the north, La Villita was the site of revolutionary activity during the Texas war for independence against Mexico. When the mission was eventually abandoned around 1792, it became a military outpost for Spain and Spanish soldiers and their families settled into the "Little Village," intermarrying with the Indians who resided there.

Eighteenth-century life was rough, including such calamities as cholera and smallpox epidemics and raids by hostile Indians. The disastrous flood of 1819 practically annihilated the town and resulted in Canary Islanders moving to the higher ground of La Villita, changing the mix of residents and home styles.

Homes for the earliest San Antonians were "palisado" jacales (shacks), constructed of mesquite or cedar-pole walls tied together with rawhide and filled in with clay. Flooring was tamped mud and roofs were of thatch. After a flood in 1819, brick, stone and adobe houses replaced the earlier structures.

As the city's character changed, so did the character of La Villita, which became a neighborhood of many cultures. A general description of the town from an October 1858 San Antonio newspaper article could apply to La Villita as well: "While the stately mansions of the wealthy command our admiration and greatly adorn the city wherever they may be located, it is the tasteful humble dwellings, making out in every direction from the noise and dust of the commercial parts of a city, that give it its greatest charm."

By the late 1870s La Villita was a thriving community. The neighborhood was home to stonecutters, watchmakers, telegraph operators, cabinet makers, and lawyers. Boarding house and saloon keepers, dressmakers, doctors and shoemakers all plied their trades in the area.

Following the turn of the century, the area gradually evolved into rooming houses and commercial and industrial developments and degenerated into a slum district by the 1930s. In 1939, city fathers acted to preserve this colorful part of San Antonio's history. During World War II the American Red Cross operated its war programs from La Villita, and after the war the restored area continued to grow and develop.

Today, La Villita stands as a monument to San Antonio's past. The arts and crafts community blossom amidst beautifully landscaped grounds and historic buildings. The cobblestone streets and plazas of the "Little Village" are also the site of frequent celebrations, including "Night in Old San Antonio" during the city's famous Fiesta. Located within walking distance of the Convention Center and hotels, this "little bit of Texan history" is certain to be the perfect venue for the Opening Night Reception of Convention 2003.

SAN ANTONIO'S RIVERWALK

Have you ever been to a place where you can relax, go on a romantic boat ride, dine on delectable cuisine from other cultures and party 'till dawn with friends, old and new? The San Antonio Riverwalk offers all this and more for attendees of Convention 2003!

Amidst the daily hubbub of the busy metropolitan downtown of San Antonio, sequestered 20 feet below street level, springs forth a vibrant city rich in over three centuries of tradition! According to legend, a Spanish missionary traveling through Texas came upon a tribe of Payaya Indians who lived among the wild grapes and Cypress trees upon the banks of the sparkling haven. The oasis they had found was named Rio Saint Antonio de Padua, from whence the San Antonio River derives its name.

People from miles around come to see the famous San Antonio Riverwalk. The cobblestone and flagstone paths border both sides of the river as is winds its way through the middle of the business district. The Riverwalk has multiple personalities—quiet and park-like in some stretches, while other areas are alive with activity. The river's downtown diversion stretches for approximately two-and-a-half miles and is shaped like a wine goblet. At opposite ends of the base are the Henry B. Gonzales Convention Center and the multi-level Rivercenter Mall, and the stem is lined with European style sidewalk cafes, a myriad of specialty boutiques, countless nightclubs and gleaming high rise hotels.

The beautiful San Antonio Riverwalk features fantastic dining opportunities.

Convention 2003 Program Committee meets in Ol'San Antone!

Yanaguana Cruises, the river's floating transportation system, provides a novel method of sightseeing and people watching in downtown San Antonio. Groups can dine aboard open-air cruisers as they wind their way along the scenic waterway. Open tour boats start from several spots along the river, providing a complete narrated circuit in about forty minutes. Some vessels serve catered breakfasts, lunches or dinners while others function as taxis.

For unique cuisine, there is something for everyone. Each terraced restaurant offers its own version of music and dining. Convention-goers are sure to find the selection incredible and the hospitality warm. Margaritas, the favorite drink of the city, are poured by the pitcher.

There is nothing like local color to give visitors a real flavor of a city. When visiting San Antonio, convention-goers will want to take their first bite at the Riverwalk — the place to be at Convention 2003!

DESTINATION: SAN ANTONIO CONVENTION 2003

The focus is on education for Convention 2003! You won't want to miss the exciting pre-convention workshops scheduled for Wednesday, April 2, 2003. These full or half-day sessions present an excellent opportunity to discover the latest advances in the field of audiology. Due to limited space, participants must pay and pre-register as indicated in the Convention registration form. Please take a moment to consider how you will benefit from the following:

Full Day Sessions:

Auditory Processing Disorders: New Trends
Frank Musiek, University of Connecticut
Gail Chermak, Washington State University
James Jerger, University of Texas at Dallas
Dennis Phillips, Department of Psychology, Dalhousie University

This workshop will provide background, as well as new information, on important areas of auditory processing and auditory processing disorders (APD). Internationally known scientists and clinicians will discuss new directions in the understanding, diagnosis and management of APD. The format of the presentations will allow ample time for interaction with participants. In addition, there will be a panel discussion and question and answer period.

Approaches to Tinnitus Treatment
Roger Ruth, University of Virginia /James Madison University
John Jacobson, Eastern Virginia Medical School
William Martin, Oregon Health Science University
Robert W. Sweetow, University of California
Denise Anne Tucker, University of North Carolina Greensboro
Richard Tyler, University of Iowa

Tinnitus and hyperacusis occur commonly in the adult population. It has been purported that as many as 10 to 12 million people in the United States are sufficiently debilitated by their tinnitus and/or hyperacusis that some form of intervention is warranted. It is for these patients that comprehensive management strategies have been developed. This workshop will provide a full day of education pertaining to the evaluation and management of tinnitus and hyperacusis. Presentations will review procedures and protocols employed by each of the members of this panel in their tinnitus clinics.

Half-Day Sessions:

Amplification Strategies for Infants and Young Children
Jeffrey Simmons, Boys Town National Research Hospital

This outstanding session will provide audiologists with a thoughtful and realistic approach to fitting hearing aids on infants and toddlers. Research findings and clinical experiences will be applied to a practical fitting protocol that covers the process from hearing aid selection through parent/family orientation. Case studies will be used to illustrate the goals of the protocol and some of the challenges associated with working with this patient population.

Auditory Learning: Practice Makes Perfect
Beverly Wright, Northwestern University
Michael Paul Kilgard, University of Texas at Dallas

This impressive workshop will provide an overview of current topics of investigation into training-induced learning of auditory skills. Areas covered will range from improvements induced by various forms of training in humans with both normal and impaired hearing, to changes associated with these improvements. Throughout the presentations, these issues will be considered in relation to the causes and treatments of hearing disorders.

Counseling Basics for Every Audiologist
Kristine English, University of Pittsburgh

Audiologists witness daily the wide range of psychosocial and emotional difficulties caused by hearing loss. Babies, children, teenagers, and adults with hearing impairment and their significant others expect more than just observation from audiologists. They expect active support in dealing with these challenges. How do we help with this non-technical aspect of hearing loss? Participants will learn counseling strategies for immediate application, in addition to those requiring more thought and reflection through case studies, role-playing, and discussion.

How Do You Know if Your Treatment Makes a Difference?
Theresa Hnath-Chisolm, University of South Florida
Harvey Abrams, VA Medical Center

An impressive array of outcome measures is available for documenting the efficacy of audiologic intervention, particularly as they apply to the selection and fitting of hearing instruments. This presentation will provide a critical review of those measures using the World Health Organization's International Classification of Functioning, Disability, and Health (ICF), and evidence-based practice as foundations for the discussion. The appropriate use of objective measures of outcome will be highlighted within the context of the hearing loss management process.

Navigating the World of Hearing Loss & Genetics
Robert Shprintzen, Upstate Medical University

This course will introduce registrants to the basics of clinical and molecular genetics followed by a description of both common and rare forms of genetic hearing impairment, including syndromic and nonsyndromic disorders. The implications of correct diagnosis will be stressed in this presentation and available resources for audiologists will be reviewed.

Pharmacology for the Practicing Audiologist
Jose Andres Rey, Nova Southeastern University

This program will introduce the audiologist to the basic pharmacological concepts associated with drug actions and adverse effects and definitions of commonly used terms. The presentation will then focus on the impact of pharmacotherapy to the practicing audiologist with emphasis on drug-induced ototoxicity and the medications used to treat tinnitus. Other topics of discussion will include the treatment of balance disorders and vertigo and the possible impact of sedating medications on electrophysiological responses.

DESTINATION: SAN ANTONIO CONVENTION 2003

RESEARCH

Check out these sizzling morsels of education that will be Featured at Convention 2003! In addition to this tempting fare, Convention attendees can choose one of more than 200 Instructional Courses, Podium Presentations and Poster Presentations.

AMPLIFICATION
- Cochlear Dead Regions: Assessment and Clinical Applications
- Digital Noise Reduction: (A Little) Beyond the Basics
- Hearing Aids: An Update
- Hearing Aids: 2002 in Review
- Pediatric Hearing Aid Prescription: Working Towards Consensus

AUDITORY PROCESSING DISORDERS
- Auditory Processing Disorders in Children
- APD Screening and Diagnosis: Consensus and Controversy

COCHLEAR IMPLANTS
- Cochlear Implants: Advanced Technology and Applications
- Cochlear Implants: An Update on Outcomes

DIAGNOSTICS
- Auditory Steady State Responses in Pediatric Audiology
- Grand Rounds: Challenging Adult Cases in Audiology
- Meeting Today's Challenges in Pediatric Assessment
- The Diagnostic Test Battery: Past, Present and Future

HEARING SCIENCE
- Clinical Utility of OAEs: The Impact of Research
- Future Timing is Everything
- Noise-Induced Hearing Loss: New Views on Susceptibility & Treatment

PRACTICE MANAGEMENT
- Innovative Hearing Aid Distribution: Where are We Headed?
- Reimbursement: New Requirements, Old problems, New Solutions
- Rescue 911: How to Make a Practice Thrive in Tough Times

REHABILITATION
- Personality Influences on Attitudes and Expectations in AR

PROFESSIONAL ISSUES
- Audiologist Assistants/Support Personnel: Task Force Report
- Licensure, CCC-A, ABA: Does it Matter?
- Update on Professional Ethics

TINNITUS AND HYPERACUSIS
- Tinnitus Management: A Critical Analysis

VESTIBULAR ASSESSMENT AND MANAGEMENT
- Vestibular Assessment: New Trends and Findings

Current research in auditory development and auditory processing disorders will be presented. Assessment protocols, focusing primarily on auditory processing skills in school aged children, will be discussed and criteria for test selection will be described. Management of APD, based on linking results of assessment to remediation strategies, will be discussed. The role of the audiologist in management will be highlighted. Current controversies in APD in children will be addressed.

EMPLOYMENT SERVICE CENTER

The American Academy of Audiology's Employment Service Center is gearing up to offer audiologists and audiology students as many employment opportunities as possible at Convention 2003. We will be offering services to job seekers, employers and those looking to sell or buy practices. The Employment Service Center is **new and improved** this year! The Employment Service Center has combined with HearCareers, www.audiology.org/hearcareers to offer even more to employers and job seekers.

EMPLOYERS:

- Post positions on HearCareers and flag them as Employment Service Center jobs
- Jobs designated in HearCareers as Employment Service Center jobs may be posted as early as January 2003 and remain posted until April 5, 2003 or a minimum of 30 days (whichever is later), for one low convention rate.
- Search a database of resumes before and during convention
- See which job seekers will be attending Convention
- Set up your own interview appointments with job seekers in advance of Convention
- Reserve interview space at the Convention in advance

JOB SEEKERS:

- Post your resume on HearCareers
- Flag your resume to show that you are attending the Convention
- Search job postings for employers who will be interviewing Convention
- Request an interview with an employer who is attending Convention
- Apply for jobs before and during Convention

Interviews: In Advance

Our goal this year is to increase the ability of employers to set up interviews before they arrive at Convention. This year Employers will be setting up their own interviews. First, employers should post their position(s) on www.audiology.org/hearCareers. You can then search the database of resumes for job seekers who are attending Convention or wait for a job seeker to apply to your posted position. It will be ***your responsibility*** to contact the job seeker and set up an interview at Convention. We will have interview space available for you on Thursday from 12:30pm until 6:00pm, Friday from 9:00am until 5:00pm and Saturday from 8:00am until 3:00pm. You will need to reserve interview space with us prior to Convention. Interview space will be assigned on a first come, first served basis. Contact Laura Franchi, Membership Benefits Coordinator at lfranchi@audiology.org or 800-222-2336 x1039 to reserve your interview space by March 10, 2003. After Convention has started, Employment Service Center personnel will be happy to assist employers and job seekers with setting up interviews.

IMPORTANT: All job seekers and all employers must check in at the Employment Service Center and provide local contact information.

PRACTICE FOR SALE:

If you have a practice for sale you can post this opportunity in the Employment Service Center. You can conduct interviews for the sale of your practice at Convention. Contact Laura Franchi at lfranchi@audiology.org or 800-222-2336 x1039 for more details

Ridin' The Winds of Change

Are you ready for the ride of your life? In keeping with the winds of change, registration and housing will once again open in December-giving our members ample time to review the preliminary program and make the necessary arrangements to be in San Antonio for The Academy's 15th Annual Convention & Exposition. The four-color Preliminary Program & Registration Book will be landing in a mailbox near you in December. You will be able to register and make hotel reservations online at www.audiology.org in early December 2002.

You'll want to register early to take advantage of not only the offerings at Convention 2003, but also the one-day Pre-Convention Workshops offered on Wednesday, April 2, 2003. Make sure you're in town that evening for the Opening Night Reception at La Villita (see article) as it is a one-of-a-kind venue.

Remember, by using The Academy's official housing bureau to make your hotel reservations, you can enjoy the special rates we've negotiated for you. And, you won't have to worry about any unauthorized charges that hotels outside of The Academy block might pass along to their guests. You'll also receive exclusive shuttle service between our official hotels and the convention center.

Remember the Alamo...Remember to register early...Remember to use convention housing.

Convention 2003 Fees:

CONVENTION REGISTRATION	Early On or before 2/7/03	Advance On or before 3/17/03	On-Site After 3/17/03
Member	$295	$360	$400
Member - International	$245	$310	$350
Non-Member	$450	$515	$555
Non Member - International	$400	$465	$505
Candidate Member	$110	$125	$145
Student Non-Member	$210	$225	$240
One Day (includes exhibits)	$150	$250	$275
Exposition Only	$150	$250	$275
Life Members	$177	$216	$240
Spouse/Guest	$200	$200	$200

PRE-CONVENTION WORKSHOPS

These fees are in addition to the convention registration. These are ticketed workshops and seating is limited so confirmation is required.

	Early On or before 2/7/03	Advance On or before 3/17/03	On-Site After 3/17/03
Full Day			
Member	$120	$140	$160
Non-Member	$180	$200	$230
Student	$ 80	$100	$120
Half Day			
Member	$ 60	$ 70	$ 80
Non-Member	$ 90	$100	$115
Student	$ 40	$ 50	$ 60

Are you ready for some Trivia Bowl?

Start forming your team now for this highly anticipated Academy tradition that pits students, researchers and practitioners against each other in an exciting battle of wits and memory. This is the one place where your command of obscure audiological tidbits can put you ahead of the pack. Join Trivia Masters of Ceremonies Gus Mueller and Jerry Northern and many of your colleagues for a high-spirited evening of free flowing food, drink and fun (cash bar). We invite everyone to participate. For information on how to put a team together, contact Annette Williams at 1(800) 222-2336 xt 1038 or by email awilliams@audiology.org.

Your Academy Wants YOU!

The Academy invites our Candidate Members to work in the Student Volunteer program at the 15th Annual Convention. This program provides graduate students in Audiology the opportunity to meet leaders in the field as well as have an opportunity to become involved in the national organization. Students will be asked to monitor Instructional Courses, Featured Sessions, Poster/Podium Presentations and assist in The Academy Center. Applicants who are chosen must be Candidate members of the Academy and will receive FREE convention registration. For more information, contact lfranchi@audiology.org.

DESTINATION: SAN ANTONIO CONVENTION 2003

When It Comes To Finding Great Speakers, It All Comes Down To WHO YOU KNOW!

How do they do it? Every year, the Convention Program Committee comes up with an intriguing speaker for the General Assembly at the American Academy of Audiology's Annual Convention & Expo. From the well-versed politician to the widely admired athlete to the occasional celebrity, you can bet they'll find a speaker of interest to just about every audiologist in the audience.

What's Their Secret?

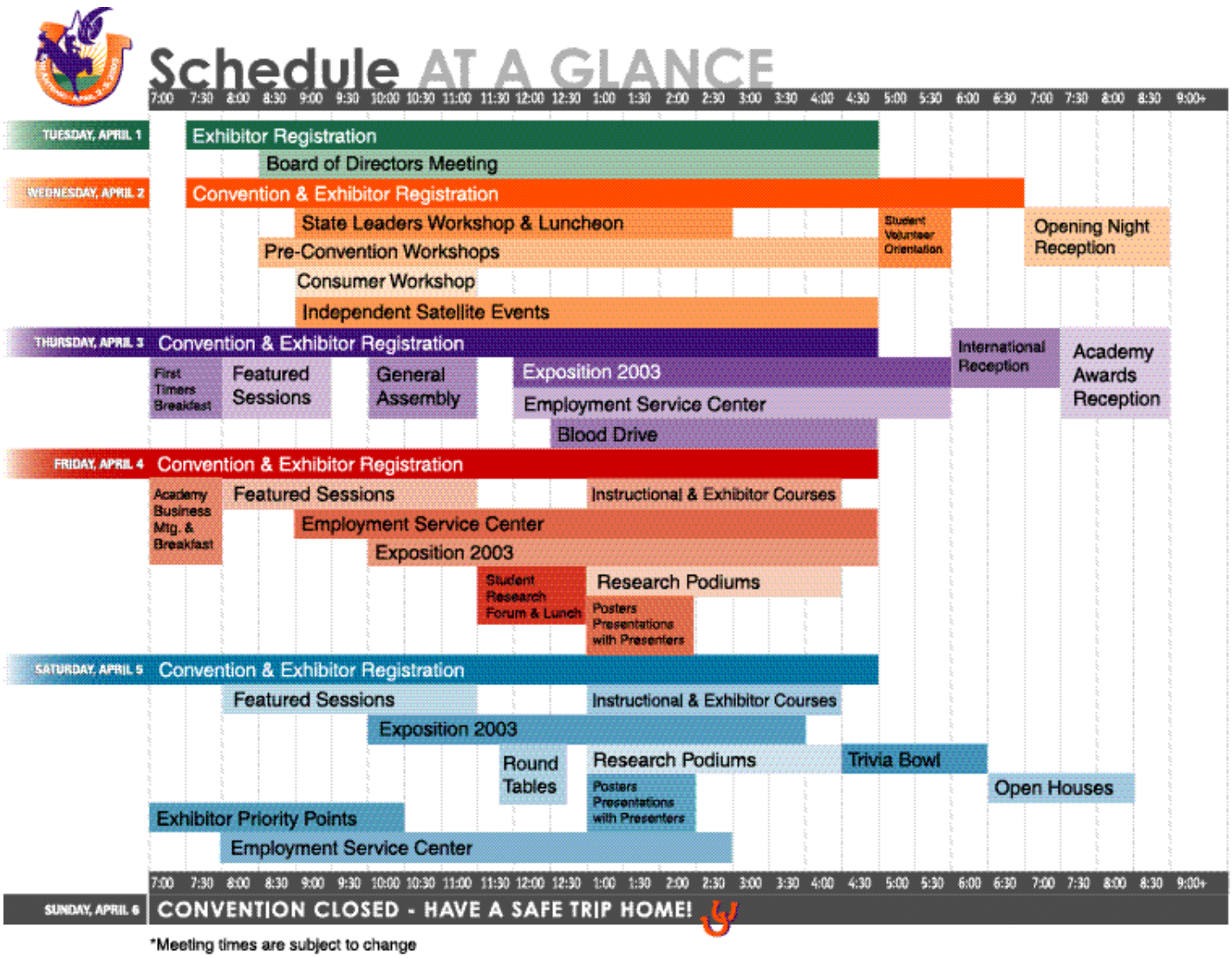
When it comes to selecting a great speaker, it's not what you know, it's who you know. We can thank our members for connecting us to most of the personalities we've had at the last few conventions: Chicago Bear Michael Singletary....80's rocker Huey Lewis....Health & Human Services Secretary Tommy Thompson...even best selling author Amy Tan. They all became our speakers as a result of their connection to someone in our membership.

So, Who Do YOU Know?

Do you have an interesting celebrity or well known sports figure who just happens to be a patient of yours? Think about it...would they make a good convention speaker? Do they have a motivational message or timely topic to discuss? Could they somehow tie in their relationship with hearing loss? These are the people we're looking for, and we want to hear from you. Send us the name of your exceptional patient and tell us why you think he or she would make a good speaker for Convention 2003 and who knows, you could be introducing one of your patients to a standing-room-only crowd in San Antonio next April!

Got a hot prospect? E-mail Program Chair Gyl Kasewurm at gyl@parrett.net or Convention Director Cheryl Kreider Carey at ccarey@audiology.org and let's get started!

All information will be available online at www.audiology.org.



*Meeting times are subject to change

2002 Election Slate
Candidates for President-Elect

Richard E. Gans
Founder & Director
The American Institute of Balance
Seminole, Florida

Education:
BS: Speech Communication, 1972, University of Tampa
MS: Audiology, 1978, University of South Florida
PhD: Auditory-Vestibular Physiology, 1983, Ohio State University

Professional Activities:
Private practitioner, 1983-present; developed multi-office regional private practices specializing in vestibular and balance diagnostics, treatment, and education; adjunct faculty/instructor for AuD Programs at the University of Florida, University of South Florida, Nova Southeastern University, Arizona School of Health Sciences, and Pennsylvania College of Optometry School of Audiology; presented and published extensively on the diagnosis and rehabilitation of vestibular disorders; served as chair for American Academy of Audiology Vestibular Task Force, 1999 to present; Advisory Board member of NAFDA and AFA, 2000 - present; Board member of the American Academy of Audiology 2001 - present; ex-officio American Board of Audiology, 2001-2002; Academy Board liaison to government and reimbursement committees, 2001-present; Academy finance committee 2001-2002; Current Secretary-Treasurer of the American Academy of Audiology, 2002.

Honors:
Omicron Delta Kappa, National Collegiate Leadership Honor Society, 1972; Wernick Award (co-recipient) for Outstanding Accomplishments and Contributions to the Field of Audiology, Academy of Dispensing Audiology, 2000.

Areas of Special Interest:
Promotion of audiology as an autonomous, doctoring profession through education, legislation and reimbursement.

Position Statement:
Professional autonomy, direct access, parity in reimbursement, and transition to a doctoring profession are keystones to our future. As The Academy president, the critical issues that I will address with vision, focus, and energy will be: Government, professional practice, education and research.

I will bring new thinking and a bold plan of action that will enable our profession to be recognized in Congress and state legislatures. We must educate our members on how to change legislation through effective grassroots lobbying and influence. If our AuDs are to have the future we have envisioned, we must effect change both in Washington and in our state capitols.

How do we ask government and third parties to pay audiologists for evaluation and treatment procedures while some corporate audiology companies and their manufacturing partners barter "free" audiology services for hearing aids to managed care? This practice threatens our viability as a true profession. This business model is dangerous and unfair to all audiologists, irrespective of job setting. If our work has no value, then what is our place in the continuum of health care providers? We must be willing to engage in open and candid dialogue of professional practices.

Our AuD programs must be strong and our PhD researchers supported, to ensure the competitiveness of our profession in attracting new generations of bright young clinicians and scientists. I propose a summit of practitioners and academicians to develop a long-term strategy.

My experience as Academy Secretary-Treasurer, Board member, government-reimbursement liaison, practitioner and educator has prepared me well for the challenges ahead. With your help, I am ready to guide this Academy into the future.

Dennis Van Vliet
Division Manager
HEARx West, LLC: HearUSA
Yorba Linda, California

Education:
BS: Biologic Sciences, 1973, University of California, Irvine
MA: Communicative Disorders, 1976 California State University, Fullerton
Student: 2001 – present, Central Michigan University DDL AuD program

Professional Activities:
Clinical Audiologist, House Ear Clinic, 1976 – 1977; Educational Audiologist: Los Angeles County Superintendent of Schools, 1977 – 1979; Vice President and Director of Audiology Newport Language, Speech and Audiology Centers, Inc., 1979 – 1989; Co-coordinator, Annual Audiology Symposia, Communicative Disorders Resource Foundation 1984-1994; Audiology Division Coordinator, California Speech-Language and Hearing Association 1987-1990; Private Practice Audiologist, Yorba Linda, CA 1989 – 1999; Program Coordinator: Jackson Hole Rendezvous 1992, 1994, 1996, 1998, 2000; Coordinator/Facilitator: Independent Hearing aid Fitting Forum, March, 1993 to August, 1994; Founding Member, California Academy of Audiology 1993-1997; American Academy of Audiology Board Member at Large 1994 – 1997; Author: "The Final Word" monthly feature in The Hearing Journal, 1996 – present; American Board of Audiology: Board of Governors – 1997 to 2001; Convention Chair: American Academy of Audiology annual convention, Los Angeles, CA 1998; Division manager, HEARx West-Hear USA, 1999 – present.

Honors:
Fellow of the California Speech-Language Hearing Association, 1993
Academy of Dispensing Audiologists: Joel Wernick Award, 2001

Position Statement
The American Academy of Audiology has accomplished a great deal in the relatively short history of the organization. We have made great strides as establishing The Academy as the resource for audiologists, as the professional organization to lobby the Capitol, work with legislators and CMS, and represent the interests, and only the interests of audiology. Rather than looking back, however, I think that it will serve us well to look to our future. We need to build on the successes of the past to ensure our future as an independent, autonomous and ethical profession.

The American Academy of Audiology should continue to play a leadership role in encouraging meaningful and rigorous accreditation standards for educational programs in audiology. As an organization of, by and for all audiologists, The Academy also needs to include, recognize and encourage researchers and practitioners in education, hearing conservation, hearing rehabilitation, vestibular rehabilitation, and the hearing sciences to maintain our strong scientific base. In addition to the AuD, the PhD degree needs to be a highly valued and respected degree within our field.

Looking forward, our profession will need to focus even more of our energy on governmental affairs and reimbursement. As technology advances, there may not be a place for consumer products, such as hearing aids, for us to rely upon as a primary reimbursement vehicle. Our future depends on our ability to identify the individual services that we provide, demonstrate the efficacy of those services through valid outcome measures, and obtain appropriate reimbursement. Our core skills and value to the public we serve must focus on services, not products. Our survival as a profession depends on fair and appropriate reimbursement for those services.

2002 Election Slate
Candidates for Member-at Large

Richard W. (Dick) Danielson
Director of Audiology
Madigan Army Medical Center, Tacoma WA

Education:
BS: Speech-Language Pathology, 1973, North Dakota State Univ.
MS: Audiology, 1974, Minot State University
PhD: Human Development and Communication Sciences, 1987, University of Texas at Dallas – Callier Center

Professional Activities:
Military Audiologist, 1974-2002 (including Audiology Supervisor and Director, Army Audiology and Speech Center, Walter Reed Army Medical Center, 1992-1999; Director of Audiology, Madigan Army Medical Center, Tacoma WA, 1999-2002); Military Audiology Association (President, 1985-1986; Executive Board 1993-1996); Washington Society of Audiology (President, 1991-1992); National Institute of Deafness and Other Communicative Disorders (Ex-officio Member, Advisory Council, 1993-1997); Council for Accreditation in Occupational Hearing Conservation 1994-2001 (Vice-Chair, Secretary-Treasurer, Chair of Course Director Development Committee); National Hearing Conservation Association (Vice President, 1996 -1997); Department of Veterans Affairs/Army Medical Command Executive Committee in Logistics and Acquisition (1997-2000); Department of Veterans Affairs/Army Medical Command Executive Committee in Logistics and Acquisition (1997-2000); North Atlantic Regional Medical Command, Washington DC (Facilitator, Guiding Coalition of Commanders and Principal Staff, 1998-99); Faculty member (currently Central Michigan University; previously Gallaudet University; George Washington University, University of Maryland, and Uniformed Services University of Health Sciences); National Aeronautics and Space Administration (NASA) Consultant, Executive Committee for Hearing Conservation, International Space Station (2001 – present; Assuming full-time consultant role to Internat'l Space Station in 2003).

Honors:
Office of the Surgeon General, "A" Prefix, 1992
Order of Military Merit, 1994
Founders Award, Military Audiology Association, 2002

Areas of Special Interest:
Hearing Conservation, medical audiology, governmental affairs

Position Statement:
The Academy has successfully emerged to represent audiologists in critical strategic arenas, including many that are still evolving. The American Academy of Audiology possesses the unique opportunity to guide and fuel activities that are critical to the viability of our profession. Our reputation among clients/patients, members of health care delivery teams, legislators, students, faculty, and collaborating researchers is strong, but we need to defuse detractors (including distractions from hectic schedules and indifference) that could potentially jeopardize our profession's progress. Audiologists are still facing transformations; we're not "there" yet. As we approach the target dates for conversion to doctoral-level entry requirement, academicians and clinicians are seeking specific, at-home tactics for implementing this strategy. Legislative drives related to reimbursement and professional recognition require continued support and innovation in response to the fast-changing dynamics of health care and education. Our marketing efforts for audiology recognition are competing with concerns among other professions, including those who believe in externally restraining our scope of practice. Our research community is seeking to sustain a balance of basic research support for our clinical practices. The Academy has the resources to achieve success in these diverse arenas, and a history that confirms that we are ready to handle the next challenges.

Theodore J. Glattke
Professor
Department of Speech and Hearing Sciences
University of Arizona, Tucson, Arizona

Education:
BA: 1962, University of Arizona
MA: 1963, University of Michigan
PhD: 1968, University of Iowa
Postdoctoral: 1968-1970, Stanford University

Professional Activities:
Director, Audiology Clinic, Stanford University 1970-1975; Professor, (1975- current), Speech and Hearing Sciences, Supervisor, Audiology Clinic University Medical Center 1979-1984, Department Head (1984-1987), Associate Dean, Science (1988-1991), Chair Social and Behavioral Sciences Human Subjects Committee (2001- current) University of Arizona, Adjunct faculty, Central Michigan University AuD program (1999 – current); Member, Communicative Disorders Review Committee, National Institutes of Health, 1976-1980; Ad hoc reviewer, United States Department of Education, National Science Foundation, United States Veteran's Administration; Member, Chair, Annual Convention Program Committee, Scientific-Professional Meetings Board, American Speech-Language-Hearing Association, 1976–1980; Editor, Journal of Speech and Hearing Research, 1984-1987; Vice President, Education and Scientific Affairs, American Speech-Language-Hearing Association, 1988-1991; Editor, Journal of Communication Disorders, 1991 – current; Ad hoc reviewer, Journal of the American Academy of Audiology, Ear and Hearing, Journal of the Acoustical Society of America; Member, Chair, Council on Professional Standards, 1996-1998; Member, American Academy of Audiology, International Committee, 2000 – current; Coordinator for Southern Arizona: Arizona Audiology Council 2002 - Member, International Society of Audiology Scientific Committee, President, XXVIIth International Congress of Audiology, Phoenix, AZ 2004; Co-editor of recent text: *Otoacoustic Emissions in Clinical Practice, 2002*; Author or co author of more than 60 articles, chapters and textbooks.

Honors:
Honors of the Arizona Speech-Language-Hearing Association
Honors of the American Speech-Language-Hearing Association
Distinguished Alumni Award, University of Iowa Department of Speech Pathology and Audiology

Areas of Special Interest:
Noninvasive physiological measures of auditory system function; improving research training in hearing science and clinical audiology; development of AuD programs.

Position Statement:
My interest in serving on the Board stems from a desire to improve links between the American Academy of Audiology and academic institutions. This will be of increasing importance as more training programs respond to the changes in credentials required of audiologists. I am particularly concerned about research personnel. The continued development of audiology as a profession will be fueled by increases in the knowledge base that supports clinical practice. If the research foundations of audiology are controlled by personnel from other disciplines, then we risk losing control of the shape of the profession to those disciplines. I hope to help The Academy complement its efforts regarding professional issues of its members with action to encourage students to pursue research careers; to support research training programs; and to encourage increased participation of research personnel in The Academy. If we are successful, then The Academy, the profession, and the persons we serve will all benefit.

2002 Election Slate
Candidates for Member-at Large

Lisa L. Hunter
Associate Professor, University of Utah, Salt Lake City, Utah

Education:
BA: Communication Sciences and Disorders, 1983, University of Montana
MA: Audiology, 1986, University of Cincinnati
PhD: Communication Disorders, 1993, University of Minnesota

Professional Activities:
Audiologist, Minneapolis Ear, Nose and Throat Clinic, Minneapolis, Minnesota, 1986-1988; Chair, Minnesota Speech-Language Hearing Association Committee for Ethical Practice, 1987-1991; Audiologist, Minneapolis Neuroscience Institute, Minneapolis, Minnesota, 1988-89; Research Assistant, Department of Otolaryngology, University of Minnesota, 1989-1993; Audiologist, Fairview-University Medical Center, Audiology Clinic, 1993-2001; Assistant Professor, Department of Otolaryngology, University of Minnesota, 1993-1999; Member of Board of Directors, Minnesota Academy of Audiology; 1994-1997; Member, American Academy of Audiology Continuing Education Committee, 1995-present; President, Minnesota Academy of Audiology, 1997; Member, Task Force on Governance of the American Academy of Audiology, 1997; Representative for Speech-Language Hearing Task Force, Minnesota Department of Health, 1997-present; Associate Professor, Department of Otolaryngology, University of Minnesota, 1999-2001; Member of the Convention Committee 2000, 1999-2000; Chair, American Academy of Audiology Education Committee, 1999-2000; Member, American Academy of Audiology Research Committee, 2002; Chair, American Academy of Audiology Publications Committee, 2002.

Honors:
Veteran's Administration Traineeship, Cincinnati, Ohio, 1985
NIH Research Assistantship, University of Minnesota, 1989-1993
Honors of the Academy, Minnesota Academy of Audiology, 2000

Areas of Special interest:
Clinical Supervision, Pediatric Audiology

Position Statement:
It is a wonderful honor to be nominated to run for the Board of The Academy. It has been a privilege to be involved in various committees within The Academy and other professional organizations over the past 15 years, and to learn about issues affecting our profession from leaders of The Academy. My primary interests are in working within The Academy and with other organizations to retain and improve the scientific and research base of our profession, so that our PhD programs are supported and encouraged within The Academy. Even though I am supportive of the AuD concept and the need to improve our clinical training model, it is critically important to the health of our profession that we maintain the knowledge base that is the foundation of our profession. The Academy has made important steps over the past several years to recognize students' research, provide funding for new investigators, and increase the number and type of research presentations (posters, platform presentations, student research forum, highlighted talks at the annual conventions). These are important developments, and if elected, I would commit to focus on this issue within the duties expected as a Board Member.

Sharon G. Kujawa
Associate Professor, Dept. of Otology and Laryngology, Harvard Medical School Director, Department of Audiology, Massachusetts Eye and Ear Infirmary Boston, Massachusetts

Education:
BA: Speech and Hearing,1975, Michigan State University; MS:Audiology, 1982, Idaho State University; PhD: Audiology; minor: Pharmacology, 1993, University of Arizona;
Post-doctoral Fellow: Auditory Pharmacology, 1993-94, Kresge Hearing Research Lab; Post-doctoral Fellow: Auditory Neurophysiology, 1994-96, Eaton-Peabody Lab

Professional Activities:
Audiologist, University of Arizona, Tucson, AZ. 1982-1989; Graduate Teaching Assistant, Dept of Speech & Hearing Sciences, University of Arizona, Tucson, AZ, 1989-1993; Post-Doctoral Research Fellow, Kresge Hearing Research Laboratory of the South, Louisiana State University Medical Center, New Orleans, LA, 1993-1994; Post-Doctoral Research Fellow (Auditory Physiology), Eaton-Peabody Laboratory, Massachusetts Eye and Ear Infirmary and Department of Otology and Laryngology, Harvard Medical School, Boston, MA, 1994-1996; Professor and Director of Audiology, University of Washington School of Medicine, Department of Otolaryngology-Head and Neck Surgery, Seattle, WA, 1997-2000; Adjunct Faculty, Department of Speech and Hearing Sciences, University of Washington, Seattle, WA, 1998-2000; Scientific/Technical Sessions, American Academy of Audiology, 1998; Research Committee, American Academy of Audiology, 1999-present; New Investigator Grant Review, American Academy of Audiology, 1999-present; Associate Professor, Department of Otology and Laryngology, Harvard Medical School, Boston, MA, 2001-present; Section Editor, *Auditory Neuroscience*, 2001-present; Faculty, Program in Speech and Hearing Bioscience and Technology, Harvard-MIT Division of Health Sciences and Technology, Cambridge, MA, 2002.

Honors:
Grants from the National Institutes of Health (NIDCD), Howard Hughes Medical Institute Research Resources, Deafness Research Foundation, Nathan Shock Center of Excellence on the Basic Biology of Aging, Royalty Research Fund (UW)

Areas of Special Interest:
Susceptibility to hearing loss, age-related and noise-induced hearing losses and their interactions, efferent feedback; research training and mentorship

Position Statement:
I feel very fortunate to have come into this field when I did. Research and technical advancements have been rapid and the implications for clinical care, far reaching. We are in a better position than ever to take the fruits of this work and integrate it into our clinical activities with the goal of providing better informed care. In light of this, it is sobering that there are few audiologists coming into the field to pursue academic and basic or clinical research careers. Without this ongoing clinical support base, the field cannot stay vital and grow. The Academy has a responsibility to support this work with its words and its resources. I would work with The Academy Board to encourage the entry of new researchers, to facilitate their mentorship, and to support the career development of existing researchers and academicians in our field. I would encourage the involvement of clinicians in this process, as they know best the clinical needs (and constraints), and will have important insights on how these developments can best be implemented in the clinical arena.

2002 Election Slate

Candidates for Member-At Large

Barbara Packer
Director of Applied Research at the Fischler Graduate School of Education at Nova Southeastern University; Adjunct Professor of Audiology, Department of Audiology, Nova Southeastern University Davie, Florida

Education:
BA: Speech Pathology, minor Psychology, 1974, Douglass College, Rutgers University
MS: Audiology, 1976, Teachers College, Columbia University
EdD: Education, 1995, Nova Southeastern University

Professional Activities:
Board member: Council of AuD Programs, 1995 - 2002; Founding Member: Florida Academy of Audiology, 1995 - present; Chair, Program Committee for Audiology, FLASHA Convention 1997; Vice-President for Education, Florida Academy of Audiology, 1998; Member: American Academy of Audiology Education Committee, 2000 - present; Associate Editor: *JAAA*, 2000 - present; NAFDA: National Advisory Board, 2000 - present; Chair: American Academy of Audiology Taskforce on Supervision of Audiology Students, 2001 - present; Chair: American Academy of Audiology Convention Sub-Committee, Research Posters & Podiums, 2001; Program Chair, American Academy of Audiology Convention 2002

Areas of Special Interest:
Supervision, AuD and Continuing Education, Aural Rehabilitation

Position Statement:
The profession of audiology faces important issues including autonomy, reimbursement, professional education, and applied research. As a board member, one of my objectives would be to emphasize the need for efficacy studies and outcomes research. These data will be essential in shaping legislative and financial agendas for our members. I believe we must solidify our scope of practice and ensure our independent practitioner status. We must improve consumer awareness and enlist the support of related health organizations and state and federal legislative bodies. Given the nature of professional competition, we must forge strong partnerships with other associations such as American Association of Retired Persons, American Board of Family Practice, and American Academy of Pediatrics. We must work at enhancing agreement with others and identify areas of common need for which we must work together for the common good. I have worked as chair, co-chair, or member of numerous Academy committees, developed and implemented the first AuD distance learning program, and, most recently, served as Chair of The Academy's Convention 2002. I will be able to draw upon these experiences to help identify issues, search for creative solutions, promote agreement, and impact positive change while minimizing discord.

Steven D. Smith
Director of Audiology, Director of Physicians Hearing & Balance Center Limited Partner, Drs. Kitchens, Chapman, & Anderson, P.A., Montgomery, Alabama

Education:
BS: Bachelor of Science in Speech and Hearing Sciences, 1989, University of South Alabama
MS: Master of Science in Speech and Hearing Sciences, 1991, University of South Alabama
AuD: Doctor of Audiology, 2001, Pennsylvania College of Optometry, School of Audiology

Professional Activities:
Clinical Audiologist, Sparks Center, UAB Speech & Hearing Center 1991-92: American Academy of Audiology (AAA) Member 1992-present; Speech and Hearing Association of Alabama (SHAA) Member 1992-present; Founding member Professional Audiology Society of Alabama (PASA) 1996; Audiology Foundation of American (AFA) Member and State Torchbearer 1995-present; American Auditory Society (AAS) Member 1995-present; Academy of Dispensing Audiologists (ADA) Member 1995-present; Newborn Infant Hearing Screening Program Coordinator, Baptist Hospital South, 1995-2001; Electrophysiological Consultant, Baptist Hospital, 1995-2001; Adjunct Instructor, Pennsylvania College of Optometry, School of Audiology 2000-present; Adjunct Instructor, Arizona School of Health Sciences, School of Audiology 2001-present; Ethics Committee, Professional Audiology Society of Alabama 2001; Electrophysiological Consultant, Med-Acoustics, Inc., 2001-present; Electrophysiological Consultant, Everest Bio-Medical, 2001-present; Electrophysiological Consultant, Bio-Logical Systems Corporation, 2002; President Elect, Professional Audiology Society of Alabama 2003

Areas of Special Interest:
Clinical utilization and research of auditory electrophysiological measures, AuD education and training, professional standards and continuing education, reimbursement issues

Position Statement:
I have been blessed in my Audiology career to have had excellent instructors, professors and mentors. Tim Holston, Robert Garcia, Art Dahle, Faye McCollister, Gerald Popelka, and James W. Hall, III have uniquely impacted upon my professional development. They each have taught me the value of hard work, determination, and dedication. Our goals as an organization, which should reflect the goals of the membership, should be focused on our continued transitioning into a doctoring profession and obtaining professional autonomy. Paramount to establishing autonomy is the development and implementation of our own professional practice standards and certification. It is my believe Audiologists must obtain recognition by government regulatory agencies and third party payers as legitimate health care practitioners. I feel strongly that we must ensure our academic rigors and clinical training meet both the needs of clinical and researched based audiologists, for our profession is build upon both disciplines. It is my desire, my goal to give back to my profession and if I am elected as a Member-At-Large for The Academy Board I can assure you I will be dedicated, determined, and motivated to work tirelessly for our organization, our profession, and you, my colleagues.

2002 Election Slate
Candidates for Member-at Large

Helena Solodar
President/Co-owner 8 office locations, Audiological Consultants of Atlanta, Inc., Audiological Consultants of Atlanta-Buckhead, Inc., Audiological Consultants of America, Atlanta, Georgia

Education:
BS Ed: 1973, University of Georgia
MS: Speech Pathology and Audiology, Dual Masters, 1975, University of S.C.
AuD: 2000, University of Florida

Professional Activities:
Private Practitioner, 1975-present; Founding member of Audiological Resource Association (ARA), 1975-present; Established and co-founded first private Speech and Hearing Clinic in Georgia, 1983; Served on Georgia State Licensure Board for Hearing Aid Dealers and Dispensers, 1986-1994; Georgia State Torchbearer Co-Coordinator *Hearing Journal*, Editorial board, 2000- present; Songbird Hearing-Medical Advisory board, 1999-present; American Academy of Audiology Marketing Committee, 2001-present; Presentations at ADA and American Academy of Audiology conventions on Private Practice and Marketing; Authored articles on private practice and marketing; co-authored book chapter, "Counseling for Hearing Aid Fitting" by Robert Sweetow; Memberships: American Academy of Audiology, Academy of Dispensing Audiologists, Georgia Academy of Audiology.

Honors:
ARA: Outstanding Audiologist of the Year Award, 1994

Areas of Special Interest:
Private Practice and Marketing

Position Statement:
In my 27 years of private practice, I have had the distinct honor and privilege to work with so many wonderful and dedicated audiologists. I have been an advocate for Audiology becoming an autonomous profession since graduate school and supported the AFA in the movement of upgrading Audiology to a doctoring profession. It has been extremely exciting to watch this evolution take place. I am extremely passionate, dedicated and committed to Audiology and believe that with determination, drive, and enthusiasm, anything can be accomplished. I consider marketing to be an essential key to the viability of our profession. In my own practice, our marketing efforts have played an important role in the success of our business. I would like our constituency to understand the value of marketing and wish to share ways to utilize marketing strategies to increase visibility and affirm credibility. I love new challenges and ask for your support in my effort to become one of your board members for the American Academy of Audiology. This is a huge responsibility and I am ready to commit my time and energy to helping the Academy achieve its goals.

Therese C. Walden
Supervisor and Chief, Audiology Clinic, Army Audiology and Speech Center, Walter Reed Army Medical Center, Washington, D.C.

Education:
BS: Communication Sciences and Disorders, 1983, Towson State University
MS: Audiology, 1985, Towson State University
AuD: Audiology, 2001, Central Michigan University

Professional Activities:
Assistant Faculty, Johns Hopkins University, 1985-1986; Clinical Audiologist, Walter Reed Army Medical Center, 1987-1997; Supervisor and Chief, Audiology Clinic, Walter Reed Army Medical Center, 1997-present; Adjunct Faculty, Gallaudet University, 2001-present; American Academy of Audiology Task Force for Ethics, 2001-2002; American Academy of Audiology Task Force for Support Personnel, 2001-present; Member, American Academy of Audiology Ethics Board, 2002-present; Member American Academy of Audiology, ASHA, MAA; Executive Secretary, Military Audiology Association, 2002-present.

Areas of Special Interest:
Adult and geriatric audiology, amplification, outcome measures, professional education, ethics and professional autonomy

Position Statement:
As director of audiology services within a large medical center, I have seen the status and scope of practice of audiologists increase over the past 15 years. This reflects our improved clinical services and our higher educational and professional standards. We need to continue this process if we are to achieve a status with our patients, the general public, other health care professionals and government regulators that is equal to the most prestigious health care professions. Critical in this process is recognition of audiologists by the CMS as entry-level practitioners for patients seeking both diagnostic and treatment services for hearing and balance disorders. In addition, effective collaboration among all professionals and organizations that are involved with hearing and balance health care is needed to elevate the professionalism and competency within the field. The American Academy of Audiology is member-driven and we need to continue to draw on the strength that lies in our diversity, continue our willingness to do what is best for the patient, remain involved in research to support evidence-based practice, and hold ourselves accountable as individual practitioners and as a professional organization – to behave as we would like to be regarded. I look forward to this challenge.

Ballots will be available in late January 2003.

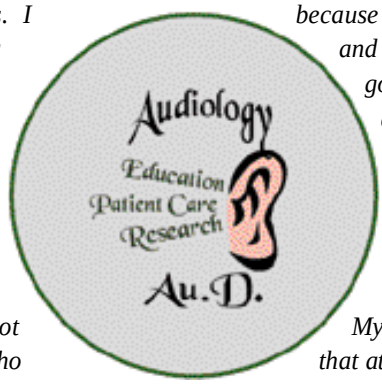
The 2003 Nominations Committee was composed of David Fabry (Chair), Robert Sweetow, Alison Grimes, Catherine Palmer, Kathy Campbell, Linda Hood, Briseida Northrup and National Office Staff Liaison Ed Sullivan.

FLORIDA ACADEMY OF AUDIOLOGY INAUGURATES WHITE COAT CEREMONY

Loavenbruck congratulates AuDs at White Coat Ceremony

On behalf of the American Academy of Audiology, and on my own personal behalf, I want to congratulate each of you and your families as you begin your preparations to become audiologists. I am particularly proud to be participating in this first white coat ceremony. To me, this ceremony and the promise you are making to this wonderful profession of audiology represent a milestone and a renewed commitment to the public service origin of our profession. Roscoe Pound, a law professor who was Dean Emeritus of Harvard Law School from 1916 to 1936, said that a profession is "a group pursuing a learned art as a common calling in the spirit of public service—no less a public service because it may incidentally be a means of livelihood."

I think that many audiologists in my generation kind of drifted into audiology - I don't think I really knew what I was choosing when I decided to become an audiologist. But if I knew then what I now know after more than 35 years of practice, I would once again choose this profession for many reasons. I would choose it for the intellectual stimulation the study of audiology offers. I would choose it for the sheer elegance and wonder that exists in the design of the auditory system - truly an incredible sensory system. I always tell my patients that hearing aids are designed by wonderfully talented engineers, but that they cannot compete with the engineer who designed the auditory system in the first place. I would choose it for the opportunity it has provided to interact with and help hearing impaired infants, children and adults and the families who love them. I would choose it for what I've learned from my patients about responding to the challenges of hearing impairment with courage and grace. I would choose it for the opportunities it provided for volunteering in my professional associations. I would choose it for the dedicated and talented colleagues I have had the opportunity to meet and work with throughout my professional career. I would choose it because I have had wonderful students to teach and learn from. I would choose it because it has provided me and my family with a very good life of important and useful work and a very good living. What more can you ask of any profession?

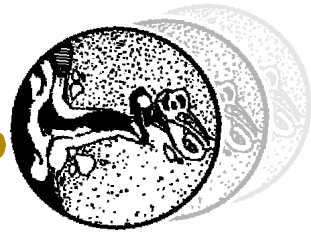


My father used to say that attitudes and values are caught, not taught. I think this is true - I don't know that you can teach "professionalism," certainly not in a single course at a single point in time - it is a process. Throughout my career as an audiologist, I have had wonderful role models who allowed me to watch and learn from them, and I wish the same for all of you as you begin your journey as audiologists. I think you should know that you have chosen very well.

Angela Loavenbruck
President
American Academy of Audiology

FLORIDA'S WHITE COAT CEREMONY

The Florida Academy of Audiology (FLAA) hosted the first Doctor of Audiology White Coat Ceremony at their recent convention in Orlando. The ninety-eight (98) students currently enrolled in AuD programs at Florida universities and their families were invited to attend the special ceremony. According to Barry Freeman of Nova Southeastern University, the purpose of the White Coat Ceremony is to "impress upon students the importance of professionalism and the symbolic role of the white coat in patient care. It promotes the values that are key to our profession in the presence of our colleagues, students, and their family and friends." Monogrammed white coats were presented to each student by a member of their university's faculty, Lesley Ericsson, President of the FLAA and Angela Loavenbruck, President of the American Academy of Audiology. In addition, all students and audiology colleagues who attended the ceremony accepted their new professional responsibilities by joining together to recite the new doctoral oath for the profession of audiology.



New Advances: Auditory Brainstem Implants

KELLY TREMBLAY, LENDRA FRIESEN & LISA CUNNINGHAM, UNIVERSITY OF WASHINGTON, SEATTLE, WA

Approximately 200 patients within the US have been implanted with an auditory brainstem implant (ABI). All of these individuals have neurofibromatosis type 2 (NF2), a disease in which individuals develop bilateral vestibular schwannomas as well as other central nervous system tumors. Complete removal of these life-threatening tumors usually results in sectioning of the auditory portion of the eighth cranial nerve, causing deafness. Because the auditory nerve no longer functions, these individuals are ineligible for a cochlear implant (CI).

The ABI and CI are similar in terms of their components except that they have different electrode arrays. Whereas the ABI has a plate array with up to 21 electrodes, the CI has a thin wire array with up to 24 electrodes. The placement of each electrode array also differs. Whereas the CI is placed in the cochlea, the ABI is placed on the surface of the cochlear nucleus.

Recently, Otto, et al. (2002), published performance results of 61 patients with the Nucleus-22 ABI device. In short, only a few patients demonstrated sentence recognition using the ABI, sound only. However, the majority of individuals benefited from the device when sound was combined with lipreading. In a few cases, scores were comparable with users of multichannel cochlear implants. These results imply that the ABI can offer individuals with NF2 an alternative to deafness.

Future generations of the device will contain microelectrodes that will penetrate the cochlear nucleus, hopefully resulting in improved speech understanding for the recipients. The U.S. Food and Drug Administration has issued an investigational device exemption (IDE) for the first clinical trial of the penetrating ABI. The first candidate is expected to undergo surgery in late 2002.

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Advance for Audiologists. Online feature article. Advances in Auditory Prostheses Detailed. September 9, 2002. www.advanceforaud.com/pastarticles/sept9_02feature4.html

For more information, see website: www.hei.org/hearhealth/diseases/nf2more1.htm

An Audiologist's Hearing: Personal Reflections

Professor Moe Bergman, EdD, Sacker School of Medicine, tel-Aviv University, Israel

I thought it would be of interest to colleagues in audiology to review my own personal auditory history in light of my professional knowledge and experiences as a clinician, teacher and researcher in the field over the span of seven decades. I have had ready access to an audiometer continuously since I entered the field in the 1930s, some years before our profession acquired its modern name, Audiology. I therefore have been testing my hearing on the evolving modern audiometers and their official calibrations, or have had colleagues or students testing me throughout all of the years since then. I recently sat down and reviewed these audiograms and selected one from each decade of my life for this report as a longitudinal history of my hearing over these decades. The audiograms presented in this report have been adjusted to current audiometric calibrations for the purpose of comparison.

DISCUSSION

Audiologists are well aware of the role that frequency resolution has on the understanding of speech, particularly when there is noise competition. When I was in my 50s, I realized that my frequency discrimination for higher frequencies was undergoing bizarre changes while I was working with graduate students in our research laboratory. We were exploring my difference limens as one of the students gradually swept across the signal generator (no sophisticated computers in our laboratory at that time). Instead of detecting small pitch changes when the high frequency was changed only a few Hz as a normal listener would, it was necessary to change it hundreds of Hz for me to detect any difference. However, in measuring the difference limen for low frequencies my practiced ears recognized even smaller changes than others could.

UNDERSTANDING SPEECH

From middle age onward, my increasing hearing loss and distorted processing at the high frequencies affected the clarity with which I heard speech. Hence, like so many of our patients, I noticed that I could "hear but not understand." An example of the increasing "muddiness" of my hearing was the need to have spoken numbers such as "56" or "66" repeated while I looked at the speaker's face since I learned quickly that "louder did not mean clearer." I was aware that I had more difficulty understanding some speakers than others, particularly when the voices were somewhat hoarse, or there was a repeated tendency to drop voice level at the end of sentences. That observation inspired our studies of the effect of different voices on the understanding of speech in the elderly. (Bergman, 1980, pp 103-105). At small-group meetings, such as clinical conferences, it became increasingly difficult to note what my neighboring colleagues were trying to say to me in a soft voice - or most exasperating - in a whisper. Physical obstructions, such as thick glass windows between me and a talker as in a bank, destroys the acoustics of the consonants and degrades the clarity of speech for me. Similarly, if a talker turns partly or wholly away from me I lose essential consonantal information.

Moe Bergman

As audiologists, we know that persons with hearing impairment require more intense speech to be understood over noise than for young persons with normal hearing. Despite the obvious assistance from the use of binaural hearing aids it is apparent to me that I still have more problems than others in noisy environments. The use of background noise and loud music in television and movies has become maddening for me now, making it even more difficult to understand the speech. As the dramatic action heats up and the background soars, the mono-channel reproducing system (e.g., the TV's single loudspeaker) vitiates nature's binaural approach to selective listening. The availability of the infrared (IR) equipment contributes much to my ability to enjoy television programs. I have found that listening through the IR system, when its frequency response has been appropriately adjusted at the earphones is superior to just turning up the volume of the TV set, with or without the use of hearing aids.

While I have greater difficulty with some voices over the telephone than with others, I now know that by removing the receiver slightly from my ear, particularly when the talker on the other end of the telephone line has a low-frequency dominated voice I hear better. This maneuver allows some of the voice's disturbing low-frequency energy to leak off. Listening area acoustics are also a confounding factor for me, particularly in large halls where the reverberation characteristics are not of the best. At international conferences, however, where there is translation equipment, I put on the earphones and sit back and hear in a relaxed fashion on the "direct" channel from the speaker talking English. It is now clear to me that before I acquired my first hearing aids I had often been disturbed while conducting classes in the university's hard-walled classrooms by my difficulty in understanding the speech of students asking questions. I recall attributing the communicative breakdown to the students at that time, in ignorance of my creeping hearing problem.

The theatre would be a very frustrating experience for me now if it were not for the infrared (IR) system, where I am hearing from the microphone pickup close to the actor instead of through the entire hall and its particular acoustics. My enjoyment of music at concerts has not been significantly affected by my hearing problem, possibly because of my familiarity with much of the music, but more probably because I do not know how much of the broad range of sound I am missing. The hearing aids do help in the theater, particularly for listening to violin concerti, although I assume that the altered dynamic range of intensities and the action of the hearing aids' limiting circuits have deleterious effects.

The use of hearing aids poses few problems for those of us who spend much of our social time with age peers. Asking for a repetition when a message is not understood, for example, is comfortably accepted, even when this occurs frequently. Listening to younger talkers,

however, can be an insuperable challenge. Like other grandparents, I find that trying to understand my grandchild's speech, either directly or over the telephone, is often close to complete failure. Conversations between my middle-age son and his son in an automobile are off-limits for the also present grandfather, who can only marvel that they understand each other!

The dreaded interactive telephone menus are a marked setback for elderly listeners, with or without a clinical hearing impairment. These are often distressingly rapid and unclear, and when the caller is using the listener's second-learned language almost impossible to react to fast enough. A hearing impaired colleague at our university says that he just pushes any number, then explains that he is hearing-impaired and needs human help. He is happy to report that this usually brings a sympathetic response.

Most disturbing for me is trying to use a second language, such as Hebrew, in which there is much necessary high-frequency information. Even were I to have a more successful ability in this second language, I realize, as our research has documented repeatedly, that the lack of a rich store of vocabulary and syntactic and semantic sophistication, as I have in my native language English, requires that I must depend more on accurate phoneme discrimination - which, of course, is frustrated by my hearing loss. The importance of the linguistic corpus in this problem has, in my opinion, been very much under-investigated.

To this can be added the expected age-related changes in central processing ability. Of particular frustration to me, at my age, is participating in professional committee activities where the combination of my weakness in this second language and my difficulty in using even the limited phonemic clues that I am hearing defeat all my efforts to be an effectively participating committee member.

One of the most disconcerting manifestations of my high tone hearing loss is the inability to hear the subtle sounds associated with the entry or exit of another person into the room when my attention is focused elsewhere. This loss of environmental monitoring has led to a "jumpiness" of uncertainty about whether I am either ignoring someone, or being observed unknowingly. Another aspect of this is not hearing the buzzer announcing that someone is requesting to be admitted either to the building or just outside our door. Another loss is the complete inability to hear high-pitched signals, such as the alarm from a wrist watch. All such relatively weak, high pitch alerting sounds are now entirely beyond my experience.

I believe that the most corrosive evidence of the effect of my gradually increasing hearing problem, beginning in middle age, was my "adjustment" to communication failure, characterized by the frequent feigning of comprehension, the ignoring of misunderstandings and the reluctance to seek clarification by requesting repetition from the talker. After each failure there was an internal debate over whether to ask (once again) for a repetition. The increasing experiences of such communication failure brought related problems of how they were managed in the presence of others who knew me closely, such as my wife. As both of us became aware of my errors of interpretation after several mis-hearings we attempted to arrive at an appropriate balance between my seeking clarification, either from her or from the talker, and having her automatically attempt to bridge the misunderstanding on the basis of her awareness of the problem. As we all know, some of the mis-hearings are very amusing, and my wife and I have shared very many particularly funny examples, often right in the middle of a conversation. Despite this, however, I thoroughly enjoy the rewards of social interchange, more so at this advanced age than before, but I admit to sharing the familiar preference of older people for the company of other older friends and family, where there is welcome acceptance of such expected impairments.

I have been using various brands of binaural hearing aids for some years now, all either in-the-ear or in-the-canal or completely-in-the-canal. I have no doubt that they have been helpful in various listening situations. There are, of course, remaining problems, for example, when there is a high level of competing conversations around me. There are also annoying problems that I may be particularly sensitive to, such as the attack and release times of the compression circuit of one pair of my hearing aids, where high level noises around me, such as the continuous applause of an audience at a concert will activate and maintain the compression action, leaving me with an essentially "dead" aid just as a companion tries to react with comments to me about the music. In brief, however, the aids are a boon to me when I want to hear speech, or even music.

CONCLUSION

It is probable that my personal history of age-related hearing impairment, beginning with subtle changes that were revealed only in clinical and laboratory studies, is representative of similar gradual changes in many long-lived persons. I am convinced, further, that the recognition of having a hearing problem is highly individual, depending upon a variety of factors such as personality differences, the need to engage in challenging verbal exchanges, having to converse often over background noise and, of course, on the severity of the loss. A long life is understandably accompanied by physical and cognitive alterations that are the grist of tomes on the aging phenomena. As a professional audiologist I am painfully aware of the grievous effects of moderate, severe and even profound age-related hearing loss in many elderly persons. For myself, while I am aware that there remain problems which are at least partly related to central changes, recognized or not, in each one of us, I readily accept the subtle, surreptitious onset and growth of the presbycusis that has been a part of my life experience, and am thankful for the clearly helpful technological devices now available.

I am in awe of the daily advances that are taking place in bio-engineering and technology that will undoubtedly bring greatly enhanced knowledge of audition and aging and will certainly be accompanied by remarkable new approaches to the amelioration of age-related hearing loss. There will be more and more people entering the categories of "the elderly", "old", and whatever term will attempt to describe those audiologists, amongst others, who find themselves in their 9th and 10th decades, as players in the saga of presbycusis. I have full confidence that they will be in the forefront of the advances, before and while they enter these decades themselves.

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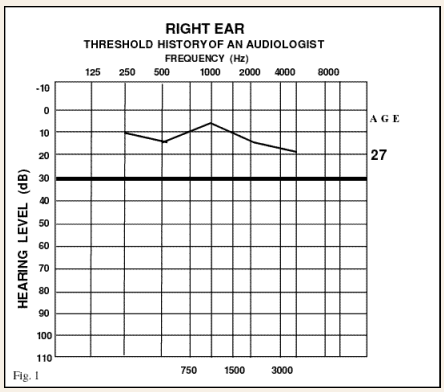

Fig. 1 MB. right ear, age 27. My audiogram during my 20s decade shows the beginning of sensorineural pathology at 3000 and 4000 Hz, although the hearing was still within essentially normal limits, with no threshold worse than 20 dB.

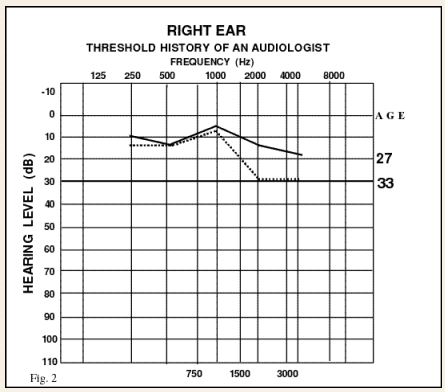

Fig. 2. MB, right ear, age 33. Six years later, there was an additional drop at 2000 and 4000 Hz to 30 dB. Because the hearing in my left ear was better than in my right ear, I did not notice any hearing difficulties.

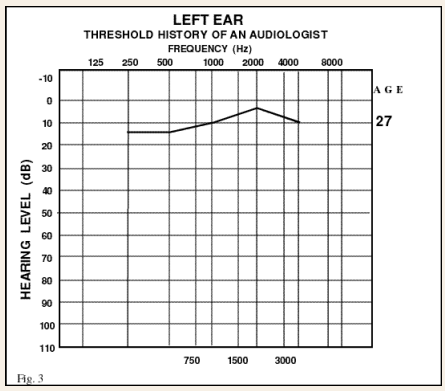

Fig. 3. MB, left ear, age 27. My left ear has a history of its own, but it shows normal hearing of 5 dB at the important frequency of 2000 Hz.

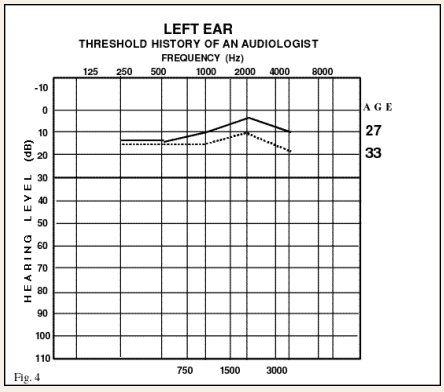

Fig. 4. MB, left ear, age 33. The very slight changes in auditory thresholds were still not enough for me to notice any hearing difficulty.

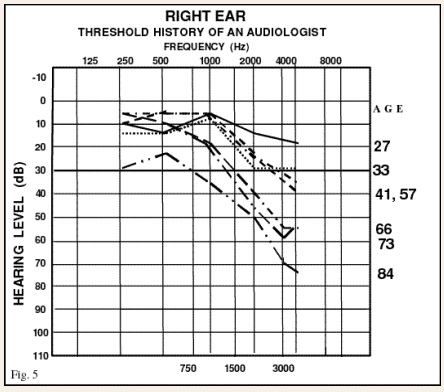

Fig. 5. MB, right ear, additional decades. In each of the following decades the hearing in my right ear declined significantly suggesting the onset and progression of "typical" presbycusis.

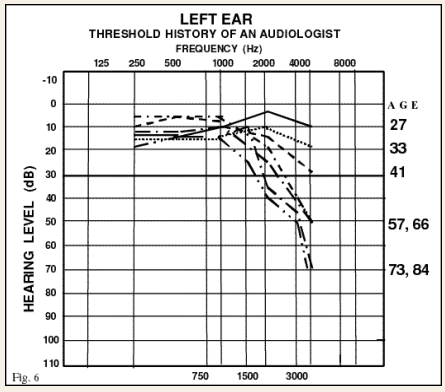

Fig. 6. MB, left ear, additional decades. As noted at age 41 there was no threshold worse than 30 dB. By age 57, however, the picture of presbycusis emerged clearly, with considerable loss at 4000 Hz. The early high frequency loss was joined by significant losses at the crucial middle frequencies, with effect on the understanding of speech becoming evident to me. The hearing in both ears has continued to decline since then.

BERGMAN'S AUDIOGRAMS

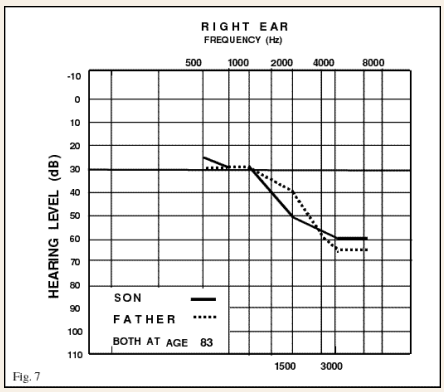

Fig. 7. Father and son audiograms, right ear, both at age 83. Audiologists, of course, also compulsively test members of their family! Since I had one of myself at that same age I thought that this was a unique opportunity to compare the hearing of father and son.

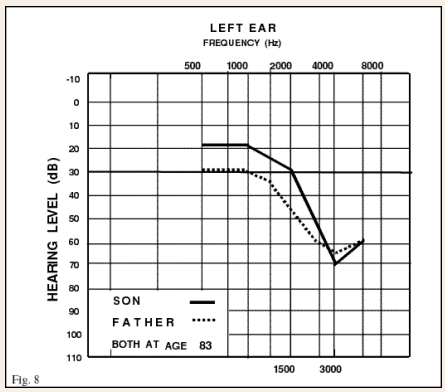

Fig. 8. Father and son audiograms, left ear, age 83. My left ear thresholds were better than my father's at the same age.

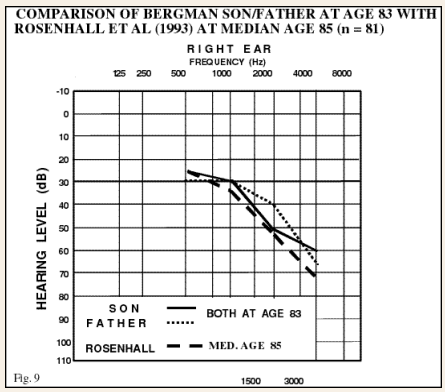

Fig. 9. Comparison with Swedish longitudinal data Since we are always alert to the possible genetic patterns of aging changes in families I have added one of the Swedish longitudinal audiograms for similarly non-smoking men at age 85. (Rosenhall et al, 1993).

WASHINGTON WATCH

LOOKING TO THE 108TH

MARSHALL MATZ AND ROBERT HAHN

The 107th Congress is coming to a close. While it is unclear as we write this column which party will be in control of the House (Republicans hold a six seat majority) or the Senate (Democrats hold a one seat majority), there will be a new Congress sworn into office in January. In the 108th Congress, The Academy's highest priority, regardless of which party is in control, will be to move forward on the issue of direct access in the Medicare program.

The 107th Congress (2001-2002) was a successful period for The Academy. Our political visibility continues to grow; our issues have moved forward; we have a new Director of Health Care Policy, Jodi Chappell; and our Political Action Committee (PAC) is more active. Secretary Tommy Thompson was our keynote speaker in 2001. And you may have noticed the picture of our President Angela Loavenbruck with Rep. Rosa DeLauro, and the picture of Craig Johnson, Chair of the PAC Committee, with Senator Tom Daschle, the Senate Majority Leader, in the last edition of *AT*. Neither a picture nor a speech should be seen as a victory in and of itself, but they are important symbols of our political progress.

There have also been a number of important developments on the administrative front during this period, mostly at the Centers for Medicare & Medicaid Services.

- At the request of The Academy, CMS issued a Program Memorandum (Transmittal B-01-28) confirming that physician supervision is not required for audiologic or vestibular diagnostic tests that are personally performed by a qualified audiologist. This reversed a statement by CMS in 1997 that physician supervision was required for vestibular function tests with recording.
- At the request of The Academy, CMS issued a Program Memorandum (Transmittal B-01-34) clarifying that Medicare reimbursement for audiologic and vestibular diagnostic tests may not be denied based on the diagnosis. If a physician refers a Medicare beneficiary to an audiologist for evaluation of symptoms associated with hearing loss or ear injury, the tests are covered by Medicare even if the diagnosis is sensorineural hearing loss and the only outcome is prescription of a hearing aid. In a recent Program Memorandum (Transmittal AB-02-080), CMS extended this policy to Medicare Part A intermediaries as well as Medicare Part B carriers. When some Medicare carriers continued to deny reimbursement for hearing tests because of the diagnosis, The Academy wrote to those carriers and persuaded them to stop this practice.
- At the request of The Academy, CMS has dropped references to the CCC-A in policies discussing credentialing of audiologists in the Medicare program. For example, in Transmittal B-02-080 discussed above, CMS deleted previous references to the ASHA national directory and made clear that state licensure is the preferred method for verifying an audiologist's credentials.
- CMS has established new prospective payment systems (PPS), replacing the old reasonable cost based payment systems, for inpatient rehabilitation facilities (IRFs) and long-term care hospitals (LTCHs). Under these prospective payment systems, if an audiologist furnishes services to an inpatient in an IRF or LTCH, the audiologist must seek payment from the IRF or LTCH and may not bill Medicare.
- With respect to the PPS for skilled nursing facilities (SNFs), CMS clarified that audiologic tests furnished to SNF residents in a Part B stay are not subject to consolidated billing; therefore, audiologists may bill Medicare for such tests under the Physician Fee Schedule. (Earlier, CMS had mistakenly stated that audiologic tests furnished to SNF Part B residents were subject to consolidated billing, apparently treating audiology as a subset of speech-language pathology services. The Academy pointed out the error.)
- CMS has issued a new regulation on Medicare coverage of "services incident to a physician's professional service." This regulation relaxed the employment requirement for "incident to" services. Medicare will now cover "incident to" services performed by an employee, a leased employee, or an independent contractor (i.e., someone who performs part-time or full-time work for which he/she receives an IRS-1099 form) hired by a physician or certain other practitioners. This means that audiologists who work part-time for a physician or physician practice may be reimbursed by Medicare for "incident to" services.
- The Academy, together with the Academy of Dispensing Audiologists (ADA), has continued to urge CMS to eliminate the physician referral requirement for audiologic diagnostic tests (i.e., to allow Medicare beneficiaries direct access to audiologists), but CMS has refused to grant this request. After several letters and meetings, CMS referred the matter to its sister agency, the Agency for Healthcare Research and Quality (AHRQ). AHRQ commissioned a report by one of its evidence-based practice centers, MetaWorks, Inc. MetaWorks issued a report concluding that the existing literature is too limited to accurately evaluate the clinical impact of direct access. The Academy and ADA then formally requested that CMS issue a national coverage decision allowing direct access. CMS declined to do so and suggested that The Academy and ADA "consider seeking a statutory change from Congress."

The Academy is poised and excited about the 108th Congress. Your Washington team is growing and energetic. But we can't do it without your involvement. Our power in Washington is directly related to your participation back home. Yes, we have "white hat" issues trying to provide better service to those who are hearing disabled; and, yes we have a Political Action Committee (PAC) (that must grow). But there are many important issues pending in Washington. How does the Congress and the Administration decide which issues to tackle? They make their decision based on what they are hearing about (no pun intended) from back home. We must make our voices heard through your active involvement and, if possible, the involvement of consumers.

Letters are still very important. Attending a local meeting with your Members of Congress is very, very effective. Getting to know the Legislative Assistant who handles health issues for your Member of Congress in the House and Senate is crucial. For your Academy staff and legislative team in Washington to take the profession to the next level of political effectiveness, it will require your participation.

Here's to a great 108th Congress!

Submitted by *Marshall L. Matz, Esq*., and *Robert Hahn, Esq*.,Olsson, Frank and Weeda, PC, Washington, DC and *Craig Johnson,* Academy Governmental Affairs Chair, Baltimore, MD.

American Board of Audiology
BOARD CERTIFIED IN AUDIOLOGY™

Catch The Wave

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MELANIE HERZFELD, BOARD CERTIFIED IN AUDIOLOGY

Never having been caught in a tidal wave, I can't say for sure that my participation with the American Board of Audiology (ABA) is the same...but it sure seems to be what I would imagine - a great wave carrying me along to some new and unexpected destination. The tidal wave that I imagine represents the rapid changes that continue to sweep the profession of audiology toward its future. The momentum is unbelievable.

The future of audiology demands that audiologists establish themselves as independent practitioners. As I recognized this fact, I decided that earning ABA certification was a concrete action I could take to demonstrate my independence. I believe audiologists deserve a program of professional certification that does not require membership in any organization, one that is not tied to any other profession, a program that requires more than just paying dues, and a program that changes along with our profession. And we all know how quickly change occurs in audiology.

Serving on the ABA Board of Governors has been an eye opening experience. Being involved as we develop changes necessary to make professional certification work, participating in exchanges of ideas, and discussing the importance of this work with other audiologists, has been a truly positive experience. For those of you who have not applied for certification, consider this an open invitation to do so. For those who have, congratulations and welcome! ABA needs all of you...or should I say all of us! We welcome your suggestions, comments and questions. Each member of the Board responds (some quickly, but all with enthusiasm!) to email queries and suggestions, so let us hear from you.

What changes are coming? Why do I think ours is a dynamic group? To begin, we are moving forward from basic certification to advanced certification programs. You will, if you have not already, hear more about specialty certification for audiologists providing cochlear implant services, specialty certification in amplification and rehabilitation, and a program important to me, advanced certification for those of us who continue to pursue a general practice. Cindy Simon and I will lead a working group that will develop education goals and experience criteria that will serve as the foundation for advanced certification in the general practice of audiology. We have come up with some interesting proposals and welcome ideas from any of our readers. Tell us what you think is necessary to demonstrate that your training and experience is superior, that your commitment to continued education is not just for show, but makes a difference!

Another idea under discussion is how best to incorporate mentoring into our professional certification programs. We hope to encourage audiologists who are Board Certified in Audiology to help new graduates as they enter our profession by serving as mentors. While we recognize that new Au.D. graduates are fully qualified to practice audiology, we also recognize that new audiologists and those they serve can benefit from the support and guidance that more experienced colleagues can offer. We believe that assisting our colleagues is part and parcel of what makes a certified professional.

We all have a responsibility to contribute to advancing our personal professional development and our profession. Let's show our willingness to be active, educated audiologists, independent practitioners with ethical practices, willing to help others, willing to move forward and willing to mentor!! The more involved we are, the greater the successes we will achieve!

PROGRAMME D'AUDIOLOGIE ET D'ORTHOPHONIE ÉCOLE DES SCIENCES DE LA RÉADAPTATION

L'Université d'Ottawa est l'institution bilingue la plus importante d'Amérique du Nord. En raison de sa grande renommée internationale, elle est devenue un incubateur de recherches dans tous les secteurs scientifiques de pointe. Située au coeur de la capitale nationale, l'Université vibre au rythme de la vie politique et technologique canadienne. Ce haut lieu du savoir est donc imprégné d'une précieuse ouverture sur le monde dont bénéficient la collectivité étudiante et son corps professoral.En matière de programmes scientifiques, l'Université offre entre autres celui d'audiologie et d'orthophonie, qui fait partie de l'École des sciences de la réadaptation. Le mandat de l'École est de former des professionnels de la réadaptation bilingues et capables de répondre aux besoins des populations francophones de l'Ontario. Le corps professoral offre une éducation professionnelle d'une grande qualité en plus de participer à l'avancement des sciences de la réadaptation par le biais de la recherche. Depuis janvier 2001, l'École occupe de nouveaux locaux,plus modernes et plus spacieux,idéals pour l'enseignement théorique et pratique.

Le Programme d'audiologie et d'orthophonie de l'École des sciences de la réadaptation de la Faculté des sciences de la santé de l'Université d'Ottawa désire combler un poste de professeur(e) en audiologie à temps complet menant à la permanence.

EXIGENCES

- Détenir un doctorat (PhD) en audiologie ou dans une discipline connexe, préférablement avec expérience de recherche au niveau postdoctoral.
- Avoir un dossier actif de recherche et de publications.
- Être capable de donner des cours en audiologie (2e cycle)
- Avoir une expertise dans le domaine de la neuro-audiologie ou un intérêt en réadaptation auditive seraient souhaitables. D'autres domaines seront aussi considérés.
- Posséder une connaissance approfondie du français permettant d'enseigner dans cette langue et une connaissance suffisante de l'anglais pour comprendre le contenu des communications orales et écrites qui sont nécessaires à l'emploi.

RESPONSABILITÉS

- Enseigner en français.
- Faire de la recherche.
- Participer aux activités universitaires.

ENTRÉE EN FONCTION

- Le 1er juillet 2003.

RANG et SALAIRE

- Le rang et le salaire seront déterminés selon les titres, les compétences et l'expérience, conformément à la convention collective.
- Le poste sera comblé sous réserve des disponibilités budgétaires.
- L'Université a une politique en matière d'emploi et encourage les hommes et les femmes à poser leur candidature.

Prière de faire parvenir votre dossier de candidature avec votre curriculum vitæ détaillé et le nom de trois répondant(e)s d'ici le 10 janvier 2003 à l'attention de:

Madame JoAnne Paradis, Directrice
Programme d'audiologie et d'orthophonie École des sciences de la réadaptation
Faculté des sciences de la santé
Université d'Ottawa
451,chemin Smyth,pièce 3071
Ottawa (Ontario) K1H 8M5

Tél. : (613) 562-5254
Téléc. : (613) 562-5428
joannep@uottawa.ca

CALIFORNIA

AUDIOLOGY FACULTY FOR AuD PROGRAM:

San Diego State University invites applications for a tenure-track position in Audiology in support of the Department's new AuD program (final approval of funding pending). A PhD in audiology/hearing science or closely related discipline, strong research abilities with a record of publications, and demonstrated excellence in teaching are required. Clinical experience and certification (CCC-A) are preferred. Primary responsibilities include teaching courses in the AuD program in area of expertise, supervising doctoral projects, pursuing own research agenda in area of interest, and service to the Department University. Preferred area of expertise includes aural rehabilitation and/or pediatric audiology. Salary and rank dependent on candidate's qualifications and budget considerations. Applicants must provide evidence of teaching ability and research experience. Send vita, 3 letters of recommendation, and letter of application that describes area of expertise, research experience/plan, and clinical experience to: Marilyn Newhoff, Chair, Department of Communicative Disorders, San Diego State University, San Diego, CA 92182-1518. Completed application files for this full-time tenure track position will be considered for review beginning November 30, 2002. The review process will continue until the position is filled. SDSU is a Title IX Equal Opportunity Employer and does not discriminate against persons on the basis of race, religion, national origin, sexual orientation, gender, marital status, age, disability, or veteran status, including veterans of the Vietnam era.

ANNOUNCEMENT OF VACANCY:

Assistant/Associate Professor, California State University, Sacramento. Tenure-track appointment in a CAA accredited program. PhD in audiology or related area. ABD considered (Doctorate must be completed within one year of appointment); CCC-A; eligible for CA licensure and CA hearing aid license. Evidence of successful teaching experience in a college or university. Teach undergraduate and graduate courses in hearing aids and in one or more of the following areas: neurophysiological audiology, psychoacoustics, industrial audiology, cochlear and retrocochlear hearing loss, central auditory disorders. Other responsibilities include development of a hearing aid dispensing program, assistance in the development of a clinical doctoral program, graduate clinical supervision, thesis supervision, advising, university and community service and scholarly activities. Begins Fall 2003. Salary commensurate with educational preparation and experience. Send letter of application, transcripts, resume and telephone numbers of at least three references to: James McCartney, Chair, Department of Speech Pathology and Audiology, California State University, Sacramento, 6000 J Street, Sacramento, CA 95819-6071; (916) 278-7341; Fax: (916) 278-7730; or jmccartney@csus.edu.Review of applications will begin December 2, 2002; open until filled. AA/EO

FLORIDA

ASSISTANT PROFESSOR VACANCY:

Nine-month tenure-track position available in audiology to start August 2003, preferably with interest in pediatrics, hearing science, and/or auditory processing disorders (although all areas will be considered). Earned doctorate, CCC-A, and eligibility for State licensure required. Responsibilities include research, undergraduate and graduate (Doctor of Audiology and PhD) teaching, and clinical supervision. Salary commensurate with experience. Interested applicants should submit an application letter outlining professional experiences and goals, curriculum vita, publication reprints, and three letters of recommendation to: Carl Crandell, PhD, Chair of Search Committee, Department of Communication Sciences and Disorders, University of Florida, P.O. Box 117420, Gainesville, FL 32611-7420. E-mail: crandell@csd.ufl.edu. Application deadline January 10, 2003. The University of Florida is an AA/EEO/ADA employer.

GEORGIA

AUDIOLOGIST POSITIONS:

Full time audiology positions both in metro Atlanta and surrounding rural area audiology centers. Strong hearing aid dispensing skills required. Great opportunity to work autonomously within a dynamic, growing, physician-owned audiology department. Very competitive salary and benefits package, including an AuD tuition reimbursement program. CFY's not eligible at this time. For further information, please contact and fax resume to: Martha Miller, Director of Audiology, The Hearing Health Care Centers, Inc. Phone (404) 256-7500; Fax (404) 252-2576; E-mail: mmiller@psc-ents.com.

MICHIGAN

AUDIOLOGIST:

Audiologist wanted for busy expanding private practice in southeast Michigan. Are you an energetic, self-motivated audiologist looking for an opportunity to grow? CCC's required. Vestibular experience helpful. Salary and bonus, benefits/full time (will consider part-time for right person). Send resume to: Metropolitan Speech and Hearing, 22777 Kelly Road, Eastpointe, MI 48021. All inquiries kept confidential.

NEW MEXICO

DISPENSING AUDIOLOGY PRACTICE FOR SALE IN SANTA FE, NEW MEXICO:

Well established. Great location. Good potential for growth. Don't miss this opportunity! Call (505) 988-9818.

VERMONT

AUDIOLOGIST:

Immediate opening for full-time or part-time certified Audiologist to compliment our multi-office ENT practice. Responsibilities include audiometry, ABR, vestibular evaluation with VNG, hearing aid fitting, dispensing, and management; patients of all ages. Competitive salary/benefit package including profit sharing/401-k plan. Must be confident, independent, and able to work closely with physicians and other professionals. Please forward your resume and letter of interest to Marlene W. Smith, Practice Administrator at Mid-Vermont ENT, P.C., 69 Allen Street, Suite 4, Rutland, VT 05701.

NEWS&announcements

First Deaf Miss America Tunes Up Cochlear Implant

Jennifer Yeagle, Audiologist, of the Listening Center at Johns Hopkins Hospital, works with Heather.

In the seven years since she was crowned Miss America, Heather Whitestone McCallum has journeyed around the world, authored three books and started a family. On August 7th, Heather was implanted with a cochlear implant at The Johns Hopkins Hospital. The device was turned on for the first time on September 19th by her audiologist, Jennifer Yeagle, with her family and children looking on. Twenty-four hours later, ABC's Good Morning America (GMA) televised a video recording of the event. Heather expressed overwhelming emotion leading to tears of happiness as she realized she was hearing sounds for the first time without her hearing aids. "Hearing my audiologist's clapping hands when the implant was turned on brought unimaginable joy to my heart," said Mrs. McCallum. The former Miss America described to GMA host, Charles Gibson, that within the first 24 hours she heard many sounds for the first time such as water running in the sink, (the sound of hair spray which she recognized as a no-no with her cochlear implant), and her children's and husband's voices. According to Jennifer Yeagle, "Heather is doing great with her new implant considering the early onset and the long duration of her deafness. Heather will likely continue to wear a hearing aid on her opposite ear, especially in difficult listening situations. She is highly-motivated to succeed with the implant and will receive therapy on a routine basis in her home city of Atlanta."

ANSI Standard on Classroom Acoustics

The long awaited American National Standard Institute publication of the classroom acoustics standard is now available. The Standard, known officially as ANSI S12.60.2002 American National Standard Acoustical Performance Criteria, Design Requirements and Guidelines for Schools, will guide educational audiologists as well as architects and consultants to create classrooms with good acoustical characteristics. The oversized study group represented a wide variety of professional membership organizations that worked together to develop a classroom acoustics standard that is keyed to the acoustical qualities needed to achieve a high degree of speech intelligibility in learning spaces. Although compliance to the standard is voluntary, improved acoustics will be of significant help to children who have mild-to-moderate hearing loss, learning or attention deficits, and those with limited skills in the English language. The Standard is available online for $35 at the ASA Standards Store at asa.aip.org.

California Signs Hearing Aid Dispensing Bill

In a move that came as a surprise to the California Academy of Audiology, AB 1914 was signed by Governor Davis last week. The governor's signature was not expected as the new bill will increase costs to Medi-Cal and was opposed by the California state legislative Finance Committee. AB 1914 allows for a Hearing Aid Assessment to be an annual benefit to Medi-Cal recipients, even though the law allows replacement of an aid only every three years, except when medically necessary. The new bill allows this procedure to be billed by any dispensing practitioner (audiologist, physician or Hearing Aid Dispenser). Recognizing that there is no standard as to what comprises a hearing aid assessment the procedure can be billed only under one code: V5010 ($40.54). Only audiologists and physicians can bill for all audiological services in addition to the V5010 code. An important aspect of this new California legislation is that the audiology scope of practice was preserved and the hearing aid dispenser practice limitations were not expanded.

Position Statement on *Pediatric Amplification Protocol* and Guideline on *Infection Control in Audiological Practice* Enter Review Stage

The Academy's newest Position Statement – **Pediatric Amplification Protocol,** and new Guideline on **Infection Control in Audiological Practice** – have been posted in the Academy Documents area of www.audiology.org and are ready for review and comment. Please take time to read both statements and email your comments to Catherine Palmer at palmercv@msx.upmc.edu or mail them to the national office: American Academy of Audiology, Attn: Sydney Davis, 11730 Plaza America Drive, #300, Reston, VA 20190.

If you would like to have these documents mailed to you, please call Sydney Davis at the national office at 1-800-222-2336, ext. 1033 or email her at sdavis@audiology.org. All comments and suggestions must be received by December 15, 2002.

NEWS & announcements

Cochlear Implants and Meningitis

The FDA has notified the Academy about a possible association between cochlear implants and bacterial meningitis. Cochlear implants are devices that are permanently positioned in the inner ear of deaf patients to help improve their hearing. The implants activate auditory nerve fibers, allowing sound signals to be transmitted to the brain. Several dozen cases of meningitis have occurred in patients with cochlear implants, and twelve known deaths have occurred. Most of the patients have been children under the age of five, but some adults have also been affected. The time between the implant and the illness has ranged from 24 hours to more than five years.

It is not certain whether the implants themselves are raising the risk of meningitis by serving as a focal point for infection, or whether some predisposing factor might be responsible. For example, some deaf patients may have congenital abnormalities of the inner ear which make them more susceptible to meningitis. In other cases, patients may have a history of otitis media prior to the surgery.

The FDA notification recommends that (1) physicians consider prophylactic antibiotic treatment prior to implanting these devices: (2) physicians promptly diagnose and treat otitis media in patients who already have the implants; and (3) suggests that patients who are going to receive cochlear implants, as well as those who already have them, might benefit from vaccinations against the organisms that commonly cause bacterial meningitis.

Audiologists are encouraged to report cases of meningitis in cochlear implant recipients. Please call 1-877-CDC-HEAR to report cases so that they can be included in the CDC-FDA study. Cases may be directly reported to the device manufacturer or to MedWatch, the FDA's voluntary reporting program. You may submit reports to MedWatch one of four ways: online at www.accessdata.fda.gov/scripts/medwatch; by telephone at 1-800-FDA-1088; by FAX at 1-800-FDA-0178; or by mail to MedWatch, Food and Drug Administration, HF-2, 5600 Fishers Lane, Rockville, MD 20857. Additional information may be obtained at www.fda.gov/cdrh/safety/cochlear.html or through The Academy's virtual seminar "Update of Meningitis & Cochlear Implants." Details at www.audiology.org.

New Auditory Processing Disorders Website

A new laboratory website for the study of auditory processing disorders has been established by James Jerger at the University of Texas at Dallas. The website is available at: www.utdallas.edu/~jjerger/ or www.texasapd.org.

MICHIGAN ACADEMY MEETING SIZZLES WITH SUCCESS!

More than 100 audiologists gathered in Grand Rapids, MI on September 20 and 21, 2002, for the Annual Meeting and Conference of the Michigan Academy of Audiology. Academy President Angela Loavenbruck provided the Keynote Address and held attendees spellbound with her lively discussion of current audiology issues. Cindy Ellison, President of the Academy of Dispensing Audiologists, stimulated interesting discussion with her presentation on reducing return-for-credit rates. Enthusiastic participants were treated to a live performance by the legendary Marion Downs and Jerry Northern when they entertained the audience with a brief history of their early days in Pediatric Audiology. In addition, Downs provided a summary of recent happenings in newborn hearing screening and Northern explored whether new clinical protocols and state-of-the-art technology are actually helping patients hear better. Academy Director of Health Care Policy, Jodi Chappell, delivered a thought-provoking address on the requirements of HIPPA regulations and Bob Nagel, owner of WhizBang Training, inspired those in attendance with innovative marketing strategies.

PASSAGES PASSAGES

Debbie Stewart has joined The College of St. Catherine, with campuses in the twin cities of St. Paul and Minneapolis and an enrollment of more than 4,600 students. Stewart has been appointed manager of the Medical Sales Program, within the Business Administration Department. Stewart was formerly national sales manager at Bernafon, Inc. in Minneapolis, MN.

The Department of Hearing and Speech Sciences at the Vanderbilt Bill Wilkerson Center for Otolaryngology and Communication Sciences announced the appointments of two new faculty members formerly associated with The Henry Ford Hospital in Detroit, MI. **Gary Jacobson**, currently editor of the American Journal of Audiology will assume the position of Director of Audiology Services and Professor of Audiology, and **Devin McCaslin** has been appointed Assistant Professor of Audiology. The new faculty members will begin their new positions in February 2003.

Gary Jacobson

After 27 years at Washington Hospital Center, **Carmen Brewer** has accepted a new position as Chief of Audiology at the National Institutes of Health. She may be contacted at the National Institute on Deafness and other Communication Disorders, Division of Intramural Research, Neuro-Otology Branch, Hearing Section, Building 10, Room 5C306, Bethesda, MD 20892. Brewer is a member of The Academy's Reimbursement Committee.

NEWS&announcements

Academy Membership Hits 8000!

When Cari Movchan of Fargo, North Dakota sent her application for membership to the American Academy of Audiology, little did she know that she would become a part of Academy history. On August 13, 2002, her application for membership as a Fellow was accepted and processed and she became the 8,000th member of The Academy! Movchan's membership in the Academy established an all time new high in total Academy membership which was begun in 1988.

Membership in The Academy has increased over the last two years by 10.7%, and has already grown in 2002 by 4.5%. The growing strength of membership makes our voice and actions on behalf of all audiologists more certain with each new member. The continued growth of Academy membership will ensure a strong future profession for all audiologists.

Canadian Academy of Audiology • Academie Canadienne d'Audiologie

CANADIAN ACADEMY OF AUDIOLOGY 5TH ANNUAL CONFERENCE

The Canadian Academy of Audiology (CAA) hosted their 5th Annual Conference October 24 - 26 at the Sheraton Parkway Hotel in Toronto, Ontario. As Canada's largest audiology conference, the CAA conference was attended by some 300 delegates from across North America. The agenda for the CAA conference showcased over 20 speakers covering a diverse range of issues facing audiology such as digital noise reduction in different environmental sounds, hearing loss in Alzheimer's and other related disorders and diseases, otoacoustic emissions and the musician, infant screening and Deaf Culture. Coupled with the conference was a trade show featuring the latest audiological technology. For information about next year's conference, contact: Tobi Liederman, CAA Conference Manager (416) 494-6672, or visit www.canadianaudiology.ca.

New CARTinfo.org Web Site Launches

The National Court Reporters Association (NCRA) has launched a new web site for Communication Access Realtime Translation (CART) services. The Communication Access Information Center site, www.CARTinfo.org, provides information regarding CART specifically for deaf and hard-of-hearing consumers of communication access services, as well as for officials who decide how access services will be provided. CART (Communication Access Realtime Translation) technology, also known as realtime captioning, can help persons who are deaf or hard-of-hearing to fully participate in such activities as conferences, religious services, educational classes and seminars or medical appointments. CART providers accompany people who are deaf or hard-of-hearing to meetings and many other events, and, using a stenotype machine and a laptop, instantly transcribe the spoken words into text that a person with hearing loss can read on a laptop computer or other screen. Additional information is available by calling 800-272-6272 (TTY 703-556-6289).

NEW ACADEMIC PROGRAMS AT JAMES MADISON UNIVERSITY

The Department of Communication Sciences and Disorders at James Madison University, in collaboration with the Division of Otolaryngology-Head & Neck Surgery in the School of Medicine at the University of Virginia, is now offering both a clinical and research doctorate in Audiology. For more information on the new doctoral programs go to http://www.csd.jmu.edu or contact Dan Halling at 540-568-3874 or hallindc@jmu.edu or Nicholas Bankson at 540-568-6440 or banksonw@jmu.edu.

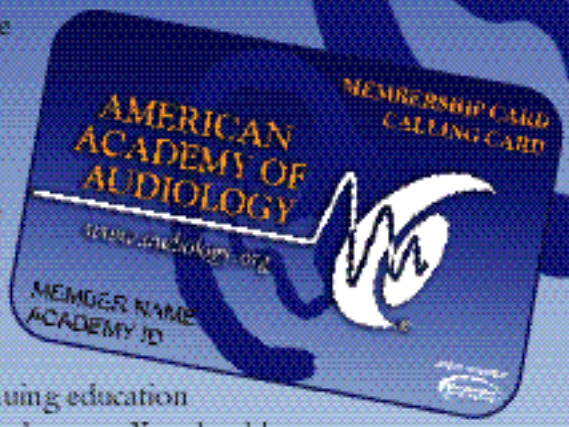
Illinois Academy of Audiology 2003 Convention

The Illinois Academy of Audiology will hold its 10th Annual Convention in Chicago on January 23-25, 2003. An outstanding scientific program is planned with speakers Robert Keith, Richard Gans, Angela Loavenbruck, Barbara Cone-Wesson, Harvey Abrams, Darrell Waggoner, John Leonetti, J. Raffin, Ted Venema, Mead Killion, Michael Gorga, Sergei Kochkin, and Charles Edmiston. For additional information visit www.ILAudiology.org or telephone 312-648-1140.

Vanderbilt Initiates AuD Program

The Department of Hearing and Speech Sciences announced the inauguration of the Doctor of Audiology Degree (AuD) program to be offered by The Vanderbilt University School of Medicine. Coursework will begin in the Fall of 2002. For more information contact Fred Bess at fred.h.bess@vanderbilt.edu or visit www.vanderbiltbillwilkersoncenter.com.

ARRIVING SOON! YOUR NEW AMERICAN ACADEMY OF AUDIOLOGY MEMBERSHIP CARD AND WORLDWIDE CALLING CARD



The American Academy of Audiology is pleased to announce that your new Academy Membership Card will be arriving in the mail very soon! This personalized card contains your name and Academy ID, so be sure to keep it in your wallet for easy reference when accessing Academy services. Use it to receive discounts on publications, registration for convention, continuing education registry, HearCareers, car rentals and more. You should also keep this card handy when accessing the member-protected area of our web site.

Your Academy Membership Card also allows you to take advantage of the most recent addition to our Member Benefit Program - the American Academy of Audiology Worldwide Calling Card! Every time you use your Academy Worldwide Calling Card, a contribution will be made to the American Academy of Audiology! Complete calling instructions are conveniently located on the back of your card so that you can make calls whenever and wherever you need.

The Academy has taken the time to research and find the best service with the most competitive U.S. and international rates for our members, and has decided to partner with GlobalPhone Corporation to provide a worldwide calling card program with low domestic and international telephone rates. Whether from home, work, or while traveling, your new member benefit will provide you with real savings on your long distance calling. For complete rate information, please visit our website at www.audiology.org/callingcard.

When compared to other calling cards, The American Academy of Audiology Worldwide Calling Card has many unique advantages:

- 7.9 cents per minute on all long distance calls within the continental U.S.
- Up to 75% savings on all international calls - 24 hours a day, 7 days a week
- NO requirement to change or cancel your current home or business service
- NO monthly service fees, NO surcharges, NO signup fees, and NO minimum usage charges - pay for actual usage and nothing more!
- NO connection fees (other calling cards charge $0.35 for "U.S. to U.S." calls, and as much as $6.00 for overseas calls)
- Six second increment billing (other calling cards may round up your calling time in full minute increments)
- Toll Free Access using phone or cellular service in over 80 countries worldwide
- Call Forwarding, Conference Calling, and Speed Dialing features
- Comprehensive, easy-to-read statements, sent to you via mail or email each month - it's your choice!

Start enjoying your new member benefit! During this Holiday Season, call your family and friends using the 30 FREE MINUTES of U.S. to U.S. long distance on your new Academy Membership Card and Calling Card.

Audiology Today

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