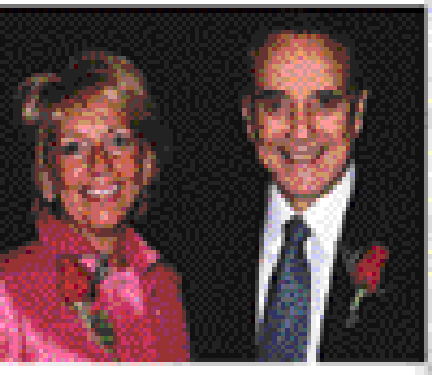
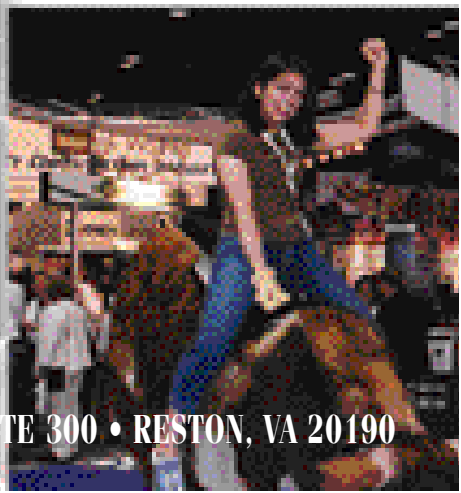
THE BULLETIN OF THE AMERICAN ACADEMY OF AUDIOLOGY

AUDIOLOGY TODAY

VOLUME 15 NUMBER 3 MAY/JUNE 2003

¡Hasta La Vista San Antonio!





Special Ethics Issue!

Caring for America's Hearing

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MAY/JUNE VOLUME 15, NUMBER 3

AUDIOLOGY TODAY

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Audiology Today accepts contributed manuscripts dealing with the wide variety of topics of interest to audiologists including clinical activities and hearing research, current events, news items, professional issues, individual-institution-organization announcements, entries for the calendar of events and materials from other areas within the scope of practice of audiology.

All copy received by *Audiology Today* must be accompanied by a 100M Zip disk or CD clearly identified by author name, topic title, operating system, and word processing program (in WordPerfect or Microsoft Word, saved as Text). Submitted material will not necessarily be returned. Specific questions regarding *Audiology Today* should be addressed to Editor, *Audiology Today*, 11730 Plaza America Drive, Suite 300, Reston, VA 20190 or by e-mail to jnorth1111@aol.com.

AUDIOLOGY TODAY

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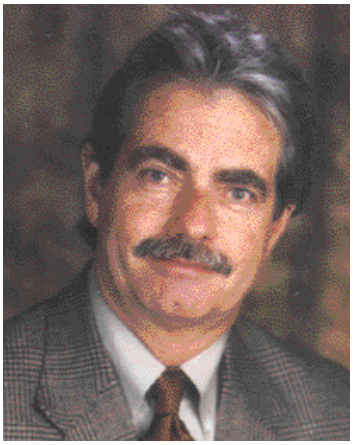
APPRECIATION IS EXTENDED TO STARKEY LABORATORIES FORTHEIR SPONSORSHIP OF COMPLIMENTARY SUBSCRIPTIONS TO *AUDIOLOGY TODAY* FOR FULL-TIME AUDIOLOGY GRADUATE STUDENTS.



To Market, To Market…

JERRY NORTHERN, EDITOR

In the midst of the festivities and excitement of the San Antonio convention, a few disparaging remarks were heard from audiologist attendees and from some of the manufacturers regarding the well-recognized "flat" hearing aid market of the past few years. The comments were accompanied by hand-wringing, the-sky-is-falling, doomsday outlooks, and woe-is-me facial expressions — and questions of what are we to do?

It is a worrisome time for the US economy, and the global situation contributes to the uncertainty of the future. People seem paralyzed about making important decisions or changes in daily behaviors, or what the future is to bring. But with so much going on around us, there is no better time to make sure our patients are able to *hear* all the news. It seems that the real task is no different today than it has been in past years - how to motivate that elusive group of 22 million hearing impaired persons to step up and take some action regarding their hearing.

Clearly, we just can sit back and wait for that to happen. Or we can take a look at our own marketing efforts to see what we can do to improve the situation. An interesting online survey was conducted by The Academy Marketing Committee during July of 2002 with some surprising results. One hundred thirteen audiologists, with an average of nearly nineteen years in the profession, responded to 24 questions concerning their marketing practices. The results showed that only about 65% of the group had any type of marketing program, i.e., an office logo, a brochure describing their practice, a fact sheet for referral sources and/or a computerized database of patients' information for mailings. Only 15% of respondents had a system in place to send follow-up letters, birthday or holiday cards, or a formal recall program to encourage periodic hearing check-ups. In terms of patient contact, only about 25% of the respondents had developed patient newsletters, educational seminars, or formalized referral-generating programs in place. The good news is that 78% had a listing or ad in the Yellow Pages – which apparently is the definition of "marketing" for many audiologists.

But help is on the way! The next Academy sponsored virtual seminar will help you establish a solid marketing program for your audiology services. Don't miss "Change Your Luck: A Fearless Approach to Getting and Keeping Patients Through Marketing and Customer Service" presented by Helena Solodar of Atlanta, GA and Gyl Kasewurm of St. Joseph, MI. Both presenters are long-time private practice audiologists with years of extensive marketing experience to share with virtual seminar participants. The seminar is scheduled for June 13, 2003 from 11:00am – 1:00 pm (EDT). Check out www.audiology.org/seminars to register or for more information. This interactive continuing education experience promises to be exceptional and to provide answers to all your marketing questions.

Jerry L. Northern, Editor

2003 Academy Election Results

ACADEMY PRESIDENT-ELECT

RICHARD GANS was elected to the office of President-Elect of The American Academy of Audiology effective July 1, 2003. Gans is Director of The American Institute of Balance in Seminole, FL. He has been serving on The Academy Board of Directors since 2001 and is currently the secretary-treasurer of the Board. Gans heads a multi-office group of offices in Florida specializing in vestibular and balance diagnostics and treatment. He is an adjunct faculty member of numerous AuD programs. Following his term as President-Elect, Gans will assume the office of President on July 1, 2004, for a one-year term.

ACADEMY BOARD OF DIRECTORS

The following three nominees were elected to The Academy Board of Directors for a three-year term beginning July 1, 2003 and running through July 1, 2006.

THEODORE J. GLATTKE is a Professor in the Department of Speech and Hearing Sciences at the University of Arizona in Tucson, AZ. Glattke is a noted authority in physiological measurement of hearing and hearing disorders. Ted has held numerous offices in many other national organizations and has been awarded the Honors of both the Arizona and the American Speech-Language-Hearing Associations. His stated area of interest is to increase The Academy's encouragement of research and improve links with academic institutions.

SHARON KUJAWA is an Associate Professor in the Department of Otology and Laryngology at the Harvard Medical School. She is also the Director of the Department of Audiology at the Massachusetts Eye and Ear Infirmary in Boston, MA. Her areas of interest include research into age-related and noise-induced hearing losses. She will work to encourage the entry of new researchers into audiology and involving clinicians in research efforts.

LISA HUNTER is a recent addition to the University of Utah in Salt Lake City, Utah where she is Associate Professor in the Department of Communication Sciences and Disorders. Hunter was previously at the University of Minnesota for 14 years in various audiology staff positions. Her areas of interest are otitis media and pediatric audiology. She hopes to help forge working relationships with other associations and advance the science basis of audiology.

HELENA SOLODAR was appointed to serve a one-year term on the Board of Directors of the American Academy of Audiology to fill the vacancy created by the election of Board member Richard Gans to the office of President-Elect. President and Co-Owner of the eight offices comprising Audiological Consultants in Atlanta, Georgia, Solodar has been in private practice for 27 years and brings to the Board a strong background in business, marketing, and reimbursement. She will begin her one-year term on The Academy Board of Directors beginning July 1, 2003.

ATTENTION ROTARIAN-AUDIOLOGISTS

Reed Norwood, an audiologist in Tennessee, has a new and interesting Rotary audiology project and needs help from other Rotarian-audiologists. This project has the promise of being beneficial both to the profession and to the Rotary Foundation. To date, about 15 Rotarian-audiologists have been identified and are helping with the project. However, Norwood would like to extend the opportunity to other Rotarian-audiologists. If you are a Rotarian and an audiologist, please contact Reed Norwood at amsi@citlink.net, or call (931) 526-8863 for additional information.

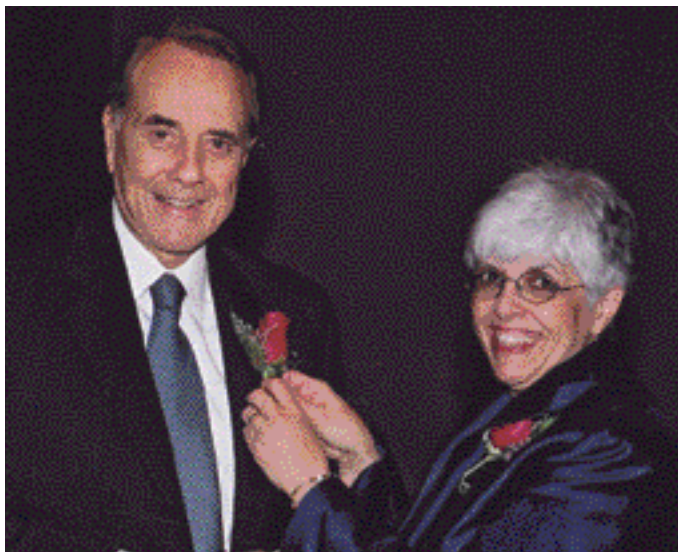
PRESIDENT'S MESSAGE

ANGELA LOAVENBRUCK, EDD, NEW CITY, NY

"THINGS THAT I CAN COUNT AND THINGS THAT COUNTED"

Presented at Convention 2003, San Antonio, TX

I have just completed what at times seemed like the shortest year of my life, and at other times like the longest year. Albert Einstein said that "not everything that can be counted counts, and not everything that counts can be counted." Since January of 2002 I have traveled to more than 18 gatherings of audiologists, generally to speak about the activities and recommendations of the Task Force on Ethics and to speak about historical and current aspects of licensure, standards, professional education and The Academy's legislative efforts on behalf of all audiologists. I have read, written and/or answered well over 3,000 e-mails, and written more than 40 "real" letters on stationery. I attended my 31st Academy Board of Directors' meeting since 1995.



CONVENTION KEYNOTE SPEAKER BOB DOLE GETS "PINNED" BY ACADEMY PRESIDENT ANGELA LOAVENBRUCK

Last fall, I participated in the third long-range strategic plan developed by your Board of Directors — a tribute to the enormous growth in Academy membership and in the complexity of issues that must find a place in our future planning. Our new Mission Statement sets the tone for the priorities and strategies identified by the current Board of Directors. I recently presided over an opening reception for the fifth national office our Academy has had since 1988 — again a tribute to our growth.

I helped to interview and hire Doris Gordon, our new director for the Accreditation Commission on Audiology Education (ACAE), and I presided over the formal incorporation of this new AuD graduate program accrediting body. The Commission is well on its way in the process for formal recognition as an audiology education accrediting organization by the U.S. Department of Education. The effort to form a new accrediting body is a cooperative effort of the American Academy of Audiology, the Academy of Dispensing Audiologists and the Organization of AuD Programs.

In December of 2002 I presented testimony before the US Department of Education protesting the continued recognition of the Counsel on Academic Programs because of its continued inappropriate requirement of a proprietary certificate as part of the accreditation of our academic programs. This requirement prevents academic institutions from using qualified licensed audiologists as student supervisors if they choose not to buy ASHA certification. We expressed our concerns because the Council on Academic Accreditation (ASHA's accrediting organization) continues to use master's degree criteria to accredit doctoral degree programs. To solve some of these problems, and to put accreditation of our academic programs in the hands of audiologists, we hope to create an innovative accreditation process — independent of any single professional association — which embodies high standards and yet is user friendly to the academic programs which voluntarily agree to be accredited.

In addition, we have continued to interact with CMS in our efforts to clarify and improve patient access to audiology services. The efforts of Jodi Chappell, Director of Health Care Policy, our lobbyists, the Reimbursement Committee chaired by Robert Glaser, and the new Governmental Relations Committee developed by Brad Stach, have vastly increased The Academy's visibility and ability to interact with Congress, CMS and other government and non-government organizations who have influence over audiology practices.

During the past year I made several visits to congressional offices to lobby for our Medicare direct patient access initiative. We want Medicare patients, like patients covered by other health insurance, to be given the option of seeing an audiologist without physician referral. It is always clear at these meetings that our legislative efforts, as well as our efforts to improve the policies and procedures in place at CMS, would have greater chances to succeed if our efforts were coordinated with those of other organizations. To that end, I met with Dr. Jonas Johnson, President of the American Academy of Otolaryngology, to suggest regular meetings between our two organizations.

We are convinced that audiologists and otolaryngologists have far more to gain in our efforts to identify, diagnose and treat individuals with hearing impairment if we work together rather than at odds with each other. I assured Dr. Johnson that audiologists do not want to practice medicine nor do we want to change or control physician licensure laws. I pointed out to him that we also hope that physicians would not want to practice audiology or change or control our licensure laws. While meetings are not yet scheduled, we hope to meet the challenge of working with the otolaryngologists during the coming year.

PRESIDENT-ELECT BRAD STACH PRESENTS A PLAQUE OF APPRECIATION ON BEHALF OF THE ACADEMY TO OUTGOING PRESIDENT ANGELA LOAVENBRUCK.

Last year, when I spoke at The Academy Convention held in Philadelphia, I said that our ability to meet our goals as a profession could not be reached if we continue to be a profession defined by a proprietary entry level clinical certificate. While we have continued to interact with ASHA in several cooperative efforts — the most important of which is participation in the American Medical Association CPT Coding process — we continue to be enveloped in legislative and bureaucratic strategies which are frequently in opposition to the ASHA agenda.

However, I have just received a new proposed rule from CMS — a rule which represents more than four years of concerted efforts by our governmental relations staff, our lobbying firm led by Marshall Matz, countless Academy Board of Directors members, and audiology members all over the country who contacted their senators and congressmen to urge CMS to make the Medicaid definition of a qualified audiologist consistent with the Medicare definition. The new Medicaid rule, like Medicare, makes *licensure* the key determinate of audiologic qualification — as is the case for every other primary healthcare provider. I must tell you that we have been opposed every step of the way in this effort by ASHA — and just before this Convention, audiologists received a mailing from the ASHA President outlining ASHA's continued opposition to this simple change in definition of an audiologist for Medicaid. The ASHA letter was full of references to speech-language pathology issues in school-based settings which have nothing whatsoever to do with the profession of audiology. The new CMS regulation would make it unnecessary for any audiologist who wants to provide services to both Medicare and Medicaid patients to hold any proprietary certificate. Mark Twain once advised that people should "Always do right — this will gratify some and astonish the rest." So my plea to ASHA is: Astonish me!! Do the right thing for audiology in the Medicaid definition and support this proposed rule change.

We are now going to need the help of every audiologist during the limited 60-day comment period which ends at 5:00 pm on June 2, 2003. (See Washington Watch in this issue of *AT*). It is of no surprise that after the proposed regulation was published in the Federal Register this month, ASHA claimed victory because their 1973 certification standards are mentioned as a minimum federal standard and suddenly ASHA stated that they would now not oppose the proposed change in regulation. However, we know that ASHA lobbyists continue to go state-by-state to try to convince Medicaid officials that their state licensure laws are not the equivalent of the 1973 standards, and therefore the state should continue to require the "current" Certificate of Clinical Competence for audiologists who wish to participate in Medicaid. We hope that ASHA would, once and for all, lobby on behalf of the audiology profession, and not on behalf of its own certificate.

We have proposed a meeting with the ASHA audiology leadership to discuss legislative strategy on other important audiological matters. The Academy strongly believes that direct access to audiology for Medicare patients must be our primary legislative effort. We are well aware that ASHA's legislative agenda is different — we don't always understand it — and we have several significant concerns about its direction. I continue to believe that our legislative efforts for the profession of audiology would be far more successful if only one national organization — the American Academy of Audiology — an organization with only audiology on

its agenda — spoke for the profession.

Finally, having told you some of the things I can count about this past year, I want to tell you about something that counts but cannot be counted. During Convention 2003, Cindy Ellison and Craig Johnson, President and President-Elect of the Academy of Dispensing Audiologists (ADA), Teri Hamill, Chair of The Academy Ethical Practice Board, and I presented our new "Ethical Practice Guidelines on Financial Incentives from Hearing Instrument Manufacturers." These guidelines are the result of months of cooperative work from an Academy Task Force on Ethics, an ADA Task Force, and our respective Boards of Directors. The most gratifying part of this year has been the interaction with literally hundreds of audiologists all over the country as well as the interaction with ADA in the development of these guidelines. Another Ethics Task Force, chaired by Yvonne Sininger, will soon complete and present "Guidelines for Ethical Practice in Research for Audiologists."

These ethics guidelines are, of course, not without controversy, but our respective committees, task forces, and Boards are unanimous in believing that the guidelines are essential to our identity and definition of ourselves as professionals with an overarching responsibility to our patients and the privilege of self-governance. The "Ethical Practice Guidelines on Financial Incentives from Hearing Instrument Manufacturers" is available for member comment in this issue of *Audiology Today* (see page 19). We have provided a draft of these guidelines to our friends and colleagues at the Hearing Instrument Association (HIA) and we are hoping to join with them in educational efforts about the guidelines. You should also review the newly developed "Guidelines for Hearing Aid Manufacturers for Substantiation of Performance Claims," printed in this issue of *Audiology Today* (see page 23).

While I am honored to have served as President of The Academy this year, I will be happy to turn the office and its duties over to Brad Stach, who will serve as President-Elect for a few more brief weeks. During the year that I served as President-Elect, my term of Presidency seemed to be far in the future. But as someone once said, "The trouble with the future is that it keeps moving closer." So Brad, the future is almost upon us and I'm glad to tell you to get ready: You're on!

BRAD STACH, PHD, ST. LOUIS, MO

THE PRIVILEGE OF AUTONOMY

Presented at Convention 2003 in San Antonio, TX.

The theme for the coming year during my Presidency of the American Academy of Audiology will be focused at one major goal: Everything we do will be aimed in one way or another at achieving the "privilege of autonomy" and living up to its obligations.

Autonomy is the emphasis here. I had the honor to be included as a member of the Founders' group that met in Houston 15 years ago. That group discussed exhaustively the need for a better educational model, for clearer representation in Washington, for increased integration of research into clinical practice. And they kept coming back to one very important concept: In order for the profession of audiology to progress, it must be free of other professions' models and free from the control of other professions'referrals - the profession needed to be autonomous. The Founders did not start out to create a new association – they all had plenty of other things to do. They started with the premise that what we needed was a better profession, an autonomous profession that directed its own future. The Founders created this Academy because they saw no other way to achieve this goal.

The price of autonomy carries with it serious responsibility. Audiology is a great profession, and we are striving to make it even greater. We do this in many ways, including the publication of excellent journals and website, the provision of continuing educational opportunities, the remodeling of our academic programs, and by supporting research and education at every turn. Our obligation is to be the best hearing healthcare providers. We must continue to take seriously this obligation as we strive to achieve the privilege of autonomy.

One way, among many, is through our new Foundation. Since last year's convention in Philadelphia we have successfully merged two non-profit entities, the former AAA Foundation and The Academy's old 501(c)(3) corporation to form the new Foundation for the Advancement of Audiology and Hearing Science (FAAHS). Members of the new Foundation's Board of Directors have been partially carried over from the original AAA Foundation and some new members were selected by The Academy Board of Directors. Barbara Packer agreed to serve as Chair of the newly organized Foundation. I expect The Foundation to become an important part of our Academy's efforts to support our academic missions in education and research; indeed, I expect the Foundation to become a powerful force nationally and internationally. We have the right leadership in place for the job. I hope you will watch for opportunities to participate in its activities and support the Foundation generously with your financial contributions.

Another means of strengthening our profession is through our Government Relations Committee. As Chairman of that committee, I am constantly reminded of how young we are as a profession, and even younger as an Academy. Fifteen years ago this week, The Academy's steering committee met in a Nashville airport hotel and agreed on bylaws; 15 years ago this month,

PRESIDENT-ELECT BRAD STACH

the Charter Advisory Committee met in Houston, adopted the bylaws, and elected officers. We had no members at that time, no database, no computers. To give you proper perspective of our status, we had only $640 in the bank!

Ten years ago we moved The Academy office to Washington DC. But at that time the move to Washington DC was only in the physical sense. Over the next five years, as we began to try to find our way around Capitol Hill, we discovered, that no one had ever heard of audiology — except as a very quiet and small suffix to the phrase "Speech-Language Pathology…."

Five years ago we extracted ourselves from our management firm and built what is today an excellent staff and our own headquarters. More importantly, we began to enjoy some public policy success. So, what have I learned from chairing the Government Relations Committee? First, when you are known as being representative of your profession, members of Congress begin to ask your opinion. And second, because of this, it is important to have an opinion and a plan of action ready to go!

To give you a single example of the challenge, not a month goes by that someone doesn't ask The Academy to support legislation on reimbursement for

hearing aids. Most audiologists I know are of two minds about this: on one hand, we want to help our patients, and we believe that hearing healthcare is important and should be a covered health benefit. On the other hand, any program for reimbursement that remotely resembles the Medicaid program would probably cause the industry to collapse. And so it is important to not just react in a knee-jerk fashion. We need to get out in front of the issues and have a long-term strategy for what we want our plan to look like at the end of the day. Then, when the hearing-aid-reimbursement question is asked, (or any other question for that matter), we can say we support legislation that helps our patients, and here is an action plan of what it should look like. We must be able to supply a plan, predict the end result, and show how it helps everyone — especially our patients. And it is that way for any number of issues. We are often asked simple questions – but the answers are commonly very complex. Our efforts with the Government Relations Committee are designed with both a short and long-term component. In the short term, we are building systems for rapid reaction to state and national legislative issues. Equally important, we are creating blueprints for what we want as the outcome in the long term.

The American Academy of Audiology Public Policy action plan has now been divided into five components.

(1) *Federal Health Policy*, under the leadership of Dick Danielson, will monitor, plan, and react to issues pertaining to OSHA, the FDA, and managed care reform.

(2) *Federal Funding*, under the leadership of Therese Walden, will look for ways that our Academy can support our friends at the NIH and the Department of Education and will find ways to support the IDEA, EHDI, and other such initiatives.

(3) *State Licensure*, under the leadership of Barry Freeman, will monitor, plan for, and support the Academy's state leaders network to ensure protection of our scope of practice.

(4) *Reimbursement*, under the leadership of Paul Pessis, will pull together the Academy's many efforts to create models for how we should submit a bill and be reimbursed, how we can support evidence-based research, and how we can help to design hearing aid reimbursement benefits.

(5) *Autonomy*. This policy area, under the leadership of Steven Smith, is going to take us to the promised land.

If you had asked me fifteen years ago, will we be free in 2003, I would have said, "of course." That we are not free is no longer tolerable. So why does audiology need to be an autonomous profession?

- So that when the profession of audiology wants to do something, we do not have to ask the permission of another profession;
- So that when the profession decides it wants a new educational model and effectuates the change necessary to create it, we do not have to wait 20 years to change the professional educational accreditation standards;
- So that when the profession decides that state licensure rather than certification should be used in the Medicaid law, we do not have to ask permission from another profession whose interests are in conflict;
- So that when qualified licensed audiologists want to commit their time to the clinical education of graduate students, those audiologists do not need to purchase certificates from anyone in order for the students to get the required credit.

And why do YOU need autonomy as a professional?

- So that a patient enrolled in this country's Medicare program can enjoy the same access to you as the legislators and administrators who make the Medicare laws and regulations;
- So that no one—NO ONE—needs the permission of another healthcare provider to see you before you are eligible to be paid.

As a profession we CAN live up to the obligations of autonomy. As an Academy, we WILL achieve that privilege.

Executive UPdate

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

The Academy Convention & Expo 2003

San Antonio was an incredible experience for all of us! Despite the current world situation, 5,773 enthusiastic attendees decided that The American Academy of Audiology's Convention & Expo 2003 made traveling worthwhile. San Antonio was a fabulous venue for our annual Convention. The Riverwalk and its close proximity to the Convention Center made for a wonderful experience.

We heard comments from several who attended the Convention in the past but had not had the opportunity to attend recently. They were impressed with the changes they were experiencing. These changes included quality educational sessions, a well-organized exposition hall, smooth registration process, excellent networking opportunities, and an overall atmosphere which fostered education and networking.

If you weren't able to attend this year, or you would like to review the General Assembly, go to www.audiology.org/convention/2003 to view the video which includes the "State of the Association" report from President Angela Loavenbruck, as well as a lively and entertaining talk by former Senator Bob Dole. You can also order educational session audio cassettes and CD-ROMS from our website at www.audiology.org/seminars. The CD-ROMs include a program that will allow you to receive continuing education units.

So if you haven't been to The Academy's Convention in several years, ask your colleagues who attended if they would recommend it. You will hear many positive comments. And if you did attend, be sure to tell your colleagues to come see The Academy convention in 2004 to experience something new and exciting. Thank you for contributing to the success of Convention & Expo 2003. We look forward to the possibility of seeing each of you in Salt Lake City in 2004 where "Audiology Rocks."

Virtual Seminars

The Academy has added a new venue for obtaining continuing education units known as the Virtual Seminar. The Academy has recently offered two highly successful Virtual Seminars, "Update on Meningitis and Cochlear Implants" and "HIPAA: How to Approach for Your Audiology Practice." The Virtual Seminar format allows you to participate in a 1 1/2 - 2 hour session, with your office mates or a group of your colleagues, in your own facility. The next exciting Virtual Seminar, "Change Your Luck: A Fearless Approach to Getting and Keeping Patients Through Marketing and Customer Service" will take place on June 13, 2003 from 11:00 am to 1:00 pm (EDT). The presenters will be two well-known marketers and members of The Academy, Helena Solodar and Gyl Kasewurm. The site registration fee for a virtual seminar is $175. Ask your colleagues to join you as the registration fee is for the phone and internet connection regardless of how many participants attend a single location. Don't miss this great educational seminar! If you have not yet participated in this exciting format, keep an eye out for a seminar of interest to you in the near future and give it a try.

CONGRATULATIONS TO THE NATIONAL OFFICE STAFF FOR ANOTHER OUTSTANDING CONVENTION!

Board of Directors Action Items Report

In an effort to provide greater communication between the Board of Directors and the membership of The Academy, a list of action items will appear periodically in Audiology Today. *The following items were approved at the April, 2003 Board of Directors' meeting in San Antonio:*

- *To approve Robert Berry and James Jerger for life membership.*
- *To accept the following recommendations from the Task Force to Review the Structure of the Convention Program Chair:*
  - *Program Chair: Preference be given to any candidate who will be an active Board member during the twelve months leading up to the convention.*
  - *Program Committee: Each sub-committee chair should make every effort to include one International Member.*
  - *Publicity: The Publicity sub-committee should be eliminated as the Editor of* Audiology Today *handles this function.*
  - *Student Research Forum Sub-Committee: The Chair of the Research Committee, or a representative from that committee, should serve as the chair of the Student Research Forum Sub-Committee, effective 2005.*
  - *Sub-committees should be added for Exhibitor Courses and Round Tables.*
- *To remove the requirement for candidates for the New Investigator Research Award to work under the supervision of a mentor. Student Research Awards applicants would continue to require a mentor.*
- *To remove the restriction for New Investigator Research Award applicants that prohibits salary support for principal investigators.*

Hear Ye...Hear Ye

LETTERS TO THE EDITOR

JAAA: Temporarily On-Line

I would like to notify all *Journal of the American Academy of Audiology (JAAA)* subscribers and readers that we are in the process of changing publishers. There will be an unavoidable delay in the distribution of print copies of *The Journal* for a few months. However, every issue will be available online (www.audiology.org) as soon as it has been set in type. You will find the January, 2003 issue online at http://www.audiology.org/professional/jaaa/14-1/index.php. The February, 2003 issue will be posted as soon as possible. We regret any inconvenience this changeover may cause to our members and readers. *JAAA* will resume our normal printed distribution schedule very shortly.

—James Jerger, Editor-in-Chief, JAAA

Medicare and Cerumen

There is a rule that the article, "Medicare: Trying to Play by the Rules," *(AT*, 15:2, 2003) omitted regarding audiologists charging the patient for cerumen removal. As author Pessis stated, the patient's signature on the Advanced Beneficiary Notice (ABN) is the appropriate mechanism for informing the patient of an obligation to pay for a service that Medicare may not cover. However, The Centers for Medicare and Medicaid Services has maintained "removal of cerumen is considered to be part of the diagnostic testing and is not paid separately." This rule was restated in the Federal Register (December 31, 2002, p.80012) when a new code, G0268, was introduced to the Medicare Physician Fee Schedule. Thus, the only circumstance under which an audiologist can charge a Medicare patient directly for cerumen removal (CPT 69210) would be when no diagnostic testing occurred on that day.

—Mark Kander, ASHA, Rockville, MD

The AuD and Dispensing

As long as hearing aid dispensers without an audiology degree are allowed to dispense hearing aids, the profession of audiology will never fully be viewed by the public as anything more than a hearing aid business. Our profession is already seen by many as being nothing more than the sale of hearing aids, comparable to that of a car salesman.

According to a survey in the March 2003 issue of *The Hearing Journal*, hearing aid specialists sell the highest number of hearing aids per month and at a lower average price than audiologists. The logical conclusion is that hearing aid dispensers sell more hearing aids because they are selling them at a lower price. At that time, audiologists will finally be viewed as the only profession with the required education to dispense amplification.

I am aware that many will not share my vision. They may believe that a better solution is to educate the public about audiology so that consumers can make informed decisions about who they contact for services or perhaps eliminate all price advertising for hearing aids. I also realize that there are ethical and knowledgeable hearing aid dispensers practicing as I write this, some of whom may even know more about dispensing hearing aids than some audiologists. But I believe that until the AuD becomes the required entry level for audiologists, we will never be recognized as the only experts to manage hearing loss and amplification.

—Terri Gilmore, Franklin, PA

EPA Holds Workshop On Noise Reduction Ratings

The Noise Reduction Ratings (NRRs) that are emblazoned on all hearing protection devices that we buy and recommend are governed by a 1979 Hearing Protector Labeling Regulation promulgated under the auspices of the Environmental Protection Agency (EPA). That elderly rule has many shortcomings, not the least of which is the fact that labeled NRRs bear little resemblance to what groups of users can expect to obtain in actual hearing conservation programs. Unfortunately the EPA's Noise Office has been essentially out of business since shortly after the regulation was promulgated and thus has been unable to consider revising and updating that regulation. Much has been learned in the intervening 23 years.

That situation is about to be rectified. In a surprising move, EPA held a workshop on March 27-28 in Washington, DC to present and review data leading to a new proposed rule on hearing protector labeling. For more information visit www.epa.gov. This provides a positive opportunity for the professional community to move forward to obtain more useful and representative ratings on Hearing Protection Devices.

—Elliott H. Berger, Indianapolis, IN, (From the Internet - NHCA Listserve)

NHCA Hosts 2004 Conference in Seattle, WA

The National Hearing Conservation Association (NHCA) will host its 29th Annual Conference, February 19-21, 2004 at the Hilton Seattle Airport in Seattle, WA. For more information, contact the NHCA office by telephone at (303) 224-9022 or by e-mail at nhca@gwami.com or visit the NHCA website at www.hearingconservation.org.

SENATOR BOB DOLE ENCOURAGES ACADEMY MEMBERS TO COMMENT ON MEDICAID REGULATION

Released last week and announced at The Academy's Annual Meeting in San Antonio, the Centers for Medicare & Medicaid Services (CMS) proposed a new Medicaid regulation that is important to all audiologists. During his address to the General Assembly at the Convention, Senator Dole urged the membership to participate in the rule making policy by sending written comments in favor of the new regulation to CMS. The regulation would create a new definition of a qualified audiologist in the Medicaid program that would be consistent with current Medicare law. The Academy Board of Directors strongly supports this proposed regulation because it would define an audiologist by state licensure rather than by a private certification. The regulation is posted on The Academy's Government Relations Web Page.

WHY IS THIS SO IMPORTANT?

Private insurance carriers must not be confused as to who is a qualified audiologist. Insurance carriers look to federal regulations to determine the appropriate definition of an audiologist. Therefore, it is important for CMS to use a consistent definition. Private carriers should use state licensure as the criteria for provider status, just as they do for other healthcare professionals. The proposed rule recognizes that state licensure is the most widespread system for qualification of health care professionals and best serves the goal of consumer protection. This regulation would expand the number of audiologists eligible to be reimbursed for services.

WHAT CAN YOU DO?

As an audiologist concerned about the future of the profession, The Academy urges you to write a letter to CMS by June 2, 2003 supporting this regulation change. Please go to The Academy's Government Relations Web Page <http://www.audiology.org/professional/gov/> for a sample letter that you can send on your letterhead. Please be advised that you must mail one original and two copies to the address on the letter. Please also fax a copy of your letters to The Academy National Office at 703-790-8631.

AUDIOLOGISTS, CHILDREN & HEARING AID USE

Kris English, University of Pittsburgh and **John Greer Clark,** HearCare, Cincinnati

Many pediatric and educational audiologists report that, unintentionally, they've become members of the Hearing Aid Police. We all know the drill: inspect a child's ears to verify that amplification is present; reprimand when it is not; and encourage compliance with rewards of stickers or tokens. When the Hearing Aid Police arrive unannounced, children who should be — but are not — wearing their hearing aids instinctively clamp their hands over their ears, worried that, "Uh-oh, she's going to be mad at me again!"

In this dynamic, hearing aids become a point of contention, pitting adult authority versus child compliance. These children have yet to discover for themselves that using amplification is in their best interests. As long as they are engaged in "hearing aid battles," they are not likely to make this discovery.

To reduce these battles and promote self-discovery, we can broaden our focus of attention from children's ears to their overall development. All children need to arrive at their own realization and decision that the use of amplification is "worth it," that they are better off with amplification than without it, and that amplification use is an acceptable means to an end. These insights will only occur if the "ends" are personally important to the child. We can preach the message that "hearing matters," but it will not "become real" until children discover this for themselves.

Although consistent hearing aid use is *our* goal, what are the *child's* goals? Ask 100 children, and you will get 100 different answers. Perhaps the child's goal is to join a Scout troop, or learn how to play soccer, or volunteer at the local pet shelter. It could be having a best friend, or reading the same book everyone else is reading, or understanding the rules of a game. We are fully aware that, unless they are members of the Deaf Community, children are more likely to reach these goals when they optimize their hearing. How can we turn what we know into a process of self-discovery?

An activity that focuses both audiologist and child on the child's goals can help. One such activity is called "Dreams and Maps," which provides an opportunity to express one's goals and to experiment with strategies that might help achieve those goals. Using a blank piece of paper, the audiologist asks the child to describe either a short- or long-term goal, and then write that goal at the bottom of the paper, leaving room to create steps to reach that goal. Now, how to accomplish that goal? Each goal and each child will involve unique steps and will each need to be considered and discussed one at a time:

AUDIOLOGIST: OK, Keith, you've said that you would really like to be able to play that video game you have at home, but you can't figure out the rules. That's your "dream" or goal right now. (Writes "learn video game" at bottom.) Any ideas about how to do this?

KEITH: No! I just start and then don't know what to do.

A: I wonder how other kids figure it out.

K: They're just smarter.

A: Well…there could be other reasons. Maybe they read the manual first, or watched and learned from other kids.

K: (shrugs) I tried the manual but couldn't get it.

A: So your first step could be, "figure out manual"?

K: (shakes head). No, I'd rather learn from another kid.

A: Got it (writes down that step at the top of the page). If we were making a map, this would be your first step. Any kid in particular?

K: (pauses, considers options). There's Ramon, I know he plays it at home, I've seen it in his book bag. And he would explain so I could understand.

A:(writes down Step #2: "ask Ramon for help"). So, while he is explaining – what will help there?

K:I know, you are thinking about my hearing aids, because I'll need to hear him. I'm OK with that, Ramon isn't mean about stuff like that.

A: (writes "Hearing aids to hear Ramon"). You've got three steps, looks like you are on your way to learning that game.

Because this goal is personally important to Keith, and because he created a personalized "map" on how to achieve this goal, he will be far more inclined to commit himself to its success. Amplification became a means to an end, not a battleground over compliance. The focus shifted from ears to "life," but the outcome was the same.

A "SAFE ENVIRONMENT"

A basic premise in personal adjustment counseling is that given a safe environment, individuals typically will choose growth – that is, they will make decisions that are in their best interests. Here, the audiologist provided that safe environment by using a neutral framework for conversation and an attentive "third ear" to learn what was important to Keith, waiting while he thought things through, and offering help as a facilitator. Given this safe environment, Keith chose growth.

TAKE HOME MESSAGE

Children with hearing loss need all the support they can get while navigating life's challenges. They also need as much practice as possible with self-expression, self-awareness, and decision-making. Audiologists can support these developmental processes by attending to how the child is living with hearing loss and promoting amplification use as a means to an end to meet personally valuable goals.

Ethical Practice Guidelines on Financial Incentives from Hearing Instrument Manufacturers

Developed by the American Academy of Audiology and the Academy of Dispensing Audiologists

FOR MEMBER REVIEW & COMMENT

American Academy of Audiology Fellows are invited to submit comments and opinions on the following guidelines. Members should submit comments to The Academy Board of Directors and The Ethical Practices Committee at ethicalpracticecomments@audiology.org prior to July 1. 2003.

The guidelines that follow are the culmination of a two-year effort that has involved two separate Task Forces of the American Academy of Audiology (AAA) and active collaboration with the Academy of Dispensing Audiologists (ADA). The Boards of Directors of both associations approved the guidelines. During his presidency, David Fabry put together the Ethics in Audiology Presidential Task Force. The Task Force members were Lucille Beck, David Hawkins, Fred Bess, Patti McCarthy, Gail Gudmundsen, Dennis Van Vliet and was chaired by Brian Walden. David Fabry, Laura Fleming Doyle and I served as ex officio members. As the result of recommendations made by this Task Force, the Academy Board appointed Teri Hamill as chair of the Ethical Practice Board, and charged her with appointing a Task Force to develop guidelines on Manufacturer/Audiologist Relationships. The Task Force members were Debra Abel, Fred Fritz, Patricia Gans, Stephen Gonzenbach, David Hawkins, Cathy Henderson Jones, Marilyn Larkin, Louis Siemenski, Thomas Tedeschi with Dr. Hamill serving as Chair. David Fabry, Brad Stach and I served as ex officio, and Cindy Ellison and Craig Johnson represented the Academy of Dispensing Audiologists.

For both the ADA and AAA, the work of Task Force members did not entail changes in the existing Codes of Ethics of each association, but rather a renewed commitment to ensuring that members have a clear understanding of the importance of avoiding conflicts of interest in our profession. Three questions were of critical importance in the deliberations of the Task Forces: 1) what does it mean to be a professional; 2) what is a conflict of interest, and 3) why is it particularly important for our associations to examine these issues at this particular time in our profession's history?

What sets professions apart from other occupations? Among the most salient identifiers of a "profession" is that its practitioners are assumed to put their patient's interests ahead of their own financial interests. Because of this assumption, society permits professionals a high degree of self-government and autonomy and codes of ethics are a primary means of self-government. Patients who seek the advice and services of audiologists must have the assurance that recommendations made for services or products are made solely on behalf of the patients' best interests. If the behavior of audiologists routinely deviates, or appears to deviate, from the rules of practice defined by our Code of Ethics, our profession would be misrepresented.

Professions of all kinds have long described conflicts of interest as an inability to make a professional judgement as someone might who was completely uninvolved. Conflicts of interest are sometimes referred to as "perverse incentives"— incentives that cause, or can appear to cause, a loss of independent judgement, a loss of impartiality or a loss of objectivity. Attorney Kevin McMunigal[1] has suggested that professions can avoid confusion about conflicts of interest by distinguishing between "harm rules" and "risk rules" and uses a basketball example to illustrate the difference. The National Basketball Association does not want its players to be involved in brawls. One way to stop this behavior would be to suspend or fine any player involved in fighting – a harm rule. Another way would be to suspend or fine any player leaving the bench when a fight occurs because this is behavior that increases the chances of a larger brawl – a risk rule. McMunigal states that "a harm rule is about sin; a risk rule is about temptation." Similarly, our efforts were centered on guidelines to reduce the "risk" of conflicts of interest in the complex relationships between audiologists and hearing aid manufacturers. At a time in our professional history where we are actively pursuing important initiatives toward direct access to our services in both government and privately funded health insurance programs, it is particularly critical that we avoid any possibility of misrepresentation.

[1] McMunigal, Kevin. "Distinguishing Risk from Harm in Conflict of Interest," *Perspectives on the Professions*, Center for the Study of Ethics in the Professions (CSEP), Illinois Institute of Technology, Vol. 17, No. 1, Fall (1997).

GENERAL GUIDELINES

The following general guidelines have been accepted by the Board of Directors of the American Academy of Audiology (AAA) and the Academy of Dispensing Audiologists (ADA):

1. When potential for conflict of interest exists, the interests of the patient must come before those of the audiologist.

Any gifts accepted by the audiologist should primarily benefit the patient and should not be of substantial value. Gifts of minimal value ($100 or less) related to the audiologist's work (pens, earlights, notepads, etc.) are acceptable. Incentives or rewards based upon product purchases must not be accepted. This would include cash, gifts, incentive trips, merchandise, equipment, or credit towards such items. No "strings" should be attached to any accepted gift.

Audiologists should not participate in any industry-sponsored social function that may appear to bias professional judgment or practice. This would include accepting invitations to private convention parties, golf outings or accepting such items as theater tickets. Meals and social functions that are part of a legitimate educational program are acceptable. When social events occur in conjunction with educational meetings, the educational component must be the primary objective with the meal/social function ancillary to it.

FOR MEMBER REVIEW & COMMENT

2. Commercial interest in any product or service recommended must be disclosed to the patient.

This would include owning stock or serving as a paid consultant and then dispensing that product to a patient.

3. Travel expenses, registration fees, or compensation for time to attend meetings, conferences or seminars should not be accepted directly or indirectly from a manufacturer.

Trips sponsored by a manufacturer that are solely educational may be accepted, provided the cost of the trip is modest and acceptance of the trip does not reward the audiologist for past sales or commit the audiologist to future purchases.

Faculty at meetings and consultants who provide service may receive reasonable compensation honoraria, and reimbursement of travel, lodging and meal expenses.

4. Free equipment or discounts for equipment, institutional support, or any form of remuneration from a vendor for research purposes should be fully disclosed and the results of research must be accurately reported.

All materials, presentations, or articles produced as a result of the investigation should also carry a disclosure of the funding source. Investigators should structure research agreements with industry to insure that the results are represented accurately, and presentation of findings is objective.

FREQUENTLY ASKED QUESTIONS

Q. Why are AAA and ADA reviewing gift giving from manufacturers?

A. Gift giving from the hearing health care industry to audiologists has been a customary practice. Gifts serve two functions. First, they remind audiologists of the name of the product made by that company. Second, they help a company establish a relationship with the audiologist. However, if the decisions made by the professional are, or appear to be, influenced by an incentive or reward, or can be viewed as not being made objectively, then a conflict of interest may be present. The professional's belief that he or she is not personally influenced is not sufficient to avoid the appearance of a conflict of interest.

Our organizations encourage manufacturer/audiologist interactions that serve to improve patient care. However, it is important that gifts do not have the potential to impact professional judgment.

Q. Why would audiologists want to adhere to these guidelines?

A. Audiologists must be committed to the principles of honesty, integrity, and fairness.

The principle of putting patients' interests first is the basis of all healthcare professions. Adhering to these guidelines reflects positively on our profession. All healthcare profession licensure acts set limits on professional behavior. In return for a license, professionals are obliged to adhere to certain standards of conduct and have the obligation to self-regulate. Additionally, adhering to a uniform code of ethical conduct may prevent the audiologist from unintentionally violating federal and state regulations.

Q. If an audiologist accepts gifts, what are the potential legal consequences?

A. Acceptance of gifts may not only be construed as constituting a conflict of interest; it may also be illegal. Federal laws make it a criminal act for an audiologist who provides services to Medicare, TRICARE, Medicaid and VA patients to solicit or receive "any remuneration (including any…rebate) directly or indirectly, overtly or covertly, in case or in kind…in return for purchasing…or ordering any goods or services…" Medicare already indirectly covers hearing aids through some private Medicare HMO plans. The Office of the Inspector General has recently issued guidelines for gift-giving activities for the pharmaceutical industry and physicians that appear directly analogous to the issues covered for audiologists in this guideline.

Q. Are incentive trips, vacation packages, gift certificates, cruises, and credits toward equipment purchases or cash received from manufacturers allowed?

A. No. The acceptance of such gifts, whether related to previous purchases or future purchases, raises the question of whether the audiologist is, in fact, holding the patient's interests paramount. There can be no link between dispensing or referral patterns and gifts.

Q. What is the difference between acceptance of trips, lease arrangements, gifts, or receiving a larger discount level?

A. Establishing any type of savings plan with a specific manufacturer creates the appearance of a conflict of interest. Discount programs, however, are generally protected by the law if they have the potential for benefiting consumers. Discount programs are considered to present ethical issues only if they involve commitments by the audiologist that compromise professional judgment.

Q. Can an audiologist accept a trip to a manufacturing facility for the purpose of training?

A. Obviously, there are times when it is more economical and/or a better educational experience can be provided when audiologists are trained together regionally or at the manufacturer's facility. While it is preferable that audiologists pay their own travel expenses, there are circumstances where it is appropriate to accept tickets and/or hotel accommodations:

- The travel expenses should only be those strictly necessary.

FOR MEMBER REVIEW & COMMENT

Cindy Ellison, Angela Loavenbruck, Teri Hamill and Craig Johnson present at the Ethics Session, Convention 2003 in San Antonio, TX.

- The conference or training must be the reason for the trip.
- Participation must not be tied to any commitment to manufacturers.
- The expense for a spouse or other travel companion may not be compensated by the manufacturer.

Q. Can an audiologist accept a lunch/dinner invitation from manufacturer's representative in order to learn about a new product?

A. Yes, modest business related meals are acceptable.

Q. What are the ethical considerations regarding attendance at sponsored social events at conventions or training seminars?

A. The following criteria should be considered before attending such events:

- The sponsorship of the event should be disclosed to, and open to, all registrants.
- The event should facilitate discussion among attendees.
- The educational component of the conference should account for a substantial amount of the total time spent at the convention.

Q. May an audiologist or a corporation obtain a loan from a manufacturer in order to purchase equipment and then repay a portion of the loan with every hearing aid purchased?

A. Audiologists are encouraged to obtain financing through recognized lending institutions or the equipment manufacturer to avoid potential conflict of interest. Repayment should include only repayment of the debt plus appropriate interest fees but with no additional considerations or obligations on the part of either party.

Q. May an audiologist "co-op" advertising costs with a manufacturer?

A. If the manufacturer wishes to share the cost of an advertisement that features both the manufacturer's name and the audiologist's name, this is acceptable as long as there are no strings attached.

Q. Is it acceptable for a manufacturer's representative to assist in seeing patients at an 'open house' at the audiologists' clinical facility?

A. Open houses are usually product or manufacturer specific with a manufacturer's representative in attendance. The consumer should be very much aware that the presentation would be focused on the purchase of hearing instruments from the featured manufacturer. However, the audiologist still has the responsibility to utilize the most appropriate instruments.

The audiologist should consider the legal and ethical ramifications involved if a non-audiologist participates in the open house.

Q. Is there a potential conflict of interest if an audiologist joins a network or buying group?

A. Businesses and organizations are free to negotiate prices on products either directly with the manufacturer or by using the purchasing power of a buying group.

Q. If an audiologist is hired by a corporation that provides hearing aids or other related devices and is offered stock options, is there a cause for concern regarding conflict of interest?

A. If the stock is in the corporation the audiologist works for, there is no conflict of interest.

Q. Are there conflicts of interest implications for researchers?

A. One of the researcher's responsibilities is to fully disclose the funding of the research, whether it is in the form of direct grants, equipment grants or other forms of compensation such as a consultantship with a sponsor. This allows the consumer of the research to evaluate the potential for conflicts of interest. Additionally, researchers are ethically responsible for ensuring the rigor of the scientific design of the experiment and the accuracy and integrity of the interpretation.

Q. Will a similar document on ethical practice guidelines be written for audiologists involved in research and academia?

A. Yes. A set of guidelines is in development to address conflicts of interest in research.

Q. How will the ethical guidelines be enforced?

A. Given the increased enforcement of anti-kickback, fraud, and abuse laws, audiologists should stay abreast of changes in regulatory landscape, and establish procedures and protocols that will protect them in their employment settings and practices. These guidelines are not meant to address all possible interactions but are an effort to assist the audiologist in cases of ethical dilemmas. At this point, education of our members is our focus. However, any profession that fails to monitor misconduct and enforce its Code of Ethics invites the loss of autonomy and the loss of trust in the profession. When such activities exist, the profession must have appropriate disciplinary procedures in place.

Guidelines for Hearing Aid Manufacturers for Substantiation of Performance Claims

HEARING INDUSTRY ASSOCIATION, ALEXANDRIA, VA

PREFACE

These Guidelines are designed to assist manufacturers in understanding and identifying the substantiation requirements for hearing aid claims, including performance or user-benefit claims. As part of that goal, these Guidelines outline a protocol that a manufacturer may follow to obtain scientific data to substantiate claims. Labels, labeling, brochures and other similar materials are promotional materials, and like advertising, claims made in these materials create substantiation requirements under the United States Food and Drug Administration's ("FDA's") and the Federal Trade Commission's ("FTC's") laws. Importantly, every claim requires some level of substantiation and the manufacturer must possess the substantiation at the time a claim is made.

To determine the appropriate substantiation for a claim, identifying the claim made is critical. Claims may be explicit or implicit, and a manufacturer is responsible, and subject to exposure, for both types. Moreover, when a claim is ambiguous, the manufacturer is charged with responsibility for all claims made, whether intended or not. Thus, promotional materials may contain multiple claims, all of which must be covered by substantiation that is appropriate for the claim made.

Endorsements or testimonials are popular mechanisms for promoting hearing aids. These communication techniques create at least two claims and thus two substantiation requirements. First, the endorser's statements must be true. Second, the endorsement also carries a typicality claim. No one would present an endorsement to communicate a solitary experience. Thus, a broader substantiation requirement than one person's experience emerges. In other words, not only does the manufacturer need to demonstrate the truthfulness of the endorsement or testimonial, but the manufacturer must have substantiation for the claim that the consumer's experience is typical.

These Guidelines serve yet another function: they provide a basis for hearing aid manufacturers to privately resolve disputes about promotional claims. HIA's Advertising Task Force developed these Guidelines as a consensus document that will assist in mediating disputes among members. By setting forth reasonable substantiation principles, the Guidelines provide a yardstick against which substantiation can be measured. As a result, there will be no surprises about the standard applied to evaluating substantiation, particularly substantiation for Type 3 claims. The intent behind private dispute resolution is to encourage the hearing aid industry to self-police and develop acceptable and useful claims and substantiation principles.This approach is preferable to government investigations of manufacturers' promotional materials and judgments about hearing aid capabilities that in the past have been considered to be ill conceived.

Carole Rogin, Executive Director, HIA

INTRODUCTION

These Guidelines present a protocol for performing evaluations of hearing aids for the purpose of obtaining scientific data to substantiate user-benefit claims of all types. Other types of scientific evidence, such as reference to published research, surveys, or controlled physical measurements may be more appropriate for some user-benefit claims.

Three types of user-benefit claims may be made by a manufacturer that would allow or require different techniques of substantiation.

Type 1. Performance claims that are generally accepted by the clinical and user communities. Type 1 claims require minimal substantiation. Examples are "many hearing aid wearers find that it is easier to communicate with friends and family" and "so tiny, only you may know it's here."

Type 2. Performance claims that are supported by information valid for the device in the context of the claim. Substantiation may be in the form of clinical data, bench data, journal articles, etc. that support the claim. For example, a manufacturer may use a journal article if it addresses the claim at issue and provides valid scientific evidence that the claim is true. Substantiation data are to be kept at the manufacturing facility. Examples of Type 2 claims are "Class D hearing instruments have been shown to have better sound quality than Class A devices" and "the circuit helps to make soft sounds audible and loud sounds comfortable."

Type 3. Performance claims involving improved speech recognition in noise. Substantiation should be in the form of data obtained using the protocol outlined in these Guidelines for speech-in-noise claims. Substantiation data are to be kept at the manufacturing facility. Examples are "for many

people, speech understanding in group situations will be much easier" and "the circuit is an environmentally-adaptive processor."

These Guidelines may be revised from time to time as changes in technology warrant or as new scientific information becomes available. Manufacturers are encouraged to bring updated information to HIA if evidence exists which may affect the contents of this protocol.

A manufacturer may apply Type 3 claims to its revised hearing aid when the design, performance specifications, and performance of the revised and the original hearing aids are essentially equivalent, with the revised device's performance at least equaling that of the original device. To the extent the manufacturer makes superiority or new claims for its revised hearing aid, additional substantiation is required. When such a new representation is a Type 3 claim, the substantiation recommendations in these Guidelines are applicable.

A manufacturer who chooses to follow a different protocol other than that recommended in these Guidelines should prepare a position paper that clearly explains and defends the merits of the alternative course of action.

GENERAL REQUIREMENTS

Substantiation of Type 2 and 3 user-benefit claims will be based on controlled clinical studies using acknowledged, reliable and valid scientific and clinical measures.

Although both objective (e.g., speech recognition or speech reception threshold in noise measures, such as NU-6, SPIN, SIN, or HINT) and subjective (e.g., self-assessment scales of benefit, satisfaction, or sound quality, including the APHAB, COSI, SADL, or IOI-HA) standard measurements may be included as substantiation for Type 2 and 3 user-benefit claims, non-standardized test measures are discouraged and should be avoided, particularly for subjective assessments. Additionally, when objective and subjective data provide discrepant results, the primary data used for Type 3 performance claims should be the objective data, which minimize the potential for experimental bias.

STUDY SITES

Data may be collected for substantiation of Type 2 claims using one study site. Type 3 studies will be conducted at a minimum of two autonomous sites, with independent principal investigators; however, only one of these sites may be a manufacturer's facility or facility in which the manufacturer has a financial stake, and the statistical determination of benefit should be evaluated consistent with the principles in Statistical Analysis, below.

In conducting Type 2 and 3 studies, data may be evaluated in several daily life situations utilizing one of several test instruments for which normative data are available.

STUDY POPULATION / PATIENT SCREENING

Subjects for Type 2 and 3 studies will have auditory characteristics/behavior appropriate for the intended claim of the device being investigated. For example, for a high gain and output hearing aid intended for high output, the subjects selected for the investigation should have severe or profound - and not mild - hearing loss.

The Study population for Type 2 and 3 studies will be fully described according to:

1. Number of subjects
2. Gender of subjects
3. Ages of subjects
4. Audiogram configurations
5. Type of hearing loss
6. Prior amplification experience
7. Pertinent lifestyle considerations
8. Ethnic background
9. Native language

Additional descriptors of the study population may be reported, including classification by auditory or non-auditory characteristics, site-of-lesion, etiology, etc., as desired.

As a general principle, the audiological tests and measurements required to be administered to a subject when behavioral tests are used will be determined by the nature of the claim and the technology under investigation. At a minimum, the following tests will be performed: pure-tone air-conduction thresholds at octave intervals from 250 Hz to 8000 Hz; pure-tone bone conduction thresholds at octave frequencies from 250 Hz to 4000 Hz; speech reception thresholds; speech recognition testing on a standardized, norm referenced speech recognition test; and the immittance test battery.

Description of the dynamic range, most comfortable range, and loudness discomfort levels may be included if relevant to the aims of the study.

Informed consent shall be obtained from each subject.

Each manufacturer must assess whether it is subject to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. If so, patient (subject) information should remain confidential in accordance with HIPAA.

INCLUSION AND EXCLUSION CRITERIA

When Type 2 and 3 studies are conducted, describe inclusion and exclusion criteria. Subjects will be selected for the investigations who have auditory characteristics that are relevant to the device or characteristic being studied.

Subjects with eighth nerve tumors should be excluded. Subjects with histories of known fluctuating hearing loss, or rapidly progressing hearing loss should be excluded, but may be included when the technology under study is specifically designed for these conditions.

Subjects should be in good health (e.g. capable of completing the study).

STUDY DESIGN

For all studies, the research strategy and experimental design selected to substantiate a claim should be appropriate to properly evaluate the characteristic, feature or instrument that is being investigated.

For Type 2 and 3 behavioral studies, any design that is going to be used will be fully described and justified.

The number of subjects required for a given Type 2 or 3 behavioral study will be ascertained with appropriate statistical power analysis. Subjects may be used as their own controls. The general recommendation is to start with at least 25 subjects per site, with the goal of having at least 20 subjects per site complete the study.

In Type 2 and 3 studies, the following procedural elements will be included and reported:

1. The number of investigators, the number of sites, and the ability of the investigators to meet the requirements of the study;
2. A complete description of all measurements made, the procedures used in making the measurements, a complete description of the environment(s) in which the testing was conducted, and a detailed description of the measurement and experimental instrumentation involved in the study;
3. Masking (blinding) is always considered appropriate in any clinical study in order to minimize bias. If this ideal cannot be achieved, a full description of expected biases and the methodology used to minimize the biases will be provided;
4. If speech testing is employed, norm-referenced, standardized speech testing materials will be used, and estimates of test-retest reliability and alternate form equivalency reported;
5. Test contents, materials and method of delivery/administration will be fully described and their use justified. The experimental design should not solely use laboratory conditions configured to maximize benefit and set false expectations regarding user benefit. In other words, the experimental design should not use idealized conditions that exaggerate favorable results. Examples are:
   - For speech understanding in noise using a fixed signal-to-noise ratio (SNR), at least one condition should be set near 0 dB SNR to insure that the benefit is not audibility but indeed speech understanding in noise.
   - For directional microphone investigations, at least one condition should utilize a balanced (e.g. diffuse) masking field with equal energy right-to-left and front-to-back with regards to the subject position.
   - For noise reduction investigations, at least one condition should utilize a broadband, preferably spectrally matched, masker.
   - For multiple loudspeaker arrays, at least one condition should utilize uncorrelated maskers.
6. In investigations of speech recognition in noise, self-report inventories of subject satisfaction, attributes of satisfaction, use, and benefit in daily life situations will be included in order to assess those properties outside of the laboratory setting. Test instruments for which normative data are available should be used, with their selection justified;
7. A study will last a minimum of 30 days to ensure that subjects have had enough time to wear the device in a variety of listening environments so they may report their experiences to the investigator;
8. If the investigator wishes to measure the subject's perception of the quality of sound of the hearing aid(s) (such as clarity, comfort, pleasantness, and lack of hollowness, etc.), they will be measured through use of standardized questionnaires;
9. Whether the investigation was performed monaurally or binaurally and, if monaural, whether the non-test ear was occluded will be reported;
10. The presence and type of earmold and venting utilized, the method of setting the volume control, whether the volume control was allowed to be fixed or varied, and the methods for and setting of each instrument control

for all conditions will be documented in a detailed manner (for both the test instrument and any control instrument that is used). Care will be taken to ensure that the same fitting procedures are followed at all study sites;

11. Whether or not aided vs. unaided testing was incorporated, and whether a comparison to a control aid was made, will be reported;
12. Graphic presentation of data should be utilized to enhance the description of the data;
13. If a claim is made to compare a new technology hearing aid versus one that is currently being worn by a subject, the study design must include adequate controls for making the comparative analysis;
14. Acclimatization effects may be included as an option of the study design; and
15. For Type 3 claims, and Type 2 claims which require clinical substantiation, manufacturers must supply scientific data from studies of their own hearing aids to substantiate their individual claims. Manufacturers may not rely on studies done by others on hearing aids similar to their hearing aid, but instead should conduct clinical studies of their own products.

QUALITY CONTROL

All hearing aids used in studies will be measured using ANSI S3.22-1996 procedures, and ANSI S3.42-1992 when broadband noise signals are employed as part of the experimental process. Probe microphone measurements will be made in accordance with ANSI S3.46 1997. If additional electroacoustic measurements detailing the performance of the instrumentation are used in the study, they will be reported.

In Type 2 and 3 behavioral studies, the method utilized for selecting, fitting and adjusting the hearing aids to the subjects will be reported and justified on the basis of its relation to the objectives of the study. An appropriately fitted hearing aid depends upon the technology used, the type of hearing loss involved, the fitting methodology employed and the objectives of the study as developed by the investigators.

The experimenter will verify that the performance of the hearing aids under study remain stable throughout the test period; e.g., that no control or other settings were altered from the specified settings.

The test subjects'audiometric thresholds will be evaluated at the end of the study. Data from subjects whose audiometric thresholds have significantly changed from the beginning of the study will be excluded from final analysis.

SUBJECT DISCONTINUATION

The experimenter will anticipate an expected number of losses in Type 2 and 3 studies, and should design for such an occurrence. Subjects who discontinue should be accounted for in the report including identifying the reason(s) for discontinuation.

SUBJECT COMMENTS

In Type 2 and 3 studies, favorable and unfavorable comments by subjects during the course of the study will be recorded and reported.

STUDY ENDPOINTS

The endpoint of a study design will have a direct focus on the claim that is being evaluated.

The performance claim(s) in question will be contained in the hypotheses of the experiment, and the endpoint(s) expressed as support either for or against the hypotheses.

In Type 2 and Type 3 studies, appropriate data may be reported to support claims of few (0-25%), some (26-50%), many (51-75%), or most (76-100%) wearers who would be expected to gain benefit.

STATISTICAL ANALYSIS

For Type 2 and 3 studies, results of clinical tests will be statistically analyzed in support of substantiation of the claims being made. Statistical analyses will use appropriate (e.g., normal, binomial, etc.) distributions with *p* values no greater than 0.05 as determinants of statistical significance.

For Type 3 studies, conclusions of benefit may be determined utilizing (a) independent analyses of the multiple research sites, or (b) pooled subject analysis across research sites, provided statistical analysis (ANOVA) does not show a significant interaction of site vs. main effect. That is, if there is a significant interaction between a site and main effect, the claim(s) may not be made.

The sponsor will determine the level of improvement needed for a clinically significant change to occur in the study. The method used to determine this level will be described and justified.

Gyl Kasewurm and Cheryl Kreider Carey, Academy National Office Deputy Executive Director

A Note from the Convention 2003 Program Chair

Gyl Kasewurm

I truly had no idea how much fun I would have serving as the Program Chair for The Academy's 15th Annual Convention. What a thrill it was to see thousands of colleagues enjoying the largest gathering of audiologists in the world. I noticed participants from all walks of life trying to catch a glimpse of the latest revelations in the world of Audiology as I trod through Convention 2003. San Antonio and the fabulous Texas venue proved to be a tremendous draw for audiologists from across the globe.

The Opening Night Reception was a perfect start to the action packed, fun-filled week. The weather cooperated and attendees were able to enjoy a delightful evening bonding with fellow audiologists amongst a backdrop of the original San Antonio. Margaritas and traditional Texas cuisine were terrific complements to the warm star-studded evening and the official opening of the Convention.

How does one top the great Opening Night Reception for the Convention? Well, having a legendary politician like Bob Dole speak at the General Assembly is not a bad start! Senator Dole delighted participants with his famous political yarns and his delightfully wry wit. "You were funnier after the election," I commented to the Senator. "That's what everyone said who didn't vote for me," he cracked. After four days of endless sessions, meetings and social gatherings, I was exhausted and truly believed that Convention 2003 had to be the best ever — at least until audiologists gather again in Salt Lake City next year for the 16th Annual Convention! Thank goodness that we will have time to rest until then!

Convention 2003 San Antonio... Super!

WHEW... the San Antonio convention "ride" has ended and the "Winds of Change" have come, calmed and passed. Another great American Academy of Audiology convention has come and gone, but it was certainly one of our best! San Antonio turned out to be a great venue with a fabulous nearby river walk that attracted audiologist to restaurants, shops and nightclubs — all hours of the day and night. The weather could not have been better with sunny skies and gentle breezes. Our 15th Annual Convention featured many highlights including a great exposition and exhibit hall, a fabulous opening session featuring Bob Dole, and a 13-year-old boy named Zachary who sang the Star Spangled Banner in a beautiful, crystal clear voice that sent chills down the spines of those in attendance.

Although the Convention was a rousing success by every standard, several factors likely influenced the total attendance. The general economic situation in the US and the global view of the Iraqi Freedom campaign were two major contributors to a slight decline in the number of convention attendees. Total attendance for Convention 2003 was 5,773 (3,384 attendees and 2,389 exhibitors) for a 12% decline from last year's convention in Philadelphia. But all things considered, those in attendance rated the convention a grand success!

Holly Hosford Dunn, Academy Board member. "Audiology took over San Antonio this week."

GENERAL ASSEMBLY

The theatre was packed to capacity as more than 2500 attendees flocked to the General Assembly. Zachary Farris, a local13-year-old, proved he was no tenderfoot to singing when he delighted the audience with his flawless rendition of the National Anthem."My eyes were brimming with tears by the time Zachary finished," commented Gail Whitelaw, the Program Chair for next year's Convention. "It will be hard to top this program next year, but you can be certain that we will try." Gyl Kasewurm, Program Chair, welcomed attendees and thanked Committee Chairs and the multitude of volunteers who worked so hard to make the Convention a success.

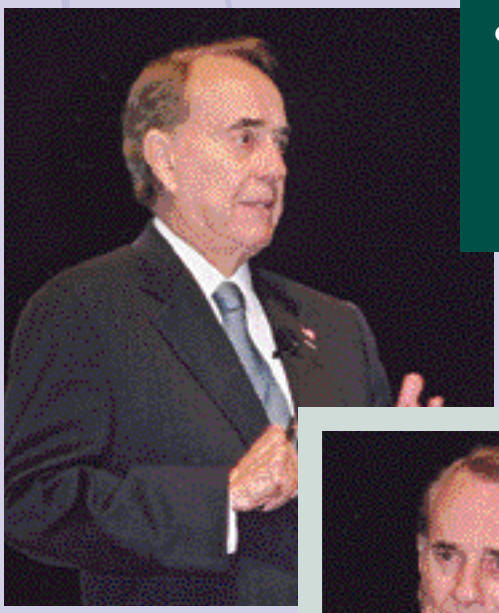
President Loavenbruck presented the Presidential Address and discussed the many accomplishments The Academy made throughout the year. Loavenbruck presented Presidential Award for Service to The Academy to Kyle Dennis for his work on the Reimbursement Committee and for his help to all of us to clarify and understand the mysteries of CMS reimbursement policies and procedures. Therese Finitzo received a Presidential Service Award for her work during the past decade as a member and chair of the Joint Commission on Infant Hearing. President Loavenbruck added her own "Unsung Hero" awards to Barbara Blattstein of New City, NY and to Carolyn Musket from the University of Texas and the Callier Center of Dallas, TX.

The packed auditorium rose to its feet as legendary politician and noteworthy American citizen, Bob Dole, stepped to the podium to speak to the crowd. Senator Dole proved that he had earned his awesome reputation when he entertained the audience with stories of his life and more than twenty years serving in the Senate.

President-elect Brad Stach outlined his vision for the future and his year of Presidential duties.

Certainly, the General Assembly served as an incredible beginning and not-to-be-forgotten event at The Academy's 15th Annual Convention.

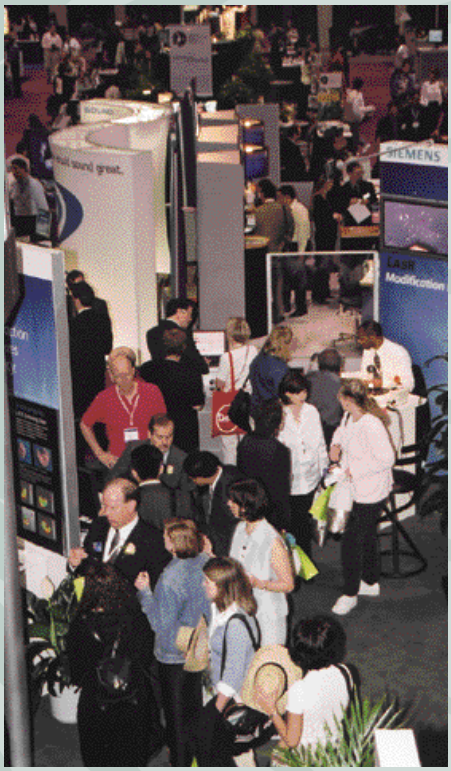
Convention 2003 Keynote Speaker Bob Dole



RIDIN' THE WINDS OF CHANGE
SAN ANTONIO · APRIL 2-5, 2003
15TH ANNUAL CONVENTION & EXPO

EXPOSITION

The Grand Opening of Exposition 2003 unveiled the latest developments and innovations in the field of audiology. The exhibit hall space set a new record for The Academy by selling out. Where else can audiologists find nearly 200 of the latest and greatest innovations in the field of audiology together in one place? The Exposition provided one-stop shopping for those who visited the extraordinary displays from manufacturers, publishers, product distributors, allied health groups and other audiology organizations. Several of the exhibitors used the exhibit hall time to offer educational activities within their booths. Passionate exhibit browsers were lured with informational goodies as well as a plethora of culinary choices including flavored coffees, cappuccinos, and even the perennial favorite, moon pies! Daring Convention attendees braced for a ride on one of the two mechanical bulls in the exhibit area, and some even indulged in a shoot-out with an old westerner, or paused to breathe in fresh oxygen or receive a whirlwind wash-down massage.



Monique Morris, Dawne Rainey, and Arun Iyer. "The Exhibit Hall is incredible and way too much to get through in a single day."

OPENING NIGHT RECEPTION

Audiologists young and old gathered to launch the 15th Annual Convention on opening night at a traditional outdoor Mexican festival. The Opening Night Reception and party attracted over 2,500 fun-seeking attendees. The charming village of La Villita served as the setting for the festivities. Excited party-goers found the event an opportune time to meet new friends and to locate others whom they only see once a year at the Convention. Participants were treated to a spread of traditional Mexican fare which included buckets of margaritas. Participants were able to wander through the many unique shops that line the streets of La Villita and took advantage of the opportunity to explore the wares of locale craftsmen. Meanwhile, Convention partyers were able to enjoy the landscape and lively conversations with fellow audiologists. Everyone is certain to remember the dynamic evening, which served as the official opening of the Convention.

Karen Jacobs, George Feddi from Mexico City and Ed Szumowski, according to George "the Convention always rejuvenates my commitment to the profession and I love the opportunity to meet new people."

INTERNATIONAL RECEPTION

More than two hundred audiologists attended the gala International Reception and took advantage of the unique opportunity to get better acquainted with audiologists visiting from countries outside the US. The reception was open to all Convention registrants and served as the perfect time to share thoughts and ideas with colleagues and Academy leadership. International Committee Chair Bob Traynor welcomed the international guests, thanked them for their attendance and assured them of their professional home in The Academy. Academy representatives reported that the number of international attendees was slightly less this year, and believe that attendance was affected by the tenuous world situation prior to the Convention. However, those who came proved that The Academy Convention has become "the place" to meet and mingle with colleagues from around the world.

Debbie Gregor, Jackie Cooper and Karen Shepherd from the UK. Jackie Cooper won the trip to Convention 2003 for being tops in her field in the UK. "Convention 2003 is huge in comparison to the Congresses in our country. It is nice to meet other folks who come from abroad. The Academy Convention is the best place to see the tremendous range of technology and the awesome exhibit hall."

STUDENT ACTIVITIES

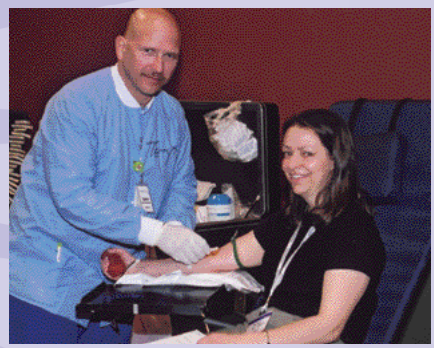
Jill Collignon and and Jeffrey Berg from the University of Louisville. "Being a student volunteer made coming to Convention possible. The issues presented in the sessions aren't always covered in the courses we take in school.The Convention has given us tons of practical information."

Nearly 400 student volunteers from more than 70 universities participated in Convention 2003 and contributed to its success. In exchange for a complimentary registration, each student was asked to donate just a few hours of their time to assist with various aspects of the Convention. The volunteers assisted by monitoring Featured Sessions, Instructional Courses, Research Presentations, Poster Sessions, and Exhibitor Sessions. In addition, student volunteers manned the Academy Store, the Employment Service Center, the Pressroom, and provided valuable assistance at the Registration Desk.

Students attended the Student Volunteer Session held under the direction of Ed Szumowski. Convention Chair Gyl Kasewurm and President Angela Loavenbruck welcomed the students and thanked them for volunteering. The enthusiastic student volunteers were coached on getting the most from their Convention experience from Jerry Northern, who has attended every Convention since the inception of The Academy in 1988. The students were provided information on other services The Academy offers including ABA Certification. The creative Co-Chairs concluded with an entertaining Power Point® presentation that highlighted the "dos" and "don'ts" of being a student volunteer.

ACADEMY BLOOD DRIVE

In 2001 Secretary Tommy Thompson challenged audiologists to help America by participating in blood drives and organ donations. The Academy responded to the Secretary's urgings and incorporated a blood drive as part of Convention 2002. This year, Chair Therese Walden reported that the Blood Drive attracted 75 people and resulted in 61 pints of donated blood, a significant increase over last year's blood drive. The San Antonio blood drive featured a competition between the AuD programs and t-shirts were awarded to the students whose program donated the most pints. The University of Louisville won the friendly competition. Walden was heartened by the response to the blood drive and plans to make this an annual event at Convention. "People are so generous with their time and their blood. I am so thrilled that the number of donations has increased this year. The nation has a shortage of blood right now and audiologists have once again risen to the challenge. Thank you to everyone who contributed!" said Walden.



ACADEMY AWARDS RECEPTION

The Academy Awards Reception boasted a standing room only crowd as The Academy acknowledged and recognized the individuals who gave unselfishly of themselves over many years to contribute to the profession of audiology. Jerry Northern obtained a well-deserved Career Award in Hearing, Fred Bess captured the Jerger Career Award for Research in Audiology, and Brenda Ryals from Virginia and Harvey Dillon from Australia received Research Achievement Awards. Rieko Darling received the Clinical Educator Award. The first Samuel F. Lybarger Award for Achievement in Industry was bestowed upon Mead Killion. Janis Wolfe Gasch was noted for her humanitarian efforts with children in Mexico.

Reed Norwood and Lynn Cook "We are so pleased with the Honorees this year. It is a list of Academy Legends. It is wonderful to meet the honorees face-to-face and to have a chance to chat informally with them."

During the informal reception the Honorees offered insights into their astonishing careers and warmed hearts with tales of their interesting lives. Attendees were able to enjoy libations while mingling with these esteemed colleagues. It was exhilarating to note the accomplishments of individuals who have made significant contributions to the profession. Certainly, the inspirational careers of the 2003 Academy Honorees motivated attendees to achieve greater heights in their own professional lives.

ACADEMY BUSINESS MEETING & BREAKFAST

Almost 80 audiologists rose early on Friday morning to hear Academy leaders discuss the accomplishments that were achieved during the past year and the vision for the future. The free breakfast may have enticed some of the attendees, but most came to hear more about the only organization of, by and for audiologists. Each Committee Chair reported on their activities and Laura Fleming Doyle, the Academy Executive Director, brought people up to speed on the recent relocation of the National Office. This meeting afforded yet another opportunity to meet face-to-face with Academy leaders to discuss the future directions of The Academy and to learn ways to get involved in the many functions that the organization performs throughout the year.

STUDENT RESEARCH FORUM

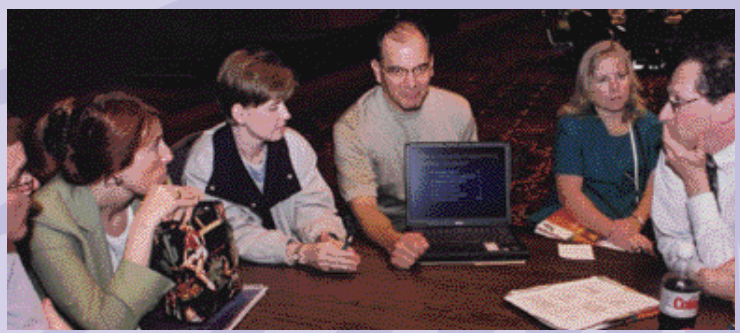
The Student Research Forum luncheon featured the results of award-winning research of five graduate students. Brian Kreisman, Kiara Ebinger, Kristi Ann Buckley, Phillip Gilley and Preitesh Pandya each presented the results of their research and received a $500 award from The Academy along with a plaque recognizing their accomplishments. Hundreds of Convention registrants took the opportunity to enjoy the tasty free lunch and took pleasure in hearing the latest research from some of the best and the brightest audiologists in the profession. Student Research Forum Chair Catherine Palmer observed that the program was well received again this year. "I received lots of good comments about the luncheon. I was thrilled that the tables were full and the room was overflowing with interested attendees. The students did a great job and the presentations went very smoothly."

"This is a great Convention! We are absolutely inspired by the great research that was completed by students. The speakers have been fabulous, the weather has been great and the margaritas are outrageous."

ROUND TABLES

The format for this traditional event was changed this year to allow professionals with common interests to interact and discuss a variety of important and/or controversial topics while sitting around an actual "round table." The 19 well-attended sessions offered an informal setting for the exchange of information and ideas. Participants were delighted that box lunches were available to purchase this year so participants were able to satisfy their cravings for both food and lively discussion during the noon hour. The event was coordinated by previous Program Chair Barbara Packer, and facilitated by noted experts in the field of audiology. Many interesting ideas emerged and were transmitted to The Academy Board for consideration and action.

Erica Friedland and Barbara Packer stated "The new format for Round Tables was very successful this year. The topics were awesome and the crowd was so interactive. It was a fun format."



PRE-CONVENTION WORKSHOPS

These full or half-day sessions provided in-depth training by the Education Committee who carefully selected speakers and "hot" topics suggested by previous Convention attendees. Topics of the sessions included Auditory Processing Disorders, Treating Tinnitus, Genetics, Counseling, Clinical Outcome Measures, Pharmacology, Infant/Toddler Amplification, and Neural Plasticity. Hundreds of attendees took advantage of the opportunity to earn additional CEUs at these outstanding Pre-Convention Workshops.

Kathy Kerst from Mayo Clinic in Rochester: "The Pre-Con course on Tinnitus reinforced many of the things I already knew and introduced me to some great new concepts. I am excited to go back home and use the information with my patients."

INSTRUCTIONAL COURSES

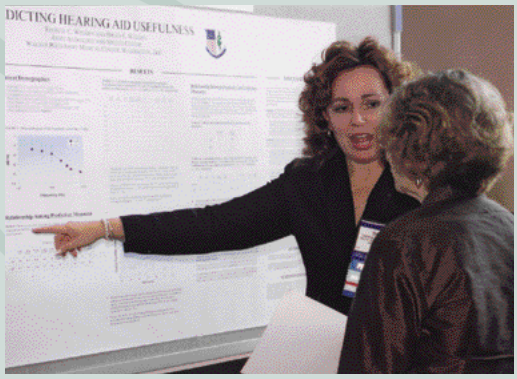
Participants at Convention 2003 faced the daunting task of choosing from 84 exceptional Instructional Courses covering every conceivable topic in audiology. The diverse range of courses was offered each afternoon at the Convention. The Committee had a very difficult time selecting from hundreds of exceptional submissions. Much discussion was focused on the "blind review" type of selection process that was employed. Gail Whitelaw, Instructional Courses Sub-Committee Chair and Convention 2004 Program Chair related, "This was a tough job! One popular submission was rejected because it had been offered for the past ten years. The Committee felt it was essential that Convention 2003 feature only the latest and freshest information in the field."

EMPLOYMENT SERVICE CENTER

The Employment Service Center (ESC) was a huge success! Job seekers posted resumes and looked for jobs while employers interviewed candidates to fill prospective positions. The ESC was located outside of the Exhibit Hall to ensure privacy and confidentiality for everyone involved. Hundreds of applicants perused postings for more than 250 available jobs. Some applicants reported that they were actually interviewed while scanning the job postings and hired on the spot! Thanks to the help of countless volunteers and Academy office liaison Laura Franchi, the ESC proved to be a tremendous asset to employers and job seekers alike and has earned its position as an integral part of the Convention.

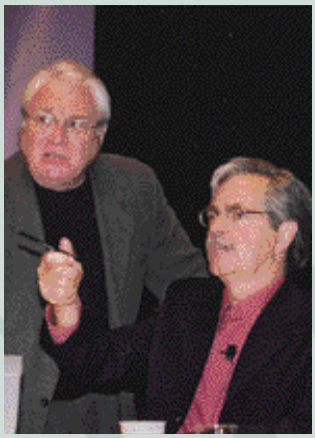
RESEARCH PODIUM & POSTER SESSIONS

The 2003 Research Podium and Poster sessions were a great success. The Podium Sessions were very well attended, with sessions on Clinical Outcomes in Amplification, Amplification Strategies, Amplification Electroacoustics and Mechanics, Research in Cochlear Implants, Pediatric Diagnostics, and Research in Hearing Science. A big Texas "Thank You!" goes to the Podium Session moderators Mary Florentine, Vishakha Rawool and Erika Zettner. The big story this year was the success of the Poster Sessions, which took place in a large atrium adjacent to the meeting rooms. There was high traffic in the poster area proving once again the popularity of this means of communicating information about audiology projects, research, and professional issues.



TRIVIA BOWL XIV

More than 600 Academy Convention attendees gathered for good times and fun competition at the XIVth Annual Trivia Bowl. The Trivia Bowl is the convention wrap-up event. Conventioneers formed some 60 teams to match wits and compare their collective knowledge of trivial events drawn from audiology history, clinical applications, items from the news media of the past year, and journals in an attempt to correctly identify answers to questions prepared by program Masters of Ceremonies, Gus Mueller and Jerry Northern. This year, for the first time, electronic keypads at each table enabled quicker and easier identification of Trivia Bowl winners. Along with a high-spirited afternoon of good times and good food and drink, the friendly competition resulted in three winning teams, a winning student team, and a winning team for the best name competition. Although some players were heard to comment on the difficulty of this year's questions, there is no question that a good time was had by all participants.



2003 TRIVIA BOWL WINNING TEAMS

FIRST PLACE WINNERS

NEARLY DEAD ZONES

Dennis Van Vliet, Dave Fabry
Robert Sweetow, Brenda Ryals
Chuck Berlin, Gail Gudmundsen
Catherine Palmer, David Hawkins
Liz Fabry, Mary Kay Chisholm

SECOND PLACE WINNERS

UP CHUCK BERLIN'S

James Beauchamp, Kara Donnelly
Theresa Liley, Shelly Jones
Beatrice Alvarado, Sig Soli
Angela Williamson, Dick Danielson
Nancy Schwartz, Theresa Schulz

THIRD PLACE WINNERS

TRAPEZOID BODIES

Dennis Burrows, Kathleen Campbell
Carmen Brewer, Sharon Kujawa
Linda Hood, Margaret McCabe
Michelle Hicks, Jayne Handelsman
Roger Ruth

STUDENT TEAM

Utah State University

SIMPLY "EAR"-RESISTIBLE

Caterina Wilson, Amy Raymond
Alison Vega, Rachel Harrison
Monica Johnson, Mindy Norris
Doug Worthington

BEST NAME

VIVA LAS TRAGUS!

Brian Kreisman, Carl Crandell
Nicole Kreisman, Andrew John
Sherri Smith, M. Samantha Lewis
Dwayne Paschall, Nadia Abdulhaq
Katie Ruffett

Appreciation is extended to our 14th Annual Trivia Bowl Title Sponsor, Siemens Hearing Instruments and to the co-sponsors, Ray O Vac and Knowles Electronics.

WASHINGTON WATCH

Medicaid Rule Proposed by CMS

On Wednesday, April 2, 2003 – just in time for The Academy Convention in San Antonio – the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) proposed a new rule (regulation) to change the definition of a "qualified audiologist" for purposes of the Medicaid program. The proposed new rule caps a four year extensive effort by your Academy.

MARSHALL MATZ, PAM FURMAN, JODI CHAPPELL, SENATOR BOB DOLE AND CRAIG JOHNSON AT THE 15TH ANNUAL CONVENTION IN SAN ANTONIO.

As you may know, CMS still has two different definitions of who is a "qualified audiologist," one for the Medicare program and one for the Medicaid program. The Medicare definition, enacted by Congress as a statute in 1994, defers to state licensure to determine who is qualified. The current Medicaid regulation (not a law) predates the trend to state licensure, and therefore still relies upon ASHA's Certificates of Clinical Competency (CCC-A). It is that Medicaid regulation CMS is seeking to change.

The new proposed Medicaid regulation would defer to state licensure to determine who is a "qualified audiologist" (as is the standard in the Medicare program). For those states that do not yet have a state licensure scheme, or for those situations that are exempt from state licensure (i.e., schools), CMS proposes a federal generic minimum definition of who would be considered a qualified audiologist.

The background section of the proposed regulation notes that after the Medicare definition was enacted by Congress in 1994, CMS began receiving letters from audiology professionals and interested parties recommending that they adopt the Medicare definition for the Medicaid program. The CMS document specifically references: (1) the "Medicaid Audiology Act of 1999" introduced by Congressman Ed Whitfield (R-KY) and Congressman Sherrod Brown (D-OH); (2) the Congressional report language agreed to in June, 2000 "urging" CMS to promulgate the regulation; and (3) the "commitment" made by Secretary Tommy Thompson to address this issue.

The American Academy of Audiology played a key role in the introduction of the Medicaid Audiology Act of 1999, the Congressional report language, and in obtaining the commitment by Secretary Tommy Thompson. You may recall that the Secretary spoke at the American Academy of Audiology Convention in San Diego two years ago.

The American Academy of Audiology has distributed an "Action Alert" with information on this rule making and a proposed letter to CMS.

It should be pointed out that this regulation change is important to all audiologists, even if you are not a Medicaid provider. Once an audiologist is licensed by a state (and nearly all states currently regulate audiologists) and is determined to be "qualified," The Academy believes that no additional certification should be necessary to serve any member of the public or participate in any federal program.

The proposed regulation would not lower the standards of the profession in any way as there is a minimum federal generic definition for who is a qualified audiologist.

The American Academy of Audiology urges all Academy members and other interested parties to comment on this proposed rule making.

It is important to note that the proposed regulation is not yet final. It seeks comments from audiologists and other interested individuals. Comments are due at CMS no later than June 2, 2003.

Marshall L. Matz, Esq. Olsson, Frank and Weeda, PC, Washington, DC

WASHINGTON WATCH

Secretary Tommy Thompson and CMS published the proposed regulation in response to The Academy and it is important to say "thank you" by participating in the rule making with a short letter of support. Comments are due at CMS no later than June 2, 2003

DRAFT

Sample Letter - Please personalize on your letterhead.

(Mail one original and two copies.)

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-2132-P
P.O. Box 3016
Baltimore, MD 21244-3016

As an audiologist in the State of _____, I would like to commend Secretary Thompson and CMS for publication of this proposed rule. I am writing in support of the rule and to urge CMS to finalize the rule.

Most importantly, the proposed rule will improve access to audiology services for Medicaid patients. More and more, new audiology graduates are declining to participate in any private certification programs, and many audiologists who previously relied on certification are no longer doing so. Therefore, deferring to state licensure is appropriate. The rule recognizes that state licensure, rather than private certification is the most widespread system for determining the qualification of health care professionals and best serves the goal of consumer protection.

The generic definition of an audiologist is very important for those states, and those circumstances (including schools), where licensure does not exist or apply. Finally, I think it is important for CMS to speak with one voice on who is a qualified audiologist and to reconcile the Medicare and Medicaid rules.

Thank you for your consideration of my views.

Sincerely,

DRAFT

ACTIONS OF THE REIMBURSEMENT COMMITTEE

Robert Glaser, PhD, Chair, **Debra Abel,** AuD, Co-Chair

One of the San Antonio Convention's Featured Sessions, "Reimbursement: New Requirements, Old Problems, New Solutions" highlighted the work of The Academy's Reimbursement Committee that was completed this past year. Under the Chairmanship of Robert Glaser, the 2002-2003 Reimbursement Committee was restructured last year to meet the needs of the fast-paced, ever-changing arena of reimbursement. The members of the Reimbursement Committee include Debra Abel (co-chair), William Beck, Carmen Brewer, Sheila Dalzell, Kyle Dennis, Barry Freeman, Richard Gans, Alison Grimes, Bob Hartenstein, Pam Ison, Craig Johnson, James McDonald, Paul Pessis, Daniel Schneider, Kadyn Williams, Jim Wise and Don Worthington.

The Featured Session was presented by a panel of the Reimbursement Subcommittee Chairs and featured the work products that resulted from the diligent efforts of the subcommittees. The following activities of the Reimbursement Committee were discussed:

- The Committee is researching and providing guidance on "Incident to" billing, non-physician work pool and advanced beneficiary notice (ABN).
- A virtual seminar on HIPAA was held on February 28 with 139 sites participating, with over 400 participants.
- The Committee is offering a HIPAA Compliance Manual produced by Gates, Moore & Co. at a reduced rate of $89 in order to provide ease of use for members to become HIPAA compliant.
- A Business Associate Agreement was approved by the Reimbursement Committee and HIA for industry wide compliance. The sample BA Agreement is available at www.audiology.org/professional/ members/hipaa/baa.pdf.
- HIPAA information with links on the Academy webpage and presentations at state meetings were offered.
- State licensure laws are now available via a U.S. map linking resource at http://www.audiology.org/professional/gov/statelaws.php.

The following fact sheets developed by the Reimbursement Committee are posted on the web site at www.audiology.org/professional/members/medicare/ :

- Advanced Beneficiary Notice (ABN) Instructions and Forms
- CPT-RUC Process
- Medicare Coverage of Cerumen Removal
- Medicare Coverage of Cochlear Implant Rehabilitation
- Medicare PIN/UPIN
- Non-Physician Work Pool

Representation at the Current Procedural Terminology/Healthcare Professional Advisory Committee (CPT HCPAC) and the Relative Value System Update Committee/Healthcare Professional Advisory Committee (RUC HCPAC) process is also an important component of the Reimbursement Committee. CPT codes are owned by the American Medical Association. New CPT codes and the modification of existing codes are underway, although they may take as long as 21 months to complete. The CPT HCPAC reviews applications for new or revised CPT codes for non-physician specialties. We have recently seen this at work with the advent of the new cochlear implant codes (92601, 92602, 92603 and 92604), and CPT code 92700 will replace 92599. The RUC HCPAC reviews recommendations on the Relative Value Units (RVU's) for physician work and practice expenses for non-physician specialties. The Academy is represented at the Practice Expense Advisory Committee (PEAC) of the AMA, and the AMA CPT and RUC meetings, and works in conjunction with ASHA's Healthcare Economics Committee.

Goals of The Academy Reimbursement Committee

- To identify the status of important topics in the reimbursement arena
- To develop accurate descriptions, definitions and information regarding the fiscal impact of contemporary reimbursement issues facing our profession
- To provide timely, useful information in an easily accessible, quick-read, quick-use format for Academy members
- To participate in regulatory and organizational activities that will increase visibility of audiology before governmental agencies and third party payors
- To monitor and assess legislative and bureaucratic issues that will/may impact reimbursement for audiology services
- To develop valid outcome data for the major procedures and treatments in the practice of audiology
- To assess reimbursement topics/issues and develop reasonable strategies and action planning to achieve well-defined and necessary outcomes to improve reimbursement opportunities for our profession.

Reimbursement Subcommittees and Chairs:

- Direct Patient Access/Limited License Practitioners (Richard Gans)
- Evidence Based Clinical Data (Kyle Dennis)
- Coding Issues (Kadyn Williams)
- Billing Issues (Sheila Dalzell)
- Non-reimbursed Practice Items
- Personal ID Number Initiative (Pam Ison)
- Communications (Alison Grimes)
- Healthcare Professional Advisory Committee (HCPAC)/Resource Update Committee (RUC) (Paul Pessis)
- State Reimbursement Regulations (Barry Freeman)

THE IMPORTANCE OF HEARING SCREENING

JAMES O'DAY, ROCHESTER, NH

During the past 20 years I have seen many significant advances in our diagnostic tools and hearing aid technology. These changes were not only of benefit to audiology but also enhanced the lives of hearing impaired individuals who seek our help. Unfortunately, out of the 22.5 million hearing impaired individuals only 5 million have sought help in the form of hearing aids. Why the discrepancy? Some argue it is because we are not primary providers through Medicare; others feel that the requirement of having a physician's signature prior to fitting hearing aid(s) reduces the access patients have to hearing aid services. Still others feel that changing our educational level to that of a Doctor of Audiology will solve the patient access problem.

In truth, a concerted effort on all three issues is needed and thankfully is being undertaken by various groups, including the American Academy of Audiology. Once these issues are resolved in our favor, patients should have easier and better access to audiologists. Currently, individuals experiencing hearing difficulty go to their family practitioner, medical clinic, nursing home, public schools, speech pathologist, etc., before being referred to the otolaryngologist (ENT) and/or audiologist.

It seems to me that the only way to improve patient access to hearing services is through the availability of wide spread hearing screening services. Not just universal newborn or infant screening, but rather the screening of patients of all ages. These hearing screenings need not be performed or supervised exclusively by audiologists, but rather by nurses, secretaries, receptionists, speech pathologists, school employees, etc. The greater exposure patients have to hearing screenings, the greater chance these people will seek help when needed.

Screening programs involve checking people rapidly against a preestablished limit of normalcy. All screening tests should be designed to identify individuals who need additional testing or medical attention. Screening tools that are successful have the following characteristics: speed, accuracy, reliability, and are inexpensive to administer. The accepted hearing screening programs in use today are the screening audiometer and written hearing surveys. Unfortunately, also in use are the whisper test, written questionnaires, the telephone hearing screening test, and single-frequency hearing screening devices. The Whisper test, Telephone Hearing Test, and single-frequency screeners are inexpensive and require little time to administer, but give little or no information about the hearing status of the patient. Hearing questionnaires are time consuming and give no real hearing information. Only the traditional screening audiometer gives useful frequency-specific information about the patient's hearing in each ear. However, the screening audiometer is expensive and the costs associated with training personnel and the time to administer a screening test make screening audiometers seldom used in medical offices. Indeed, the American Medical Association and various public health web sites reveal that there are no standards for screening hearing in adults. Without standards or guidance from credible agencies, patient access to hearing screening will be severely limited. This lack of hearing testing is both the fault and the responsibility of audiologists to create change.

Acceptance and success of any hearing screener is dependent on much more than just effectiveness and accuracy. The entire health care community needs to be educated to the need for and the importance of hearing screening in all age groups. Our challenge is to identify those with hearing impairments so that treatment of their problem can be initiated. These lofty goals can indeed be accomplished by our professional organizations as well as through each individual audiologist. As the importance and implementation of wide spread hearing screening is realized, our profession of audiology will come of age, and we and those with hearing impairment will reap the benefits.

Adult Hearing Screening Featured in *JAMA*

The April 2003 issue of *The Journal of the American Medical Association* (Yueh, Shapiro, MacLean and Shekelle. *JAMA*, Vol. 289:15, 2003) published a review and discussion of the screening and management of adult hearing loss by primary care physicians. Citing the fact that hearing loss is the third most prevalent chronic condition in older adults with important effects on their physical and mental health, the article recognizes that most older patients are not assessed or treated for their hearing loss. The article is based on a search from 1985 - 2001 of *MEDLINE, HealthSTAR, EMBASE,* and *Ageline* for articles and practice guidelines for screening hearing in adults.

The authors cite screening tests that reliably detect hearing loss, i.e., audioscope, combination of otoscope and audiometer, self-administered questionnaire, and the Hearing Hand Inventory for the Elderly-Screening Version. However, they point out that the value of routine screening for improving patient outcomes has not been evaluated in a randomized clinical trial and that adherence to the use of hearing aids in adults is low. Their conclusion is that older adults can be screened for hearing loss using validated methods and that effective treatments exist to improve outcomes.

RESEARCH IN AUDIOLOGY EDUCATION: INTO THE ABYSS

JOSCELYN R. K. MARTIN, AUD, MAYO CLINIC, ROCHESTER, MINNESOTA AND LINDA SEESTEDT-STANFORD, MA, CENTRAL MICHIGAN UNIVERSITY.

As healthcare professions evolve, there is an increased emphasis on standards of education and training. In its own evolutionary process, the profession of audiology has focused on clinical education through development and implementation of the Doctor of Audiology (AuD) degree. The AuD degree symbolizes a full-scale commitment by the profession to clinical education (Battle, 2001). Standards and guidelines from professional organizations will be changing to reflect this commitment.

As Doctor of Audiology programs were initiated there were no minimum requirements in place to support curricula. Seestedt-Stanford and Weddington (1996) described the design of Central Michigan University's AuD clinical education program as a "challenging opportunity." Debate continues regarding appropriate standards for graduate programs in audiology. There has been little dispute, however, that future audiologists must be better prepared in the clinical arena if the profession is to continue to thrive and, ultimately, best serve the patient population.

While the profession of audiology has historically created minimum standards for the clinical education and training of new audiology professionals, very little research in the area of clinical education techniques and processes has been generated and shared specific to the discipline of audiology. "The lack of research in this area is ironic given the fact that our profession's collective effectiveness is dependent on the success of clinical training procedures" (Rassi, 1978 p. 2). Central to effective clinical training are strategies implemented by teacher/clinicians to facilitate learning in the academic environment. The study of teaching methods, termed pedagogy, includes theories of learning and the manner in which goals of education are achieved. Clinical education pedagogy, therefore, is the study of **how** students are taught to be clinicians rather than an emphasis on **what** they are taught.

Clinical instructors are basically left to their own devices when it comes to developing an approach to teaching. Models that clinical instructors adopt to educate graduate students typically come from the instructors who taught them. Further, many clinical instructors have no formal training in teaching methodology, learning styles, and student development, thus their pedagogical approach is often based on trial and error. The methodology of clinical education is often considered a "mysterious" process. Supervisors themselves cannot concretely describe how and why it works. The apprenticeship model continues to dominate as the key pedagogical approach. Consequently, teaching and learning processes remain relatively stable with little innovation or change.

It is not the intent of this paper to minimize the importance of the content that is taught, but rather to stress that the pedagogical methods in the clinical education of audiologists require additional study. The way in which students are trained to become audiologists may impact considerably on their acquisition of information, skill and competency. What research is available that speaks to pedagogical issues in the profession? Has there been an increased emphasis on research in clinical teaching with the transition of the profession to doctoral education? These two key questions were the basis of a recent study conducted by Martin (2002).

Nine widely-circulated audiology journals* from the past twenty-years were reviewed in order to determine the presence of research related to audiology clinical education. In total 10,200 articles were examined. Of these, just sixteen articles were found regarding the education and training of audiology students. Further, only two articles were identified (a mere 0.00019 percent of the original 10,200 articles reviewed) that described research specific to pedagogy in audiology.

This analysis of the audiology literature suggested that research on clinical education methodology is not readily available in the existing popular audiology journals. The implication of such a finding is that there is little discussion going on regarding the merits of this type of research or the importance of this research area to the profession. The obvious impact of this discovery is that research is not available to assist the profession in finding better approaches to clinical education. There may be several possible reasons for this.

First, relevant pedagogical research may be in other publications not specific to the profession of audiology. It was apparent through a search of the relevant literature, however, that few articles, chapters, books, dissertations, and recent meeting and conference proceedings have been published relating to audiology specific clinical education. If the information exists, it is not being published in conventional audiology journals or other publicly available professional resources.

Second, the research may be generated internal to universities, and simply not shared with the audiology community at large. This has not been investigated, so it would be impossible to speculate whether or not this has occurred. Without shared, peer-reviewed research publications, it is difficult to ensure the evidence-based nature of any such possible studies.

A third consideration is that clinical education research is simply not being generated. A possible reason for this is the fact that this type of research may not be consistent with university faculty tenure and promotion guidelines. Tenure

RESEARCH IN AUDIOLOGY EDUCATION: INTO THE ABYSS

and promotion may be more likely to be granted on the basis of publications in basic audiologic research. Further, audiology faculty may not feel that the profession values this type of research and that it should be relegated to the education department of a university.

Another possible explanation is that the appropriate persons to conduct such research studies are not involved in the process. For example, in university settings there may be a distinct division between those that teach in the clinic and those that teach in the classroom. It is possible that professionals conducting research are not those serving as preceptors to students in the clinic. The clinical personnel that supervise and teach may not be familiar with the fundamentals of the research process as it pertains to either basic scientific or applied clinical research. In cases where clinicians are knowledgeable about the research process, their stature as non-faculty members may preclude them from participating in such research activities.

One possible solution to the lack of research in the area of pedagogy in audiology may involve practitioner audiologists generating additional applied clinical research, including that which is supervision related. At the April 2002 meeting of the American Academy of Audiology, Cone-Wesson and Christenson encouraged this suggestion with their presentation entitled "Clinical Research in Audiology" (Cone-Wesson and Christensen, 2002).

The evolution of the profession to the doctor of audiology (AuD) degree should encourage clinical practitioners to look more critically at existing and new research. Also, the possibility of a partnership or mentorship program encouraging collaboration between audiologists in clinical and research settings should be investigated. Dowling (2001) suggested that an alliance between clinical practitioners and established researchers might be beneficial.

A second possible solution to this issue may be addressed from an organizational perspective. Other professions have created organizations specifically dedicated to clinical education. There are also professional organizations that operate special interest divisions dedicated to clinical education and training. Audiology does not yet have such a division of its own.

A third option is for audiology to establish an ongoing publication that speaks to clinical education, training, and supervision. Several other health professions have journals dedicated to clinical education. Such a journal could be devoted specifically to the clinical supervision of AuD students, and marketed to university supervisors and non-university based audiologists who may be externship supervisors. The possible limited readership, however, may result in another option — a regular section on research in clinical education in an existing, widely read audiology journal.

Clinical supervision and teaching methods and the research pertaining to them have not been readily available to audiologists. Preceptors for fourth year Doctor of Audiology students will include audiologists with and without university affiliations. As such, the methods and research must be made available to the general audiology community. Training in supervision methods must be provided for preceptors of students regardless of the work setting of the supervising audiologist. This apparent lack of inter-disciplinary training has left audiology at an impasse, leaving clinical education a process of tradition, not a process of discovery and change.

With the evolution to the AuD degree, the profession will have many questions to answer about clinical education for audiology students. Some of these are questions that can be answered through the greater research base in clinical education in audiology that is suggested in this paper. Additional research recommendations for the future could include, but not be limited to, evaluation of: current practice; use of patient simulations and problem based learning; various models for externship placements, including models from other professions; methods for assessing students and preceptors; methods for assessing learning outcomes (e.g. forms or scales).

The profession of audiology has called for evidence-based practice. An evidence base specific to the pedagogy of clinical education in audiology is needed as well. The future of the profession depends upon the willingness of the entire audiology community to participate in shaping clinical education.

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* *American Journal of Audiology, ASHA Leader* (formerly *Asha*), *Audiology Today*, *Ear and Hearing*, *The Hearing Journal*, *Hearing Review*, *Journal of the American Academy of Audiology, Journal of Speech, Language, and Hearing Research*, and *Seminars in Hearing*.

American Board of Audiology
BOARD CERTIFIED IN AUDIOLOGY™

ABA CONVENTION ACTIVITIES

The recent San Antonio Convention and Exposition provided a forum to discuss a wide variety of political and professional topics important to the future of audiology and to the quality of services that we provide our patients. The meeting also provided an opportunity for the American Board of Audiology to participate in a number of activities as described below:

The ABA Board of Governors met to review progress in the development of a specialty certification program for audiologists providing cochlear implant services (CIS) as described below. The ABA Board is moving forward to start the process for this exciting new specialty certification program.

Robert Keith represented the ABA at a Featured Session to discuss professional certification. Keith described how the ABA's certification program meets the challenges of an evolving profession focused on transitioning to a doctoring profession. Discussions were lively, but clearly the ABA's goals are intelligent steps towards meeting the certification needs of audiologists in a wide range of practice settings.

The ABA convention hall exhibit provided opportunity for Board members to meet individually with convention attendees. More than 300 convention attendees requested applications for ABA certification.

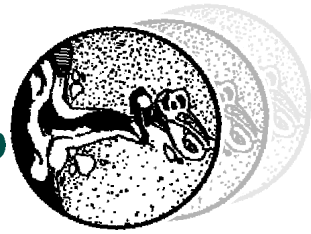
The ABA Round Table offered another opportunity for audiologists to discuss certification and its value to our profession. Round table participants heard a diverse range of opinions on several aspects of certification, as well as the expectations and standards that the sponsors of such programs must address.

ABA Board members Melanie Herzfeld and Cindy Simon met with an ABA Working Group to develop plans for improving the quality of the continuing education experience that is a fundamental part of ABA certification. The results from this Working Group are expected to lead to important changes in future certification activities of the ABA.

Specialty Certification in Cochlear Implant Services

The ABA Task Force on Cochlear Implant Specialty Certification, chaired by Cheryl DeConde Johnson and Patricia Chute, has outlined the requirements for specialty certification in this clinical practice area. Working with Applied Measurement Professionals, Inc., the ABA Cochlear Implant Services (CIS) Task Force created a job analysis survey for use in detailing the necessary job tasks of a CI specialist. Audiologists whose practice concentration is in Cochlear Implant Services are urged to contact Phil Darrin, Director of Certification for the American Board of Audiology (ABA), at pdarrin@audiology.org or 703/226-1060 as soon as possible to participate in this important survey.

It is necessary for us to create a directory of all audiologists working primarily with cochlear implants. The survey will then be emailed to each registered cochlear implant audiologist. Those audiologists that contact the ABA will also be on the distribution list for important news related to this new certification program, including information pertaining to eligibility requirements and possible specialty certification test dates. Team Leaders, made up of Cochlear Implant Specialists, have been appointed to write the items that will comprise the specialty certification examination. Development of the test question items will be largely based on the job analysis provided by the CIS survey. Please take a moment to register for this important survey. You do not have to hold ABA certification to complete this survey. We need your help to make this specialty certification program a successful means to identify audiologists who are uniquely qualified to provide cochlear implant services to patients.



What Causes Age-Related Hearing Loss?

Lendra Friesen & Lisa Cunningham, University of Washington, Seattle, WA

While it is well-known that hearing loss increases with age, the etiology of presbycusis is not clear. What changes happen in the aging cochlea that result in age-related hearing loss? Often, humans with age-related hearing loss also have lost some of the outer hair cells of the organ of Corti. Therefore, it has long been suspected that this loss of outer hair cells is the underlying cause of age-related hearing loss. However, it is difficult to separate the effects of noise and aging in the human population, since many older adults with presbycusis also have a significant history of noise exposure. Thus the outer hair cell loss in many older humans could be the cumulative result of a lifetime of noise exposure.

One classic set of audiometric findings in age-related hearing loss includes high-frequency sensorineural hearing loss with relatively normal thresholds in the lower frequencies. This is often accompanied by a significant loss of speech intelligibility. This set of findings has been termed *sensory presbycusis* (Schuknecht, 1974). A second set of audiometric findings in the aged population includes a relatively flat hearing loss across frequencies with good speech intelligibility. This type of hearing loss has been termed *metabolic presbycusis*, and it is associated with degeneration of the stria vascularis, not the hair cells (Schuknecht, 1974).

Like humans, gerbils demonstrate both the sensory and metabolic types of presbycusis (Schmiedt and Schulte, 1992; Gratton and Schulte, 1995). Unlike humans, it is feasible in gerbils to separate the effects of noise and aging by raising the animals in a very quiet environment for their entire lives. Gerbils aged in quiet develop hearing losses that vary widely from one individual to another, but all of them show some threshold shift, especially at the high frequencies (Tarnowski et al., 1991). This high-frequency hearing loss often occurs in the absence of concomitant hair cell loss (Tarnowski et al., 1991). It appears that the hearing loss seen in quiet-aged gerbils is the result of deterioration of the stria vascularis and a decrease in the endocochlear potential (EP) (Gratton et al., 1996). Decreases in EP are known to reduce the function of outer hair cells and diminish the output of the cochlear amplifier. These data have led to the hypothesis that hearing loss solely due to age is the result of an energy-starved cochlear amplifier (Schmiedt et al., 2002).

Can human presbycusis result from decreases in EP and deterioration of the stria vascularis? Mounting evidence suggests it can. Atrophy of the stria vascularis is a common finding among aged humans (Hawkins and Johnsson, 1985). While it is not possible clinically to measure EP, cochlear metabolic dysfunction can be indirectly measured using growth (input-output) functions of distortion product otoacoustic emissions (DPOAEs) (Gates et al., 2002). This is because DPOAEs measured at low stimulus intensities result primarily from the action of the cochlear amplifier (Kemp, 1978). Recently Gates, et al. (2002), measured DPOAEs and hearing thresholds in 432 adults and found a greater decline with age in hearing thresholds than in DPOAE input-output functions. These results agree with the gerbil studies and indicate that a loss of strial function and a decline in EP account for a significant amount of age-related hearing loss in humans.

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"On-Hold Time"—an Often-Overlooked Marketing Opportunity

Wendy Brown, Applied Media Technologies Corporation, Clearwater, Florida

When a patient calls an audiologist's office to make an appointment or get information, they are often put "on hold." That can be frustrating to the caller. Savvy service providers are working to enhance the "patient experience," but they often overlook the first opportunity they have to create a good impression: the time telephone callers spend "on hold" before speaking with a member of staff. "Hold" time is a fact of life for every practice; it is simply not possible to staff efficiently and eliminate hold time completely. If the average "hold" time is 30 seconds, a practice that receives 100 calls a day, 260 business days a year, has callers on hold 200 hours a year! Many callers left in "dead air" simply hang up, and they may not call back.

Some practices play the radio on hold. However, under copyright law this requires the payment of hefty annual fees to ASCAP, BMI and SESAC, the organizations that collect music royalties. Playing music tapes or CDs requires the same royalties as radio. "Elevator" music is expensive and provides no marketing benefit. The best solution is a mix of music and messages about your practice. It's inexpensive, and makes otherwise dead "on hold" time productive.

The earliest "on hold" systems consisted of an endless cassette tape playing on an inexpensive tape player. They required constant maintenance and suffered from frequent quality and breakdown problems. The advent of CDs offered a better solution; they never wear out, they sound great, and you can fit over an hour of messages.

CDs themselves are great, but using "off the shelf" consumer-grade CD players to play "on hold" messages doesn't work. They're not designed to be played continuously and will burn out quickly. Most only allow the repetition of a single track or the whole CD. Repeating a single message is monotonous; repeating the whole CD means it can't contain time-sensitive messages like holiday greetings. Also, the output volume of most CD players is inadequate for "on hold" use, so an additional amplifier is required. Finally, if there's even a momentary power interruption, a regular CD player loses its programming and stops.

CD players that have been developed specifically for "on hold" applications solve these problems. Costing under $500, these players are designed for continuous-duty, preserve their programming if power is lost, and have built-in amplifiers. A CD can contain messages for each holiday, special promotions, and other time-sensitive material, which can be programmed into the playlist only when they're needed.

A lower cost option for practices not needing the large message capacity and programmability of CD is players using digital memory chips (about $250). The newest ones utilize removable "memory cards" like those used in digital cameras. There are no moving parts to wear out or break, so the systems provide years of trouble-and maintenance-free performance.

Choose your message production vendor carefully. Many vendors can provide both the player and production services, which allows a single point of contact. If there's a problem, there's no squabbling between an equipment vendor and a service provider regarding responsibility. Many smaller vendors do not have staff copy-writers, so you must provide a ready-to-produce script. Ask about turnaround times. Many smaller vendors rely on sub-contract studio engineers and narrators, and production can take awhile, especially if you need post-production changes. Check references. Upstart "on hold" vendors are everywhere, and some are nothing more than a lone radio DJ moonlighting from home. Some use music that's not properly licensed, subjecting you to potential legal liability. They tend to disappear as quickly as they appear, leaving you "holding the bag." A vendor that's been in business at least five years is a safe bet.

Avoid any vendor that insists on a contract for ongoing monthly or annual fees. Vendors that insist on a service contract are hoping you'll forget to use the service, resulting in a "money for nothing" windfall for them. If a vendor does a good job initially, you'll likely return for updates when you need them. Anyone that tries to lock you into a service contract obviously isn't confident that his quality of service will make you want to return.

Don't even consider leasing. Back when on-hold players cost over $1000, leasing was a way to make them affordable for smaller businesses. The price of "on-hold" players is now so low that you can easily afford to buy one outright. Leasing an "on hold" package poses great risk. Here's why: the message-on-hold vendor technically sells to the leasing company a package that includes a player and a number of message updates. The leasing company pays the message-on-hold vendor for the whole package in advance (including the future updates), and then turns around and leases the package to you, typically for three years. The leasing company contract specifically states that they have no responsibility for services the message-on-hold vendor is supposed to provide. If the message-on-hold vendor can't (or won't) perform, you're still "on the hook" for the lease payments. Message-on-hold vendors go out of business all the time. There is simply no reason to expose yourself to this risk. Quality vendors will gladly sell you a player with an initial message production, and then sell you updates when you need them. "Pay as you go" means no risk.

Message topics are limited only by your imagination. Promote wellness tips, detailed insurance procedures, and introduce staff members. Low-key information is the key. Frequently thank the caller for holding. Don't be afraid to be creative and entertaining. Callers will really enjoy the messages, and you'll turn them into satisfied patients.

FEDERAL REGISTER
PAGES 15973-8 FEDERAL REGISTER VOL. 68, NO. 63
WEDNESDAY, APRIL 2, 2003 PROPOSED RULES

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

SUMMARY: This proposed rule would revise the requirements for audiologists furnishing services under the Medicaid program. In addition, it would create consistency with the Medicare requirements that define a qualified audiologist by recognizing the role of State licensure in determining provider qualifications. These revised standards would expand State flexibility in choosing qualified audiologists.
DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on June 2, 2003.
ADDRESSES: In commenting, please refer to file code CMS–2132–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission or e-mail.

Mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2132–P, P.O. Box 3016, Baltimore, MD 21244–3016.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses: Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.
For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.
FOR FURTHER INFORMATION CONTACT: Linda Peltz, (410) 786–3399.
SUPPLEMENTARY INFORMATION:
Inspection of Public Comments:
Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786–7195.

Copies: This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access*, a service of the U.S. Government Printing Office. The Web site address is:
http://www.access.gpo.gov/nara/index.html

I. Background

A. Legislation

Medicaid Requirements

Title XIX of the Social Security Act (the Act) authorizes Federal grants to States for Medicaid programs that provide medical assistance to low-income families, the elderly, qualified pregnant minors, and persons with disabilities. The Medicaid program is jointly financed by the Federal and State governments and administered by the States. Within Federal rules, each State chooses eligible groups of beneficiaries, types and ranges of services, payment levels for services, and administrative and operating procedures. The nature and scope of a State's Medicaid program is described in the State plan that the State submits to us for approval. The plan is amended whenever necessary to reflect changes in Federal or State law, changes in policy, or court decisions. Under section 1902(a)(10) of the Act, States must provide certain basic services. Section 1905(a)of the Act identifies categories of services States may provide as medical assistance.

Under the Medicaid program, services for individuals with speech, hearing, and language disorders historically have been permitted under the Secretary's discretionary authority under section 1905(a)(11) of the Act. In our regulations, at 42 CFR 440.110(c), we require that the beneficiary be referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law for services furnished by, or under the direction of, a qualified audiologist or speech pathologist. As currently defined at §440.110(c)(2), an audiologist or speech pathologist is an individual who has a certificate of clinical competence from the American Speech-Language-Hearing Association (ASHA); completed the equivalent educational requirements and work experience necessary for the certificate; or completed the academic program and is acquiring supervised work experience to qualify for the certificate.

Medicare Requirements

Section 1861(ll)(2) of the Act defines audiology services to include hearing and balance assessment services furnished by a qualified audiologist, as the audiologist is legally authorized to perform under State law. Section 1861(ll)(3)(B) then identifies the minimum qualifications that a qualified audiologist must have to participate in the Medicare program by defining a "qualified audiologist''as an individual with a master's or doctoral degree and who—

- Is licensed as an audiologist by the State in which the individual furnished those services; or
- In the case of an individual who furnishes services in a State that does not license audiologists, has—
  - + Successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience);
  - + Performed not fewer than 9 months of supervised full-time audiology services after obtaining a master's or doctoral degree in audiology or a related field; and
  - + Successfully completed a national examination in audiology approved by the Secretary.

B. Current Medicaid Program Experience

Since its inception, the Medicaid program has permitted States the option of providing services for individuals with speech, hearing, and language disorders. Audiology services may be provided in a variety of settings at the State discretion. States have the option of providing audiology services to their adult Medicaid population, but because of the mandatory Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, must provide audiology services to Medicaid eligible persons under 21 years of age who have been evaluated and found in need of the service. In fact, Medicaid pays for a substantial number of medical services provided to children with disabilities in schools (''school-based services") according to the Individuals with Disabilities

CONSUMER WORKSHOP

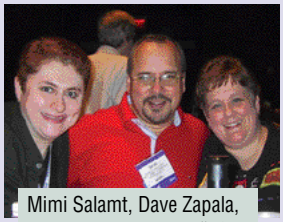
For the second year in what is bound to become a convention tradition, The Academy hosted a Consumer Workshop for the residents of San Antonio. Sixty-four consumers took time out of their busy day to hear fifteen local audiologists discuss the most recent research and developments in the field of audiology. This year a "CART" captioning service was presented during the seminar for each speaker. This service was clearly appreciated as several of the participants were wearing cochlear implants.

Members of the local audiology community did a wonderful job of bringing audiology to the people of San Antonio.

ON-LINE CEU MANAGER & CONVENTION EVALUATION

Convention attendees may register their continuing education convention attendance on-line through CEU Manager until May 30, 2003. CEU Manager may be found at www.audiology.org/convention/2003/ceu.php.

Convention attendees are invited to complete a short evaluation questionnaire available on The Academy website. A random drawing will be held mid-May from all of those members who complete the on-line evaluation to select two winners who will receive complimentary registration to the Convention 2004 in Salt Lake City.



Mimi Salamt, Dave Zapala, and Megan Mulligan. "After this great Convention, the Trivia Bowl is like a dessert to a good meal. We love the new format and feel like we are on Jeopardy. It's a great way to wrap-up the Convention."

"The parties are the best part of Convention. Where else can you go and have so many fun times to choose from in such a short period of time? We wish the Convention happened more than once each year!"

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Inaugural Meeting of the Academy of Federal Audiologists and Speech-Language Pathologists

The Executive Committee of the Academy of Federal Audiologists and Speech-Language Pathologists (AFASLP) announced today the selection of Douglas Noffsinger as the Academy's first President. Noffsinger is Past-President of the Association of VA Audiologists (AVAA) and Chief of Audiology and Speech Pathology at the VA Greater Los Angeles Healthcare System. Other major organizations within the AFASLP are the Military Audiology Association (MAA) and the Association of VA Speech-Language Pathologists (AVASLP). The Academy presidency will rotate among the three organizations.

The executive group also announced the appointment of David Miller as President-Elect and Thomas Hutchison as Secretary-Treasurer of the Academy. Miller is President of AVAA and Chief of Audiology and Speech Pathology at VA San Diego Healthcare System. Hutchison is Head of the Audiology Division, Naval Health Care New England, in Portsmouth, NH. In addition to the officers mentioned above, the AFASLP Executive Committee consists of Beverly Hildebrand, Chief of Audiology and Speech-Language Pathology at VA Central Arkansas Healthcare System, and Lt. Col. Angela Williamson, Flight Commander, Audiology/Hearing Conservation at Robins Air Force Base, GA, and President of the Military Audiology Association. Other members are Lucille Beck, Director of the VA National Program in Audiology and Speech Pathology and Chief Consultant to the Secretary of Veterans Affairs for the Rehabilitation Strategic Health Group, and the Audiology Service Consultants to the Surgeon Generals of the Army, Col. David Chandler; Cmdr. Nancy Hight of the Navy, and Lt. Col. Martha Ann Stokes of the Air Force.

AFASLP membership includes military and civilian Audiologists and Speech-Language Pathologists employed by branches, departments, and agencies of the U.S. Government, both in the United States and overseas. As the umbrella organization for the three government employee associations, it is one of the largest organizations of its type in the world. The Academy seeks to bolster inter-agency cooperation within the Federal Government and to promote the membership's interests to private and commercial concerns in the hearing and communications industry, as well as to professional associations. It creates or reviews consensus statements on major issues of interest to its membership, and promotes those interests. It provides active support of a mission that includes clinical service, education and research.

Lucille Beck addresses the Association of VA Audiologists at Convention 2003 in San Antonio, TX.

Officers of the Academy of Federal Audiologists and Speech-Language Pathologists (AFASLP) (standing from left) Douglas Noffsinger, Tom Hutchinson, David Chandler. (seated) David Miller, Lucille Beck and Angela Williamson.

Education Act (IDEA) (Pub. L. 105–17, enacted on June 4, 1997). Our current regulations at §440.110(c)(2), require audiologists to hold a certificate of clinical competency from ASHA, or its equivalent, to furnish audiology services. Current regulations also permit services to be provided under the direction of a qualified (ASHA certified) audiologist.

C. Consistency with Medicare Program

Before the Social Security Amendments of 1994 (Pub. L. 103–432, enacted on October 31, 1994), the Medicare and Medicaid regulations both required speech pathologists and audiologists to meet the academic and clinical experience requirements for a Certificate of Clinical Competence granted by ASHA. In accordance with section 146 of the Social Security Amendments of 1994, Medicare revised its statutory requirements for speech pathologists and audiologists, removing the requirement for ASHA certification and placing primary reliance for determining provider qualifications on State licensure.

After the revision of the Medicare requirements in 1994, we began receiving letters from audiology professionals and interested parties recommending that we adopt the Medicare definition of qualified audiologists. In addition, the introductory text of the legislation entitled ''The Medicaid Audiology Act of 1999'' (H.R. 1068); and the Committee Report for FY 2001 Labor, Health and Human Services, and Education Appropriations bill (Report 106–645, page 108), recommended that we adopt the Medicare definition of ''qualified audiologist'' in the Medicaid program; that is, recognize the role of State licensure in determining provider qualifications. The proponents recommending the change stated that the Medicaid definition had not changed in over 20 years and predated the national trend toward greater reliance on State determinations of professional qualifications through licensure.

Last year, after repeated requests to reconcile the differing definitions, we agreed to consider possibilities for changing the Medicaid regulations to bring them into closer conformity with the Medicare requirements by recognizing State licensure in defining a qualified audiologist in a manner that would not compromise State flexibility and quality of care.

We began by conducting meetings with stakeholders and interviewing national organizations to determine the implications that this change would have on Medicaid programs, providers, and beneficiaries. Based on the information gained from those encounters, we now believe it is possible to enact a change to the Medicaid definition of qualified audiologist to recognize the role of State licensure, while simultaneously incorporating standards that address our concerns regarding quality standards of care.

The requirements proposed in this rule reflect our goal of maintaining Medicaid's quality standards while simultaneously being responsive to States, stakeholders, and beneficiaries. Our proposed provider standards recognize the role of State licensure in determining provider qualifications, while preserving the State's flexibility and professional industry standards that aid in ensuring quality services to all Medicaid beneficiaries.

II. Provisions of the Proposed Regulations

This proposed rule only addresses the qualifications of audiologists as defined under §440.110(c)(2). At this time, we do not propose to change the requirements under this section pertaining to qualified speech-language pathologists.

We are proposing to make the following revisions to the regulations:

- In §440.110(c)(2), to define audiologists separately from speech pathologists.
- To add a new §440.110(c)(3) to define ''qualified audiologist''. ''A qualified audiologist means an individual with a master's or doctoral degree in audiology who—

(i) Is licensed as an audiologist to perform those services by the State in which the individual furnishes those services, providing that the State licensure requirements meet or exceed the requirements in paragraph (c)(3)(ii)(A) or (c)(3)(ii)(B) of this section;''.

(ii) In the case of an individual who furnishes audiology services in a state that does not license audiologists or that exempts audiologists practicing in specific institutions or settings from licensure, the individual must meet one of the following standards:

(A) Has a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association; or

(B) Has successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience under the supervision of a qualified master or doctoral-level audiologist), performed not less than 9 months of supervised full-time audiology services after obtaining a master's or doctoral degree in audiology, or a related field, and successfully completed a national examination in audiology approved by the Secretary.

Similar to Medicare's statutory revision in 1994, our proposed regulation will remove the requirement for ASHA certification as the sole standard for determining provider qualifications and will place primary reliance on State licensing.

Our goal in revising the Medicaid audiology provider qualification standards is to make both programs' requirements consistent where possible while also incorporating minimum clinical and academic requirements that reflect nationally recognized industry professional standards. In doing so, we seek to ensure that regardless of where the Medicaid beneficiary receives the audiology services, the services would be provided by highly trained professionals.

To accomplish this goal, our proposed requirements differ from Medicare's through the inclusion of minimum provider academic and clinical practicum standards applicable in States that license audiologists, as well as in States that either exempt audiologists from licensure or that do not license audiologists at all.

''Under the Direction of''

To afford States the flexibility they currently have under Medicaid to determine qualified providers, we plan to retain the alternative requirement for providers who are not themselves qualified audiologists to work ''under the direction of''a qualified audiologist. Section 440.110(c)(1) allows for services to be furnished by or ''under the direction of''a qualified audiologist. This means an individual who is working under the supervision of a Federally qualified audiologist may furnish Medicaid audiology services.

We interpret the ''under the direction of'' requirement to mean that a qualified audiologist who is directly affiliated with the entity providing audiology services must supervise each beneficiary's care. To meet this requirement, an audiologist must see the beneficiary initially, prescribe the type of care provided, and review the need for continued services throughout treatment. The audiologist must assume professional responsibility for the services provided and ensure that the services are medically necessary. The concept of professional responsibility implicitly supports face-to-face contact by the audiologist at least at the beginning of treatment and periodically thereafter. Thus, audiologists must spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of medical practice.

For an audiologist to be affiliated with an entity, there must be a contractual agreement or some other type of formal arrangement between the audiologist and the entity which enumerates the audiologist's supervisory obligations relating

to the care provided to the beneficiaries. Moreover, documentation must be kept supporting the audiologist's supervision of services and ongoing involvement in the treatment. As stated above, we would retain the provision regarding services provided under the direction of an audiologist.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the Federal Register and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the provisions summarized below that contain information collection requirements: §440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

Section 440.100(c)(3)(iii) states that an individual who provides Medicaid audiology services must maintain documentation to demonstrate that they meet the standard(s) set forth in this section. While this requirement is subject to the PRA, we believe this requirement is a usual and customary business activity and the burden associated with this requirement is exempt from the PRA, as stipulated under 5 CFR 1320.3(b)(2) and (b)(3).

If you comment on any of these information collection and record keeping requirements, please mail copies directly to the following: Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Room N2–17–23, 7500 Security Boulevard, Baltimore, MD 21244–1850, Attn: John Burke CMS–2132–P,
and
Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn.: Brenda Aguilar, CMS–2132–P.

IV. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the major comments in the preamble to that document.

V. Regulatory Impact Statement

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993), Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives, and if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually).

We are unable to provide a specific dollar estimate of the economic impact this proposed regulation would have on State and local governments and participating providers. Because the flexibility permitted under Medicaid allows States to provide audiology under various Medicaid benefits, it is not possible to capture accurate expenditure data.

We have determined, however, that this proposed rule is not a major rule under Executive Order 12866, and the Secretary certifies that this proposed rule would not have a significant economic impact on a substantial number of small entities. We have made this determination because while we believe this rule would permit States to have more flexibility in determining who is qualified to provide audiology services, we do not anticipate any increase in States'use of audiology services due to this regulation. Section 804(2) of title 5, United States Code (as added by section 251 of Pub. L. 104–121), specifies that a ''major rule'' is any rule that the Office of Management and

Budget finds is likely to result in—

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment productivity, innovation, or on the ability of United States-based enterprises in domestic and export markets.

In addition, consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), we prepare and publish an initial regulatory flexibility analysis for proposed regulations unless the Secretary certifies that the regulations would not have a significant impact on a substantial number of small entities. For purposes of the RFA, we do not consider States or individuals to be small entities.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. For purposes of the RFA, audiologists that generate total revenues of $6 million or less in any 1 year are considered to be small entities. The Small Business Administration categorizes small businesses for Audiologists along with physical, occupational, and speech therapists. The total number of providers within this category that have total revenues of between $5 million and $7.5 million or less in any one year is 23,823 that they consider small businesses. Those firms and establishments with total revenue above $7.5 million are not considered small businesses according to the SBA. Therefore, approximately 0.92 percent of audiologist would be considered small businesses. For further information on the SBA size standards see 65 FR 69432. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds. This rule will not have a significant impact on small rural hospitals. The Medicaid program permits States the flexibility to provide audiology services under a variety of mandatory and optional benefits. The majority of States do so, mainly as either independent practitioner

services, as part of a nursing facility service or community-based clinic services, or as part of their home health or school-based services programs. In addition, current Medicaid rules permit States the flexibility to provide audiology services by, or under the direction of, a qualified audiologist. This provider flexibility is recognized by states and is widely used to provide audiology services to children through school-based services programs. Because the proposed rule retains the ability for audiology services to be provided ''under the direction of,'' the changes proposed in this rule would not have an impact on how States currently provide services to their Medicaid populations. Therefore, small rural hospitals would not be affected. Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditures in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. We do not anticipate this rule would have an effect on the States, local or tribal governments, or on private sector costs. As we stated earlier, this regulation would give States more flexibility in determining qualified audiologists thereby giving them the ability to choose from a larger provider pool of ''qualified'' individuals. However, because we expect the primary users of Medicaid audiology services, such as, children and seniors, to remain fairly constant, we do not anticipate any significant increase in the use of audiology services due to this proposed rule. In addition, because Medicaid audiology services are optional for states to provide to their Medicaid populations, many states choosing to do so limit utilization in some manner. In addition, many states limit the use of optional services such as audiology in favor of mandatory Medicaid benefits. States providing audiology services to children under the EPSDT program primarily do so a part of their school-based services program under IDEA. Since all 50 states currently have a school based services program in operation, we do not anticipate this rule to have any significant effect on audiology services provided to Medicaid children. Additionally, recognizing that states currently use the flexibility permitted in the Medicaid law to provide audiology services ''under the direction of''a qualified audiologist, we expect states will continue to do so by providing audiology services using individuals working under the supervision of qualified audiologists.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts a State law, or otherwise has federalism implications.

We do not believe this proposed rule in any way would impose substantial direct compliance costs on State and local governments or preempts or supersedes State or local law. This proposed rule would permit States to use State licensed audiologists to provide Medicaid audiology services, thereby giving them increased flexibility in providing Medicaid audiology services. In addition, after researching national audiology usage and reviewing States' currently approved Medicaid States Plans, we anticipate that most, if not all, qualified audiologists currently enrolled in the Medicaid program would continue to be qualified as a result of the continued flexibility proposed in this rule. We also anticipate that States will continue to provide audiology services by using the additional flexibility already granted under the Medicaid program to provide audiology services using individuals meeting State provider qualifications and working within State practice acts ''under the direction of''a qualified Medicaid audiologist. We believe the additional flexibility proposed in this rule to recognize State licensure will serve to enhance States ability to provide services. We do not, however, anticipate this rule will have a significant affect on the actual provision of audiology services in State Medicaid programs and therefore does not have Federalism implications.

B. Anticipated Effects

We anticipate this proposed rule will give States increased flexibility in determining who is a Medicaid qualified audiologist. We also anticipate that the quality care standards proposed in this rule would help ensure that Medicaid audiology services continue to be provided by, or under the direction of, highly qualified and trained individuals. Additionally, we believe conforming the Medicare and Medicaid provider requirements would help eliminate any confusion providers may experience in complying with Federal rules and help reduce or eliminate conflict where audiologists provide services to both the Medicaid and Medicare populations (such as in nursing facilities or through home health care agency providers). Additionally, this proposed rule also serves to eliminate inconsistencies in Medicaid provider standards by no longer recognizing equivalency rulings. Under the current Medicaid rules, states can seek equivalency rulings from their State Attorney General in instances where they believe State licensure is equivalent to ASHA certification. Since the proposed rule recognizes State licensure that meets Medicare-equivalent standards, equivalency rulings are no longer necessary or required. We believe States would look favorably on the elimination of equivalency rulings since they proved administratively burdensome and time-consuming to obtain.

C. Alternatives Considered

In developing the policies set forth in this proposed rule, we met with professional organizations and interested parties to solicit their ideas and concerns. We also worked with our national regional office Staffs to review currently approved Medicaid state plans for information on the provision of audiology services in States'Medicaid programs. We considered the role of audiology services in the Medicaid program and the potential impact changes in the standards for audiology providers would have overall. We considered several options that included (1) no change to the current Medicaid audiology requirements, (2) retain current requirements but issue updated policy guidance on issues such as provider equivalency authority, (3) rewrite the current Medicaid regulations to adopt the current Medicare requirements, and (4) rewrite the current Medicaid regulations to adopt the Medicare standards, but with minimum standards that would apply in States that do not license or that exempt some practitioners from State licensure requirements.

After much research and consideration of the impact of each of the options, we concluded that option 4—the standards proposed in this rule—best satisfy the commitment made by the Secretary and address the request raised by interested parties to conform the definition of a qualified audiologist under the Medicare and Medicaid programs by recognizing the role of state licensure as a Medicaid provider requirement. We also concluded that the standards proposed in this rule best continue to recognize states rights under Medicaid by retaining program flexibility while at the same time also building in quality standards that continue to ensure Medicaid services are provided to all Medicaid-eligible individuals by recognized, highly trained professionals.

D. Conclusion

For the reason stated above, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this rule would not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of

Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 440

Grant programs—Health, Medicaid.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services would amend 42 CFR chapter IV, part 440 as set forth below:

PART 440—SERVICES: GENERAL PROVISIONS

Subpart A—Definitions

1. The authority citation for part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security

Act (42 U.S.C. 1302).

2. In §440.110(c), the introductory text of paragraph (c)(2) is revised, and new paragraph (c)(3) is added to read as follows:

§440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

* * * * *

(c) *Services for individuals with speech, hearing, and language disorders.*

* * * * *

(2) A ''speech pathologist'' is an individual who—

* * * * *

(3) A "qualified audiologist''means an individual with a master's or doctoral degree in audiology who—(i) Is licensed as an audiologist to perform those services by the State in which the individual furnishes those services, providing that the State licensure requirements meet or exceed those in paragraph (c)(3)(ii)(A) or (c)(3)(ii)(B) of this section;

(ii) In the case of an individual who furnishes audiology services in a State that does not license audiologists, or that exempts audiologists practicing in specific institutions or settings from licensure, the individual must meet one of the following standards:

(A) Have a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association; or

(B) Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience under the supervision of a qualified master or doctoral-level audiologist), performed not fewer than 9 months of supervised full-time audiology services after obtaining a master's or doctoral degree in audiology, or a related field, and successfully completed a national examination in audiology approved by the Secretary.

(iii) Individuals who provide Medicaid audiology services must maintain documentation to demonstrate that they meet the standard(s) set forth in this section.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: November 26, 2003.

Thomas A Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: January 28, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–8021 Filed 3–31–03; 8:45 am]

BILLING CODE 4120–01–P

PASSAGES PASSAGES **PASSAGES** **PASSAGES**

Laurel Christensen has been appointed Director of North American Research Audiology by the GN ReSound Group. Christensen was previously associated with Etymotic Research. In her new position at GN ReSound, Christensen will remain in Chicago and manage research activities for both the Beltone and ReSound hearing instrument brands. She will continue to serve as an outside faculty member for both Northwestern and Rush Universities.

Mayo Clinic in Rochester, MN announces the appointment of **Jodi Cook** to the Department of Otorhinolaryngology where she will have clinical responsibilities and conduct clinical research related to hearing aids. She was previously Director of Audiology for Songbird Hearing Inc.

Robert Wolf has re-joined Siemens Hearing Instruments as Vice President, Business Development. Wolf left Siemens 2 1/2 years ago and has since held executive positions with Audiology Online and Sonic Innovations.

Ellen Kurtzer White of Rhode Island recently lost her battle with cancer at the age of 49. As the Chair of the Rhode Island Pediatric Task Force she worked tirelessly to write protocols for testing and fitting hearing impaired children in Rhode Island. She graduated from the University of Rhode Island and received her master's degree from Vanderbilt University. White earned an AuD degree through the University of Arizona's distance learning program. White was a grant manager at New Connections in Rhode Island.

Arthur N. Schildroth, 75, whose work for 23 years as a senior research associate at Gallaudet University included a long-running national study of hearing-impaired children across the country, died of cancer April 7 at his Silver Spring home. He also advised educators on achievement testing of deaf children and wrote extensively on deaf education issues. His books included "Deaf Children in America" and "Deaf Students and the School-to-Work Transition."

Kenneth Donnelly, of the University of Cincinnati, died suddenly from cancer on April 19 at the age of 66. Donnelly was Professor of Audiology in the Department of Communication Sciences and Disorders of the McMicken College of Arts and Sciences of the University of Cincinnati. Named the first Program Director of Speech and Hearing at UC in 1967, Donnelly also served as Head of the Department of Communication, Speech and Theater from 1970 through 1980; President of the Ohio Council of Audiology, Chair of the Development Committee of the Board of Directors of St. Rita School for the Deaf; Member of the Board of Trustees for Workshops for Retarded Citizens. An author and national and international lecturer, Donnelly loved working with and for deaf children. This interest brought him to study programs for deaf children in the Dominican Republic in 1983 and to establish a hearing clinic in Managua Nicaragua in 1991. When asked what he enjoyed most about his professional and teaching career he would respond, ''Teaching undergraduates and graduates about the wonderful world of audiology and the miracle of hearing.''

Ira Hirsh received the Peter H. Raven Lifetime Achievement Award from the Academy of Science of St. Louis. Hirsh has been with the Central Institute for the Deaf (CID) and Washington University since 1951. Hirsh published the influential textbook, "The Measurement of Hearing," and more than 100 scholarly articles dealing with psychoacoustics and audiology topics. Hirsh has been recognized with awards from numerous professional organizations such as The Acoustical Society of America, ASHA, and the Royal Society of Medicine, and an Honors Career Award in Hearing from the American Academy of Audiology in 2000.

2003 Iowa SLHA Convention

The 2003 Iowa Speech-Language-Hearing Association Convention will be held in Des Moines, Iowa on October 23-25, 2003. Program and registration information will be available in late summer. For registration and/or exhibit information, please contact ISHA at 535 S.W. 5th Street, Des Moines, IA 50309 or email Sheila Dietz at sdietz@assoc-mgmt.com

NAFDA NEWS

On January 29, 1999, the National Association of Future Doctors of Audiology (NAFDA) had its first national meeting in Louisville, Kentucky. This year, NAFDA is poised to expand to more than 2500 members with support from eleven corporate partners in education and 48 Advisory Board members. Membership in NAFDA includes all four-year AuD students, distance learning AuD students, alumni members, and life members. All AuD students are automatically NAFDA members and, upon earning their degree, they are honored as alumni members. Life membership is a special recognition.

Today there are more than 600 four-year AuD students, nearly 1300 distance learning students, and more than 800 practicing Doctors of Audiology. In the Fall of 2003, 41 AuD programs from across the nation will be accepting students. It is estimated that more than 400 NAFDA four-year members attended the American Academy of Audiology Convention in San Antonio. The Executive Officers include Kelly Newman (Nova Southeastern), Vice President; Jennifer Woo (Buffalo), Secretary; and Chizuko Tamaki (Gallaudet), Treasurer. The 2003 NAFDA President is David Jardine from the University of Louisville.

NAFDA is currently developing a database of fourth year AuD practicum experiences. Fourth year AuD positions will be posted on the NAFDA website (www.nafda.org) to allow students to explore opportunities that will fulfill the AuD requirements. If interested in posting a position, please contact Monica Johnson at mjohnson@nafda.org.

Visit The OAE Portal

The OAE Portal is a web site dedicated to scientific and clinical advances in the areas of otoacoustic emissions, neonatal hearing screening and cochlear biophysics. The site www.otoemissions.org went live in June 2001.

The OAE Portal provides a collection of the available knowledge concerning (a) otoacoustic emissions (OAEs), (b) neonatal hearing screening and cochlear mechanics, and (c) related scientific and clinical applications, covering in detail various aspects from general information to specific scientific themes. Information on the website addresses different audience groups and offers a wide range of on-line lectures and white papers.

STAVROS HATZOPOULOS AND THIERY MORLET

The Portal brings together respected European, American and Australian scientists from nine different countries, forming a 14-member web editorial committee. The Web Editor of the site is Stavros Hatzopoulos, of the Center of Bioacoustics at Ferrara University, Italy. Web-assistant Editors:Thiery Morlet, New Orleans, USA; Katia De Almeida, São Paulo, Brazil; Antoni Grzanka, Warsaw, Poland. Editorial Board Members are Paul Avan, Ferrand, France; Graciela Brik, Buenos Aires, Argentina; Jenny Chan, Hong-Kong, China; Ted Glattke, Tuscon, Arizona, USA; Marlis Knipper, Tübingen, Germany; Eric L. LePage, Chatswood, Australia; Brenda Losburry-Martin, Rockville, MD, USA; Mark Lutman, Southampton, UK; Glen Martin, Denver, CO, USA.; Jacek Smurzynski, Basel, Switzerland.

NEWS & ANNOUNCEMENTS

CONTINUING EDUCATION CORNER

Reminder:

Enter your Convention 2003 CEUs into CEU Manager by May 30th!

It is your responsibility to enter your Convention 2003 CEUs online at http://audiology.org/convention/2003/ceu.php. Accessing CEU Manager from your home or office will be available until May 30, 2003. You must be on The Academy's CE Registry to print a transcript. For a CE Registry form go to www.audiology.org/professional/ce/.

DID YOU MISS CONVENTION 2003?

If you weren't able to make it to Convention 2003, Convention 2003 can still make it to you! Six CD-ROMs are available from the following educational categories: Amplification/Diagnostics, Auditory Processing Disorders, Pediatrics, Practice Management, Rehabilitation and Ethics (fulfills ethics CEU requirements for ABA certificants).

Each CD-ROM includes complete audio and slides from 2 Featured Sessions in the categories mentioned above. CEUs (.3) are available upon fulfillment of the educational requirements for each CD-ROM. The cost is $75 per CD-ROM for members. For more information go to www.audiology.org/CEUCD-ROM.

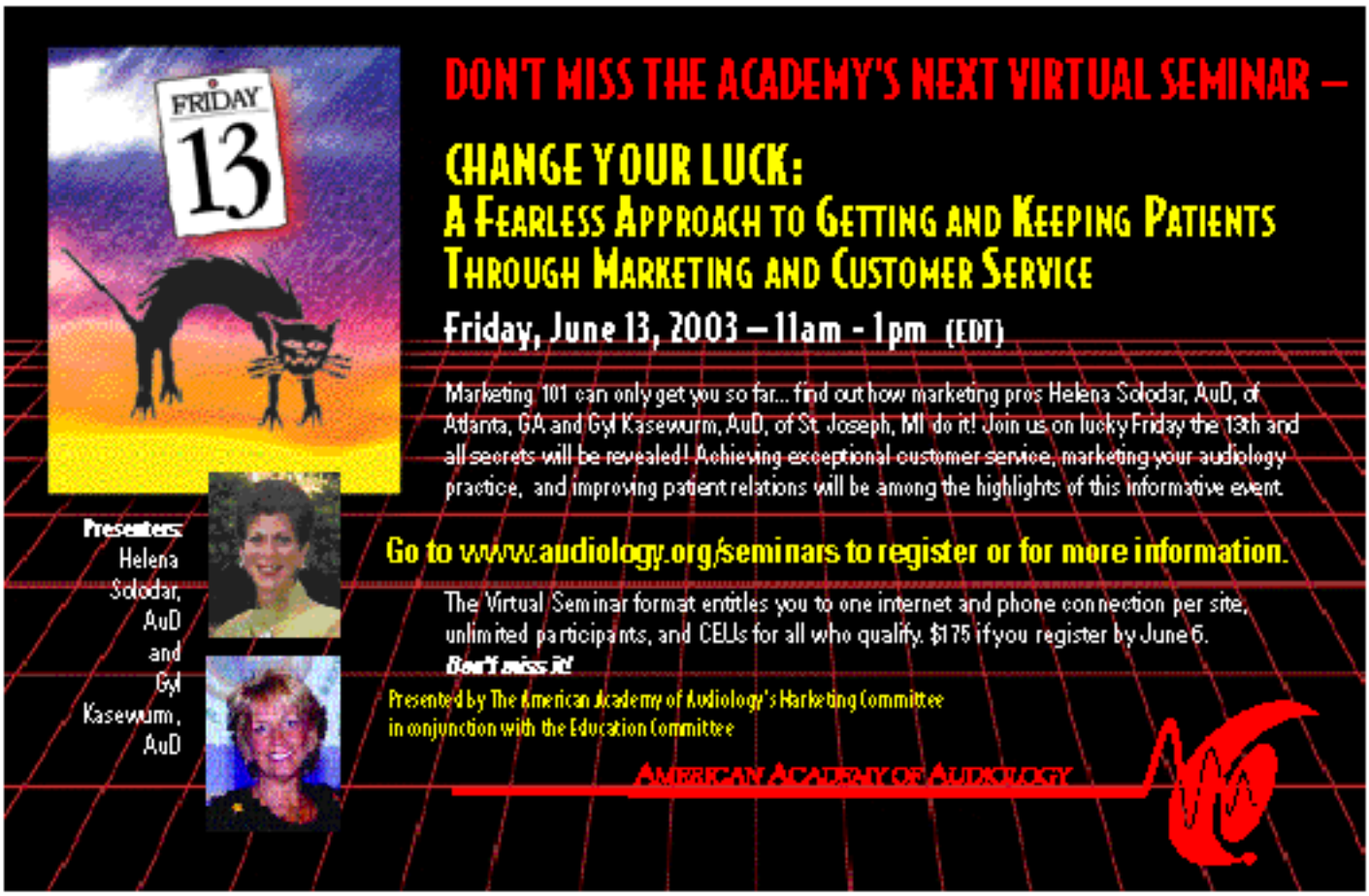
VIRTUAL SEMINAR CDS

If you missed the successful Virtual Seminars that The Academy held this past winter, it's not too late to gain the valuable information from the following topics:

CD1 Update on Meningitis and Cochlear Implants

CD2 HIPAA "How To" Approach for your Audiology Practice

You'll receive complete audio, handouts and the opportunity to earn .2 CEUs if you fulfill the educational requirements. The cost of the CD is $50 for members. For more information go to ww.audiology.org/CEUVS.



Membership and Member Value Growing!

The American Academy of Audiology has had an action packed year since we last gathered in Philadelphia. The Academy's membership ended 2002 at our highest level of membership in our history with 8,235 members. This is a 7.6% growth over 2001.

The Academy staff has been actively involved in monitoring and reporting on state and federal issues as they relate to reimbursement, licensure, and professional autonomy, to name a few.

The Academy has added more member benefits and services to increase the value of your membership. Over the past year, you have been provided with the additional benefits of:

- GEICO Auto Insurance
- A Dual Membership Card and GlobalPhone Calling Card
- Communication Science and Disorders Dome Search Engine Online Subscription
- Academy Credit Card Enhanced with World Points Rewards Program
- Improved Employment Service Center at Convention
- Increased functionality and information for members through www.audiology.org including *JAAA* Online, an Expanded Governmental Affairs / CapWiz, HIPAA / Reimbursement Area, a New Research Page, and more.

Spread the word to your non-member audiologist colleagues. Encourage them to join The Academy and take advantage of Academy benefits. Together audiologists can move the profession forward. For more information on Membership or Member Benefits contact us at 800-222-2336.

NOT JUST A MEMBERSHIP CARD... THE ACADEMY MEMBERSHIP CARD & WORLDWIDE CALLING CARD

More services - specifically for you!

YOUR PERSONALIZED ACADEMY MEMBERSHIP CARD...

In December 2002, the American Academy of Audiology mailed to you a permanent Academy Membership Card, with your name and Academy ID. Carry it with you for quick and easy reference when accessing The Academy web site. If you did not receive your Membership Card, be sure to contact your Academy's Membership Department at (800) 222-2336.

A DUAL FUNCTION - IT'S ALSO A WORLDWIDE CALLING CARD!

Your Membership Card also provides an added Academy member benefit: The Academy Worldwide Calling Card. With a recently reduced US/US rate of 5.9 cents per minute and up to 75% off international calls, your Academy Worldwide Calling Card provides real savings with the convenience you would expect from a calling card. Use it to make calls from any telephone or mobile phone in the U.S. and in over 80 countries worldwide via toll free Direct Access Numbers. Experience long distance calling with no activation fees, minimum monthly charges, connection fees, or surcharges of any kind!

Wait...There's more! BE SURE TO TAKE ADVANTAGE OF THE MANY FEATURES YOUR ACADEMY WORLDWIDE CALLING CARD HAS TO OFFER...

- **CONFERENCE CALLING —** Conference Calling "on demand" for up to 16 people means you do not need to schedule the call ahead of time. Call each party and bring them into conference on the fly!
- **INTERNATIONAL CALLBACK SERVICE** — International Callback is available at no extra charge for members traveling to a country without Direct Access Numbers. Contact Customer Support for set up and instructions.
- **SPEED DIAL —** Store up to 99 phone numbers for convenient one-touch dialing to family, friends and colleagues.
- **MONTHLY STATEMENTS VIA MAIL OR EMAIL** — See whom you called, when you called, and for how long you talked - that's it! No small print, no hidden charges or fees, no surprises.
- **ONLINE ACCOUNT MANAGEMENT** — The "My Account" feature allows you to check call details in real time, make changes to account information, print current International Direct Access Numbers, and refer friends online.
- **BALANCE INQUIRY—** No web access at the moment? Check your account balance at any time using any touch-tone phone.
- **PAY FOR YOUR CALLS AND NOTHING MORE** — Academy members are billed automatically for "actual usage only" at the end of the month to their credit card of choice.
- **SUPPORT THE ACADEMY —** For each call you make, GlobalPhone makes a financial contribution to The Academy

So activate your Academy Worldwide Calling Card today - risk free - and receive 30 minutes of calling FREE!

** 30 free minutes must be used within the month of activation. Any unused minutes after this time will be forfeited.*

BRAZIL

Deborah Price recently spent nine days in Brazil's rainforest where she tested and treated 216 natives living in seven remote villages along a 210 mile stretch of the Upper Rio Negro River. Price works through the Rio Negro Foundation and makes periodic visits to train practitioners and treat patients in South America.

Academy Board Member, Ted Glattke, recently participated in the First International Instructional Course offered by the newly established Brazil Academy of Audiology. More than 100 audiologists and physicians attended the course which was held in Sao Paulo. Glattke is pictured below with Doris Lewis, the President of the Brazil Academy of Audiology.

AuD Offered by Kent State University and The University of Akron in Joint Program

Kent State University and The University of Akron are offering a joint doctorate in the field of audiology. The Ohio Board of Regents have approved the program and applications from students are now being accepted for classes that begin in the Fall 2003 semester. The Northeast Ohio AuD Consortium (NOAC), a joint effort of the two universities, coordinates the four-year post-baccalaureate program leading to the degree of Doctor of Audiology. Plans call for 16 students to be enrolled per year, eight from each school. Students can enter the AuD program from either institution, and will have the opportunity to take classes and use facilities at both campuses. For more information, call The University of Akron at (330) 972-6118 or Kent State University at (330) 672-2672 or visit www.kent.edu/aud.

NEWS & ANNOUNCEMENTS

AuD Scholarships Established at Rush University

Rush University is pleased to announce the establishment of the Gyl and David Kasewurm scholarships for Doctor of Audiology (AuD) students. One scholarship for tuition support will be awarded to a student for each of the next five years. Gyl Kasewurm, who received her AuD degree in 2000, is an enthusiastic supporter of audiology students. Gyl and her husband, David, have owned and operated Professional Hearing Services in St. Joseph, Michigan since 1983. Kasewurm lectures in AuD programs, provides externships at her private practice, and serves on the AuD Advisory Board of Rush University.

Jergers Are First Dome Customers

Susan and James Jerger stopped by the Communication Sciences and Disorders Dome exhibit at the San Antonio Academy Convention. The Jergers placed the first order for the new Dome on-line reference service. The Dome is an internet high-tech professional resource and reference database developed specifically for audiologists and the communication sciences. The Jergers are shown above with Angie and Sadanan Singh, officers of the Board of Directors for Content Scan, Inc. and creators of the Dome. Visit www.audiology.org for information about the Dome and to place your order through the American Academy of Audiology.

Arizona School of Health Sciences Grants 92 AuD Degrees

The Arizona School of Health Sciences (ASHS), a school of A.T. Still University, granted 92 Doctor of Audiology (AuD) degrees to transitional students at its March 15th commencement in Mesa, AZ. In addition, A.T. Still University bestowed the University's first honorary Doctor of Humane Letters to ASHS alumna Anita Pikus, of Bethesda, MD. Pikus provided the ASHS graduates with an inspiring address with insight on professional pioneering and personal responsibility. Audiology graduates along with family and friends and ASHS Audiology faculty and staff held a reception and dinner the night before graduation. The event featured camaraderie, an AuD pinning ceremony, and the donation of $3,100 on behalf of this year's audiology graduates to benefit the new ASHS Audiology four-year residential program.

CLASSIFIED ADS • CLASSIFIED ADS

INDIANA

ASSISTANT/ASSOCIATE PROFESSOR OF AUDIOLOGY:

Full-time nine-month (summer negotiable) tenure-track position in Audiology. The position is available August 22, 2003, and is part of an AuD program that was established in 1995. Responsibilities: teaching undergraduate and AuD level courses; conducting research; mentoring students and providing clinical supervision to doctoral level students enrolled in a CAA accredited program in audiology.

Minimum qualification: Asst Prof status-ABD in audiology or related discipline near completion, CCC-A, and eligibility for Indiana state licensure. Assoc Prof status-earned doctorate in audiology or related discipline, eligibility for Indiana state licensure, and record of scholarly activities. Preferred qualification: strong background in the physical sciences and/or computer technology.

Send letter of application, vita, transcripts, and three letters of recommendation to: Mary Jo Germani, PhD, Department of Speech Pathology and Audiology, Ball State University, Muncie, IN 47306. (Inquiries are welcomed: (765) 285-8162 or mgermani@bsu.edu.) Review of applications will begin February 28, 2003, and will continue until the position is filled (www.bsu.edu).

Ball State University is an equal opportunity, affirmative action employer and is strongly and actively committed to diversity within its community.

VERMONT

AUDIOLOGIST:

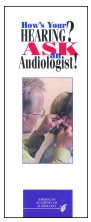
Immediate opening for full-time or part-time certified Audiologist to compliment our multi-office ENT practice. Responsibilities include audiometry, ABR, vestibular evaluation with VNG, hearing aid fitting, dispensing, and management; patients of all ages. Competitive salary/benefit package including 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.

For information about our employment web site, HearCareers, visit www.audiology.org/hearcareers. For information or to place a classified ad in *Audiology Today*, please contact Patsy Meredith at 303-397-3190 or Fax 303-372-3189.

Put The Academy's
Marketing & Educational Tools
To Work For Your Practice

The American Academy of Audiology publishes a wide variety of brochures and multi-media materials that can help you educate your patients and market your services.

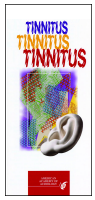
B R O C H U R E S



How's Your Hearing? Ask An Audiologist!
This newly updated brochure now includes more in depth information on how hearing is evaluated, what causes hearing loss, how we hear, signs commonly associated with hearing loss and more. (pkgs of 100) Members: $40.00; Non-Members: $50.00.

What Is An Audiologist?
Looking for a way to enhance both patient and community awareness? This brochure actively promotes the role of the practicing audiologist as a critical provider of hearing health services. (pkgs of 100) Members: $25.00; Non-Members: $30.00.

Selecting the Hearing Aids That Are Right For You
Choosing hearing aids can be a confusing and often stressful experience for those dealing with hearing loss for the first time. This brochure offers a step-by-step guide to purchasing hearing aids and covers a broad range of hearing aid topics including styles, technology, and why consumers should consult an audiologist. The Academy's Pre-Purchase Assessment Guideline for Amplification Devices is also included. (pkgs of 100) Members: $40.00; Non-Members: $50.00.



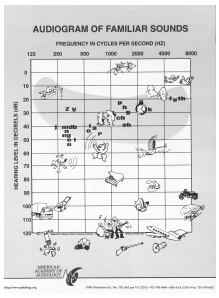
Tinnitus
The patient who complains of hissing, roaring or ringing in the ears offers a special challenge to audiologists and other hearing health professionals. "Tinnitus" includes detailed information on what causes tinnitus, who suffers from it, what treatments are currently available, and what one can do to minimize its effects. Geared toward patients and their families, the brochure encourages tinnitus sufferers to consult an audiologist who is knowledgeable about tinnitus to help develop a management program. (pkgs of 100) Members: $40.00; Non-Members: $50.00.

Newborn Hearing Screening
Intended for both parents and allied health professionals, this informative brochure emphasizes the importance of hearing screening for newborns. The brochure explains why a baby should be tested as soon as possible, how the testing will be done and the hearing milestones that are a part of an infant's normal development. (pkgs of 100) Members: $40.00; Non-Members: $50.00.

Your Baby's Hearing
Ideal for new parents, this brochure contains information on infant hearing milestones and hearing loss with simple advice for parents. Highlighting the importance of normal hearing in babies, it encourages parents to seek help from audiologists to request hearing testing. Available in English and Spanish. (pkgs of 100) Members: $25.00; Non-Members: $30.00.

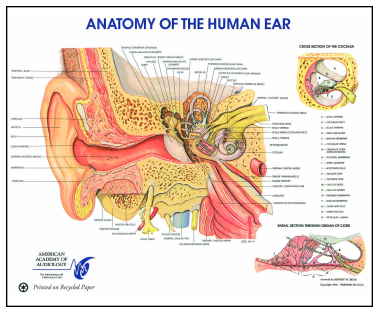
HIV/AIDS Related Hearing Loss
Intended for anyone concerned about this issue for themselves, a family member or a friend, this brochure discusses the connection between HIV/AIDS and hearing loss. Explains how this type of hearing loss can be prevented, what treatments are available, and why it's crucial for HIV/ AIDS patients with hearing loss to work closely with an audiologist. (pkgs of 100) Members: $25.00; Non-Members: $30.00.

C H A R T S • P O S T E R S



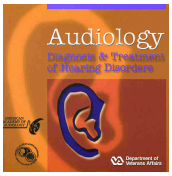
Audiogram of Familiar Sounds
Illustrates the frequency and intensity of general English sounds during normal conversational speech relative to common environmental sounds. Black & White. (pkgs of 100) Members: $25.00; Non-Members: $30.00.

Ear Anatomy Chart & Poster
This attractive full-color illustration is an updated version of the classic Zenith Ear Chart by Ernest W. Beck. Small Poster (8.5" x 11") (pkgs of 100) Members: $30.00; Non-Members: $35.00 Large posters (17" x 22") (single copy) Members: $4.50; Non-Members: $7.00.

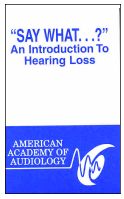


Ear Anatomy Write-On/ Wipe-Off Chart
This full-color 14" x 16" laminated ear anatomy chart allows you to write directly on the illustration and erase by wiping off with a damp cloth. Ideal for educating patients about the inner workings of the ear. (single copy) Members: $12.00; Non-Members: $15.00.

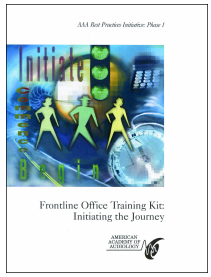
INTERACTIVE & EDUCATIONAL TOOLS



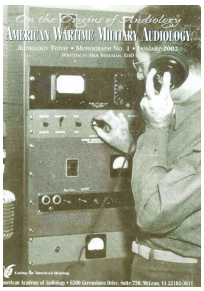
Diagnosis & Treatment of Hearing Disorders CD-ROM
This interactive educational program provides a tutorial review and illustration of current major test procedures in audiology, including behavioral and electrophysiologic techniques. In addition, it covers a wide range of disorders and pathologies, explores in-depth case studies, and includes an online exam that can be used to obtain CEUs from the American Academy of Audiology and the American Academy of Otolaryngology - Head and Neck Surgery. $95.00 each (10% discount of 5 or more).



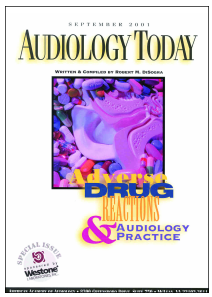
"Say What...?" An Introduction to Hearing Loss Audio Cassette
This 12 minute tape discusses hearing and hearing loss and includes an activity segment of 10 discrimination words filtered with various low-pass filter cut off frequencies to simulate sensorineural hearing loss. Ideal for student and adult audiences, medical and allied health in-service presentations. Members: $12.00 each; Non-Members: $15.00 each.



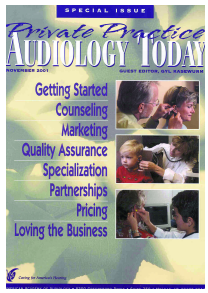
Frontline Office Training Kit
This indispensable resource can improve the way your front office staff interacts with patients. The kit includes an informative videotape, educational audio cassette, an easy-to-use reference book, and a workbook — everything you need to ensure that every patient is met by someone who is a good communicator AND a good listener. Members: $100.00 each kit; Non-Members: $120.00 each kit.



Academy Monolith #1: American Wartime Military Audiology (2002)
The origin of audiology is generally acknowledged to have evolved from the rehabilitative services developed by the military during WWI and II. Audiology pioneer Moe Bergmen authors this well documented and widely researched historical account detailing the birth of the profession. (24 pages) Members: $12.50; Non-Members: $15.00.



Adverse Drug Reactions & Audiology Practice (2001)
Drugs may have a serious impact on hearing and auditory perception. This comprehensive listing of 315 side effects provides important information to audiologists and is a valuable reference tool. (20 pages) Members: $15.00; Non-Members: $20.00.



Private Practice (2001)
This wonderful resource provides everything you need for a successful private practice. Nationally known experts in the field cover many topics including getting started, counseling, marketing, quality assurance, specialization, partnerships, pricing and loving the business. (32 pages) Members: $15.00; Non-Members: $20.00.

MARKETING MATERIALS

The Complete Physician's Referral Starter Kit
You can effectively market your audiology services to physicians with the highly acclaimed, test-marketed Complete Physician's Referral Starter Kit. Each Starter Kit includes the comprehensive Building Bridges Instructional Binder and the Physician's Hearing Health Kit, which comes complete with a Physician's Handbook, 25 educational brochures on hearing loss for patients, an interactive PowerPoint presentation for "lunch & learns," and the HearPen Screener. Members: $75.00; Non-Members: $90.00

Supplemental Physician's Hearing Health Kits
Drop off one of these handy kits to every physician you want to partner with. Each Physician's Hearing Health Kit comes complete with a Physician's Handbook, 25 educational brochures on hearing loss for patients, an interactive PowerPoint presentation for "lunch & learns," and the HearPen Screener. Members: $50.00; Non-Members: $60.00

Hearing Loss?
Brochure refills for the physician's kit. Cultivate your growing relationship with the physician each time you drop off more educational patient brochures on hearing loss. Each full-color brochure includes indicators for detecting hearing loss, reasons why the patient may be unaware of a hearing loss, general information on hearing aids, the Hearing Health Quick Test, and room for your practice's contact information on the back. (pkgs of 100) Members: $40.00; Non-Members: $50.00.

BROCHURES & CHARTS

(100 in each package)	Member	Non-Member	Quantity	TOTAL
How's Your Hearing? Ask An Audiologist!	$40.00	$50.00	_____	$_____
Selecting the Hearing Aids That Are Right For You	$40.00	$50.00	_____	$_____
Tinnitus	$40.00	$50.00	_____	$_____
What is an Audiologist?	$25.00	$30.00	_____	$_____
HIV/AIDS Related Hearing Loss	$25.00	$30.00	_____	$_____
Newborn Hearing Screening	$40.00	$50.00	_____	$_____
Your Baby's Hearing	$25.00	$30.00	_____	$_____
Your Baby's Hearing (Spanish)	$25.00	$30.00	_____	$_____
Audiogram of Familiar Sounds	$25.00	$30.00	_____	$_____
Ear Anatomy Chart (8.5 x 11)	$30.00	$35.00	_____	$_____
Ear Anatomy Poster (17 x 22")	$ 4.50	$ 7.00	_____	$_____
New! Ear Anatomy Write-On/Wipe-Off Chart	$12.00	$15.00	_____	$_____

EDUCATIONAL & MULTIMEDIA

JCIH Year 2000 Position Statement	$ 1.00	$ 1.00	_____	$_____
Clinical Practice Algorithms & Statements	$ 1.00	$ 1.00	_____	$_____
Special Audiology Today: Private Practice	$15.00	$20.00	_____	$_____
Special Audiology Today: Adverse Drug Reactions	$15.00	$20.00	_____	$_____
New! American Wartime Military Audiology Monolith	$12.50	$15.00	_____	$_____
"Say What?" Audio Cassette	$12.00	$15.00	_____	$_____
Diagnosis & Treatment of Hearing Disorders CD	$95.00	$95.00	_____	$_____
Frontline Office Training Kit	$100.00	$120.00	_____	$_____

MARKETING MATERIALS

Complete Physician's Referral Starter Kit	$75.00	$90.00	_____	$_____
Supplemental Hearing Health Kit	$50.00	$60.00	_____	$_____
Hearing Loss? (brochure refills for Kit; pkgs of 100)	$40.00	$50.00	_____	$_____
			SUBTOTAL	$_____
*International orders, contact The Academy for quote.			Postage & Handling *(Add 10%)*	$_____
			Tax *(Virginia residents add 4.5%)*	$_____
*Prices are subject to change			**GRAND TOTAL**	$_____

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