

MAR/APR
2018

American Academy of Audiology
www.audiology.org

AUDIOLOGY

TODAY

The magazine of, by, and for audiologists

Preparing Your Practice

Pre-OTC

**PRIVATE
PRACTICE IN A
TIME OF
BIG HEALTH**
Enhancing Our Position

EYES AND EARS
Securing Our Scope

**GENETICS AND
HEARING LOSS**
Academy Research
Conference 2018

Revolutionary

Not all captioned telephones are created equal. CaptionCall is the one that revolutionized the industry with no-cost phones and free delivery, installation and in-home training, and we continue to raise the bar. Give your eligible patients CaptionCall—**the GOLD STANDARD in captioned telephone service.**



Access the New Whitepaper by Dr. Frank Lin

“Hearing Loss and Healthy Aging.”
Visit www.captioncall.com/provider



With CaptionCall, your patients will enjoy the smoothest scrolling captions (SilkScroll®) and most powerful amplification available (up to 121.5 dB SPL) for the ultimate calling experience.



Give your patients the very best.
Give them CaptionCall!
www.captioncall.com/provider | 1-877-385-0936

 **CaptionCall®**
Life is Calling

Professional certification is required for your patients to participate in this no-cost program.

Your patients have so many reasons to stay in touch on the phone.



Your patients receive:

Free Phone.
Free Service.
Free Set up.
No contracts.

Req. submission of 3rd party certification form.




Make all their calls easy again.

Patients who have used the phone for a lifetime find it difficult to stay in touch without it. Help your patients reengage in life with a free Sprint CapTel captioned phone. Your patients can follow what's being said by reading live captions of every call.

Free for you and your patients. You receive a free kit with everything you need to offer Sprint CapTel in your practice (even a demo phone!)

Learn More ► professionals.sprintcaptel.com • **877-805-5845**

CapTel is intended for use by people with hearing loss. Individuals with hearing loss must complete & submit a Third Party Certification of Eligibility signed by hearing health professional to be eligible for free Internet-based CapTel phone. **Free CapTel Phone Offer:** Requires submission of 3rd party certification form. See www.captel.com/thirdparty.php for details. CapTel Captioning Svc. funded through FCC provisions. CapTel callers are responsible for their own long distance call charges. Sprint reserves the right to modify, extend or cancel offers at any time. See sprintcaptel.com for details. **Other Terms:** Offer/coverage not avail. everywhere. Restrictions apply. ©2017 Sprint.



Mar/Apr 2018
Vol 30 No 2

18

Proactive Planning: Preparing Your Practice Pre-OTC

As the landscape of hearing health care shifts and adjusts to the disruption that over-the-counter (OTC) hearing aids may bring to the hearing technology market, the Academy remains committed to the best interests of our members and patients. Dr. Sydlowski has authored this article as a member of and on behalf of the Academy Board of Directors to inform our members and help them proactively prepare for the possible changes ahead.

By Sarah A. Sydlowski

32

Private Practice in a Time of Big Health

This article is a review of the shift toward mergers in health care, and its potential effects on audiology as a profession and the independent audiology practice. The challenge of the profession should be to remain autonomous within this structure. We cannot be so focused in one direction and ignore our blindside. We need to be able to anticipate the hit so that we can counter it and maintain, or hopefully enhance, our position.

By Bre Myers

44

Eyes and Ears

Audiology and optometry have similar roles in scope of practice and similar concern for disruptive innovations. Medicine is under constant disruption from non-physician groups for expansion of service. Optometry has been successful in securing their scope of practice. Will audiology be the disruptor or the disrupted?

By Christopher Spankovich

52

Genetics and Hearing Loss: Academy Research Conference 2018

Given the strong relationship between genetics and hearing loss in audiological practice, the Academy continues its commitment to providing audiologists the latest on genetics research as it relates to hearing impairment in clinical practice through the annual Academy Research Conference (ARC).

By David Fabry

62



8	PRESIDENT'S MESSAGE	Listening to the Music in Nashville By Jackie Clark
12	KNOW-HOW	It Takes a Village: Lessons in Group Aural Rehabilitation Therapy By Aaron M. Roman
17	CALENDAR	Academy and Other Audiology-Related Deadlines and Meetings
17	THE WEB PAGE	What's Trending
62	CASE STUDY INVESTIGATION (CSI)	When Is Ménière's Disease Not Ménière's Disease? By Anne Hogan
68	CODING AND REIMBURSEMENT	Advanced Beneficiary Notice of Noncoverage Use: Mandatory or Voluntary? By Kristiina Huckabay and Kari Morgenstein
72	PUBLIC RELATIONS	Should You Fear the Press? By Vicki Bendure
74	FOCUS ON FOUNDATION	Getting to Know the New Trustees
77	SAA SPOTLIGHT	Audiologists with Hearing Loss: A Different Perspective By Amanda Demas, Kelsey Roy, and Audrey Taylor
82	ABA SOUNDING BOARD	ABA's New Chair and Her Vision
85	ACAE CORNER	Educating AuD Students for the Practice of Evidence-Based Audiology By James Hall III

Academy News

88	AUDIOLOGY ADVOCATE	Audiology Advocacy Comes to Nashville By Rebecca West
92	2018-2019 BOARD NOMINEES	Review this Year's Candidates for the Academy Board
98	2018 HONORS AND AWARDS	Review this Year's Winners
103	JUST JOINED	Welcome New Members of the Academy

EDITORIAL MISSION

The American Academy of Audiology publishes *Audiology Today* (AT) as a means of communicating information among its members about all aspects of audiology and related topics.

AT provides comprehensive reporting on topics relevant to audiology, including clinical activities and hearing research, current events, news items, professional issues, individual-institutional-organizational announcements, and other areas within the scope of practice of audiology.

Send article ideas, submissions, questions, and concerns to fabryd@icloud.com.

Information and statements published in *Audiology Today* are not official policy of the American Academy of Audiology unless so indicated.

COPYRIGHT AND PERMISSIONS

Materials may not be reproduced or translated without written permission. To order reprints or e-prints, or for permission to copy or republish *Audiology Today* material, go to www.audiology.org/resources/permissions.

© Copyright 2018 by the American Academy of Audiology. All rights reserved.



AABR • Audiometry • Tympanometry • OAE

New! touchTymp



touchTymp

ALL-TOUCH impedance line

- Screening and Diagnostic Probes*

New Spring 2018 - Air & Bone combination models

**Features depend on touchTymp model*



MA 28

Air • Bone Audiometer

- Compact and portable with built-in handle & integrated storage compartment



MA 42

Air • Bone • Speech

- 2 channel audiometer
- Mobile carry case included
- Special tests: MCL, Sisi, Decay, ABLB, MCL

MA 41

- 1.5 channel audiometer also available



Ero•Scan®

Otoacoustics Emissions (OAE)
Screener and Diagnostic

- 4, 6, and 12 frequency DPOAE testing protocols
- Easy pass/refer results

Show Specials
AAA Booth #433

MAICO Diagnostics

10393 West 70th Street
Eden Prairie, MN 55344

Tel.: 888.941.4201
Fax: 952.903.4100

e-mail: info@maico-diagnostics.com
Web: www.maico-diagnostics.com

AUDIOLOGY

TODAY

The American Academy of Audiology promotes quality hearing and balance care by advancing the profession of audiology through leadership, advocacy, education, public awareness, and support of research.

Editor-in-Chief

David Fabry, PhD | fabryd@icloud.com

Associate Editors

Sumitrajit Dhar, PhD
M. Samantha Lewis, PhD
Bre Myers, AuD, PhD
Christopher Spankovich, AuD, PhD

Editor Emeritus

Jerry Northern, PhD

Executive Editor

Amy Miedema, CAE | amiedema@audiology.org

Art Direction

Suzanne Chanesman

Marketing Manager

Amber Werner

Editorial Assistant

Kevin Willmann

Web Manager

Marco Bovo

Advertising Sales

Alyssa Hammond | ahammond@networkmediapartners.com | 410-316-9851

AMERICAN ACADEMY OF AUDIOLOGY OFFICE

Main Office

11480 Commerce Park Drive, Suite 220, Reston, VA 20191
Phone: 800-AAA-2336 | Fax: 703-790-8631

AMERICAN ACADEMY OF AUDIOLOGY MANAGEMENT

Executive Director Tanya Tolpegin, MBA, CAE | ttolpegin@audiology.org

Vice President of Public Affairs Kitty Werner, MPA | kwerner@audiology.org

Vice President of Communications and Membership Amy Miedema, CAE | amiedema@audiology.org

Senior Director of Finance and Administration Sandy Fulgham | sfulgham@audiology.org

Senior Director of Meetings and Education Kim Mydland | kmydland@audiology.org

Senior Director of Business Development Carrie Dresser | cdresser@audiology.org

Senior Director of Advocacy and Reimbursement Kate Thomas, MA | kthomas@audiology.org

Director of Membership and IT Administration Sarah Sebastian, CAE | ssebastian@audiology.org

American Academy of Audiology Foundation Manager Rissa Duque-Yangson | ryangson@audiology.org

Student Academy of Audiology Associate Director Rachael Sifuentes | rsifuentes@audiology.org

American Board of Audiology Certification Manager Natalie Rogers | nrogers@audiology.org

Accreditation Commission for Audiology Education Director Meggan Olek | molek@audiology.org

BOARD OF DIRECTORS

PRESIDENT

Jackie Clark, PhD
University of Texas Dallas Callier Center
jlark@utdallas.edu

PRESIDENT-ELECT

Lisa Christensen, AuD
Cook Children's Hospital
lisavchristensen@gmail.com

PAST PRESIDENT

Ian M. Windmill, PhD
Cincinnati Children's Hospital Medical Center
ian.windmill@cchmc.org

MEMBERS-AT-LARGE

Bopanna B. Ballachanda, PhD
Audiology Management Group
bbalachanda@gmail.com

Holly Burrows, AuD
Walter Reed National Medical Center
holly.l.burrows.civ@mail.mil

Melissa E. Heche, AuD
New York Speech and Hearing
mheche@ny-sh.com

Francis Kuk, PhD
Widex ORCA-USA
fkuk@aol.com

Tracy Murphy, AuD
Audio-Vestibular Lab
tracy_murphy@comcast.net

Virginia Ramachandran, AuD, PhD
virginia.ramachandran@gmail.com

Brad Stach, PhD
Henry Ford Hospital
bradstach@mac.com

Sarah Sydlowski, AuD, PhD
Cleveland Clinic
sydlows@ccf.org

Chris Zalewski, PhD
czalewski1@verizon.net

EX OFFICIOS

Tanya Tolpegin, MBA, CAE
Executive Director
American Academy of Audiology
ttolpegin@audiology.org

Jennifer Whittaker
President, Student Academy of Audiology
jeni.whittaker.saa@gmail.com

Audiology Today (ISSN 1535-2609) is published bimonthly by the American Academy of Audiology, 11480 Commerce Park Drive, Suite 220, Reston, VA 20191; Phone: 703-790-8466. Periodicals postage paid at Herndon, VA, and additional mailing offices.

Postmaster: Please send postal address changes to *Audiology Today*, c/o Membership Department, American Academy of Audiology, 11480 Commerce Park Drive, Suite 220, Reston, VA 20191.

Members and Subscribers: Please send address changes to membership@audiology.org.

The annual print subscription price is \$126 for US institutions (\$151 outside the US) and \$61 for US individuals (\$114 outside the US). Single copies are \$15 for US individuals (\$20 outside the US) and \$25 for US institutions (\$30 outside the US). For subscription inquiries, telephone 703-790-8466 or 800-AAA-2336. Claims for undelivered copies must be made within four (4) months of publication.

Full text of *Audiology Today* is available on the following access platforms: EBSCO and Ovid.

Publication of an advertisement or article in *Audiology Today* does not constitute a guarantee or endorsement of the quality, safety, value, or effectiveness of the products or services described therein or of any of the representations or claims made by the advertisers or authors with respect to such products and services.

To the extent permissible under applicable laws, no responsibility is assumed by the American Academy of Audiology and its officers, directors, employees, or agents for any injury and/or damage to persons or property arising from any use or operation of any products, services, ideas, instructions, procedures, or methods contained within this publication.



Visit us at
Booth #738



The next ~~big~~ ^{small} thing
by Dry & Store[®]
DryMax[®]

Made in USA

see more at dryandstore.com/drymax

EAR TECHNOLOGY CORPORATION

Helping people hear better, every day._{sm}

Proud to be the exclusive distributor for Resonance equipment in the U.S.

eartech.com | 1-800-327-8547 | info@eartech.com



Innovative solutions
for hearing assessment



Devices designed, developed and
manufactured entirely in Italy

see more at eartech-resonance.com

Listening to the Music in Nashville

It seems fitting, as we converge on “Music City” Nashville for our 30th Annual Conference of the American Academy of Audiology, to take time to enjoy the music. After all, “music gives a soul to the universe, wings to the mind, flight to the imagination, and life to everything” (Plato). But, music and musicians can also teach us important life lessons. I once read that harmonious and enjoyable bluegrass music requires the stringed instrument musicians (e.g., guitar, mandolin, fiddle, banjo, bass, dulcimer, etc.) to play in specific chords set by the lead instrument.

If one song highlights the banjo, then all of the instruments use those chords suitable to the banjo. Apparently, the players become masterful at effortlessly changing chords to suit the other instrument. Each song will have different, unique chords suited to the lead instrument. Each member of the band understands the importance of maintaining the constant rhythm while also adapting to each other's musical lead.

Our AAA Annual Conference is a reminder of the many instruments and voices of the Academy membership. Over the conference's four-day period of time, we are able to appreciate the breadth and depth of skills and personalities within the profession of audiology. Indeed, our Academy membership

ranges from Fellows, Affiliates, International Members, Student Members, Undergraduate Associates, Life Members, Retired Members, etc. Within those broad categories, about 67 percent of our members have the sole terminal degree as AuD; 10 percent hold an alternate type of doctorate (i.e., PhD, EdD, MD, etc.); 24 percent hold some form of master's degree (e.g., MAuD; MS; MA; etc.). When we turn the data in a different direction, about 80 percent of our members are female and 22 percent of our members are private practice owners/employees. However, the data never tell us about unique needs, experiences, or wants of our members within each broad category. We do not see how many private practice owner/employer members focus their attention to learn more about pediatric audiology or hearing conservation or genetics or ...?

Our AAA 2018 Program Committee began searching in 2016 for over 30 hours of CEU content that would be appealing to the many “instruments” that make up our Academy membership; allowing for time of harmony, listening, and trying new and unique chords. A few of this year's enticing offerings include glimpsing into the future of audiology and health care (Jeff Goldsmith, PhD); empowering leaders to ignite impact in the workplace (Tacy Byham, PhD); looking at early childhood education



with a public health approach (Dana Suskind, MD); public relations media training; genetics and hearing loss; cochlear implant-mediated perception of music (Charles Limb, MD); the NEW workshop for office staff; NEW Advocacy Workshop; the Membership Meeting (Thursday at 11:15 am); and the First-Time Attendee Orientation.

Come join us in Nashville as we listen and learn to play along with each other's music. [AA](#)

A handwritten signature in black ink that reads "Jackie J. Clark". The signature is fluid and cursive.

Jackie Clark, PhD
Board Certified in Audiology
President
American Academy of Audiology



INTELLIGENT TODAY.
SMARTER TOMORROW.

HEARING HAS
EVOLVED.

COMING MAY 2018.



Preview the New Evolution of Hearing Aids.
Widex Cinema. AAA 2018 Booth #613.

1.888.474.5530 | widexpro.com

Boost efficiency across your



Win an
audiometer from
Otometrics

Offer ends
April 30, 2018

Entry Code:
OTO1803-AT

OTO1803-AT

855.283.7978

www.audiologysystems.com/otosuite

Call 855.283.7978 for a live demo or visit

clinic!



Gain more time for patient care

Otometrics offers a wide range of flexible devices and PC-based hearing care solutions. They all run on Otosuite® – the integrated audiology software platform that enables you to work from one application during the entire client journey. From diagnostics and counseling to fitting and verification you:

- **Save time and reduce errors** by entering data only once
- **Ensure accurate data management** with easy connectivity to Noah and external Electronic Medical Records (EMR)
- **Create customized reports** by combining data across devices
- **Get more from your equipment** – add new devices quickly as your needs change and your practice grows

Whether you need basic or specialized audiometric testing, Otometrics has the solution for you. Let us help you achieve more with an integrated clinic today!

Enter to win an audiometer:
audiologysystems.com/otosuite

us at AAA 2018 booth #621

 **otometrics** | **audiology systems**
a division of natus



It Takes a Village: Lessons in Group Aural Rehabilitation Therapy

By Aaron M. Roman

Every Tuesday around 2:15 pm, a clamor of voices can be heard outside of my office.

These are not the voices of students, excited to end their school day, nor are they the voices of my faculty co-workers, filling their coffee mugs. Instead, these voices come from the six individuals that consist of the weekly group aural rehabilitation session. These six individuals come from a variety of backgrounds, with a diverse arrangement of hearing impairments, but all share one common goal—to improve their hearing beyond what their current situation provides.

As anyone who has worked with the hearing-impaired population is aware, there is no magical switch when it comes to hearing loss. Activating a cochlear implant after years of long-term hearing loss does not restore hearing to normal levels, nor does simply wearing a well-programmed pair of hearing aids. Instead, listening improvement occurs with time, acclimation,

patience, and, most importantly, persistence. In this article, I will outline the most important takeaways that I have learned through administering weekly group therapy. It is my hope that you may learn from where I stumbled.

Lesson #1: Developing (Measurable) Goals Is Hard

One of the most important lessons that I learned as a relatively recent graduate from my doctorate program is that the best way to ensure success is to develop realistic, measurable goals. As audiologists, we have a continually growing number of subjective questionnaires at our disposal, which can successfully assess individual performance. Using these questionnaires with a setting of six patients, however, has repeatedly proven a difficult task.

Having no access to the one, perfect questionnaire, my team begins group therapy by administering

the Patient Expectation Worksheet (PEW) to each individual at the very beginning of the therapy semester (group therapy is provided each semester), to assess the range of expectations within the group. Developing realistic expectations for therapy outcomes is essential for any intervention protocol, and helps create a strong initial dialogue with the patients involved (Palmer and Morner, 1999).

The PEW allows the patient to reflect on individual goals and score their personal success in each situation from “Hardly Ever” to “Almost Always.” All of the PEWs were reviewed and the communication goals were divided into the following five categories:

1. Speech Reading
2. Lip Reading
3. Repair Strategies
4. Social Participation

5. Listening Effort

These categories were used to develop goals and activities targeted throughout the semester.

At the end of the semester, the communication goals set down by the patient were individually reviewed and re-scored. Overall, patients demonstrated improvement in four out of the five categories, with Speech Reading alone showing no change over the semester.

Lesson #2: Developing the Group Takes Time

In any group therapy setting, the clinician is exposed to a variety of patient personalities with diverse backgrounds. As you will see from the Hearing Handicapped Inventory for the Elderly (HHIE) scores, we had participants who demonstrated significant handicaps with a range in severity. Impact of hearing impairment, however, is not the only factor that make this group diverse.

For example, our recent group consisted of both men (n=3) and women (n=3), included ages ranging from the mid-60s to the mid-80s, and included both hearing aid users and cochlear implant users. All of this leads to the obvious fact that expectations from patient to patient were different, as was perception of relevance, depending on the task. Each individual patient involved in the group therapy sessions completed the HHIE (Ventry and Weinstein, 1982) prior to enrollment in the therapy. The average social and emotional handicaps of the group was 68 percent and 64 percent, respectively. For overall handicap, the group reported a 66 percent handicap overall, with scores ranging from as low as 56 percent, and as high as 100 percent handicap.

Those administering group rehabilitation should be pleased to read

that evidence suggests that as time progresses, members of the group tend to be more cohesive (Macnair-Semands and Lese, 2000), and my experience supports this finding. As the semester progressed, those who were initially more vocal, yielded to those more reserved. Individuals from within the group also began sharing their own insights and information that facilitated meaningful discussion. It was the supervising audiologist's job to ensure that the information was correct.

Lesson #3: One Size Does Not Fit All

The largest hurdle in group aural rehabilitation is developing effective goals that address the needs of the groups. Harder still is developing activities that appropriately move the entire group towards these goals.

Using the measurements discussed in Lesson #1, my team had goals and now had to develop ways to meet them. As audiologists, we are more than well-aware of the benefits of customized treatment. In hearing aids, we use real-ear measurements to customize the amplification to the ear. Treating a group in aural rehabilitation is very much like generalizing the measurements of one ear to a group. So how do you make effective activities?

According to a study by Boothroyd (2007), an effective aural rehabilitation program should have four components:

1. **Sensory Management**—addressing deficits in functionality. For audiology patients, this usually entails hearing aids and/or cochlear implants, although other sensory devices, such as alerting devices and assistive listening devices, could be applied in this area.

2. **Instruction**—discussing the use of the sensory management technique. This can include care and maintenance of the hearing aid/cochlear implant, and can also go so far as when to use certain device settings, or discussion on directional microphones or signal-to-noise ratios.

3. **Perceptual Training**—programs that are developed to target specific goals (i.e., “hearing in noise”). This is heavily focused on during group sessions. Perceptual training programs may include speech reading, working memory training, or listening-in-noise tasks.

4. **Counseling**—discussion of quality of life (QoL) impact to the individual and/or the group. Counseling can focus on emotional attributes to hearing impairments, or be educationally-driven in which the audiologist provides information about the hearing system and the impact of hearing loss to the physical body. Beyond hearing loss alone, evidence suggests that educational counseling can be extremely beneficial in counseling patients with tinnitus (Henry et al, 2007).

In the group setting, activities and goals generally focus on the later three components of Boothroyd's design. To address the individuality of the patient, it might be necessary to provide extra “homework” to individuals within the group. This homework may be informational in nature, such as doing additional research on assistive devices, or more based on training such as listening training software.

Lesson #4: Social Interaction Can Be Powerful Medicine

Remember that clamor of voices? One of the most beneficial rewards to observe as a clinician is the social growth of six persons with hearing loss. It is well established that hearing loss is linked to social isolation (Mick et al, 2014) and poorer QoL measurements (Ciorba et al, 2012). Thus, the social interaction of individuals with hearing loss can be beneficial by itself.


In the context of a group therapy setting, patients that participate develop a bond that allows them to share ideas, experiences, and set-backs. They teach each other self-advocacy skills, link them to other members in the community, and provide a canvas that each patient can use to comfortably discuss their situation that a clinician alone may not be able to provide.

One other benefit observed during group therapy was in the inclusion of significant others. Evidence shows that, in situations where group therapy members bring a significant other, both the patient and the significant other benefit (Habanec and Kelly-Campbell, 2015). In the therapy I supervised, the significant others brought about interesting topic discussions that even the patients did not bring up.

Onward and Upward: Where to Go From Here?

As audiologists, it is our job to ensure that patients function at the top of their listening ability. While the benefit of aural rehabilitation programs to help reach this goal is apparent, the current health-care climate is not supportive from a billing and scheduling perspective. It is my hope that through sharing my experience, you can reflect on your patients and

can begin to develop ideas on how to best serve their needs.

Moving forward, more research in the field of aural rehabilitation, particularly group aural rehabilitation, is needed to demonstrate the importance of this activity on patient outcomes. Through this research, the construction of outcome measurements specific to group therapy would be extremely beneficial to clinical practice. Furthermore, implementing group therapy will not only provide a much-needed benefit to those in the hearing loss community, but will provide visibility to the profession of audiology and the continued development of our field. 

Aaron M. Roman, AuD, is an assistant professor at West Chester University in West Chester, Pennsylvania, and is a member of the Academy's Business Enhancement Strategies and Techniques (BEST) Committee.

References

- Boothroyd A. (2007) Adult aural rehabilitation: What is it and does it work? *Trends Amp* 11(2):63–71.
- Ciorba A, Bianchini C, Pelucchi S, Pastore A. (2012) The impact of hearing loss on the quality of life of elderly adults. *Clin Inter Aging* 7:159.
- Habanec OL, Kelly-Campbell RJ. (2015) Outcomes of group audiological rehabilitation for unaided adults with hearing impairment and their significant others. *Am J Audiol* 24(1):40–52.
- Henry JA, Loovis C, Montero M, Kaelin C. (2007) Randomized clinical trial: group counseling based on tinnitus retraining therapy. *J Rehab Res Dev* 44(1):21.

Macnair-Semands RR, Lese KP. (2000) Interpersonal problems and the perception of therapeutic factors in group therapy. *Small Group Res* 31(2):158–174.

Mick P, Kawachi I, Lin FR. (2014) The association between hearing loss and social isolation in older adults. *Otol Head Neck Surg* 150(3):378–384.

Palmer CV, Mormer E. (1999) Goals and expectations of the hearing aid fitting. *Trends Amp* 4(2):61–71.

Ventry IM, Weinstein BE. (1982) The hearing handicap inventory for the elderly: a new tool. *Ear Hear* 3(3):128–134.

Join us at our new booth #1332



Stop by to see our new booth, try our products, learn from industry experts & earn CEU credits.

Special product pricing available.

You are also very welcome to join our AAA2018 learning modules:

"Comparing the caloric and video head impulse test findings in different vestibular disorders" by Kamran Barin, Ph.D., Consultant

"Diagnostic OAEs: The who, what, why, when and how" by Jessica Arrue Ramos, Clinical Product Manager, ABR/OAE, Interacoustics

Experience more online at interacoustics-us.com

Micromedical by Interacoustics

Earn CEUs your way:

- In booth training
- Online
- Live at AAA


Interacoustics
Academy


Interacoustics

ABR/OAE

Balance Assessment

Fitting Systems

Middle Ear Analyzers

Audiometers

Interacoustics is a world leading diagnostic solutions provider in the fields of hearing and balance assessment. We help the professional audiologic world reach new milestones through continuous developments and a constant focus on integration and direct customer value.

Interacoustics USA 10393 West 70th Street Eden Prairie, MN 55344 T +1-800 947 6334 info@interacoustics-us.com



SENNHEISER

SET 880

High-quality TV listening system.
Made in Germany.

The + in TV listening.



Your + in living together:
Enjoy TV listening without disturbing your loved ones – thanks to five individual hearing profiles and Speech Intelligibility Button.

Your + in convenience:
Experience intuitive handling – with large volume control and automatic on/off function.

Your + in flexibility:
Discover wireless freedom and simple switching between two connected audio sources.

Find out more:
sennheiser.com/set880

What's Trending!

March 7–10

Meeting

CI2018 Emerging Issues in Cochlear Implantation
Washington, DC

www.acialliance.org/page/CI2018

March 21–24

Meeting

2018 Speech-Language-Hearing Association of Virginia (SHAV) Conference
Williamsburg, VA

<http://shav.org/index.php/shav-conference/>

April 11–14

Meeting

CAPCSD Conference 2018
Austin, TX

www.capcsd.org

April 18

Meeting

Academy Research Conference 2018, Genetics and Hearing Loss
Nashville, TN

www.AcademyResearchConference.org

April 18–21

Meeting

AAA 2018, the Academy's Annual Conference and Exposition
Nashville, TN

www.AAAConference.org

 9,371



Audiologists are listed as one of the 32 jobs that pay more than \$70,000 a year, on average, and earned a stress tolerance rating of 71 or lower, according to O*NET.

Published February 2

www.facebook.com/audiology

10,900 



Want to be more creative and feel a little happier? Play this song for 15 seconds.

#audpeeps

Published January 17

www.twitter.com/academyofaud

 2,000



A University of Louisiana at Lafayette professor has spearheaded a study into the possible application of proteins produced by sea anemone into the human ear as a remedy for noise-induced hearing loss.

Published January 18

www.linkedin.com

330 



This adorable baby is hearing his mother's voice for the very first time.

#Repost@people

Published January 8

www.instagram.com/academyofaud

PROACTIVE PLANNING

Preparing Your Practice **Pre-OTC**

BY SARAH A. SYDLOWSKI



As the landscape of hearing health care shifts and adjusts to the disruption that over-the-counter (OTC) hearing aids may bring to the hearing technology market, the Academy remains committed to the best interests of our members and patients. Dr. Sydlowski has authored this article as a member of and on behalf of the Academy Board of Directors to inform our members and help them proactively prepare for the possible changes ahead.

By now, audiologists are well aware that 2017 was a landmark year for audiology, or more specifically, for the industry that provides devices to manage our patients' hearing loss. Following the release of a series of reports calling for increased affordability and accessibility of hearing aids, including those from the Federal Trade Commission (FTC), the President's Council of Advisors on Science and Technology (PCAST), and the National Academies of Science, Engineering and Medicine (NASEM), President Trump signed the FDA Reauthorization Act of 2017 into law. Contained within this law is language that compels the Food and Drug Administration (FDA) to develop proposed regulations for over-the-counter hearing aids.

Although the labeling and introduction of these devices is likely years away, the eventual disruption of the market is top of mind for anyone currently dispensing hearing devices. In reality, consumers are already being inundated with information about personal sound amplification products (PSAPs) and "hearables," which,

Integrated verification for a simpler workflow

Aurical® streamlines the entire fitting process while ensuring quality and efficiency at every step. Now you can verify hearing instrument fittings automatically using Aurical with hearing instrument-fitting software from ReSound, Beltone, Phonak, Oticon, Bernafon and Sonic.

Faster and more precise fitting

If you are like most busy hearing care professionals, you may skip the verification process to save time. Now you can fit without compromise, by performing real-ear measurements automatically with Aurical. Integrated verification means you can make an automated fit to the manufacturer-independent prescriptive targets, or use a proprietary target from inside the hearing instrument fitting software:

1. Phonak Target
2. ReSound Aventa and Smart Fit
3. Beltone Solus Pro and Solus Max
4. Oticon Genie and Genie 2
5. Bernafon OasisTM
6. Sonic EXPRESS^{fit} Pro

Aurical simplifies the entire verification process for a fast and precise fitting. What's more, depending on the fitting software you use, various advanced functionalities are available to enhance the fitting process. For example, Phonak's TargetMatch offers ear canal transform measurements and guidance to position the probe tube to the correct depth - delivering added confidence and customization.

Smoother workflow and easier training

It's now easy to make verification a standard element in your clinic workflow. Instead of learning and working in two software programs, you can verify hearing instrument fitting directly from within the fitting software – streamlining the fitting and verification process. The shorter learning curve helps your clients benefit from verified fittings sooner.

A complete, modular fitting solution, Aurical® encompasses audiometry, PMM, HIT, video otoscopy and a HI programming interface in one system. Hearing care professionals can use the modules independently or combine them as needed.



Aurical makes verification easier with integrated verification to a prescriptive target from within the hearing instrument fitting software. The example above shows Phonak TargetTM using TargetMatch.

What is IMC2?

Inter Module Communication 2 protocol (IMC2) – the new HIMSA standard for integration between hearing aid fitting and real-ear modules - allows fitting and measurement modules to “talk” to each other directly. This means the verification process is automated providing hearing care professionals with a simplified and integrated fitting workflow – resulting in a better fitting experience for the hearing care professional and the client.

How far do IMC2 and Aurical go?

Aurical is enabled IMC2. The full IMC2 capabilities of Aurical support coupler-based fitting and other measurement approaches beyond the integrated real ear fitting. This gives the hearing instrument manufacturers that are currently integrating with Aurical the opportunity to expand their integrated applications, thereby delivering more benefits to hearing care professionals. Manufacturers that are not yet using IMC2 can consider Aurical as a solid platform to start with.

Learn more about Aurical at otometrics.com/aurical

although not regulated by the FDA or labeled for the management of hearing loss, are readily available and becoming more visible.

The extent to which this disruption will be an innovation for hearing health care remains to be seen. In the interim, audiologists are left with questions of the unknown. Some audiologists may feel threatened by the changing environment in which emphasis is placed on the device, and the value of diagnostic and therapeutic care may seem to be minimized. Others may view looming changes as an opportunity to expand their practice to reach individuals who may not have previously considered investigating options to manage their hearing loss. Some audiologists may be worried that potential patients could do more harm by not seeking appropriate care or misusing over-the-counter (OTC) devices. Most audiologists should and do have questions about what the reality of the impact of OTC devices will be on their practices, their patients, and the reputation of the profession.

While OTC devices have not yet entered the marketplace, the American Academy of Audiology (the Academy) recognizes that members have questions now. As the only organization of, by, and for audiologists, the Academy is committed to supporting its members in this changing health-care environment.

WHY IS A NEW CLASS OF OTC HEARING AIDS BEING DEVELOPED?

The PCAST, FTC, and NASEM reports stemmed in part from the perception that the cost of hearing care, and more specifically the cost of hearing aids, prevents some individuals from seeking treatment for hearing loss, particularly since many third-party payers do not cover hearing aids. This includes Medicare where hearing aids and associated services are statutorily excluded. There is also concern from consumers that the cost of hearing devices is not entirely transparent, which is likely exacerbated by the perpetuation of the longstanding practice of bundling the cost of services with the device.

Further, the geographic distribution of hearing care providers, including audiologists, is such that there are many areas in the United States in which individuals cannot readily access hearing care services. Finally, consumers are demanding greater control over their health care, including the desire to “self-direct” their hearing health care.

These themes led to several agencies recommending consumer access to OTC hearing devices. These recommendations were based, in part, on both emerging technologies that could provide hearing benefit and the

perception that an ever-increasing, technologically savvy population might have the capability to fit and program hearing devices themselves (Academy, 2018).

WHAT ARE OTC HEARING AIDS?

It is important to highlight the fact that at the time of publication of this article, OTC hearing aids do not exist. Rather, there is legislation in place that compels the FDA to create labeling that will guide the development and implementation of a new category of FDA-regulated hearing devices that are available to individuals with hearing loss without the prescription or recommendation of a licensed professional. Any discussion of the specifics of what OTC technology will involve is purely speculation at this stage. The OTC law passed by Congress (S934: FDA Reauthorization Act of 2017) defines an OTC device as one that

- a. *uses the same fundamental scientific technology as air conduction hearing aids (as defined in section 874.3300 of title 21, Code of Federal Regulations) (or any successor regulation) or wireless air conduction hearing aids (as defined in section 874.3305 of title 21, Code of Federal Regulations) (or any successor regulation);*
- b. *is intended to be used by adults over the age of 18 to compensate for perceived mild-to-moderate hearing impairment*
- c. *through tools, tests, or software, allows the user to control the over-the-counter hearing aid and customize it to the user’s hearing needs;*
- d. *may—*
 - (i) *use wireless technology; or*
 - (ii) *include tests for self-assessment of hearing loss; and*
- e. *is available over-the-counter, without the supervision, prescription, or other order, involvement, or intervention of a licensed person, to consumers through in-person transactions, by mail, or online.*

NOTE: Though the FDA Reauthorization Act signed into law directs the FDA to create a category of OTC hearing aids for adults with perceived mild-to-moderate hearing loss, the Academy maintains its position that OTC devices be labeled as intended for use by adults with mild hearing loss and with mild communicative impairments.

Academy Recommendations to FDA

1 Labeling for OTC devices should include language that advises the user that better outcomes are achieved when a comprehensive audiological examination is conducted prior to the acquisition of an OTC device.

2 Labeling should address utilization of OTC devices, including both hearing aids and/or PSAPs, by individuals younger than age 18. Specific language should be included, noting that use of OTC devices by individuals younger than age 18 should only occur under the direction of a licensed audiologist.

3 Labeling of OTC devices should advise consumers to seek an evaluation by an audiologist if they are not receiving satisfactory results with an OTC device.

4 Labeling of OTC devices should specify that the output may exceed levels that could cause either additional hearing loss or initial hearing loss in those with normal hearing. Standards for the acoustical characteristics of these devices should be set to limit these risks.

5 Labeling of OTC devices should advise consumers to seek an evaluation by an audiologist when they notice any change in their hearing, including temporary changes, as sustained long-term exposure to moderate-to-high output levels may have a negative effect on hearing.

6 The Academy recommends that the FDA regulations related to the sale and purchase of OTC devices specify that OTC devices are medical devices and not consumer electronics.

7 The FDA should take steps to mitigate consumer confusion regarding the difference between PSAPs and OTC hearing aid devices.

OTC hearing aids and PSAPs are not necessarily interchangeable terms. The FDA published draft guidance (DHS, 2013) that defines a PSAP as a wearable electronic product that is not intended to compensate for impaired hearing, but rather is intended for non-hearing impaired consumers to amplify sounds in certain environments, such as for hunting or other recreational activities. Although these devices are subject to applicable provisions of the Radiation Control for Health and Safety Act of 1968, under which FDA regulates electronic products that emit sonic vibrations, such as sound amplification equipment, they are not regulated for patient safety by the FDA because they are not medical devices. Audiologists could conceivably recommend OTC hearing aids and PSAPs for the mitigation of hearing loss, but it is important to recognize that PSAPs are not FDA-regulated for that indication.

WHEN WILL OTC HEARING AIDS BE AVAILABLE?

The law mandates that the FDA develop and publish rules no later than three years after the enactment of the law. The FDA has begun the process of collecting information and data, including input from professional organizations, federal agencies, and consumer groups, and could publish proposed rules anytime within the next three years. Included in the proposed rules will be the time frame for the FDA to receive feedback from the public on the proposed rules.

During this time, organizations, agencies, or individuals can provide comments, suggest modifications, or suggest different options for the proposed rules. It is also possible that the FDA will hold a public hearing at which time oral testimony can be provided on the proposed regulations. At the close of the comment period, the FDA will

evaluate any oral or written testimony and determine whether any changes in the proposed rules are necessary. Within six months (180 days) of the close of the comment period, final rules will be published, along with a date of enactment (Academy, 2018).

HOW IS THE ACADEMY REPRESENTING AUDIOLOGIST INTERESTS?

The Academy has been actively engaged in responding to announcements related to OTC hearing aids and also has been proactively involved in influencing the development process by remaining in close and constant communication with key federal agencies, including the FTC and FDA, as well as key legislators.

In October 2017, several Academy Board members had the opportunity to meet with the FDA and provide a number of recommendations (see sidebar 1) that Academy leadership believes are important to protect the best interest of consumers.

Also in 2017, the Academy released a statement (Academy, 2017) regarding the accessibility and affordability of hearing health care for adults. In part, this statement supported consumer autonomy with respect to control over their health-care decisions, as well as the concept that consumers may be able to “self-identify” the presence of a communication problem, functional limitation, or participation restriction; however, the Academy did not support the concept of “self-diagnosis” and “self-treatment.” The Academy believes individuals who have self-identified a hearing loss or communicative impairment are best served when diagnosis leads to the development of a comprehensive treatment plan that may include instruction, counseling, rehabilitative services, and/or amplification products.

Furthermore, the Academy endorsed the need for increased awareness of hearing loss and its comorbidities as part of annual primary care examinations, and encouraged increased referral for a comprehensive evaluation with the understanding that there is no “normal” age-related hearing loss, and any degree of hearing loss should be appropriately evaluated. In short, the Academy endorsed completing a hearing test anytime hearing loss is suspected and encourages members to do the same, on any available platform.

The Academy is also actively working to position itself to be a go-to resource for media, legislators, and industry to represent the interests of members and patients who expect the highest quality of evidence-based care. The Academy recognizes that questions regarding the changing landscape of hearing management abound and has developed a guidance document to assist audiologists in understanding the differences between existing products and OTC devices, to be ready to answer questions about these devices, and possibly to begin to pre-position clinical practices in anticipation of the availability of

AUDITORY RECORDINGS FOR

Word Recognition & SRT

Processing Disorders

Training/Therapy

And More!



AUDITEC, INC.

PHONE (800) 669-9065

WEBSITE www.auditec.com

EMAIL auditecinfo@auditec.com

- ✓ **Constraint-Induced Auditory Therapy**
- ✓ **Auditory Continuous Performance Test**
- ✓ **Spanish Word Recognition & SRT**

FOR EXCESSIVE EAR WAX BUILD UP...

Debrox[®]

Carbamide Peroxide 6.5% Non USP*

EARWAX Removal Aid



use as directed

Safely and gently cleanses ear with microfoam action

Easy for patients to use at home

#1 Doctor & Pharmacist
RECOMMENDED

Debrox.com/Professionals

MORE
**MICROFOAM
ACTION!**
*Coming this
spring!*

OTC devices. This guidance will be updated as the regulations for OTC devices become available. The guide is available on the Academy's website (www.audiology.org/over-counter-otc-hearing-aids).

HOW CAN THE PUBLIC PREPARE FOR OTC HEARING AIDS?

The Academy recognizes its role as a reputable resource for patients and is committed to increasing public awareness of hearing loss, hearing devices, hearing protection, and the role of the audiologist. The Academy also recognizes that OTC hearing aids are not the only aspect of management of hearing loss that may be confusing to those seeking care. There are numerous providers, facilities, and pricing structures. While hearing aids are the most recognizable intervention for hearing loss, implantable options may be more appropriate in certain cases; however, many people who are candidates for implantable technologies never know their hearing could be improved with something other than hearing aids. Patients also may not be aware of the benefits of assistive technologies and aural rehabilitation and the necessity of seeking care that is comprehensive in its approach. And of course, consumers are being inundated with media publications with headlines heralding the introduction of OTC hearing aids to the market.

The Academy knows that consumers are seeking to self-direct their hearing care and frequently seek their own information outside of a health-care provider's office. For this reason, a series of guidance documents for consumers (see sidebar to the right) are being developed to assist individuals with hearing loss in understanding the differences among existing products and OTC devices, their hearing health-care provider's credentials, questions to ask when considering hearing devices, and why hearing health care is so important.

These guides are also excellent resources for referring physicians, legislators, insurers, and the media to reference when considering best practices when seeking hearing health care. These guidance documents will be updated as the regulations for OTC devices become available. Resources are available on the Academy's website (www.audiology.org/get-involved/public-awareness).

HOW CAN AUDIOLOGISTS PREPARE FOR OTC HEARING AIDS?

Unfortunately, the concepts of "hearing devices" and "hearing health care" have become interchangeable in the common jargon. That is to say, many individuals assume

Example Resources for Non-Audiologists

- Hearing Health Overview
- Signs of Hearing Loss
- Types of Hearing Loss
- Who to See/Who Are Audiologists
- Types of Hearing Devices
- Financial Considerations
- Tips for Successful Management of Adult Hearing Loss

a hearing device is the sole component of hearing health care. In fact, hearing devices are simply one aspect of a comprehensive and multifactorial approach to achieving optimal hearing. OTC hearing aids are one type of device on a spectrum of management options ranging from personal sound amplifiers to implantable hearing devices.

Furthermore, all hearing devices are one component of a comprehensive evaluation and treatment plan that typically begins with evaluation of hearing ability and speech understanding and may include discussion of aural rehabilitation and communication strategies, tinnitus management therapies, and assistive and alerting devices. Hearing health care encompasses a range of services and technologies that together can improve an individual's overall experience. Moving forward, it is necessary for audiologists to lead the conversation regarding the importance of comprehensive evaluation and supplemental services in the overall management of hearing loss.

Strategies for Successful Practice

1. Be highly transparent in your communication with patients.

In addition to the creation of an OTC category of hearing aids, the NASEM (2016) report also called for audiologists to empower consumers and patients in their use of hearing health care. This includes increased transparency for consumers to understand their options in obtaining hearing health care. Audiologists should be sure to utilize meaningful test batteries and review the results and implications with patients in understandable terms.

Discuss with patients the advantages of appropriate management of their hearing loss and the many ways in which their lives can be improved by seeking hearing care. Routinely apply best practices to all aspects of practice and demonstrate to patients why those practices are directly beneficial to them.

Finally, be transparent in communications regarding costs; the Academy encourages its members to distinctly describe device and professional fees to support patients' greater understanding of costs associated with their care.

2. Lead the conversation by enhancing public awareness.

There is a need to improve publicly available information on hearing health, as highlighted in the NASEM (2016) report. It is unrealistic to expect that audiologists can make a meaningful difference to public messaging by only interacting with the patients in their own practices. Take the important message of "have your hearing tested" to any platform you can. Audiologists can influence the messaging consumers are receiving and help change the conversation from device oriented to care oriented, but it will be necessary for all audiologists to commit to changing the conversation.

The Academy offers numerous resources through the website (Academy, 2018b) including consumer fact sheets and a public relations tool kit. Reach out to referring physicians, local media, and use electronic media to emphasize the importance of hearing evaluations. Not sure you know how to interact with the media? Plan to attend the Public Relations Media Training Learning Lab at AAA 2018, or one of two one-hour mini media training sessions in the exhibit hall.

Four topic areas on which to focus your public awareness outreach efforts include the following:

- The insidious nature of hearing loss, its impact and comorbidities, and why seeking good care early is key to successful mitigation
- The role of audiologists and how audiologist training/scope of practice differs from other hearing care providers
- Importance of hearing care, not only devices, in successfully managing communication challenges associated with hearing loss
- When discussing hearing devices, emphasize the importance of obtaining a comprehensive audiological evaluation before pursuing intervention

3. Prepare your practice.

The Academy recommends a hearing care delivery model that optimizes safe and effective management of hearing loss and is firm in its position that such a model includes the following:

- a. Determination of appropriate management options based on a comprehensive evaluation and individual hearing needs assessment performed by an audiologist;
- b. Consideration of a spectrum of hearing management options that may be appropriate, including, but not limited to, hearing aids, assistive listening devices, implantable technologies, communication strategies, and auditory-based therapy;
- c. Recommendation for medical assessment and intervention when appropriate;
- d. Counseling and recommendations that are cognizant of individual factors that may limit access to appropriate hearing health care, including but not limited to geographic constraints and financial limitations (Academy, 2018).

The Academy also recognizes that the spectrum of hearing management options may appropriately include OTC devices when they become available, provided that a comprehensive hearing test has been completed and the technology is appropriate for the hearing loss. As such, audiologists may

consider how to incorporate these devices into their practices and should begin considering how they may address questions from consumers regarding selection and maintenance. Reconsideration of an “unbundled” pricing structure may be most advantageous, particularly when offering these devices (Academy 2016 and 2016b).

It is also important for audiologists to note that although the FDA has announced that it intends to no longer enforce the requirement of the medical waiver prior to fitting a hearing aid, at time of publication, this requirement remains on the federal register. The FDA released this information through a guidance document, which only serves as a recommendation, unless specific regulatory or statutory requirements are cited. As such, most state licensing agencies would still enforce the requirement until such time as the requirement is removed at the federal level.

States may also have their own waiver requirements written into state licensure rules or statutes. Certain payers may also require a letter of medical

necessity or physician referral prior to the dispensing of hearing aids. Audiologists should contact their state licensing agencies with questions, but it is likely that the practice of obtaining clearance or a waiver must continue at this time.

CONCLUSION

As the landscape of hearing health care shifts and adjusts to the disruption that OTC hearing aids may bring to the hearing technology market, the Academy remains committed to the best interests of our members and patients.

Fundamentally, the care audiologists provide has not changed. The value audiologists bring to the successful management of hearing loss must be recognized by the public in order to be impactful. In a highly technical society dependent on gadgets and gizmos, it is natural that consumers would focus on a device to solve their concerns. It is the role of audiologists to educate the public about the role of the device in a comprehensive



You need the *right* portable audiometer.

SHOEBOX Audiometry is the first iPad audiometer optimized for testing outside of a sound booth. Offering automated and manual testing modes—plus intelligent background noise monitoring—all with the portability of a tablet.

WWW.SHOEBOX.MD/GOING-MOBILE

SHOEBOX
AUDIOMETRY



*find your
purpose*

in a life-changing career opportunity!

*At HearUSA & HearCanada,
you'll not only do what
you love, you'll be loved
for what you do!*

That's what happens when you
become a member of our team.
Because here, you get to do
something few other careers offer:
the chance to change people's lives
every day!

We offer Audiologists:

- Exciting full-time opportunities
- An established, dynamic and growing company
- Highly competitive compensation packages
- Career growth
- Hearing center locations across the US & Canada

Students

Join us at the hottest whiskey & music bar in town! Meet our team, learn about internships, our externship program and exciting job opportunities. This VIP meet-up can do amazing things for your career!

The Stage on Broadway

Wednesday, April 18

7:30 pm – 10:00 pm

RSVP at: hearusa.co/aaa18-rsvp

RSVPs by: April 4, 2018

We'll be at AAA2018!

April 18-21 in Nashville.


Visit us at booth #701

careers.hearusa.com

 **HearCanada**
Canada's Most Trusted Name in Hearing Care.

 **HearUSA**
America's Most Trusted Name in Hearing Care.

management program and to encourage anyone concerned about their hearing to seek appropriate evaluation and care.

The Academy leadership will continue to work to make resources available to members to share in their communities, but the effectiveness of these efforts rests on the commitment of the membership to utilizing those resources. The future of audiology depends on all of us. 

Sarah Sydlowski, AuD, PhD, CISC, is the audiology director of the Hearing Implant Program at the Cleveland Clinic in Cleveland, Ohio. She is also a member of the 2018 Academy Board of Directors and the Immediate Past President of the Ohio Academy of Audiology.

Acknowledgements: The following Academy Board members were part of the working group that developed the Academy Guidelines that contributed to the content of this article. Thank you to Bopanna Ballachandra, PhD; Melissa Heche, AuD; Tracy Murphy, AuD; Brad Stach, PhD; and Ian Windmill, PhD.

References

American Academy of Audiology. (2018) *Audiologists' Guide to Hearing Aids, PSAPs, Hearables, and OTC Devices*. Available at www.audiology.org/over-counter-otc-hearing-aids.

American Academy of Audiology. (2018b) Consumer-friendly fact sheets. Available at www.audiology.org/get-involved/public-awareness.

American Academy of Audiology. (2017) Statement of the American Academy of Audiology with respect to accessibility and affordability of hearing care for adult consumers, January 26. Available at www.audiology.org/publications/accessibility-and-affordability-hearing-care-adult-consumers.

American Academy of Audiology. (2016) Guide to Itemizing your professional services. Available at www.audiology.org/sites/default/files/PracticeManagement/GuidetoItemization.pdf.

American Academy of Audiology. (2016b) Statement of the American Academy of Audiology with respect to increasing transparency in hearing aid dispensing, October. Available at www.audiology.org/practice_management/compliance/transparency-hearing-aid-dispensing.

National Academies of Sciences, Engineering, and Medicine (NASEM). (2016) *Hearing Health Care for Adults: Priorities for Improving Access and Affordability*. Washington, DC: The National Academies Press.

U.S. Department of Health and Human Services (DHHS). (2013) Regulatory Requirements for Hearing Aid Devices and Personal Sound Amplification Products—Draft Guidance for Industry and Food and Drug Administration Staff. Available at www.fda.gov/MedicalDevices/ucm373461.htm.

THE 31ST ANNUAL CONFERENCE OF THE AMERICAN ACADEMY OF AUDIOLOGY

The Best of Audiology

SAVE THE DATE.

AAA 2019
Columbus, OH

March 27-30

Tympanometry Solutions

amplivox



On
Display at
AAA
#1307

202(H) Handheld Tympanometer

- User defined; 1000Hz or 226Hz probe tone
- Programmable ipsi and contralateral reflex measurements at 500Hz, 1,2 & 4kHz



302 Desktop Tympanometer

- 226Hz (+ 1000Hz Optional)
- Ipsi and contra reflex tests; 500Hz, 1,2, 4kHz



NEW Otowave 102

Updated Design

- Extra Functionality
- Live Tymp
- Fast Reflex Testing



FREE NOAH interface included with all Amplivox equipment

The SMART choice in Audiometry™

Amplivox is a global manufacturer of reliable and robust audiological equipment. Standard warranty period for all Amplivox products is 2 years.

10393 West 70th Street
Eden Prairie, MN 55344
www.amplivox.us
info@amplivox.us
888-941-4208





Private Practice IN A TIME OF BIG Health

BY BRE MYERS

This article is a review of the shift toward mergers in health care, and its potential effects on audiology as a profession and the independent audiology practice. The challenge of the profession should be to remain autonomous within this structure. We cannot be so focused in one direction and ignore our blindside. We need to be able to anticipate the hit so that we can counter it and maintain, or hopefully enhance, our position.

The #1 Most Profitable Ancillary Service for Private Practice Audiologists



This system-driven, ancillary balance treatment program will help you generate more revenue from balance and dizzy patients than you can from hearing care, while ALSO increasing your hearing aid sales!

Request information now at:
www.AuDBalance.com



Previous articles have addressed growing concerns within the field regarding impact and changes in the practice of audiology now that big-box stores and their low-cost hearing aids are reality. There has also been much debate surrounding third-party payer plans that reimburse for hearing-aid services, but at a much lower rate than most independent audiology practices can afford to accept.

Another, perhaps more disturbing issue that the profession must address, or at least be cognizant of, is the growing trend of hospitals purchasing small primary care and specialist practices. These acquisitions continue to merge other previously independent health and medical care facilities under a much larger corporate umbrella, and may impact practice patterns. This article reviews the shift towards mergers in health care, and its potential effects on audiology as a profession and the independent audiology practice.

HOW DID WE GET HERE?

Goldstein (2001) eloquently summarizes the transition from audiology as primarily an academic pursuit aimed at rehabilitation to the adoption of hearing-instrument dispensing within the profession, in order to ensure that our patients were receiving appropriate devices, adequate services, and follow-up care. Unfortunately, with little business training and relatively few examples to go by, well-meaning audiologists adopted similar business models (i.e., bundling services with devices, not charging for hearing tests, etc.) as those we wished to protect our patients from.

While the technology of hearing aids has transformed dramatically over the past few decades, the model of traditional dispensing has not. Arguably, audiologists, particularly

those that focus solely on adult hearing aid dispensing, are unfortunately viewed by the general population as not significantly different from hearing instrument dispensers (except for that expensive degree hanging on the wall). Yes, there are true centers of professional excellence that abide by the best practice guidelines for fitting and dispensing, but there are also many who do not. Yes, there are some that are adopting unbundled service models, but there are many who have not.

The point of this article is not to enter into a debate into the merit or feasibility of various dispensing practices. However, some historical context is important to determine the best direction ahead.

The point of this article is not to enter into a debate into the merit or feasibility of various dispensing practices. However, some historical context is important to determine the best direction ahead.

ANOTHER FRONT TO WATCH

As pointed out recently by Frazer (2017), less than half of the hearing

Experience a customer favorite SONIC

**See why Sonic is exceeding expectations
of both patients and professionals.**

Enchant, built on our revolutionary SoundDNA platform, is helping people experience natural sound better than ever. Plus, our innovative professional solutions continue to attract audiologist and clinic loyalty.

Learn more about Sonic and try the
Enchant demonstrations at AAA 2018!

Visit Booth 1417

www.sonici.com.





instruments are being dispensed by independent offices in the United States. Many instruments were provided by manufacturer and retail storefronts with the prediction that this share will increase over the next few years. Frazer (2017) suggests that unification of the independents to gain equivalent buying power will help to level the financial playing field between independents and large retail/manufacturer chains. In other words, by concentrating purchasing power, we are able to negotiate lower cost-of-goods, enabling the audiologist to offer lower prices while still maintaining the necessary margins in order to collect a salary and keep the doors to our practices open.

This is not a new concept. Currently, various buying groups and practice management cohorts do exist and have existed for years. Enrollment benefits in these groups can include lower cost-of-goods, marketing, staffing support, business development, etc. However, while the cost per device is significantly reduced compared to single-unit costs they are not as low as needed, possibly due to the need for these entities to cover their costs in running their business and support services. It is important for a practice considering joining one of these groups to do their research, as internal structures and associations may cause potential concerns down the road.

NOT QUIET ON THE WESTERN FRONT

While the manufacturer/big-box store “non-health-care” retail model is a disruptive concern, there may be yet another. We must consider what is happening in the health-care arena. It turns out that audiology is not the only health-care profession looking at minimizing overhead in order to increase chances of survival.

A 2016 article by David Squires and David Blumenthal reports that the number of small physician private practices have been steadily decreasing for the past 30 years. They report that solo practitioner offices that once accounted for 41 percent in 1983 has shrunk to just 17 percent in 2014. They also note that practices of 25 or more physicians grew from five percent to 20 percent in that same time.

The authors give a few reasons for this trend. First, the younger generation of physicians report preference to larger practices for reasons like stability and better “work-life balance,” instead of the unpredictability and entrepreneurial stresses solo practices offer. Second, the retiring physicians are not being replaced with new solo physicians, ultimately leading to a “cohort effect” (Squires and Blumenthal, 2016).

In addition to the consolidation and retirement factor, Kocher and Sahni (2011) report that hospitals are buying

independent primary-care physician offices at a fast rate. These buyouts often result in substantial initial monetary loss (\$150,000 to \$250,000 per year over the first three years). The rationale behind this, they state, is the potential long-term return on investment these practices have to offer. By incorporating primary-care physicians

their patients to your office, or will the expectation be that they refer to a provider that shares their electronic health record? Hospitals and health networks are also acquiring specialty practices at a growing rate. They are building nearly impenetrable fortresses of health care.

AT THE MACRO LEVEL

We should not just consider the impact of independent practices merging with hospitals. That is just the tip of the iceberg. According to the Institute for Mergers, Acquisitions and Alliances, health-care deals topped \$2.64 trillion between 2000–2015 (MacDonald, 2017). The mergers of hospitals into health networks spanning large territories is a continuing trend that has been growing in the past few years. With ever decreasing reimbursements and increasing costs, health-care entities have adopted this model under the assumption that consolidation will guarantee survival.

These expansions have raised serious concerns and are reportedly scrutinized for violations of antitrust laws. The antitrust laws are designed to protect the public from one entity monopolizing the market. However, large regional health-care giants have been allowed to continue and dominate certain areas due to their assertion that, by consolidation, they are able to provide better services to meet unmet needs of the communities and do so more cost efficiently. Those in opposition of these mega-mergers argue that large health networks force health plans to accept all providers contained within their system, which could ultimately lead to higher insurance costs and premiums.

So, what is actually happening? Melnick and Konkyck (2016) found that hospital prices in the largest health networks in California increased from 2004–2013 at a much faster rate than others (113 percent compared to 70

To deny that the consolidation of health care is happening is dangerous. The challenge of the profession should be to remain autonomous within this structure.

into their network, they will retain specialist referrals and eventually break even and profit from these referrals a few years after the initial loss.

You might be thinking “Isn’t this a violation of the STARK Laws?” Because the physician has given up ownership for employment, these internal referrals are in fact, not in violation (Gosfield, 2003). This should be a concern to any independent audiology practice, as some have spent countless hours and marketing dollars building a referral base of primary-care physicians. What happens when the local independent primary-care office is acquired by the large regional health center? Will they still refer

percent). This difference led to an approximately \$4,000 difference in admittance costs per patient. The results of this study argue against the notion that large multi-hospital networks included in the study are meeting their goal of lowering costs and improving efficiency.

CAN AUDIOLOGY FUNCTION WITHIN BIG HEALTH?

That is a tough question. But there is some hope. Take the Veterans Administration (VA), for example. They have been able to negotiate lower cost-of-goods in terms of hearing aids and have an integrated referral network whose providers have access to the patient's comprehensive electronic health record. The VA is also the largest employer of audiologists (over 1,100) on staff. The VA system is not perfect, no system is. However, they are positioned to perform self-examination, and implement programs and policy aimed at improving quality of care.

There are also many examples of strong, independent audiological departments within many other hospital programs. But as mergers continue, it is important to reflect upon office policy, particularly as previously independent practices join forces. Are audiologists from previously independent "Group A" using the same billing codes as the hospital and every other group they are now a part of?

WHAT BIG HEALTH MEANS FOR COMPLIANCE

While hospital mergers are not new, the new wave of Big Health strategy was set into high gear, reportedly, as a response to the changing reimbursement landscape. The primary aim of the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) is to provide higher-quality, patient-centered care at a lower cost (Thomas, 2016). This switch in billing and reimbursement philosophy may be a disruptive force in and of itself. The burden of billing and compliance may prove to be the straw that breaks the small practices' backs, particularly those who have not fully converted to electronic health records and billing software.

While the repeal of the sustainable growth rate (SGR) formula in 2015 and the shift towards a value-based reimbursement has happened, its full effects on practices, large and small, obviously have yet to be realized. However, it would appear that larger organizations might have the upper hand in transitioning to this new reimbursement model. The ultimate goals of MACRA are to increase the level of transparency within health care and to address growing costs, but to also emphasize

quality-of-care. Those entities with built-in support systems will be better equipped to perform the necessary systematic reviews without the burden falling upon the practitioner or office staff.

What does MACRA mean to audiology as a profession? Unfortunately, that is a tough question as audiologists are currently not allowed to participate in the quality reporting portion of MACRA, Merit-Based Incentive Payment Program (MIPs) for 2017 and 2018. However, audiologists can "practice" submitting MIPs, which replaced the previous quality reporting system (PQRS) that ended in 2016 (Thomas, 2016).

Transitioning to MACRA and the new health-care system that is lurking on an ever-closer horizon is going to be tricky at best. One way to prepare, if independent practices haven't already, is to transition away from paper charts and adopt an integrated electronic health record (EHR). The EHR is a game changer and one of the two principles that MACRA is using to facilitate better care. EHRs and billing software with the capability to meet compliance standards can be an expensive endeavor to



UNIQUE OPPORTUNITY TO OWN WELL ESTABLISHED PROVIDER IN CENTER OF MENLO PARK, CALIFORNIA.

STRATEGICALLY LOCATED IN SILICON VALLEY



- Large parking lot with 72 parking spaces adjacent to building, with free 3-hour parking
- Owners wish to retire after nearly 50 years of business
- Provider has been in same location for over 30 years
- Contracts with major insurance referral sources
- Owners willing to assist in finding financing

CALL: (650)-323-6191
or EMAIL: ahacllc@gmail.com

independent practitioners. Fifteen years ago, paper charts were still considered the gold standard and the electronic chart was considered complimentary (Stausberg et al, 2003). With more and more facilities of various sizes switching from paper to electronic records, we see the benefits in the form of coordinated care, access to data, integrated billing, and research (Crenshaw, 2016).

WHERE DO AUDIOLOGY AND INDEPENDENT PRIVATE PRACTICES FIT INTO BIG HEALTH?

Have we positioned ourselves as a profession to retain autonomy within a larger health network, or will our services within these large health networks be swallowed up by other medical professions? Will we be recognized as a part of the rehabilitative service providers (i.e., speech-language services)? Where do vestibular diagnostics and rehabilitative services enter into the equation? Will the independent practice be able to stand up to insurance companies and suppliers, and command better reimbursement, lower cost-of-goods?

Squires and Blumenthal (2016) maintain that small independent practices will still have a place in the future. There will always be those that prefer small practices to large. The concept of knowing your provider and developing a close relationship with them, particularly in more rural areas, is looked upon as a key benefit to patients. Those patients get the feeling that they aren't just a number. There is also evidence, at least in the primary-care setting, that smaller practices have lower rates of preventable readmission to hospitals.

Interestingly, Squires and Blumenthal's (2016) suggestions to primary-care physicians surviving big health are

similar to Frazer's (2017) advice to audiologists surviving big-box stores. A few helpful strategies include the following:

- Encourage physician networks that enable small practices to share resources.
- Provide technical support to solo and small practices, as the HITECH Act did through a system of regional extension centers.
- Develop payment models that include upfront grants or loans for practices to invest in necessary infrastructure.
- Improve health information technology so that it reduces—rather than increases—the burdens of solo practice (Squires and Blumenthal, 2016).

CHANGING THE MODEL, CHANGING THE PROFESSION

Is the previous and currently most recognizable model of hearing health-care delivery sustainable (i.e., bundled hearing aid price structure)? Are we still in the position where the hearing aid is the answer to all of our patients' hearing needs? Numerous examples have repeatedly demonstrated that when the thrust of a cure or answer is on a "widget," those with the cheaper, most available, or most desirable "widget" will have an advantage. When we undervalue the knowledge and services that are required for our patients to be successful with them, we are truly undervaluing ourselves. This mindset is proving to be devastating to our legitimacy as a member of the health-care team.




PHARMACY AS AN EXAMPLE

Audiologists often compare themselves or look to other professions within healthcare for guidance. One area that we may have overlooked, but is worth investigating, is pharmacy. We have all witnessed the corporatization of pharmacies over the past decade. Where an independent pharmacy once stood, either a Walgreens, Rite Aid, or CVS (or all in some towns) have been erected.

Mabee (2015) warns that corporate leaders and store managers fail to recognize the importance or value a pharmacist brings to the table. He argues that proper patient care, particularly in the case of complex and sometimes deadly drug interactions, is at odds with the corporate mindset of “never discouraging a sale.” While hearing aids themselves have not proven to be deadly, ignoring hearing- and ear-related issues can be. Zangaria (2015) suggests the need for innovation and creative utilization, the specific set of skills that her training as a pharmacist has given her.

WHAT NEXT?

To deny that the consolidation of health care is happening is dangerous. The challenge of the profession should be to remain autonomous within this structure. We cannot be so focused in one direction and ignore our blindside. We need to be able to anticipate the hit so that we can counter it and maintain, or hopefully enhance, our position.

The unfortunate truth is that, as many have pointed out, complacency with the status quo within the field is rampant. Why? Perhaps it is because the ones who are often hit first are the independent practitioners while the rest of us are somewhat cushioned from the direct effects of legislation, market disruptions, and health-care trends. But how long will the cushion remain? 

Bre Myers, AuD, PhD, is an assistant professor and clinical audiologist with the Osborne College of Audiology at Salus University in Elkins, Pennsylvania. She is also an associate editor for Audiology Today and www.audiology.org.

References

- Crenshaw B. (2016) Big Data and Audiology: Using Integrated Database Resources to Enhance Research and Clinical Practice in Audiology. *Audiol Today* 28(1):42–49.
- Dafny L. (2014) Hospital industry consolidation—Still More to Come? *N Engl J Med* 370:198–199.
- Frazer G. (2017) Future of Independent Practice in Audiology. *Audiol Today* 29(4):57–61.
- Goldstein D. (2001) Hearing aid dispensing: a historical vignette. *Audiol Today* 13(3):39.
- Gosfield AG. (2003) The stark truth about the Stark Law. *Fam Pract Manag* (10):27–33.
- Kocher R, Sahni N. (2011) Hospitals’ race to employ physicians—the logic behind a money-losing proposition. *N Engl J Med* 364:1790–1793.
- Mabee RL. (2015) Is corporate pharmacy shooting itself in the foot? *Modern Medicine Network*. <http://drugtopics.modernmedicine.com/drug-topics/news/corporate-pharmacy-shooting-itself-foot> (accessed November 15, 2017).
- MacDonald I. (2017) Hospital merger mania continues throughout the country *Fierce Health Care*. www.fiercehealthcare.com/finance/hospital-merger-mania-continues-throughout-country (accessed November 8, 2017).
- Melnick G, Fonkych K. (2016) Hospital Prices Increase in California, Especially Among Hospitals in the Largest Multi-hospital Systems. *J Health Care Org, Prov Finan* 53:1–7.
- Squires D, Blumenthal D. (2016) Do Small Physician Practices Have a Future? *To The Point. The Commonwealth Fund*. www.commonwealthfund.org/publications/blog/2016/may/do-small-physician-practices-have-a-future (Accessed November 8, 2017).
- Stausberg J, Koch D, Ingenerf J, Betzler M. (2003) Comparing paper-based with electronic patient records: lessons learned during a study on diagnosis and procedure codes. *J Am Med Infor Assoc* 10(5):470–477.
- Thomas K. (2016) Centers for medicare and medicaid services’ new quality payment program. *Audiol Today* 28(5):52–53.
- Zangaria M. (2015) Editorial: Innovation: the promise of financial viability for pharmacy practice opportunities. *J Pharm Pract Res* 45:259–260.

ONE POSSIBLE
SIDE EFFECT
OF OUR WAX
IMPACTION
TREATMENT.
A SMILE
FROM EAR
TO EAR.



CLINICALLY PROVEN, TO DISSOLVE WAX, IN ONE TREATMENT

EARWAX MD®

WELCOME TO THE COMFORT OF CLEAR

EARCAREMD.COM

INNOVATIONS IN CERUMEN REMOVAL

Earwax MD®, a novel cerumen cleaning aid,
shows promise in clinical study

By Douglas Fullington, MD



The problems with ear wax

Cerumen impaction is one of the most common ear-related reasons to seek medical attention, affecting 1 in 10 children, 1 in 20 adults, and 1 in 3 elderly patients. Moreover, patients with hearing aids are particularly susceptible to cerumen accumulation, and 60% to 70% of all hearing aid repairs are caused by contact with cerumen. According to the 2017 clinical practice guidelines, nearly 50 million dollars were spent by Medicare for cerumen related procedures. Symptoms of cerumen impaction include hearing loss, feeling of fullness, pain, itching, tinnitus, odor, and dizziness. General practitioners are becoming more reluctant to manually extract cerumen due to complications like bleeding, perforated eardrums, dizziness, and infections, making cerumen management a growing segment of the ENT's practice.¹

Cerumenolytics: Are they effective?

Along with irrigation and manual extraction, cerumenolytic agents are recommended in the American Academy of Otolaryngology-Head and Neck Surgery Foundation clinical practice guidelines on cerumen removal, and it is encouraged that these techniques be used in combination with one another. The problem with current cerumenolytics is their questionable efficacy. Multiple studies have demonstrated that these products are no more effective than distilled water at solving the problem of impacted cerumen.^{2,3}

Earwax MD® - the one-two punch

Scientists at EOSERA® developed Earwax MD, a novel, patent-pending topical drop that uses a dual-action approach to dissolve cerumen. This dual-action technology solubilizes the lipids and wax while simultaneously disrupting the sheets of skin cells (keratinocytes) that are continually shed from the ear canal. In laboratory studies, this one-two punch is substantially more effective at breaking down human cerumen samples than currently available cerumenolytics, such as 6.5% Carbamide peroxide ear wax removal systems.⁴

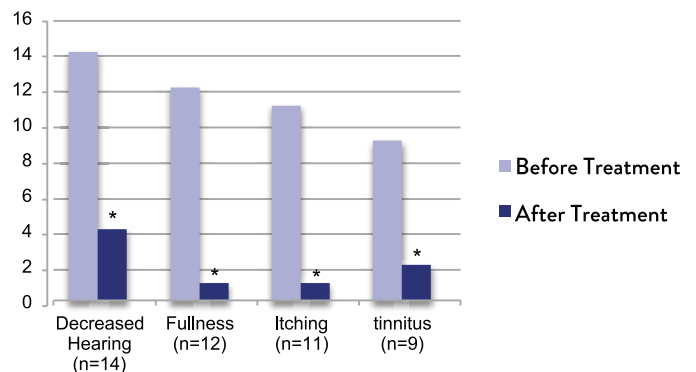
Earwax MD - clinical study design

Recently, a clinical study evaluated the efficacy and safety of Earwax MD. A total of 30 ears with at least 50% cerumen impaction at the time of enrollment were dosed with Earwax MD for 15 minutes prior to low-pressure irrigation with warm water. This procedure could be repeated one time, if needed.⁵

Success in cerumen removal

After one treatment with Earwax MD, majority of ear canals (53%) were completely clear of cerumen, with 100% tympanic membrane visualization. Greater than 85% of all ears had total clearing of cerumen after 1 or 2 treatments. All but one ear tested showed a substantial reduction in cerumen.⁵

Improvement in Cerumen Impaction Symptoms



Dramatically reduced symptoms

Before treatment, 90% of ears were symptomatic, with more than half having 2 or more ear-related symptoms. After treatment, symptoms were dramatically reduced by 82%. Specific symptoms demonstrating a statistically significant reduction after treatment were impaired hearing, fullness, itching, and tinnitus.⁵

Treatment satisfaction

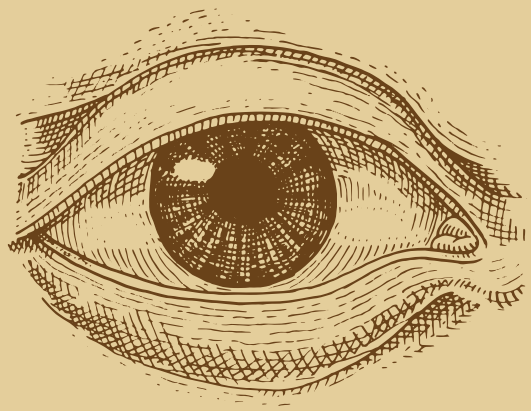
The satisfactory rate relating to the application process was 100%. Participants were satisfied with the application process in terms of time involved, the comfort of the application process, and the rinsing procedure.⁵

Conclusion

The clinical study results of this new product, Earwax MD, demonstrated promising success at cerumen removal when used in combination with irrigation. This efficacy translated into a dramatic reduction in symptoms for these patients and should be considered for both in-office and at-home treatment of impacted cerumen.

Recently published in the peer-reviewed journal, *BMC Ear, Nose and Throat Disorders*. Send an email to info@eosera.com to receive your link to view the publication.

WWW.EARCAREMD.COM

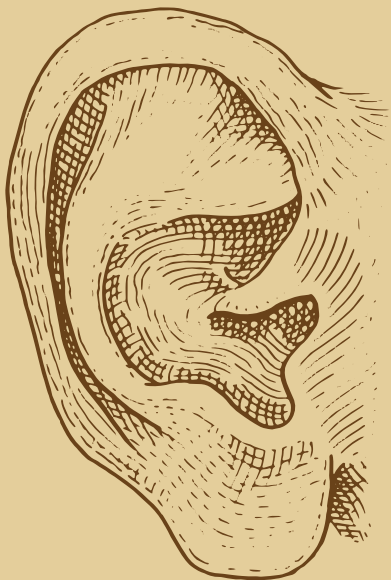


EYES

&

EARS

BY CHRISTOPHER SPANKOVICH



AUDIOLOGY AND OPTOMETRY ARE SOMEWHAT PARALLEL PROFESSIONS. OPTOMETRY HAS BEEN SUCCESSFUL IN SECURING THEIR SCOPE OF PRACTICE. HOW WILL AUDIOLOGY COMPARE?

Optometry and audiology are somewhat analogous professions in the scope of vision and hearing care. They have similar roles in the hierarchy of ophthalmologist-otolaryngologist and opticians-hearing instrument specialists. Optometrists, however, have recognition as limited license physicians (LLP), limited prescription rights, and some surgical authority. Let's dig in deeper and learn more about optometry.

COMPARING THE PROFESSIONS

From our quick snapshot in TABLE 1, it is clear that optometry has been around as an independent profession for much longer and is a little over three times larger in labor force. The differential in labor force is intriguing given that hearing loss has a higher prevalence than vision loss

with age (i.e., 26 percent of older adults have hearing loss versus 15 percent with vision loss [NCHS, 2010]).

Education

The years of education are comparable and there is no requirement for post-graduate residency, though options exist within optometry. Unlike audiology, optometry maintains its own entrance and national board examinations. The optometry entrance exam called the Optometry Admissions Test has four parts: natural sciences (including biology, general chemistry, and organic chemistry), physics, reading comprehension, and quantitative reasoning. However, most audiology programs use the general record examination (GRE) as part of their admission process. The general GRE test is comprised of analytical writing, verbal reasoning, and quantitative reasoning. There is no science component, unless a

THE GREATEST THREAT PHYSICIANS FACE IS THAT THE VAST MAJORITY OF EXISTING DATA DEMONSTRATE NO SIGNIFICANT DIFFERENCE BETWEEN MID-LEVEL CARE PROVIDED BY A PHYSICIAN AND A NON-PHYSICIAN.

program requires a GRE Subject Test in a specific area.

Audiology and optometry licensure are contingent upon passing a national exam. Currently, for audiology this is the Praxis examination in audiology facilitated by the educational testing service (ETS). The Praxis test series are generally used to assess knowledge for teaching. Optometry licensure is contingent upon passing the National Board of Examiners in optometry exams. This is a three-part exam generally taken over years three and four of the optometry program. There are also special examinations required depending on state scope of practice.

Law and Scope of Practice

State licensure law dictates scope of practice. While audiology does not maintain pharmaceutical prescription rights, optometry does have limited prescriptive privileges. Interestingly, it took optometry over 70 years after initial state licensure laws to establish its first state with prescription rights, and over 25 years for the profession to have prescription rights adopted by all 50 states. In most states, optometrists are limited to topical medications and limited oral drugs such as short-duration antibiotics, antihistamines, and analgesics.

The field of optometry has been more successful than most non-MD professions in expanding their scope of practice. Psychologists have been trying for almost 30 years to win prescription privileges, so far only two states have granted this expansion (Louisiana and New Mexico). Podiatrists have faced significant resistance from medical and orthopedic associations to include the ankle under their scope of practice. Despite the successes of optometry regarding scope of practice expansion, the process has been slow. In addition to the previously mentioned time period for garnering prescription rights, securing surgical privileges has also been a challenge. This was first awarded in Oklahoma in

TABLE 1. Quick Snap Shot

*2014 Bureau of Labor Statistics

The breakdown of practice setting and revenue were derived from the "The State of the Optometric Profession: 2013" report and ASHA/AAA survey reports and represent approximations.

	AUDIOLOGY	OPTOMETRY
Current Labor Force*	13,000	40,000
Median Pay*	\$76,000	\$106,000
Average Age	44.9 years	46 years
% Male/Female (Approx.)	20%/80%	60%/40%
State Licensure Est. (year)	1969	1901
First Clinical Doctor of Degree Awarded (AuD or OD)	1996; Baylor	1923; Pennsylvania College of Optometry
Pre-Entrance Requirements	Some programs require communications sciences and disorders degree or course work; common prerequisites: life science, physical science, behavioral science, statistics	Pre-optometry (non-degree program); common prerequisites: English, calculus, statistics, biology with lab, inorganic chemistry with lab, organic chemistry with lab, physics with lab, psychology
Entry Exam	Graduate Record Examination	Optometry Admission Test
National Board Exam	Praxis	National Board of Examiners in Optometry—three-part exam over four years
Accreditation Body	Council on Academic Accreditation; Accreditation Commission for Audiology Education	Accreditation Council on Optometric Education
Years of Education	3-4	4
Number of Programs	74	23
CMS Status	Other Diagnostic	Limited Licensed Physician since 1986
Post-Graduate Residency	None	Optional 1-2 year in various sub-specialties
First Prescription Fights (year and state)	None	1971; Rhode Island
50th Prescription Rights (year and state)	None	1997; Massachusetts; DC in 1998
Surgical Limited Rights (year and state)	None	1998; therapeutic laser in Oklahoma
Independent Private Practice	21%	57%
Big Box or Chain	6%	24%
Otolaryngology or Ophthalmology Practice	27%	8%
Other Practice (e.g., hospital, VA, etc.)	46%	11%
Principle Revenue Sources	Diagnostics and hearing aid dispensing	Eye examinations and sale of corrective devices
Average Revenue Per Diagnostic Exam (per hour)	Not available	\$306
Average Sale for Devices (not revenue)	\$2,347 average hearing aid retail sale price	\$227 glasses and \$152 contact lenses

WILL AUDIOLOGY BE THE DISRUPTORS OR THE DISRUPTED?

1988. The profession of optometry then had to wait nine additional years to get very limited privileges in a second state (New Mexico).

Practice Setting and Salary

Practice setting is also significantly different between the two professions. The majority of optometrists work in private practice or in franchise practices. Audiologists, on the other hand, have a larger footprint in hospitals, residential health facilities, and in non-audiologist owned practices (e.g., ENT-owned). Both audiologists and optometrists derive the majority of their revenue from diagnostic evaluations and device sales.

The higher abundance of private practice and expanded scope of practice with LLP status (e.g., pharmaceutical and surgical privileges) for optometry likely reflect the contrast in median salary compared to audiology. However, the gender profile of each profession may also be a factor. This does not dictate discrimination or view of audiology as a lesser profession due to larger female prevalence. Indeed, the separation in median salary remains even when stratified by sex.

A survey by the American Optometric Association (AOA) in 2011 found median income for female optometrists was \$103,500 and \$131,000 for male optometrists: women were earning 77 percent of men's earnings. In this same survey, males reported working almost 200 more hours per year and, among females, nearly 50 percent were new practitioners (less than 10 years) compared to 26 percent of males.

After accounting for these variables, the female-to-male annual earnings ratio was over 95 percent. The American Academy of Audiology's (the Academy) compensation and benefits survey from the same year showed males with a median salary of \$95,000 and females \$73,000, with a comparable female-to-male earning ratio of 77 percent.

Similar to optometry, only 24 percent of the males surveyed had less than 10 years of experience, while 39 percent of females had less. Independent of gender, salary contrast remains. The audiologist to optometrist earnings ratio is 70–72 percent for both males and females. Claudia Goldin, an expert in gender pay gap has suggested the largest factor in gender pay disparity is “temporal flexibility” with minimal impact of outright discrimination, competitive drive, or bargaining ability (though these can be factors). Temporal flexibility refers to greater flexibility in work hours, work schedule, etc. (Goldin 2014).

This begs the question, is it possible that temporal flexibility underlies the wage gap for audiologists and optometrists? Would greater emphasis and support for private practice ownership close this gap?

DISRUPTIVE INNOVATION

Audiology and optometry also have a common concerns for disruptive innovations. A primary concern voiced by audiologists on many social media platforms is the potential loss of revenue due to over-the-counter (OTC) amplification threats. Over-the-counter glasses or non-prescription reading glasses, however, have existed for many decades, and the revenue derived from prescription corrective lenses remains strong.

Optometry is not immune to disruptive innovation. Online eye exams and prescriptions bypassing a traditional

visit to the eye doctor are available and creating a stir. For example, Opernative offers an online refractive eye test and prescription glasses.

Other disruptive players include EyeNetra and Warby Parker. EyeNetra is a smartphone-based vision diagnostic tool that allows for accurate self-administered refraction results and prescriptions. EyeNetra can also be used by optometrists to enable remote testing or mobile clinic services. Comparable efforts in audiology are SHOEBOX™ audiometry.

Warby Parker is like an Apple store for glasses. With a focus on designing and creating frames and a commitment to user experience, they upended the traditional market which is dominated by a single company that makes most of the eyewear that exists in the world. Warby Parker also has a socially conscious platform where they donate a pair of glasses to VisionSpring for every pair sold. This is a fairly common market strategy in audiology; numerous companies manufacture hearing aids and it is common for manufacturers to have their own private label platform and have philanthropic aims.

Another interesting innovation is self-adjusting glasses. Joshua Silver, a physics professor at the University of Oxford in England, has created self-adjusted glasses using silicon oil. He hopes to sell them for \$1 a pair. They are currently sold for \$19. Lower cost, self-adjusted hearing aids or personal sound amplification technology exists and will soon expand in the United States with recent passage of the Over-the-Counter Hearing Aid Act. Though something of quality at \$1 a pair is not likely.

MEDICINE AND DISRUPTION

Audiology and optometry are not the only fields that are being disrupted. Medicine is under constant pressure from non-physician groups for expansion of service. Most disruptions have a general trend for



Otodynamics

ANNIVERSARY YEAR

T 1-800-659-7776 E info@otodynamics.com

www.otodynamics.com

VISIT US AT
AAA
BOOTH 1325

Otodynamics
OAE/+ ABR



Otoport

DP CLINICAL

Exactly What's Needed For Clinical OAEs

Otoport DP Clinical provides high quality **12 frequency DPgrams** with normative range markers from **1 to 8kHz**. Tests are highly configurable. You can pre-configure **two clinical DPOAE modes** which are easily accessible. Select the stimulus level from 6 L1,L2 combination and choose the analysis display as half octave or DPgram.

Add TEOAE to complete your clinical OAE examination. TEOAEs analysis displayed as a **waveform** or as **½ octave bands, 1-4kHz**. There are two pre-configurable TEOAE clinical modes.

The Otoport DP Clinical pediatric screening mode is **fast and highly effective** with newborns and children, alerting you to the possibility of both conductive and cochlear losses. For pediatric screening the Otoport DP Clinical **visual distraction displays**, help keep them quiet. One of 3 cartoons will engage the child. The cartoon gradually fills with color if the child is quiet but colors fade when child is noisy.

SATISFIES CPT code 92588 and 92587
(92558 and 92586 with options)

EXPANDABLE Add automated ABR screening with the easy to fit ABR sleeve

OAE/+ ABR



t: 1-800-659-7776
e: info@otodynamics.com
www.otodynamics.com

ANNIVERSARY EDITION

Otodynamics


simplification to disrupt complexities (Christensen et al, 2000). The greatest threat physicians face is that the vast majority of existing data demonstrate no significant difference between mid-level care provided by a physician and a non-physician, e.g., nurse practitioner (Isaacs and Jellinek, 2012).

Data to this effect can also be found for audiology. Zapala et al (2010) examined over 1,500 records of Medicare-eligible patients seen at the Mayo Clinic in Florida. The records seen jointly by audiology and otolaryngology (n=352) were reviewed by four blinded reviewers (two otolaryngologists and two audiologists) to judge if the audiologist treatment plan would have missed a medical condition. Records of patients seen by audiology only (n=1,198) were reviewed by a neuro-otologist who judged if a referral would be recommended based on the test results.

The results showed there was no discrepancy in treatment plans for over 95 percent of cases. In no case did an audiologist miss a condition associated with significant mortality or morbidity. The neuro-otologist reviewing the second set of cases found that only audiology services were needed in nearly 80 percent of the cases. Further, there was strong evidence that audiologists referred to otolaryngology when appropriate.

CONCLUSION

Audiology and optometry have many similarities and face comparable disruptive forces. Optometry has been more successful in securing their scope of practice and up-marketing their profession. In other words, through greater internal control (e.g., specialty admission and board exams), securing LLP status, and expanding their scope of practice, they have disrupted those “above” them (i.e., ophthalmology) rather than fight a reactionary and likely futile battle with disrupters from below (e.g., OTC devices).

Disruptions are inevitable and the general trend is for simplification to disrupt complexities (Christensen et al, 2000). What remains to be seen is if audiology will be the disruptors or the disrupted. 

Christopher Spankovich, AuD, PhD, is an associate professor, director of clinical research and clinical audiologist at the University of Mississippi in Jackson, Mississippi.

References

American Academy of Audiology. (2016 and 2011) 2016 and 2011 Compensation and Benefits Report. Available from www.audiology.org.

American Speech-Language-Hearing Association. (2016) 2016 Audiology survey. Survey summary report: Number and type of responses. Available from www.asha.org.

Christensen CM, Bohmer RMJ, and Kenagy J. (2000) Will disruptive innovations cure health care? *Harv Bus Rev* Sept-Oct.

Goldin C. (2014) A Grand Convergence: Its Last Chapter. *American Economic Rev* 104 (4):1091–1119.

National Center for Health Statistics. (2010) Vision, hearing, balance, sensory impairment in Americans aged 70 years and over: United States, 1999-2006, www.cdc.gov/nchs/data/databriefs/db31.pdf.

Isaacs S and Jellinek P. (2012) Accept No Substitute: A Report on Scope of Practice, Physicians Foundation. <https://hbr.org/2000/09/will-disruptive-innovations-cure-health-care#comment-section>.

Zapala DA, Stamper GC, Shelfer JS, et al. (2010) Safety of audiology direct access for medicare patients complaining of impaired hearing. *J Am Acad Audiol* 21(6):365–379.



ARC18 GENETICS AND HEARING LOSS

Given the strong relationship between genetics and hearing loss in audiological practice, the Academy continues its commitment to providing audiologists the latest on genetics research as it relates to hearing impairment in clinical practice through the annual Academy Research Conference (ARC).

BY DAVID FABRY

Audiology Today (AT): We are here with Kathleen Arnos, PhD, who is chair of the upcoming Academy Research Conference (ARC) 2018 on genetics and hearing loss, which is being held on April 18, 2018, the first day of the AAA 2018 Annual Conference in Nashville, Tennessee. Dr. Arnos, thanks for taking the time to chat today; please tell us a little bit about why you choose *this* topic.

Kathleen Arnos (KA): Sure. Well, I was involved since the inception of the idea for the conference itself, so that means I had a lot of input on the topics and speakers, which was nice. We had a small subcommittee that discussed this over a period of several weeks. I think that we had a really great opportunity to put together an agenda of speakers that addresses a comprehensive range of topics related to genetics that will hopefully be of interest to both clinicians and researchers. It's such an incredible time in human genetics in terms of diagnostics and new technologies, and the impact on clinical practice is just amazing. This has already started to impact the diagnosis and potential treatment of hearing loss and will have even more of an impact in the next few years. It's changing so fast.

AT: Completely agree with you! As a person who has worked with clinical studies with adults who have hearing loss, we often go to great lengths to characterize hearing loss, gender, age, and other attributes, but often spend little time exploring a person's genetic history, because until recently, inexpensive tools have not been available to clinicians or patients.

We talk about the fact that two persons with same audiogram can have very different experiences with amplification, and yet we don't consider that their genetic history could provide additional clues as to why there are such large differences across individuals. There are a lot of data sitting right in front of us that could help explain these differences in the lab, and also importantly, in the clinic.



More recent technologies in human genetics fall under the category of “next generation” DNA sequencing, which can involve sequencing the whole genome, or large portions of the genome in families, looking for mutations or changes.



KA: Exactly, I think that this two-pronged approach of using the traditional tools that we've always had in the audiology field (e.g., the clinical diagnostic evaluation tools) can be supplemented by the addition of the “bare-bone” genetics information, such as a person's family history of hearing loss and how it's inherited, and include what we call their phenotype (what other characteristics may be associated with the hearing loss).

Now we have added something new—you might call it “genomic” information with a better picture of a person's genetic makeup that can



The silent wounds of war

What you should know about veteran patients

A veteran's hearing loss journey can be a bit more colorful and complicated than your average patient. For veterans who have served in combat, hearing loss is often intertwined with other comorbidities incurred from their time in service. While working with your veteran patients, please consider the following:

Veterans may not always listen to your advice. From the moment they first enlist, military members are taught to trust in those who stand beside them. An unbreakable bond is created and the result is a tight-knit community built on trust and credibility. In short, veterans will most likely listen to another veteran before anyone else.

Don't take it personally – this doesn't mean they won't acknowledge your credentials or your expertise. It just means the concept of trust can be especially complex for a military member and the phrase "I've got your back" has an entirely different meaning.

Creating a rapport may take a little extra effort and time. Ask your veteran patients about their time in service and you'll probably discover a few valuable insights – especially useful in the development of a treatment plan.

Veterans have two or more chronic conditions. Veterans are often very humble and may not be quick to open up about their service to healthcare providers. As a result, they have a tendency to hold back valuable information that may affect their care. While tinnitus and hearing loss continue to be the top two service-connected disabilities (according to the VA), almost 60% of disabled veterans with higher disability ratings have more than one disability. As an example, the average number of comorbidities reported during the Gulf War era is six.

Typically there is a lot more going on with your veteran patients than is apparent. Conditions such as Traumatic Brain Injury and Post Traumatic Stress Disorder are at the forefront of these comorbidities. These are sensitive topics that your veteran patient will

more than likely not share right away. To effectively treat veterans holistically, other comorbidities must be explored meaning some proactive encouragement may be required.

As our veteran population continues to grow, healthcare providers of all varieties are learning that understanding a veteran's journey is essential to providing the best holistic care. Hearing loss continues to be the most prevalent silent wound of war and is one of the many challenges our veterans continue to bring home.

For more information about treating veterans holistically and the Heroes With Hearing Loss Program:

**Visit: HeroesWithHearingLoss.org/hhc
Join us at: AAA 2018, Booth #327**

have a tremendous effect on identification, prognosis, and treatment. That approach is getting better and better, and we tried to put together a slate of speakers that would reflect all of that, including information about the genomics approach to everything from newborn hearing screening to adult-onset hearing loss and presbycusis. We wanted to cover a broad range of topics and consider how these new technologies in genetics will impact clinical treatment.

AT: I couldn't agree more. I have the agenda in front of me, and it looks like a great slate of topics and presenters. In addition, you have included a panel discussion and plenty of time for audience interaction with the faculty.

KA: So, all these speakers are both clinicians and researchers, so they have that very helpful approach to the topic. We start the day by going back to the basics of genetics. Often, when we do this we start by talking about infants and children with hearing loss because we know a lot about the genetics of congenital and early onset hearing loss. It tends to be more Mendelian, in that inheritance patterns associated with genetic forms of congenital and early-onset hearing loss is often more straightforward. We understand a lot about that, and we use the basic tools of pedigree analysis and what we know about Mendelian inheritance (e.g., dominant, recessive, x-linked) and what we know from population studies that have been done over the last 20–30 years.

That is, looking at the proportion of children and adults who have hearing loss that we feel is genetic so that we can break it down as to exactly how it is inherited. For example, we know that for congenital moderate-to-profound hearing loss, the most common

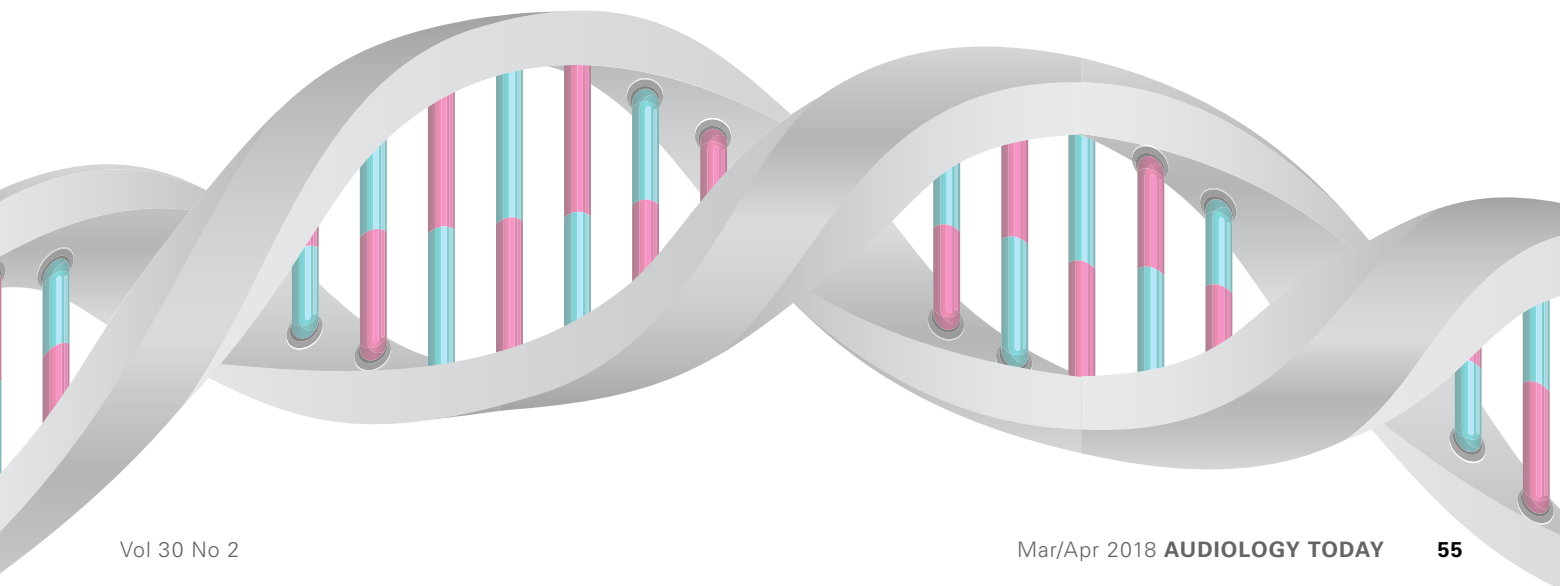
genetic pattern is autosomal recessive inheritance. That's an example of some of the basics. We know much less about adult onset or progressive forms of hearing loss, and as we go through the day we're going to be talking more about that. We will be making a distinction between Mendelian-inherited traits, which as I mentioned encompasses more of the congenital, early-onset hearing loss, versus complex inheritance or a combination of genes and environmental impacts that result in the hearing loss. Complex inheritance is much more important for age-related hearing loss and noise-induced hearing loss, and we will get into that later in the morning.

AT: Wow, that sounds like a very comprehensive overview of the basics of genetics, for people looking to update their knowledge in these areas.

KA: Yes, and in addition to the basic genetic approaches (e.g., looking at the "pedigree," audiograms of family members and possible inheritance patterns), we will also be getting into diagnostic approaches and how that has changed over the last few years, and how we expect it to change in the coming years. For example, for some syndromes that we know are associated with hearing loss, there are very targeted approaches for looking at DNA mutations if the genes for those syndromes have been identified. These targeted approaches to looking for gene mutations can result in a more precise diagnosis for families.

AT: Terrific!

KA: More recent technologies in human genetics fall under the category of "next generation" DNA sequencing, which can involve sequencing the whole genome, or large



portions of the genome in families, looking for mutations or changes. These technologies now allow us to test for mutations in many genes at the same time. This is often done when we don't know much in the pedigree or the phenotype of an individual to guide us in testing. Therefore, we would use a broader approach in next-generation sequencing. The disadvantage of that at the present time is that it is very expensive, but the cost is coming down.

“

In addition to the basic genetic approaches, we will also be getting into diagnostic approaches and how that has changed over the last few years, and how we expect it to change in the coming years.

”

One of our speakers, Dr. Arti Pandya, will be talking about testing and counseling in the area of “precision” medicine. Suppose that a child who is born with severe-to-profound sensorineural hearing loss has suspected autosomal recessive inheritance based on family history. Right now, the most sensible approach, depending on the ethnicity of that child, is to do stepwise genetic testing for a gene called Connexin 26 (Cx26), because it is common in that situation. Current

testing strategies in situations like this start with a targeted approach looking for Connexin genes (Cx26 or Cx30).

The testing strategy is now changing toward gene-testing “panels” which Drs. Pandya and Morton will discuss in greater detail. With these panels, you can test for many different genes—essentially 100 or more—with one sample. Currently, there are issues with identification of unknown variants, but that's getting better, and the costs are coming down. Clinicians need to be aware of this testing so that they can talk to families about it and get an idea of where this is going in the future.

AT: Indeed. I assume that you mean services such as “23andMe.com,” which I see advertised on television quite frequently. It seems like there is tremendous interest in this type of testing, and if I were the parent of a child with hearing loss, I would certainly want to get more information regarding whether this is useful.

KA: Yes, those forms of “direct-to-consumer” genetic testing do exist and as a matter of fact, more and more families are going to these websites in search of answers. 23andMe, for example, is broad DNA sequencing, where they look for a variety of different things, and they can come back and say, “Oh, you have a genetic change that might make you more susceptible to deep vein thrombosis (DVT), so you shouldn't ride on airplanes without walking around frequently.”

AT: (Laughing) That's the story of my life! I feel like I've logged many miles walking the aisles of airplanes, as it turns out I am more prone genetically to DVT.

KA: Or they could come back and say that tests indicate that you are more

susceptible to colon cancer, so you may want to change your habits, and so on. I have had profoundly deaf adults contact me and say, “I just did 23andMe testing and found out that I have two mutations in this gene called Connexin 26, so what does this mean?”

AT: Talk about health-care “consumerism!”

KA: Yes, it’s like “Wow!” Previously that type of testing was only available through physicians, and now it’s gone much more mainstream.

AT: Yes, the megatrend of availability of these sophisticated data to individuals enable them to take a more active role in their health care and lifestyle decisions. If we can use the genetic information to help assist with diagnosis, treatment, and even prevention of specific health conditions, then the future of hearing and balance clinical care may look very different indeed.

For example, with respect to noise-induced hearing loss, if a person knows that she or he is more susceptible to acoustic trauma, then you can go to greater lengths to prevent that from happening. Furthermore, it can help explain some of those individual differences between temporary and permanent threshold shifts (TTS and PTS) between two colleagues who both work in the same noisy workplace. It’s fascinating how this may evolve in the future.

KA: Indeed. Dr. Lustig, who is on the agenda for late in the morning, will be talking about age-related and noise-induced hearing loss and I think that for clinicians, this represents the majority of the patients that they see

on a daily basis. So, having something related to genetics is exciting.

AT: For sure!

KA: As you say, trying to identify individuals who are susceptible before the fact is intriguing, but that can also be a double-edged sword. For example, with 23andMe, they may come back to you and say that you don’t have this particular mutation that makes you more susceptible to heart attacks, and you decide that you can eat anything you want, when there may be other genes that could still cause problems for you in this area. Regardless, however, these new technologies and what we are learning about complex inheritance involving genes and environmental factors interacting together can really be helpful clinically in the coming future. There’s a lot of work being done, and a lot of new research in these areas.

Dr. Kelley Dodson will talk about vestibular disorders and unilateral hearing loss. She’s done some research trying to identify some susceptibility genes for those types of disorders, and she will discuss progress in this area during her talk. We have a long way to go, but it’s moving pretty fast!

AT: This sounds like a fantastic agenda, and well worth it for clinicians and researchers to come to Nashville a day early. We’ve only highlighted a few of the sessions; what would you say are the top three overall “takeaways” for attendees of this conference?

KA: I guess that one of them would be, for clinicians, getting up-to-date facts that allow them to talk to families and individuals with hearing loss a little bit more clearly about genetics, the possible impact, and what they should be aware of that is coming in the future. Communicating this information to families is important, because it can be complicated and a little overwhelming. But, there are things that we see in the newspaper every day, and clinicians need to be able to consider how (and if) they will be able to be applied to the clinical treatment of hearing loss.

AT: There will undoubtedly be “apps” developed in the future that will make all kinds of promises regarding genetic testing. “Lab on chip” technologies are very promising, but there may also be a lot of confusing or misleading information (e.g., Theranos, which over-promised and under-delivered), and audiologists have the opportunity to provide clarity for individuals and families who are seeking information regarding hearing and balance laboratory testing. Being at least “conversant” about the topic will be highly beneficial, and the first part of the agenda will help with the basic vocabulary and emerging concepts.

KA: Yes, this information is important for pediatrics (when there is a family history) and also when there isn't a family history of hearing loss. Some clinicians may think that genetics isn't that important for the patients that they see because the contribution of genetic factors in the etiology has not been clarified, and while that may be true today, it most certainly won't be the case in the future.

The information presented will also be important for age-related and noise-induced hearing loss, (which comprise the majority of adult-onset hearing losses) and non-traditional or complex inheritance. I think that this is related to the second major takeaway on research developments that will impact clinical care in the future. A realistic perspective on the ongoing research will be important, and although some may come away a little disappointed that we haven't progressed further than we have in terms of understanding the genetics of these disorders, but there are lots of changes coming, and they are coming fast.

AT: Yes, and speaking as a member of the Baby Boomer generation that has acquired hearing loss, in part, from a combination of aging, noise exposure, and genetic factors, I would certainly leave no stone unturned regarding diagnosis and treatment of hearing loss, including seeking out genetic counseling based on my phenotype. Much of this might not be possible yet, but if there are any circumstances that the practitioner should be aware of, this meeting would be a great place to convey that information for clinicians. What's the last take-away item?

KA: I think that it would be that as we look toward the future, what can we expect? I've asked Dr. Cynthia Morton, who is the last speaker, to talk about therapeutics. Anybody who reads the newspaper (carefully) has come across the topic of “gene editing” or CRISPR (an

acronym for a technique used for gene-editing), which is a type of genetic engineering in which DNA is inserted, deleted, or replaced in the genome of a living organism using engineered nucleases or “molecular scissors.”

The technology is incredible and it is going to be helpful for many things, including cancer diagnostics and even for identification (and treatment) of viral infections. I think that a good takeaway pertains to the status of gene-editing and what are the “pros and cons” of the technique—it's a very controversial topic. A few months ago, a lot of us were surmising that there weren't a lot of applications related to hearing loss yet, but people are starting to publish about experiments in animals that may become clinically applicable.

AT: As they say, objects in the mirror may be closer than you think.

KA: And that's a little scary.

AT: Well, I look forward to seeing you and hearing from you and the other faculty in Nashville at the Academy Research Conference. Registration is open through www.AcademyResearchConference.org.

Thank you again, for taking the time to speak with us. 

David Fabry, PhD, is the chief innovation officer at Starkey Hearing Technologies and the editor-in-chief of Audiology Today and www.audiology.org.

Kathleen Arnos, PhD, joined the Gallaudet community in 1983 as a research scientist in the Gallaudet Research Institute. In 1996, she joined the faculty in the Department of Biology and is currently chairperson of the Department of Science, Technology, and Mathematics. In 1984, she established the Genetics Program at Gallaudet which provided genetic evaluation and counseling services to deaf people through 2009 in collaboration with Virginia Commonwealth University and Children's National Medical Center. Over the past 30 years she has been actively involved in research on hereditary deafness to study common genes causing deafness, best practices in genetic counseling for Deaf and hard-of-hearing people, and the impact of genetic testing on the Deaf community.



REGISTER TODAY!

ARC18 GENETICS AND HEARING LOSS

APRIL 18 | NASHVILLE, TN | THE FIRST DAY OF AAA

Hearing loss is the most common congenital sensory impairment and birth defect. It has been well established that genetics plays an integral role in more than half of congenital hearing losses. Given the strong relationship between genetics and hearing loss in audiological practice, the Academy continues its commitment to providing audiologists with the latest on genetics research as it relates to hearing impairment in clinical practice through the annual Academy Research Conference (ARC).

This one-day translational conference is chaired by Kathleen Arnos, PhD, who has assembled a world-renowned lineup of speakers to present their latest findings.

www.AcademyResearchConference.org

Funding for this conference was made possible [in part] by 1R13DC016546-01 from National Institute of Deafness and Other Communication Disorders.



Kelley Dodson, MD
Virginia Commonwealth University

Genetic Associations with Vestibular Disorders and Unilateral Hearing Loss

Marci Lesperance, MD
University of Michigan

The Basics of Genetics for the Clinician

Lawrence Lustig, MD
Columbia University Medical Center

Age-Related Hearing Loss and Noise-Induced Hearing Loss: Old Problems and New Paradigms

Cynthia Morton, PhD
Brigham & Women's Hospital, Harvard University

From Etiologic Diagnoses to Personalized Therapies for Hearing Loss

Arti Pandya, MD
University of North Carolina

Genetic Testing and Counseling in the Era of Precision Medicine

Comprehensive Hearing Health Care: Your Advantage

By Jim Skjeveland


Providing excellent care for your patients is likely the reason you joined the hearing health-care profession. But with the coming over-the-counter solutions, audiologists must fight the “no-professional-needed” perception of drugstore hearing instruments. The key to competing is contrasting practices by providing full-service care that builds long-term relationships with patients.

As you know, total patient care extends well beyond the device itself, and requires a holistic approach that uniquely addresses each patient’s everyday hearing challenges. This care is central to reversing the natural isolation that can occur from untreated hearing loss.

For many patients, isolation starts on phone calls, a part of life that was once second nature becomes increasingly difficult over time, eroding important relationships with friends and loved ones. Addressing this simple reality is one area where your practice can stand out on the competitive landscape, and it’s one of the most direct ways to foster the social engagement that patients need.

Amplified phones offer one option; however, the progressive nature of hearing loss suggests a more comprehensive solution could lead to longer term patient satisfaction. A captioned telephone from Sprint CapTel pairs amplification with real-time captions, enabling patients to hear what they can on phone calls and—through captions displayed on the phone’s built-in screen—also read what they miss. They pay nothing for Sprint CapTel phones and service, and audiologists can recommend them using a simple form.

Providing comprehensive hearing health care and a range of treatment options can not only set your practice apart, but also deliver fantastic outcomes for your patients.

Learn more about Sprint’s no-hassle program today. Visit <http://professionals.sprintcaptel.com>. 

CONTENT PROVIDED BY SPRINT CAPTEL

Jim Skjeveland, MBA, is the client director with Sprint CapTel, in Overland Park, Kansas.

Breaking Habits: Maximize Patient Satisfaction with Rechargeable Hearing Aids

By Katrina Sylvester

With new technology comes the need for new patient counseling. Hearing aid users have made it clear they would prefer rechargeable




hearing aids over their disposable-battery counterparts. And now, nearly every major hearing aid manufacturer offers select products with silver-zinc rechargeable batteries built in. Silver-zinc batteries provide patients with the convenience of all-day power and the flexibility to use disposable batteries, if needed.

After years of using disposable zinc-air batteries, patients have developed behaviors that are not ideal for rechargeable silver-zinc batteries. One example is the opening of the battery door to reboot the hearing aid when the low battery signal is heard.

With rechargeable batteries, rebooting can override the smart circuitry in the battery door into believing it has a traditional disposable battery installed. This can over-discharge the battery and lead to a “short-day,” or short battery run time.

With rechargeable batteries, if a low-battery warning from the hearing aids is received, counsel your patients to place the hearing aids in the charging base or replace the batteries with non-rechargeable zinc-air batteries.

Proper patient counseling will create a positive user experience with rechargeable batteries and allow patients to experience all of the benefits that reliable rechargeable hearing aids provide. Visit “Ask the Expert” at zpowerhearing.com for additional patient counseling tips and best practices for the use of rechargeable hearing aids. 

CONTENT PROVIDED BY ZPOWER, LLC.

Katrina Sylvester is the director of marketing for Zpower, LLC, in Camarillo, California.

POWERING TODAY'S TOP HEARING AIDS ON A SINGLE CHARGE!



ZPower silver-zinc rechargeable batteries are now available for select products from nearly every major hearing aid manufacturer. ZPower batteries provide all-day power and the flexibility to interchange with disposable batteries. Plus, they are safe and recyclable.

www.zpowerhearing.com

Zpower®
The Better Battery

WELCOME BACK to an ongoing series that challenges the audiologist to identify a diagnosis for a case study based on a listing and explanation of the nonaudiology and audiology test battery. It is important to recognize that a hearing loss or a vestibular issue may be a manifestation of a systemic illness. Being part of the diagnostic and treatment “team” is a crucial role of the audiologist. Securing the definitive diagnosis is rewarding for the audiologist and enhances patient hearing and balance health care and, often, quality of life.

CSI Reference Guide:

Visit www.audiology.org and search keywords “CSI Reference Guide.”



When Is Ménière’s Disease Not Ménière’s Disease?

By Anne Hogan

Dizziness is a common complaint, with approximately 35 percent of adults reporting dizziness, with the prevalence increasing dramatically with age (Agrawal, 2009). As the profession of audiology has evolved, so has our understanding of the various disorders that cause imbalance and dizziness. This article will walk you through the case of Sunny Susan (patient’s name changed to protect identity), a woman who I first saw as a balance patient after she had spent over 22 years struggling with recurrent dizziness and progressive hearing loss.

Initial Consultation

The first time she was seen at the clinic was 12 years prior to her visit with me. She was age 54 years, and was referred by her primary care physician for hearing loss, potentially due to occupational noise exposure. No other symptoms, besides a gradual hearing loss, were noted. At that time, a mild high-frequency hearing loss, with a pattern

consistent with noise exposure, was found. Tympanometry and acoustic reflex results were also noted as normal (see FIGURE 1).

Back Again

She returned to the same clinic six years later, due to dizziness and decreased hearing. At that time, her hearing had dropped in the low and mid frequencies, and a slight air-bone gap was seen at 500, 2000, and 4000 Hz. Tympanometry and acoustic reflex results were normal again. At this time, Sunny Susan was also referred to an otolaryngologist for dizziness, as the clinic did not yet have vestibular testing (see FIGURE 2).

Third Time’s a Charm

She was back again, three years later (nine years since baseline), due to hearing difficulties, bilateral, pulsatile tinnitus, as well as ongoing dizziness. This time, the audiogram revealed a moderate, rising to mild, low-frequency conductive hearing loss with bone-conduction thresholds at -10 dB HL at 500 and 1000

Hz. Tympanometry revealed that the middle ear pressure was slightly negative (-75 and -100 daPa MEP for the left and right) with present reflexes. The audiologist at that time noted that she experienced dizziness during acoustic reflex threshold testing with stimulation to the right ear and not the left. The patient was then referred to the otolaryngologist to rule out a middle ear disorder (see FIGURE 3).

In the meantime, she had traveled quite a distance to be seen by a larger medical facility, and had received a diagnosis of Ménière’s disease. Twelve years since baseline, she landed on my schedule, as the clinic had added vestibular assessment the year prior. She reported balance problems with a veering to the left side for 10 years, with increased dizziness with bending forward, straining, or blowing her nose. At this visit, the hearing test was the same configuration since the last one, but much worse in the low frequencies, inching toward “severe.” Unfortunately, acoustic reflex thresholds were difficult to interpret due to a poor seal/excess needle deflection (see FIGURE 4).

Fortunately, at this time, I was able to move forward with balance testing, which included modified Clinical Test of Sensory Integration of Balance (mCTSIB) testing, and Video Nystagmography (VNG). As I progressed, however, I already had some thoughts in mind in terms of potential etiology. Was it Ménière’s Disease, as previously diagnosed? I doubted it. Why? Well, first, we must consider the configuration. While the hearing loss presented as a reverse-slope hearing loss, it is conductive, and not sensory neural.

The next thing that caught my attention was the dizziness provoked while bending down. We all learn that benign paroxysmal positional

vertigo (BPPV) is the most common cause of dizziness (von Brevern, 2007), so it is important to rule that out. Although other things didn’t align, as follows:

1. Conductive hearing loss with normal tympanograms
2. Progressive hearing loss
3. Dizziness when straining or blowing her nose

At this point, what else could it be?

Perhaps an uncompensated unilateral weakness, due to the veering, with a “poor historian,” and perhaps head-turns were the issue, not the positions? We have all had poor historians in our clinics, and she just wasn’t one of them.

Tests and Results

On to testing! As mentioned earlier, in that clinic, we had VNG and mCTSIB, using dense foam. The results may surprise you... or might not.

- Oculomotors are within normal limits (Good! Not central!).
- Gaze testing is negative for nystagmus in any position, with and without target.
- High-frequency headshake is negative for post-headshake nystagmus.
- Positional testing (moving slowly, as we should for this test!) is negative for nystagmus in any position, with or without fixation.
- Dix-Hallpike is “non-classical abnormal:” patient has dizziness in both head right and head left.
 - Nystagmus onset is almost instantaneous (non-classical)

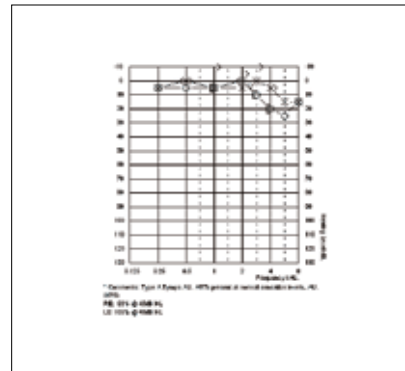


FIGURE 1. Baseline audiogram, 12 years prior to final diagnosis

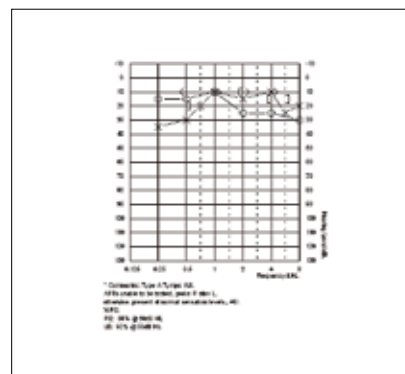


FIGURE 2. Second audiogram, six years since baseline.

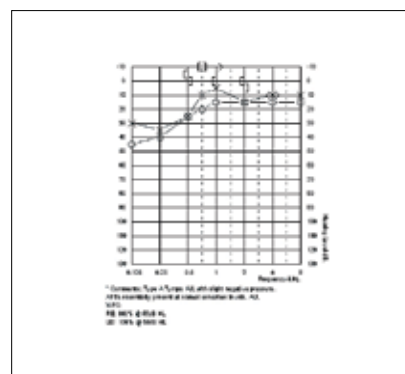


FIGURE 3. Audiometric results from third audiogram, nine years since baseline.

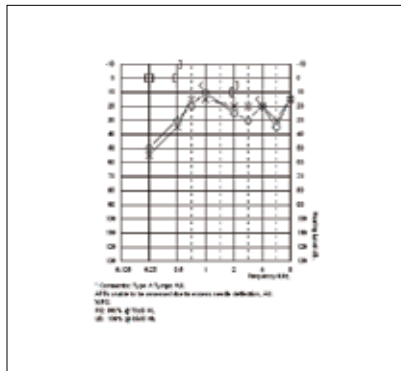


FIGURE 4. Final diagnostic audiogram.

but it does slow and resolve over the course of one to two minutes (lasts longer in the right ear).

- The nystagmus itself is a vertical nystagmus in each position, which is typically deemed as a central finding, right?
- Caloric testing reveals a strong, symmetric response.
 - No significant unilateral weakness or directional preponderance.
- mCTSIB is mildly abnormal, with the patient unable to stand on foam with eyes closed for more than 15 seconds.

Any ideas as to where this is going?

In an informal assessment, recording of the patient’s eyes as she did a valsalva maneuver revealed, again, a vertical nystagmus.

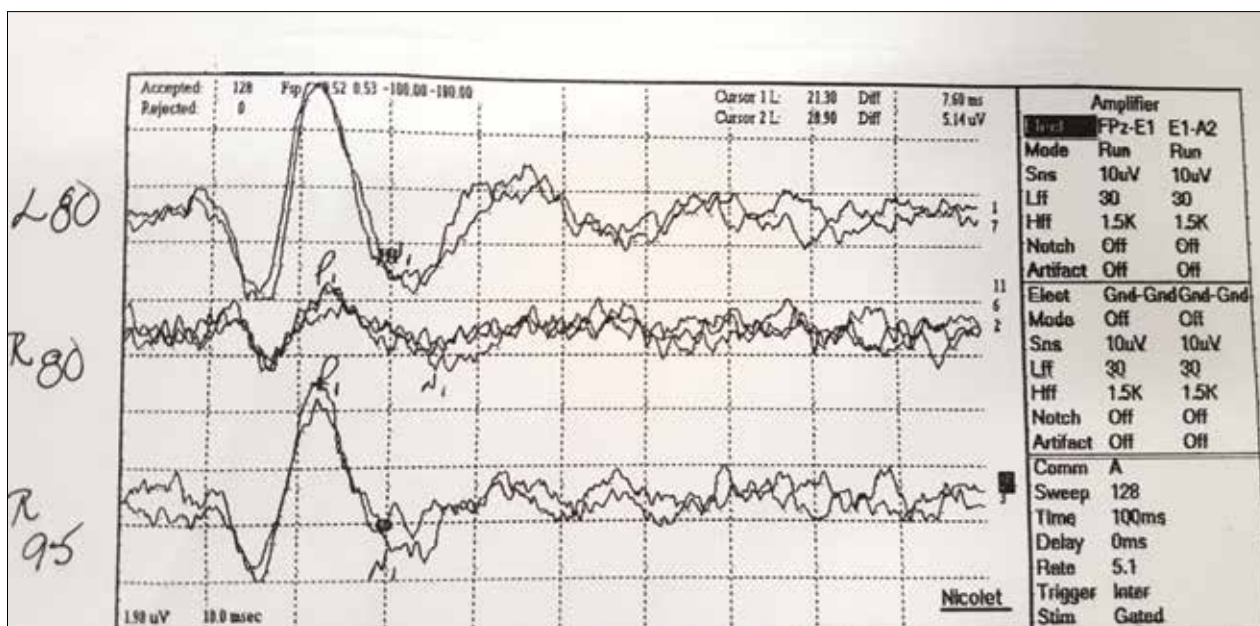
What’s next?

From our wheelhouse of tests, the next test for me was cervical vestibular evoked myogenic potentials (cVEMP). Due to scheduling constraints, my colleague completed this testing. cVEMP testing revealed strong, symmetric responses at 95dBnHL. Testing at 70dBnHL showed a sustained N1-P1 response (see FIGURE 5).

Still guessing?

My next recommendation was for a fine-cut computed tomography (CT) scan, and I requested this of the primary care physician, who was the referring physician. When I learned that two weeks post-testing they had not yet ordered the test, and instead had recommended the patient come back to discuss hearing aids, I called and spoke with the nurse. (Note: In this community, the primary physicians often had an overload on their cases, so the nurse was my first line of communication). After having

FIGURE 5. VEMP results from Sunny Susan, shortly after VNG.



to convince her that no, the patient did NOT have Ménière's, the CT was finally ordered.

At this point, I enlisted the help of our neighbor otologist, who I had the good fortune of collaborating with across cases. He gladly met with the patient and explained the CT results with her, and steered her to the closest surgeon for the procedure.... Who just happened to be at the large facility that misdiagnosed her. Nonetheless, with the encouragement that she would be back to see me after the surgery, she headed off for surgery.

The surgeon and patient agreed that the right side, which had showed a larger dehiscence and greater symptoms when provoked, would be the first side for surgery.

Unfortunately, surgery does not always go as planned.

Surgery

While in surgery, almost as soon as the surgeon had reached the dehiscence, the patient, in her words, "started to bleed out, so they packed up and got me out of there as soon as possible." On the bright side, her symptoms did reduce, probably due to a packed canal (deadened canal). When asked if she would be returning for surgery on the left, the patient said, "I'm feeling better, and just glad for each minute I have on this earth."

Perspective is everything, isn't it? 

Anne Hogan, PhD, is assistant professor of audiology at Pacific University in Forest Grove, Oregon. This study was reviewed and approved by her institutional review board.

“Findings consistent with bilateral superior semicircular canal dehiscence.”

References

- Agrawal Y, Carey JP, Della Santina CC, Schubert MC, Minor LB. (2009) Disorders of balance and vestibular function in US adults: data from the National Health and Nutrition Examination Survey, 2001-2004. *Arch Intern Med* 169(10):938–944
- von Brevern M, Radtke A, Lezius F, et al. (2007) Epidemiology of benign paroxysmal positional vertigo: A population based study. *J Neurol Neurosurg Psych* 78(7):710–715



REGISTER

BEFORE
APRIL 17
AND SAVE!

FIRST-TIME ATTENDEE ORIENTATION

Wednesday, April 18
12:00–12:45 pm

Music City Center

Is this your first time attending the AAA conference? Join us for an overview that will help you make the most of this incredible experience. This is also a great opportunity to meet other attendees of AAA 2018.

CELEBRATE AUDIOLOGY

Wednesday, April 18
5:00–7:30 pm

Exhibit Hall

Enjoy a fun-filled way to kick-off the first evening of AAA 2018. Join us in the exhibit hall for entertainment while you mingle with colleagues and industry representatives. Partake in the open bars and food available in and out of the booths.

SPONSORED IN PART BY
HAMILTON CAPTEL.

AAA FOUNDATION HAPPY HOUR (\$)

Wednesday, April 18
7:00–8:30 pm

Omni Nashville

Enjoy a cocktail and some amazing appetizers while catching up with old and new friends.

PHILANTHROPIC SUPPORT PROVIDED
IN PART BY **PHONAK, LLC.**

SAA CHEER FOR EARS BENEFIT (\$)

Wednesday, April 18
8:00–11:00 pm

Rock Bottom Brewery

Continue the party after *Celebrate Audiology* and head over to this fun-filled event with fellow students and professionals from across the country.

SPONSORED IN PART BY **PHONAK, LLC.**



APRIL 18-21
#AAAConf18

HONORS AND AWARDS BANQUET (\$)

Thursday, April 19

7:00–8:30 pm

Omni Nashville

Recognize the individuals who have dedicated their lives to improving the audiology industry.

SPONSORED IN PART BY **PHONAK, LLC.**

PEDAL FOR THE PAC (\$)

Thursday, April 19

7:00–9:00 pm

Pedal Tavern House

Show your support for the Academy's Political Action Committee (PAC) by registering for a tour of the famous Broadway area on a Pedal Tavern that includes several stops at local bars with fantastic live music.

INTERNATIONAL RECEPTION

Thursday, April 19

8:30–9:30 pm

Omni Nashville

Welcome our international colleagues and become acquainted with audiologists from all over the world.

SUNRISE YOGA (\$)

Friday, April 20

6:00–7:00 am

Omni Nashville

Invigorate your body and spirit and create a peaceful center prior to starting your day of education.

NIGHT OUT IN NASHVILLE AT THE WILDHORSE SALOON (\$)

Friday, April 20

8:00–11:00 pm

Wildhorse Saloon

Polish off your dancing shoes to enjoy a fun-filled evening with friends and colleagues.

SPONSORED IN PART BY **AMPLIFON.**

ZUMBA (\$)

Saturday, April 21

6:00–7:00 am

Omni Nashville

Forget the workout and join the dance fitness party with your colleagues and friends. Zumba combines high energy and motivating music with unique moves and combinations that allow the Zumba participants to dance away their worries. Suitable for all fitness levels.

Advanced Beneficiary Notice of Noncoverage Use: Mandatory or Voluntary?

By Kristiina Huckabay and Kari Morgenstein

Understanding the correct use of the Advance Beneficiary Notice of Noncoverage (ABN) Form CMS-R-131 is important to ensure billing compliance for traditional Medicare (Part B). Audiologists may face challenges determining when Medicare covers a service and when an ABN is required. Federal law requires that providers, including audiologists, must notify a Medicare beneficiary in advance when a service that Medicare typically covers is likely to be denied and/or when the item or service is not considered by Medicare to be medically reasonable and necessary. The ABN meets this requirement. To better understand when an ABN should be used, let's take a closer look at how Medicare identifies covered services.

In the simplest terms, to be reimbursed by Medicare for covered audiology services, the audiologist must have the following:

1. Documented medical necessity*
2. A physician or a non-physician practitioner's order for the audiology evaluation

**Medically necessary hearing evaluations include, but are not limited, to the following: evaluation to determine the cause of hearing loss, tinnitus or balance disorders; changes in hearing, tinnitus or balance; diagnostic testing before and periodically after cochlear implantation; analysis and programming of cochlear or brainstem implants;*

audiologic re-evaluation following medical/surgical treatment; failure of hearing screening (Centers for Medicare and Medicaid Services).

If both conditions have not been satisfied, the audiologist will need to consider the specific scenario to determine if a mandatory ABN is required. Mandatory ABNs are required when the service performed is typically a covered service under Medicare, though in the particular case not all requirements for coverage have been obtained.

A voluntary ABN may be issued when services are excluded or do not meet Medicare coverage requirements (i.e., tests that do not have a referral, non-covered treatment such as cerumen management, tinnitus treatment, hearing aids, hearing evaluation for the purpose of a hearing aid, routine monitoring). In many cases, a mandatory ABN will not be required; however, each clinic/clinician may decide to provide a voluntary ABN in the interest of transparency.

The ABN should only be used with traditional Medicare (Part B). Medicare Advantage Plans (Part C) may have their own coverage guidelines and notice of noncoverage forms. CMS prohibits use of the ABN form for Medicare Advantage Plans (Centers for Medicare and Medicaid Services 2017, 2012).

After determining if ABN use is mandatory or voluntary, the audiologist will now be prepared to submit

the claim with the appropriate modifier using the CMS definitions below:

- **GA: Waiver of Liability Statement Issued as Required by Payer Policy, Individual Case.** This should be used when a mandatory ABN is obtained.
- **GY: Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit.** This may be used in combination with the GX modifier; allows for auto-denial from Medicare to bill the patient's secondary insurance if the secondary payor provides audiology coverage.
- **GX: Notice of Liability Issued, Voluntary Under Payer Policy.** This can be used when a voluntary ABN was obtained and may be used in combination with the GY modifier.
- **GZ: Item or Service Expected to Be Denied as Not Reasonable and Necessary.** This modifier can be used if a service was provided that did not meet medical necessity and the ABN was not provided. This should be a rare occurrence if the audiologist carefully reviews supporting documentation and conducts a thorough case history prior to providing a service.

In cases when a mandatory ABN is issued for procedures that are typically covered, but there is a question

of medical necessity, a claim must be submitted to Medicare. The GA modifier is reported for each procedure in question.

Claims that are excluded or never covered by Medicare do not require an ABN. The claim does not need to be submitted to Medicare. In a case where the patient wants the claim submitted, and you have issued a voluntary ABN, the GY and GX modifiers must be used. CMS indicates that the voluntary ABN “serves as a courtesy to the beneficiary in forewarning him/her of impending financial obligation. When an ABN is used as a voluntary notice, the beneficiary should not be asked to choose an option box or sign the notice” (Centers for Medicare and Medicaid Services, 2012).

While the general guidelines are straightforward, once faced with nuanced chart notes and face-to-face discussion during a case history, audiologists may find themselves in the gray zone of ABN use. The following examples are meant to provide guidance for various scenarios which may arise before or during the clinical encounter.

1. An ABN should be utilized for
 - a. Medicare Part B
 - b. Medicare Advantage plans (Part C)
 - c. Medicare Part D
 - d. Both 1 and 2

ANSWER: a. Medicare Part B

2. A patient is scheduled for a non-covered service and you provide a voluntary ABN. The patient chooses Box 1 (to bill Medicare). The appropriate modifier(s) in this scenario is
 - a. GA

- b. GY
- c. GX
- d. GY and GX

ANSWER: d. GY and GX

3. Examples of scenarios where a mandatory ABN should be issued and GA modifier utilized include
 - a. Frequency of testing is more than typical
 - b. Patient had a recent hearing test at an ENT clinic then seeks a second opinion and second ENT refers for an audiogram
 - c. Physician referral exists, but medical necessity is not clear
 - d. All of the above
 - e. None of the above

ANSWER: d. All of the above

4. Patient has self-referred for a sudden hearing loss and has a secondary insurance that may cover the testing.
 - a. Call physician for referral
 - b. Provide a voluntary ABN and utilize the GX modifier
 - c. Utilize the GY modifier to submit the claim to Medicare for denial. Utilize both the GY and GX modifiers if a voluntary ABN is issued
 - d. Bill Medicare because medical necessity is met

ANSWER: c. Utilize the GY modifier to submit the claim to Medicare for denial. Utilize both the GY and GX modifiers if a voluntary ABN is issued.

5. A patient presents for a hearing test one year after his/her initial test. The patient brings a physician referral and indicates that he/she is not aware of a change in hearing, but wants to be sure it hasn't changed.
 - a. Explain that this test would be considered routine and not covered; issue a voluntary ABN and use GY and GX modifier if the patient wants the claim submitted to Medicare
 - b. Bill Medicare because a physician order was received
 - c. Sign a mandatory ABN and submit with GA modifier
 - d. None of the above

ANSWER: a. Explain that this test would be considered routine and not covered; issue a voluntary ABN and use GY and GX modifier if the patient wants the claim submitted to Medicare.

6. A patient calls your clinic for a hearing evaluation and they are self-referred. Your office staff should:
 - a. Inform the patient to call their physician for a referral per Medicare guidelines
 - b. Inform the patient of the estimated cost for the evaluation due to self-referral status
 - c. Ask for the patient's PCP and call the PCP to obtain a referral
 - d. Schedule the visit and let the audiologist figure it out during the visit

ANSWER: b. Inform the patient of the estimated cost for the evaluation due to self-referral status

The American Academy of Audiology (the Academy) also has a detailed ABN decision matrix that may assist you in your decision-making (see FIGURE 1). This document can also be accessed by visiting the Academy’s website and searching “ABN decision matrix” (Burton, 2012).

To learn more about ABN use, attend the learning module at AAA Nashville, “All Things ABN-Medicare’s Advance Notice of Noncoverage for Audiologists” presented by Annette Burton, AuD. There are also many Medicare resources available to audiologists on the Academy website within the Practice Management section. Particularly relevant is a collaborative document from the American Academy of Audiology, Academy of Doctors of Audiology, and American Speech-Language-Hearing Association regarding “Medicare Frequently Asked Questions.” Members can access this page by searching keyword “Medicare” on the Academy’s home page (www.audiology.org). For additional information on use of the ABN, search keyword “ABN” on the Academy’s website.

The Academy would also encourage all audiologists to review the Medicare Benefit Policy Manual, Chapter 15, Section 80.3, Audiology Services for extensive information on Medicare coverage of audiology services.

FIGURE 1. Advance Beneficiary Notice (ABN) of Noncoverage Decision Matrix

Advance Beneficiary Notice (ABN) of Noncoverage Decision Matrix

Is the patient enrolled in the original Medicare program?

YES



NO →

ABN should not be used.

Is a licensed audiologist performing the service?

YES



NO →

Does not meet definition of a covered service. Mandatory ABN is not required, may utilize voluntary ABN if desired.

Does Medicare cover the service when performed by an audiologist?*

YES



NO →

Does not meet definition of a covered service. Mandatory ABN is not required, may utilize voluntary ABN if desired.

Did the physician or NPP order this service?

YES



NO →

Does not meet definition of a covered service. Mandatory ABN is not required, may utilize voluntary ABN if desired.

In this instance, is this service considered routine?*

NO



YES →

Does not meet definition of a covered service. Mandatory ABN is not required, may utilize voluntary ABN if desired.

In this instance, does Medicare consider this service medically reasonable and necessary?*

NO



Mandatory ABN is required

MAYBE, NOT SURE



Mandatory ABN is required

YES



Covered services do not require ABN

**Please utilize guidance in the *Medicare Benefit Policy Manual*, chapter 15, section 80.3 and any Local Coverage Determinations (LCD) issued by your Medicare Administrative Contractor (MAC) to guide your decisions regarding coverage and medical necessity.

For more detailed information, see the CMS ABN webpage: www.cms.hhs.gov/Medicare/Medicare-General-Information/BNI/ABN.html.

For Coding and Reimbursement questions,
e-mail reimbursement@audiology.org.^{AT}

Kristiina Huckabay, AuD, is director of audiology services at Swedish Medical Group and lecturer at the University of Washington in Seattle, Washington. Kari Morgenstein, AuD, PASC, is an assistant professor at the University of Miami Medical Center in Miami, Florida.

References

The Advanced Beneficiary Notice Commonly Asked Questions. American Academy of Audiology. www.audiology.org/sites/default/files/practicemanagement/abn_collaborationacademy.pdf (accessed January 30, 2018).

Burton A. (2012) ABN Decision matrix: a systematic approach for determining the correct use of the ABN for audiologists. *Audiol Today* 24(4):60–62.

Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual Chapter 15. www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf (accessed January 30, 2018).

Centers for Medicare and Medicaid Services. (2012) Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, Updated Manual Instructions. www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7821.pdf (accessed January 30, 2018).

Centers for Medicare and Medicaid Services. (2017) Medicare Learning Network: Medicare Advance Written Notices of Noncoverage www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf (accessed January 30, 2018).

Recent Grads!

Maximize your membership benefits and Fellow Up!

Recent grads are eligible to receive discounted Fellow membership dues for the first two years following graduation. Become a part of the Academy as a **New Professional and Fellow Up!**

To learn more, visit www.audiology.org. Search keyword **UPGRADE**.



AMERICAN ACADEMY OF AUDIOLOGY 



Should You Fear the Press?

By Vicki Bendure

As public relations professionals, we encounter mostly two types of clients—those who prefer to ignore media (“if you don’t engage, they can’t write bad information about you”); and those who are fairly lackadaisical about what they say to media, including what they post on social media.

There should be a middle ground, as everyone should have some apprehension in dealing with the press. Media 101 says, “they are reporters, not your friends,” and “nothing is off the record.” Choosing to ignore media calls does not guarantee that you’ll stay out of a news story.

In spite of the “fake news” era and depending on the outlet, stories in the media have five times more (and greater) credibility than advertising. The media can be an efficient,

low-cost avenue in getting your story out in front of existing and potential patients.

The best way to tell your story is to be proactive about it. Call a local reporter and invite him or her to tour your practice, to see a hearing test, and learn about what you do. Or call the reporter and ask to meet for coffee close to the media outlet. Building a relationship is the first important step to getting positive news coverage. In building a relationship you also become the “go-to expert” for that reporter for anything hearing related. If you establish yourself as a good source who will respond to media in a timely manner (return phone calls as soon as possible), and make the reporter’s work easier, you’ll easily become the trusted source.

Do Your Homework

Before you reach out to a reporter or call a reporter back, go online and search for his/her current position at the media outlet. Look up articles that have been recently written to get a sense for interest, tone, and beat. Know who you’re contacting. He or she could be an investigative reporter or a consumer reporter and the tone of the story will be significantly different than if it’s a medical reporter writing about the profession or hearing testing. Never speak with a reporter until you know exactly what type of reporter he/she is. Then prepare.

Gather your notes before calling back. If the reporter has left you a message and you have no idea what he/she is writing about, call them

back and ask. Tell him or her that you'd like to get all of the information they need so you can best help them. If you need to buy time to gather more information, politely tell the reporter that you will pull together the information and call them right back. Or, if you have a patient, then tell them you'll call back after your patient. You don't need to be caught off guard. Just make sure to call them back when you say you will.

Don't Be Afraid to Ask Questions

Ask what the story is about. Ask if the reporter is talking to other audiologists or companies or just to you. As long as you ask the questions within the context of being able to provide the best information to the reporter, they'll talk with you. If the story is electronic (television or radio), ask where they would like to shoot or tape. You may have to go to a studio location or they may want to come to your office. Ask if they would like to speak with a patient, if you have a patient they can talk with. Often that makes the story even more compelling.

Most importantly, ask about their deadlines. You will want to find a patient, get to the studio, clear your patient schedules, etc., to meet the deadline. Respecting deadlines is critical to reporters, especially if you ever want to be called on by him or her again.

Speak Publicly Whenever You Can

Public speaking training is a good basis for media training. It forces you to condense your story and boil down your occupation into sound bites. It also allows you to best determine the media hook for your story. Media are simply telling stories to an audience. The media landscape is competitive because every outlet wants to draw the most readers, listeners, or viewers. The better you are in front of an audience and the better you are at speaking, the better you will be on camera and in interviews.

The key to good media interviewees is the same as public speaking—you cannot ignore your audience. There are some who are so secure speaking and so love to hear themselves speak that they'll stand in front of an audience all day and yammer on. Everyone in front of them may be asleep. Just as with media, you have to be in tune with the audience. You have to be in tune with the reporter. Carefully listen to the questions and respond in concise, easily understood answers.

No one ever fully masters public speaking or dealing with the press. It requires constant practice. Even if you've been on national television, you will still need to practice your message and practice listening to the reporter.

Don't Be Afraid to Change the Course of Discussion

If the interview is going in a direction where you're not comfortable, politely change the course. There's a media training technique called "bridging" which helps you get the conversation back on track or drive it where you'd like for it to be. It is as simple as stating, "I'm not certain about that but what I do know is..." or "that's a great question but here's what is probably more meaningful..." or, "the point I'd really like to get across is..."

Often a reporter will ask at the end of an interview, "anything else you'd like to add?" Often the interviewee (just being relieved that the interview is over), will say, "no, I think that is everything." Never let that opportunity pass by. Instead, always take the opportunity to either add more important information or reinforce a point you made earlier.

Social Media

With social media, stories can quickly travel. Often people don't realize that anything in the public domain can be news. Between what you post on social media platforms and what you e-mail around in your office (even with confidential disclaimers at the bottom), everything is susceptible to being sent outside of the office. It's not unusual for a reporter to look at your accounts when he/she is working on a story—even your personal accounts. Posting or sharing controversial information (political viewpoints, etc.), could impact a news story. It's important to ask yourself before posting or e-mailing, "if a news outlet picked this up, would it damage my reputation or that of my practice?"

Vicki Bendure with Bendure Communications has media trained and coached C-Suite executives, physicians, attorneys, and other professionals across the country. She and a colleague will host a Media Training Learning Lab as well as two, one-hour mini training sessions at AAA 2018, April 18, in Nashville. For more information, visit www.AAAConference.org.

Getting to Know the New Trustees

The Foundation is excited and proud to welcome our new trustees. Drs. Kukula, Banjeree, and Brudereck will serve on the Foundation Board through September 30, 2020. These trustees will join our other board members and work with the Academy and other affiliated organizations to fill the Foundation's mission. We hope you enjoy hearing more about their experiences, backgrounds, and unique personalities.



Jane Kukula, AuD
PRIVATE PRACTICE
Mentor, Ohio

What's your favorite part of being an audiologist? I love being in private practice and all that comes with it. I especially enjoy working for myself. While it's a busy practice, I still set my own pace with patients creating time to enjoy getting to know them, share a laugh or shed a tear or two. Plus, I find it rewarding to help people hear again, putting them back in touch with their families and friends. I've practiced for many years and still haven't tired of positively impacting people's lives.

Do you have fundraising experience?

My fundraising skills were first honed as a member of the Willoughby Junior Women's Club where we raised funds for community projects and programs, putting on dinner parties, reverse raffles, auctions, and the Spring fashion show.

What things do you do for fun outside of the profession?

I enjoy time with family and friends, and occasionally bingeing on Netflix. I like doing things with my hands such as jewelry making and I've been learning machine quilting. I would love to see the world and I am working on it one trip at a time.

Tell us about your family.

I come from a large family and many are still in the greater Cleveland area. Though I don't have children, I treat my nieces and nephews like they are my children.

Were there any Foundation projects that you were surprised about when you joined the Board?

I knew of the scholarships and research grants, but wasn't as aware of the support of public awareness aspect.

What are you most excited to see in Nashville?

I am looking forward to just seeing Nashville and taking in the sites. My hope is to hear someone famous playing in a local bar, or any celebrity sighting would be a fine with me.

What's the first career you dreamed of having as a kid?

I dreamt of being everything from a teacher to a movie star. Some of the highlights were an architect, a physician, fashion designer, dancer, and an artist.

What was the last text you sent?

"Have safe travels," it was sent to my nephew and his wife on their way to Cancun.

Where is the most interesting place you've been?

I love Europe, especially Italy. The Amalfi coast of Italy is definitely a favorite.

If you could instantly become an expert in something, what would it be? I would love to be an IT expert, the one who comes in and saves the day when the computers go down.



Shilpi Banerjee, PhD
OWNER OF SKAFOLD LLC [which provides technical consulting services]
Hillsboro, Oregon

What is your favorite part of being an audiologist?
The people I am proud to have as colleagues and friends.

Do you have fundraising experience?
Some, for state audiology organizations.

What things do you do for fun outside of the profession?
Travel, read, small DIY projects.

Tell me about your family.
Sometimes I want to disown them, but most of the time I love them.

Were there any AAAF projects that you were surprised to learn about when you joined the board?
Member Assistance Program.

What are you most excited to see in Nashville?
Friends and colleagues from around the world.

What's the first career you dreamed of having as a kid?
Astronaut, truck driver.

What's the last text you sent?
"Do you have a minute to talk?"

Where's the most interesting place you've been?
Churchill (Canada), Amazon (Brazil), Poprad (Slovakia), Hambantota (Sri Lanka), Moscow (Russia), Sofia (Bulgaria)...the list goes on.

If you could instantly become an expert in something, what would it be?
Reading people.



Mindy Brudereck, AuD
OWNER OF BERKS HEARING PROFESSIONALS, LLC [a private practice with two locations]
Wyomissing, Pennsylvania

What is your favorite part of being an audiologist?
Helping people improve their communication. I love getting to know my patients, and developing a good connection with them.

Do you have fundraising experience?
Yes, mostly for audiology organizations.

What things do you do for fun outside of the profession?
Go to the Poconos with my family.

Tell me about your family.
I am married, my son and stepson are both 13 years old and my daughter is 10 years old. We have two dogs, Clark W. Griswold and Molly.

Were there any AAAF projects that you were surprised to learn about when you joined the board?
Member Assistance Program.

What are you most excited to see in Nashville?
To go to Robert's Western World and have the Recession Special!

What's the first career you dreamed of having as a kid? Maid or veterinarian.

What's the last text you sent?
"He had already cleaned it up by the time I went upstairs." My son wrote something mean about his siblings on the mirror after a shower.

Where's the most interesting place you've been?
Kalaupapa, Hawaii.

If you could instantly become an expert in something, what would it be?
Woodworking. 🛠️

LECTURE SERIES

BROUGHT TO YOU BY



AMPLIFY: LEAD LIKE A GIRL AND IGNITE THE IMPACT OF WOMEN LEADERS

Presented by **Tacy M. Byham, PhD**

Dr. Tacy M. Byham is chief executive officer at Development Dimensions International (DDI). Lead Like a Girl will empower all leaders to declare their true worth and ignite impact in the workplace, from the start of their careers all the way to the C-Suite.

She is the co-author of the acclaimed book, *Your First Leadership Job: How Catalyst Leaders Bring Out the Best in Others*, and will be on hand for a book signing during AAA 2018.



THURSDAY | April 19
3:00-6:00 pm

Marion Downs Lecture in Pediatric Audiology

THIRTY MILLION WORDS: A PUBLIC HEALTH APPROACH TO EARLY CHILDHOOD EDUCATION

Presented by **Dana L. Suskind, MD**

Dr. Dana L. Suskind is a professor of surgery and pediatrics at the University of Chicago. In her presentation, she will discuss the Thirty Million Words Initiative, which develops and disseminates evidence-based, parent-directed programs that encourage parents to harness the power of their words to build their children's brains and shape their future.



FRIDAY | April 20
9:00-11:00 am

PHILANTHROPIC SUPPORT PROVIDED IN PART BY THE OTICON FOUNDATION.



★ ★ ★
AAAConference.org

★ ★ ★

APRIL 18-21
#AAAConf18

Audiologists with Hearing Loss: A Different Perspective

By Amanda Demas, Kelsey Roy, and Audrey Taylor

On Thursday, April 6, 2017, at AudiologyNOW! (now AAA Annual Conference) in Indianapolis, Indiana, the annual Deaf and Hard-of-Hearing Audiologists Meeting sparked connections and a desire to change perspectives.

At first, only a few people were gathered around a conference table. However, people were soon grabbing chairs to accommodate everyone trickling into the room. At this meeting, a community was born. Audiology students and professionals with hearing loss went around and shared their own experiences. The hearing losses of those present spanned a variety of types, degrees, and etiologies. Surprisingly, of the 35 attendees, approximately 30 were students.

One by one, the students began to realize they were not alone, and this was a safe place to ask questions

and discuss their experiences. Their questions included, “What strategies do you employ to perform listening checks on hearing aids?” “How do you score word recognition more accurately?” “How do you deal with discrimination when it occurs?” At the end of the meeting, the students walked away knowing they established a community, even if they were the only AuD students with hearing loss at their respective universities.

A couple of weeks later, Kelsey Roy, a third-year AuD student at the University of North Carolina-Chapel Hill, and Audrey Taylor, a third-year AuD student at the University of Texas at Dallas, reached out to the national Student Academy of Audiology (SAA) regarding their experience at the meeting. They had a desire to form a committee, with the goal of connecting audiology students with hearing loss,

and empowering them to face the unique challenges that hearing loss presents on their paths to becoming audiologists.

During the summer of 2017, the SAA Board of Directors voted in favor of Roy and Taylor’s idea, and the Deaf and Hard-of-Hearing Students Subcommittee was placed within the SAA Chapter and Member Relations Committee. Amanda Demas, senior at Loyola University Chicago, joined Roy and Taylor on the Deaf and Hard-of-Hearing Students Subcommittee.

When asked about her experiences with hearing loss and the field of audiology, Demas said:

I had my hearing tested for the first time at age five during a routine school screening. My family was surprised by the results, and later testing revealed a bilateral, mild-to-moderate, sensorineural



hearing loss. Since I did not have a family history of hearing loss, this was a startling realization. My audiologist helped my family cope with this diagnosis and helped as I adjusted to my first pair of hearing aids.

Over the years, we maintained a strong relationship. She helped me develop a positive outlook on my prognosis, and encouraged me to consider a career in the field. My personal experiences with hearing loss and my audiologist is what ultimately guided me to pursue a degree in audiology. I hope that other students with hearing loss find the same motivation in their diagnosis.

While there may be additional obstacles, I believe that audiologists with hearing loss bring a unique perspective to this profession, and can truly empathize with their patients. This deeper understanding of hearing loss helps foster patient care, and demonstrates that hearing loss does not have to be a debilitating diagnosis.

Audrey Taylor had a similar experience, as she did not pass her hearing screening at a speech-language pathologist's office when she was four years old. She was initially diagnosed with a bilateral sensorineural hearing loss at MD Anderson. Her follow-up care was performed at Texas Children's Hospital, where she was the first child fit with a digital hearing aid. When recalling her experiences, Taylor said:

As a pediatric patient with hearing loss, I received compassionate and quality care, which inspired me to give back to others. During my college summer breaks, I volunteered with Texas Children's Hospital.

My most memorable appointment while volunteering was with a three-month-old who underwent an ABR following PE tube surgery. The parents were devastated when their child was diagnosed with hearing loss. I remember the mother weeping as the audiologist spoke with her and her family regarding their options. After they finished, the family approached me to inquire about my hearing loss. We discussed that from my experiences, hearing loss does not prohibit one from achieving his/her goals. I told them about my accomplishments, and hope instantly came back into their eyes. Afterwards, the audiologist told me that I have a gift.

Due to my own experiences with hearing loss, I could do something she could not, despite her years of experience. That clinical situation ignited a passion within me. I plan to be a lifelong advocate for individuals with hearing loss, striving to give them every opportunity to succeed.

Kelsey Roy was diagnosed with mild-to-moderate hearing loss at the age of five years old, but did not receive amplification until 18 years old. She was diagnosed during a time when it was not as common to fit digital hearing technology on children with hearing loss unless it was a severe-to-profound loss. Roy said:

I did not realize how much I was missing until the day I wore hearing aids for the first time and had that eye-opening experience. Ever since that moment, I've wanted to help others with hearing loss appreciate how life-changing hearing technology truly is. I have a passion to help people who don't know that things can get better, much like I

was years ago. I empathize with patients, and I prove that hearing assistive technology is nothing to be ashamed of. I truly believe that hearing loss is not a disability, and audiologists with hearing loss have found their true calling.


Conclusion

While these young women are passionate and motivated about the profession and their future patients, they also have a desire to improve the lives of other audiology students with hearing loss. They know firsthand that students with hearing loss face additional challenges in the academic environment. Their hope is that, through education, they can reduce the discrimination and barriers that students may face, even within the field of audiology.

This year, the Deaf and Hard-of-Hearing Students Subcommittee is in the process of creating resources for students with hearing loss. These will supplement existing resources such as the applying to audiology graduate school packet, and will further expand on them by discussing how to register with the disability office at a university, providing suggestions for reasonable accommodations, and helping students gain a deeper understanding of their legal rights.

Additionally, at the AAA 2018 Annual Conference in Nashville, Tennessee, the subcommittee has planned the inaugural Deaf and Hard-of-Hearing Students meeting, to be held in conjunction with and prior to the Deaf and Hard-of-Hearing Audiologists meeting. The goal is to provide an outlet for students with hearing loss to openly discuss the unique challenges they may face in their local academic and clinical environments, and acquire


strategies on how to best advocate for themselves as students and soon-to-be professionals.

This meeting will provide students a safe space to share experiences with those who go through similar situations, separate from professors or potential employers. The Deaf and Hard-of-Hearing Students meeting is the first of many steps in collaborating with colleagues to better the audiology profession. 

Amanda Demas is an undergraduate student at Loyola University Chicago and a member of the SAA Chapter and Member Relations Committee. Her audiological interests include pediatrics and research on language development in that population.

Kelsey Roy is a third-year student at the University of North Carolina in Chapel Hill and a member of the SAA Chapter and Member Relations Committee. Her audiological interests include cochlear implants, hearing aids, hearing assistive technology, and aural rehabilitation.

Audrey Taylor is a third-year student at the University of Texas at Dallas and a member of the SAA Chapter and Member Relations Committee. Her audiological interests include pediatrics, cochlear implants, aural rehabilitation, hearing assistive technology, and public education regarding living with hearing loss.




EXPAND your knowledge beyond the classroom.

INTERACT with peers, luminaries, and potential employers.

ACQUIRE the latest clinical advances in audiology from top experts in the profession.

**6TH ANNUAL
SAA
CONFERENCE**

APRIL 21 Student Academy of Audiology 

**NASHVILLE, TN
AT AAA 2018
8:00 am – 2:00 pm**



New Members of the Student Academy of Audiology

Miranda Adamczak
Halee Albertson
Emma Alscher
Elizabeth Ayo
Katherine Baker
Emily Ball
Emma Beaver
Alexandra Berlin
Lara Binbrikan
Gabrielle Bissell
Lindsey Bittinger
Stephanie Bodet
Kristina Bowdrie
Helen Boyd-Pratt
Haleigh Bradley
Carolyn Brennan
Alexa Brody
Kalie Buchman
Margaret Butler
Amanda Cegelske
Sara Chaffee
Jillian Chapman
Taylor Chesnet
Kirston Clifton
Julie Colaianni
Haley Connolly
Rose Dawson
Leah Demko
Brianna Diaz
Karrigan Dillman
Beth Dove
Tyler Drake
Nicholas Faillace
Sabrena Fennell
Emily Ferguson
Djemila Fields
Michael Figueiredo
Arielle Flowers
William Fox
Faith Gentry

Brooke Goodson
Hannah Gospodinsky
Shabnam Habibi
Ashleigh Harrison
Natalie Hayes
Hannah Hays
Jenna Hendler
Patricia Herz
Kendra Hoffman
Hannah Holtz
Madeline Horan
Anna Hutton
Chris Hylander
Izabela Jamsek
Rebecca Johnson
Danielle Jorgenson
Kristina Katanic
Perri Keehn
Erin Kelly
Brittney Kinikin
Corinne Kohan
Shreya Kondle
Alexis Kritenbrink
Kyle Langfitt
Brittany Larson
Alexandra Lathe
Heather Lemajeur
Lindsey Leonard
Rachel Lynch
Amelia Mainardi
Jessica Marlowe
Lauren Martin
Alisha McDaniel
Sallie McElroy
Gemma Messina
Ann Miller
Anna Miller
Abigail Mispagel
Holly Mulhern
Abby Muller
Olivia Naegle
Marianna Naples
Aubree Newman
Stephanie Noeller
Shelby Northup
Paxton Oliver-Bingham
Savannah Pena

Nicole Pendleton
Alyssa Pfaffe
Meghan Phelan
Tyler Phillips
Jitpakorn Pichaitanaporn
Lauren Pike
Rachael Piper
Olivia Planas
Laura Potter
Sarah Pounder
Gabrielle Rakidzich
Brianna Ralston
Olivia Riemer
Raquel Rojas
Conner Rouch
Natalie Safdar
Kayla Scott
Grace Smith
Allison Snead
Sara Sommers
Briana Stanikmas
Nicole Stebbins
Abby Stoll
Tara Stremlan
Katie Swail
Grace Szatkowski
Mackenzie Thaxton
Rachel Treiber
Anna Uminski
Alicia Vilnyanskiy
Julia Visaggio
Hanna Waldo
Hannah Weinman
Meghan West
Erin Westbrook
Tracy Wilkinson
Evangeline Wong
Emma Woolf
Trevor Wright
Carolyn Zaitzew
Jillian Zaloga
Ashley Zambetti
Gabrielle Zerrusen



Activities at AAA 2018

*Advance Your
Career with
a Specialty
Certification!*

**PEDIATRIC
AUDIOLOGY SPECIALTY
CERTIFICATION EXAM**

Wednesday, April 18, 2018
9:00–11:30 am

ROOM 104 A

Applications are due
February 18, 2018, and late
registrations will be accepted
until March 18, 2018.

www.boardofaudiology.org

CERTIFICANT NETWORKING LOUNGE

Wednesday, April 18–Saturday, April 21
OPEN DURING ACADEMY CENTRAL HOURS

Network, take advantage of charging stations for your mobile devices, and relax with club-style seating. Wear your special certificant lanyard for entrance to the lounge.

SPEED UPDATING

Open to all attendees!

Thursday, April 19
3:00–5:00 pm

PRODUCT THEATER

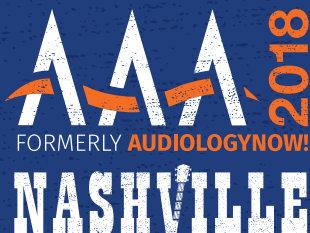
Meet leading audiologists, tap into their knowledge banks, and ask practice questions. This event is FREE.

CERTIFICANT MIXER

Thursday, April 19
5:00–6:30 pm

CERTIFICANT NETWORKING LOUNGE

Enjoy small bites and a beverage while networking with other ABA certifiants. Wear your special certificant lanyard to gain access. Attendees may bring one guest. The event is free to ABA certifiants.



★ ★ ★
AAAConference.org

★ ★ ★

APRIL 18-21

#AAAConf18

ABA's New Chair and Her Vision

Jennifer (Jenne) Tunnell, AuD, Board Certified in Audiology, PASC, and a CH-AP certificate holder, is the 2017 chair of the ABA Board of Governors. She has worked in South East Asia and the Middle East, and has been in the field of audiology for 20 years. Currently, Dr. Tunnell works in southern Minnesota and is the manager of Mayo Clinic Health System Audiology for Minnesota.

What led you to the field of audiology?

When I was a child, I was fascinated with Helen Keller's story and her lifelong challenges living with deafness and blindness. She stated in her autobiography that her blindness separated her from things and that her deafness separated her from people. That passage stuck with me over the years. Add to that the fact that my father is an audiologist and a brilliant pianist, and you can see my path was pretty much written in the stars! Growing up as a witness to his love of music and passion for the profession really ingrained in me the possibilities the field holds in terms of helping people connect with the world through sound.

What is the most rewarding part of your job?

When I see a family back for their child's hearing aid or cochlear implant check, and the child doesn't want to part with their devices for me to clean/program them! That's when I know that we have truly provided something meaningful for the child. I also love how much variety there is in our profession. No two days are the same! There is always something unique about each patient that we see, and always something new to learn!

What is the most challenging part of your job?

Avoiding burnout. Working in a helping profession is not without demands and difficulties. It's hard to

step back and not take work home. It is a constant effort to ensure that you are taking time apart from the job to provide balance in your life.

What difficulties do you see with hearing loss?

I often see patients who are hesitant to talk about their hearing loss with me. There is a perception that age has something to do with hearing loss and no one wants to feel old.

Hearing loss can be difficult to talk about as there are several stigmas associated with it. One thing that we provide at our clinic, and I feel is vitally important, is a support group. We provide a support group for patients, as well as their families,



and give them a safe space where they can advocate and support one another.


Do you have any hobbies?


I love to travel and study foreign languages. At one point, I could provide instructions for a hearing test in 12 different languages! I also love singing, drawing, cooking, and throwing theme parties.

What would you like to see during your time as the chair of the ABA Board of Governors?

This is an exciting time to be involved in ABA! We are on the brink of groundbreaking changes that will propel us further along the path toward becoming the most comprehensive certification of, by, and for eligible practicing audiologists. We plan to launch new offerings to improve accessibility for new graduates entering into the profession, and are planning new programs that will continue to provide opportunities for new and seasoned professionals to advance their careers along a tangible path to success.

Happenings in ABA!

- In addition to Dr. Jenne Tunnell taking over as chair of the ABA Board of Governors at the December 6–8, 2017, in-person meeting in Reston, Virginia, Dr. Dennis Van Vliet was nominated as the vice chair.
- New board members Dr. Jennifer Drohosky, Dr. Alison Grimes, and Dr. Joscelyn Martin were also in attendance.
- In April 2018, the ABA Board of Governors will be meeting at AAA 2018.
- The new CH-TM is off to a great start with 62 registrations and 28 completions. Part Two of the CH-TM will be out Spring 2018. Don't forget to sign up!
- Over 300 individuals are CH-AP certificate holders. Congratulations! 



Attending AAA 2018?

Find your next career opportunity or employee!

Employers—post a job and schedule interviews with candidates on-site.

Job seekers—post your resume and make sure you click the “attending AAA 2018” box so employers can schedule interviews with you.

Visit www.HEARcareers.org for more information.

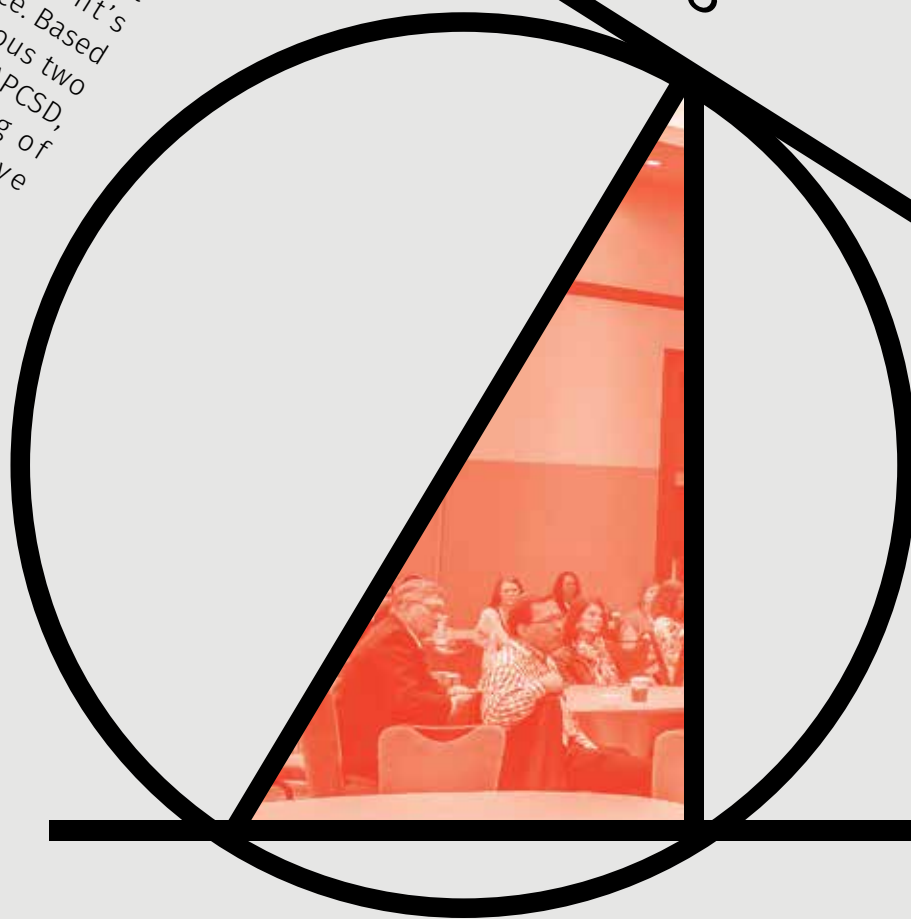
AMERICAN ACADEMY OF AUDIOLOGY

ATTENTION: Educators, Preceptors, and Students!

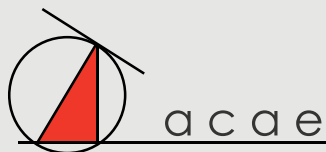
THE 2018 THIRD ANNUAL CLINICAL EDUCATION FORUM will continue to provide relevant and important topics highlighting a student's clinical education experience. Based on the success of the previous two forums, ACAE together with CAPCSD, will prepare a full morning of presentations and interactive experiences for participants.

SAVE THE DATE!
Saturday, April 21
8:00 am-12:00 pm
NASHVILLE, TN

2018 CLINICAL EDUCATION FORUM AT AAA 2018



CO-HOSTED BY:



Visit us at www.acaeaccred.org to learn more about how your program can benefit from ACAE.

Educating AuD Students for the Practice of Evidence-Based Audiology

By James W. Hall III

This article is the second of a two-part series on evidence-based audiology and the education of audiologists. In the first article (Hall, 2018), the concept of evidence-based audiology was reviewed. Also, challenges in the incorporation of evidence-based audiology into doctor of audiology (AuD) programs were identified. This article offers general and specific steps and strategies for more effectively instilling in doctor of audiology students the principles of evidence-based audiology, and their application in clinical practice.

One simple and logical way to define evidence-based audiology is to adapt the definition of

evidence-based medicine to our profession. With full credit and acknowledgment to Dr. David Sackett (Sackett et al, 1996), we might paraphrase him in defining evidence-based audiology as the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients with hearing loss and related disorders. The practice of evidence-based audiology means integrating individual clinical expertise with the best available external clinical evidence from systematic research. Part one of this series identified multiple serious challenges inherent in the instruction of evidence-based audiology.

There is no widely-accepted or endorsed strategy for instilling in doctor of audiology students the principles of evidence-based audiology, but university AuD programs might consider including the following components into the process.

Evidence-Based Clinical Culture

All academic and clinical faculty members in AuD programs must be fully committed to preaching and practicing evidence-based audiology. Clear and strong statements in support of evidence-based audiology should be prominent in the descriptions of the mission and



curriculum of AuD programs. Systems should be in place to verify consistent, evidence-based practice in clinical settings, ranging from routine clinic chart audits to regular review of clinical policies and protocols to ensure compliance with current clinical practice guidelines.

Most undergraduates entering an AuD program lack requisite research skills such as a rudimentary knowledge of statistics or experimental design.

A Required Course Devoted to Evidence-Based Audiology

Scheduled within the first year of the program, the course is perhaps best co-taught by one AuD-level faculty member with extensive clinical experience and duties, along with another PhD-level faculty member with research expertise.

Logical subject matter in the course would include the following:

1. An introduction to research methodology and experimental design
2. Lectures on best practices, standard of care, and professional liability
3. Preparation of a research proposal suitable for an Institutional Review Board (IRB)
4. A systematic review of clinical practice guidelines in audiology

Weekly Audiology Grand Rounds Conferences

This traditional clinical learning forum in health professions, often scheduled early in the morning before everyone heads off to their busy clinics, provides students with a weekly reminder of the importance of evidence-based audiology. Attendance is mandatory for students and faculty alike.

Typically, the one-hour grand rounds format begins with a student giving a case study presentation, including a relevant literature review, followed by faculty-led questions and comments, plus a group discussion with student participation. Occasionally, visiting professors or local audiologists are invited as grand rounds speakers. AuD programs lacking large and diverse clinical patient populations might consider participating via teleconferencing in audiology grand rounds conferences available at other universities or teaching medical centers.

Regular Journal Article Reviews

This is another time-honored fixture in the education of health professionals. Perhaps once or twice every month, a student is assigned the responsibility of selecting one or more peer-reviewed articles for review. Although all students (and faculty) are expected to read the article (s), the designated student presents a critical review of the article before opening up the session to questions, comments, and discussion. Academic and clinical faculty members actively participate in these journal article review sessions.

Some readers may wonder why a research or “capstone” project is not listed among the forgoing components of the educational effort to promulgate evidence-based practice in education. AuD-student-supervised research projects often do not achieve their intended goal, that is: “... students must

be critical consumers of research and be able to apply this knowledge in evidence-based practice (ACAE, 2016).” A host of practical problems conspire to minimize the value of the required student research project.

Most undergraduates entering an AuD program lack requisite research skills such as a rudimentary knowledge of statistics or experimental design. Not surprisingly, the majority of AuD students are interested in developing clinical competence rather than research skills. Faculty schedule and interest is another serious limitation. The research committee directing each AuD student project consists of multiple busy faculty members who lack the time and motivation for this additional workload, particularly since the effort rarely leads to an academic payoff like a peer-reviewed publication.

Due to time-consuming requirements, such as securing IRB approval and subject recruitment, plus competing clinical practicum demands, student research projects may linger on for months or even years with inconsistent and inadequate progress. Speaking from my experience as a faculty member, sadly, not all students complete their project before graduation. To be sure, some research projects meet the intended goals for select doctor of audiology students, some of whom decide to pursue a PhD degree and a career as a clinical scholar.

Conclusion

The time has come for a more intensive, comprehensive, and coordinated approach for evidence-based audiology education of doctor of audiology students

with close collaboration among varied stakeholders, including AuD academic programs, major preceptorship sponsors of fourth-year externships, and the Academy’s affiliated organizations (AAA Foundation, Student Academy of Audiology, American Board of Audiology, and Accreditation Commission for Audiology Education). ⁴¹

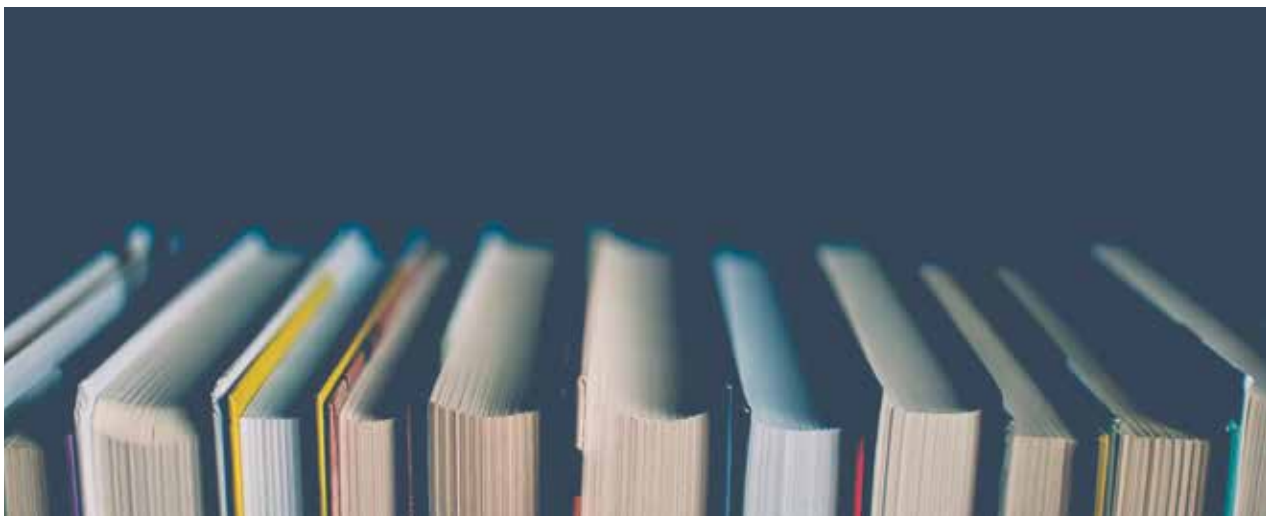
James W. Hall III, PhD, Board Certified in Audiology, is a professor in the Osborne College of Audiology at Salus University and a professor in the Department of Communication Sciences and Disorders at the University of Hawaii. He is also the chair of the Accreditation Commission for Audiology Education (ACAE).

References

Accreditation Commission for Audiology Education (ACAE). (2016) *Accreditation Standards for the Doctor of Audiology (AuD) Program*

Hall JW. (2018) What is evidence-based audiology? *Audiol Today* 30(1):74–75.

Sackett D, Rosenberg WMC, Gray JAM. (1996) Evidence-based medicine: what it is and what isn’t. *British Med J*, 312:71–72.



AUDIOLOGY ADVOCATE

Audiology Advocacy Comes to Nashville

By Rebecca West

When people think of Nashville, they probably think of country music and cowboy boots. However, this April, audiologists from all over the world will meet in Music City for AAA 2018 to reconnect with old colleagues, get caught up with industry updates, attend educational sessions—and, yes, have some fun exploring this fun and historical city.

AAA 2018 offers many diverse options to expand your professional horizons, and one of the biggest opportunities this year will be immersing yourself in the world of audiology advocacy. Throughout the conference, there will be numerous advocacy-related events, covering everything from the basics to in-depth sessions on state issues and Medicare. Whether you want to dive into the details of legislation or network with colleagues while supporting the Academy's political action

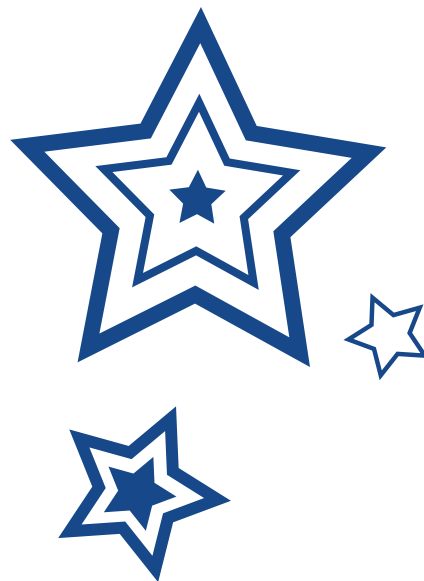
committee (PAC), there are advocacy events for everyone at AAA 2018.

For an interactive, comprehensive, advocacy learning experience, start your conference off with the new Advocacy Workshop, to be held April 18, from 8:30 am to 12:30 pm. It is a great opportunity for both seasoned advocates and beginners who want to learn the basics of how government works and what the Academy's priorities are in the advocacy world.

The Academy is engaged on numerous impactful issues and helps members advocate for their profession, from state and local issues, to hosting visits to Capitol Hill. Attend the workshop to learn all about the Academy's advocacy efforts and the current issues, including how you can get involved through the Academy's Grassroots Advocacy Network.

Not only will the Advocacy Workshop lay out current legislative

and regulatory issues impacting the profession, but it will teach attendees to talk about how these issues affect them and why they are important to audiologists. Discuss strategies for audiology advocacy and advancing audiology policy initiatives and find the issues you are passionate about. There will be opportunities to interact and



BE AN **AUDIOLOGY** Adv☆cate!

Network with advocates and **learn** more about what you can do for your profession at these **AAA 2018** events.

ADVOCACY WORKSHOP

Wednesday, April 18
8:30 am–12:30 pm

Davidson Ballroom C

The Advocacy Workshop will feature an overview of current legislative and regulatory issues impacting audiology, as well as strategies for effective advocacy to advance audiology policy initiatives. There will also be opportunities for interaction and networking with other grassroots advocates.

PEDAL FOR THE PAC (\$)

Thursday, April 19
7:00–9:00 pm

Pedal Tavern

Show your support for the Academy's Political Action Committee (PAC) by registering for an exciting new event. This unique Nashville event will feature a tour of the famous Broadway area on a Pedal Tavern and includes several stops at local bars with fantastic live music.

STATE FAIR

Friday, April 20
12:30–2:30 pm

Exhibit Hall

Join the Academy for the third annual State Fair. The State Fair is an opportunity for state audiology organizations to promote the benefits of state membership and allow attendees to connect with individuals from their state and other states.

Contact Rebecca West at rwest@audiology.org to participate in this event.



★ ★ ★
AAAConference.org

★ ★ ★

APRIL 18-21

#AAAConf18

network with other grassroots advocates and fellow audiologists who have participated in advocacy events in the past. This workshop aims to teach you how to effectively communicate with your elected representatives, and give you the tools and resources you need to get involved on any level.

Also on Wednesday, April 18, a Featured Session from the Coding and Reimbursement Committee, titled “Landlords, Equipment, Payers... Oh My! Top 10 Tips for Navigating Contracts in Health Care” is being offered. Sit in on the session from 2:15–4:15 pm to learn how to better manage your practice’s contracts from Radha V. Bachman, a top-rated health-care attorney.

On Thursday evening, get away from the convention center and show your support for the Academy’s PAC by heading into downtown Nashville for the Pedal for the PAC event. The PAC is an essential part of the Academy’s advocacy operation, allowing the Academy to make campaign contributions to key legislators, candidates, and committees that support audiologists and hearing health-care initiatives. Making these contributions helps to ensure support for the Academy’s federal policies and gains access to exclusive events and briefings for Academy representatives, who use these opportunities to advocate face-to-face on issues affecting audiologists and their patients. Registering for Pedal for the PAC is a great way to support the PAC, while also enjoying a uniquely Nashville experience.

Pedal for the PAC participants will hop on board a “Pedal Tavern” for a tour of historic spots, local bars, and, of course, plenty of live music. Attendees will see places where country music legends began their careers and learn interesting Nashville facts from their tour guide while spending a fun

evening with other AAA 2018 attendees. Pedal for the PAC will take place from 7:00–9:00 pm on Thursday, April 19. There is limited space for this event, so make sure you sign up early to guarantee your spot!

On Friday, April 20, pay a visit to the third annual State Fair, which will be held in the exhibit hall from 12:30–2:30 pm. The State Fair has grown every year since it began in 2016, becoming an unparalleled opportunity to learn what state audiology organizations are doing all across the country. This is a chance to get involved with your local audiology organization, learn about the benefits of state membership, and connect with other individuals from your state and other states.

In addition to these events, there will be several learning modules for conference attendees interested in advocacy, policy, or coding and reimbursement. The State Relations Committee’s “Current State Issues: Identifying and Understanding Licensing, Legislative, and Regulatory Trend” will feature a panel of state leaders discussing current state issues—a great module for anyone curious about the legislative and regulatory issues affecting them close to home. This learning module will take place on Friday, April 20, 3:00–4:00 pm.

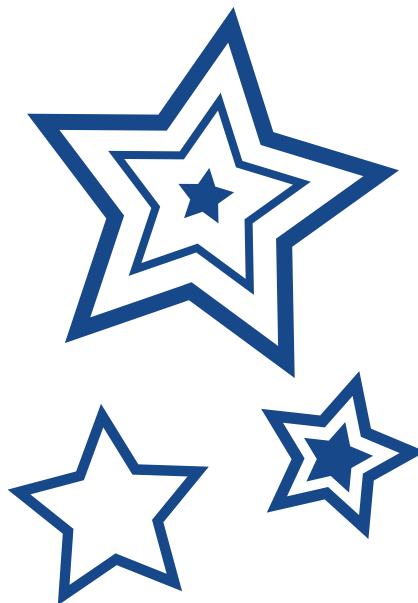
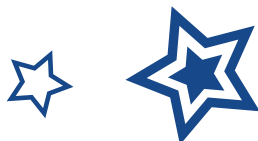
Also on Friday, the Coding and Reimbursement Committee will

be hosting two learning modules, “Medicare Basics” from 8:45–9:45 am and “All Things ABN: Medicare’s Advance Notice of Noncoverage for Audiologists” from 7:30–8:30 am. Keep an eye out for these modules as the complete conference schedule is revealed and make sure you take these learner-focused, interactive courses designed to provide practical knowledge to practicing audiologists.

For anyone who cannot attend AAA 2018 but wants to get involved, we encourage you to visit the “Advocacy” tab on the Academy’s website, where you can catch up on the latest government relations or coding and reimbursement news, read up on the PAC, and visit our Legislative Action Center for up-to-date legislative priorities and engagement opportunities, like sending letters to your congressional representatives. Additionally, any Academy member is always welcome to join our Grassroots Advocacy Network to receive frequent advocacy updates and learn about local opportunities.

The Academy’s advocacy department is busy advocating on issues with Congress and regulatory agencies, and AAA 2018 is the perfect opportunity to learn about all the facets of audiology advocacy and find opportunities to get involved. Whether you’ve already been to Capitol Hill or are newly interested in the world of advocacy, these events and sessions will help you grow as an advocate and leave Nashville with the tools and connections you need to confidently engage in advocacy throughout the year. We hope that you make advocacy part of your AAA 2018 experience! 

Rebecca West is the Academy’s advocacy coordinator.



EARN UNLIMITED CEUs

PURCHASE
the CEU PACKAGE for

\$109

MOST POPULAR WEB SEMINARS

CEUs

Tinnitus: Causes, Characteristics, and Biologic Bases (<i>Tier 1</i>)	.3
Low-Gain Hearing Aids as a Treatment Option for Patients with Normal Hearing Thresholds Who Exhibit Auditory Processing Deficits	.1
Understanding the Audiological and Vestibular Effects of Traumatic Brain Injury (<i>Tier 1</i>)	.3
Marion Downs Lecture in Pediatric Audiology: Brain Changes in Hearing Loss	.15
Amplification Effects on Neural Processing	.15

UPCOMING LIVE WEB SEMINAR

MARCH 26, 2018, 12:00 PM ET
Strategies to Improve Parental Engagement

PRESENTER:
Ivette Cejas, PhD

.....
0.1 CEUs

VISIT eAUDIOLOGY.ORG TO VIEW THE COMPLETE LIBRARY OF LIVE AND ON-DEMAND SEMINARS.

2018–2019 BOARD OF DIRECTORS ELECTIONS

Vote

The members presented in this issue of *Audiology Today* are nominees for the president-elect and three member-at-large positions on the Academy's Board of Directors.

One of the nominees for president-elect will be elected by the general membership to serve a three-year term (one year as president-elect, one year as president, and one year as past president) beginning October 1, 2018, and ending September 30, 2021.

Three of the candidates for the member-at-large positions will be elected by the general membership to serve a three-year term, beginning in October 1, 2018, and ending September 30, 2021.

The 2018 American Academy of Audiology election of new board members will be held from April 23, 2018, through May 25, 2018, immediately following the AAA Annual Conference.

All Fellow members with an electronic address in the database will be sent an e-mail linking them to our election Web site. Please note the election website is separate from the Academy website. The link you receive in the e-mail is unique and can only be used by the member receiving the e-mail. Once used, the unique link is disabled.

It is anticipated that the new board members and the new president-elect will be announced in late May/early

June 2018.

Expanded biographical information, position statements, and short videos are available on the election and Academy website, www.audiology.org. Voting for the leadership of the Academy is an important privilege of membership for Fellows of the American Academy of Audiology.

**You are encouraged to
vote and let your voice
be heard!**

2018-2019 BOARD OF DIRECTORS NOMINATIONS

President-Elect



Bopanna B. Ballachanda, PhD
Adjunct Professor, Texas Tech University

BS: Speech and Hearing, University of Mysore, 1973

MS: Audiology and Hearing Impairment,
University of Texas Dallas, 1982

PhD: Audiology and Hearing Impairment,
University of Texas Dallas, 1988

I want to be innovative and lay the foundation for the future of audiology beyond 2020. My goals include the following:

1. Elevate the profession of audiology
2. Create a better awareness of the profession of audiology and the professionals to the public
3. Improve compensation to our professionals
4. Support the educational and research needs in audiology.

My background and experiences in academia (professor at two universities; wrote the first syllabus for AuD), research (auditory neuroscience), professional issues (first to cerumen management and implement teleaudiology), and clinic work (16 clinics and managed a total of 60 staff including 18 audiologists with several million-dollar annual budget) has allowed me to understand the needs of the audiology profession.

I have seen the Academy grow from its infancy to the current status as the leading organization, not only in this country, but around the world. I have served the Academy in many capacities as a past and present board of director, trustee of the Academy's Foundation, and chair and member of committees and task forces. I understand the inner workings of the Academy and that has prepared me to be the next leader of this organization.

I understand the delicate nature of leading the profession of audiology in turbulent waters, to achieve the aspirations and goals of our members to be independent, financially secure, and respected by our peers as an independent profession.



Catherine Palmer, PhD
Associate Professor, University of Pittsburgh

BS: Communication Sciences and Disorders/Education,
University of Massachusetts, 1984

MS: Audiology and Hearing Impairment,
Northwestern University, 1985

PhD: Audiology and Hearing Impairment,
Northwestern University, 1991

I have dedicated my professional life to serving individuals with communication challenges related to hearing loss. I have been fortunate to do this through direct clinical care, educating future audiologists, providing continuing education, providing professional service, and adding to our knowledge base through research. Patients with hearing loss and balance disorders deserve to have access to experts in communication and balance; those experts are audiologists.

I believe that being involved in national leadership will provide me with an opportunity to use my skill set to not only help our profession position itself for changes that are coming but to make sure we chart our own course, keeping what is best for individuals with hearing loss and balance disorders at the forefront of our decision-making. The Academy Board provides the leadership for the profession of audiology and is the voice of audiology to a myriad of stakeholders. I would welcome the opportunity to be part of this leadership and to work with the board and the entire membership to move towards our preferred future of accessible, affordable, best-practice based hearing and balance care.

Given the opportunity to provide leadership as an AAA Board Member, I will work tirelessly to ensure that audiologists are viewed as leaders in the prevention, assessment, and treatment of hearing and balance disorders.

2018-2019 BOARD OF DIRECTORS NOMINATIONS

Member-at-Large



Chris Araj, AuD
Board Certified in Audiology
Founder, Owner and Audiologist,
Pearland Hearing Aids and Audiology

BS: Communication Disorders, Lamar University, 2007
AuD: Audiology, Towson University, 2011

I've been involved in our Texas Academy for the past several years and I want to be more active on the national level. I've been on the slate twice for the ABA Board of Governors but unfortunately was not elected. I think that I provide a unique perspective being a new professional with prior leadership experience and being a practice owner that started a business independently from scratch.



Samuel Bittel, AuD
Audiologist, Hearing and Balance Specialists
of Kansas City

BS: Psychology, Fort Hays State University, 2001
BA: Sociology, Fort Hays State University, 2002
AuD: Audiology, Nova Southeastern University, 2008

Audiology needs people who are passionate about keeping our profession viable and forward moving through active involvement in our professional organizations. It is imperative that the Academy engage young private practitioners who are highly motivated to drive audiology forward. This is vital as we consider the challenges that our profession will face in the forthcoming years (from OTC hearing aids and third-party reimbursement to direct access and professional organization unification). Those of us with a lot of skin in the game and a vision for the future of our profession must be actively involved.

I feel that I fit the mold of what our profession and the board need. I am highly motivated to help steer audiology in a direction that benefits audiologists and the patients we serve first. The time to rest on our laurels has passed. We have settled for low salaries and reimbursement, physician referral requirements, fragmentation amongst our professional organizations, questionable educational standards, and an underappreciation/misunderstanding of our services from the medical community and the public for long enough. The Academy needs a passionate board now, as our profession often seems reactionary and not proactive. It is time to aim high, and I am ready for the responsibility.

I have done all that I can through state-level involvement and want to dedicate my energies to audiology at the national level. Audiology is my passion and I want to do all that I can to better our profession.

2018-2019 BOARD OF DIRECTORS NOMINATIONS

Member-at-Large

**Andrea Green, AuD**

Board Certified in Audiology
Assistant Professor, University of Miami

BS: Communication Sciences and Disorders,
University of Oklahoma, 2010

AuD: Audiology, Vanderbilt University, 2014

My positive experiences within the Academy, strong sense of professional duty, and unique perspective as a new professional have encouraged me to pursue a position on the Academy Board of Directors. I believe the Academy is poised to “steer the ship” in consistently innovating and challenging our education system, advocating for our patients and membership, and developing public awareness campaigns. Accordingly, I have dedicated a significant amount of my time and efforts in supporting the Academy through my professional involvement. These experiences have been invaluable in positively altering the trajectory of my career and encouraging me to increase my level of involvement in our organization.

Additionally, as audiologists, it is part of our professional responsibility to contribute to our field. Though there are a variety of ways to contribute, I am most passionate about volunteer leadership. Therefore, I would like to serve on the Academy Board as part of my professional responsibility as an audiologist, helping to affect positive change for the future of our field. Finally, I am motivated to pursue this position to provide a fresh perspective as a new professional. It is of the utmost importance for the Academy to continue its mission of representing and engaging all audiologists.

In continuing this legacy and ultimately ensuring the future of our organization, it is important to give a voice to all audiologists and include board members that represent diverse perspectives. As a new professional, I could contribute constructive and creative ideas to help shape the implementation of the Academy’s strategic plan.

**Dawn Hulthen Kongscol, AuD**

Board Certified in Audiology
Director, ENT Ancillary Services

BS: Communicative Disorders, University of Akron, 1995

MS: Audiology, University of Akron, 1996

AuD: Audiology, A.T. Still University, 2012

I believe it is important to be a part of our professional organization and contribute back into our field our expertise due to the changes to hearing aid availability, governmental legislative changes, insurance billing, licensure challenges, and defining our future goals and objectives. We, as a group, weather significant challenges from outside our profession. I believe my position in a large ENT and audiology practice has enabled me to have a diverse perspective that could be beneficial.

Having established and grown a significant extern program has provided me a view of the future through their eyes, and a first-hand look at the training and preparedness we are providing future audiologists. As a profession, we need to be better and stronger in our academic training and externship programs to build a group ready to absorb the changes that are coming. We rely on the information provided by our professional leaders and the Academy, and I would like to contribute toward making our Academy a stronger resource and driving force in the future of our profession.

2018-2019 BOARD OF DIRECTORS NOMINATIONS

Member-at-Large



Steven Madix, PhD
Associate Professor,
Louisiana Tech University

- BA:** Pre-professional Speech Language Pathology and Audiology, Louisiana Tech University, 1995
- MA:** Audiology, Louisiana Tech University, 1997
- MA:** Speech Language Pathology, Louisiana Tech University, 1999
- PhD:** Speech and Hearing Science, University of Tennessee, 2005

I am interested in serving on the Academy board because I have spent the last several years advocating for audiology in my home state of Louisiana, and have been successful in advancing our profession there. I would like to share the things that I have learned through advocacy with the Academy board to help plan and implement positive changes for the profession on a bigger scale.

Working at a university, it is important to me that the students we recruit and prepare to be audiologists enter into a field where other health care professionals are aware of their value and respect their contributions to health care. Many things are occurring around us that will change the way the public views us, and the way we will interact with them, as well. There is opportunity in these changes and I want to help ensure that audiology has the leading voice in these conversations so that we can advance our profession.



Kari Morgenstein, AuD, PASC
Director, University of Miami Children's
Hearing Program

- BS:** Speech and Hearing Sciences, Indiana University, 2009
- AuD:** Audiology, University of Florida, 2013

Like many other health care professions, audiology currently has many challenges facing us. With teamwork and collaboration, we can turn these challenges into opportunities. As a collective unit, audiology can continue to move in the right direction. We must start by doing a better job of engaging all of our members, including new professionals. While it is cliché, the reality is that these new professionals are the future of audiology. We need to invest in new professionals early in their careers and capitalize on their passion, enthusiasm, and unique perspectives. As a past president of the Student Academy of Audiology, a member of the New Professionals Subcommittee, and of the New Professional Audiology Conference Steering Committee, I have been fortunate to see firsthand the dedication that this group of professionals has and their unwavering desire to elevate the profession. As a 2013 graduate, I am interested in serving on the Academy Board so that I can be the voice of new professionals on the national level. I have several innovative ideas on how we can cultivate and engage all members, including new professionals. While this may not be an easy task, it is one I am ready to conquer through hard work and perseverance.

2018-2019 BOARD OF DIRECTORS NOMINATIONS

Member-at-Large

**Ashley Paige Peterson, AuD, PhD**

Board Certified in Audiology
Director of Hearing and Balance/
Chief Operating Officer, Great Hills ENT/
Hearing and Balance Center of Austin

BS: University of Wyoming

MA: 2005

AuD: Audiology,
University of Kansas Medical Center, 2007

PhD: University of Kansas, 2010

As I see it, if you feel that something needs to change you have one of two options: (1) Step up and be part of the solution, or (2) Keep your opinions to yourself. As an entrepreneur, clinician, and preceptor I see many areas where our profession can improve. I am interested in service to the Academy board because I believe that bringing new ideas and insights to the table may lead to solutions we may not have thought possible.

It is easy to sit in the comfort of your own home and criticize how things are going from the safety of Facebook or an e-mail thread, it is quite another to actively attempt to be part of the solution. Having served on two committees in the past, I know the dedication of those who volunteer to serve our profession as well as those with the Academy. It takes work. Messy, dedicated, unrecognized, long-hours away from your family work. I am willing and able to put the time in to help make the future for other audiologists a bit brighter at the end of my term.

**Angela Shoup, PhD**


Professor, Otolaryngology; Chief,
Communicative & Vestibular Disorders, UT
Southwestern Medical Center

BS: Speech Pathology and Audiology,
University of Texas at Dallas, 1989

MS: Communication Disorders,
University of Texas at Dallas, 1992

PhD: Human Development & Communication Sciences,
University of Texas at Dallas, 1994

As an active and engaged audiologist, I appreciate the shared responsibility of contributing time and effort to the betterment of our profession. I have been a member of the American Academy of Audiology for many years and have had the opportunity to serve in multiple capacities. Through these experiences, I have recognized the multi-faceted contributions of the Academy to the professional life of members and to the quality of services we provide to our stakeholders. These stakeholders include patients who come to us for support with hearing, tinnitus or balance difficulties, and also their families, the public, students, and scientists. The Academy serves to elevate our profession by providing an aspirational code of ethics, scope of practice, and guidelines for professional comportment.

The Academy provides tools to achieve these aspirations through web-based continuing education, publications, practice management tools and educational offerings at conferences, including but not limited to the annual Academy meeting. Further, the Academy seeks to educate other stakeholders through legislative efforts and public relations outreach. The Academy promotes educational excellence for audiologists and for students entering the profession, and supports research and innovation in hearing and balance. All of these are crucial for the profession to remain viable—and all require not only financial support, but also time and talents of volunteers. My personal and professional philosophies align with the dedicated vision of the Academy. As I have benefited from the efforts of my colleagues, I am interested in contributing through service on the Board of Directors. 



2018
HONORS
AND
AWARDS

Honors of the Academy

Awarded to one audiologist and one non-audiologist for their exceptional support of the field of audiology and/or the patients we serve by focusing on issues that directly affect the profession and/or consumers with hearing loss and balance disorders.



David A. Zapala, PhD

David A. Zapala, PhD, is an associate professor of audiology in the College of Medicine, Mayo Clinic Foundation. He is also a senior consultant in otorhinolaryngology and the chair of the audiology division at the Mayo Clinic Florida. He is active in direct patient care; resident, fellow, and post-doctoral mentorship; clinical research; and clinical information management. From a research perspective, he has focused on mathematical modeling methods to improve audiological and vestibular diagnostics and to quantify the functional consequences of hearing impairment.

Dr. Zapala has served on the American Board of Audiology, the American Academy of Audiology Board of Directors, and the American Balance Society Board of Directors. He is also a past president of the Tennessee Academy of Audiology. He is currently funded by the National Institute on Deafness and Other Communication Disorders to study ways of decreasing the cost of hearing health care associated with hearing aid use.

Jerger Career Award for Research in Audiology

Awarded to an individual for research contributions in the field of audiology/hearing science, whose work has had major impacts on the field and/or practice of audiology.



Laurie Eisenberg, PhD

For over four decades, Laurie Eisenberg, PhD, has conducted research on the evaluation and capacity of children with hearing loss to develop speech and language skills. Most notably, she formed an early research partnership with

Dr. William F. House that focused on the pioneering single-channel cochlear implant. These seminal studies paved the way for today's more advanced multichannel systems. More recently, again, as a pioneer researcher, Dr. Eisenberg played a significant role in the development of the auditory brainstem implant.

Over the past 20 years, she has also focused on the development of methods for fitting and evaluating the efficacy of hearing aids in children with more moderate hearing losses. Together, these research interests of Dr. Eisenberg have provided her with continuous federal funding for over 25 years. In combination, her research efforts represent the standard of care for both children and adults with severe-to-profound hearing loss.

Outstanding Early-Career Audiologist

Awarded to an individual who has been practicing in the field of audiology for generally less than 10 years, who has made outstanding contributions to the profession. The recipient shall have made notable contributions in one or more of the following areas: outstanding clinical practice and/or patient care; teaching or mentoring; advocacy; research; and exceptional service to the profession of audiology.



Jamie Bogle, AuD, PhD

Jamie Bogle, AuD, PhD, began her graduate career at University of Colorado in Boulder earning her AuD in 2007 and PhD in 2010.

Following this, she was a research fellow at Gallaudet University and a post-doctoral position at Mayo Clinic Jacksonville in the area of vestibular research. Since graduation, she has grown her career exponentially in a short period of time. She is currently employed at the Mayo Clinic in Scottsdale. In addition, she holds academic appointments at several universities, has many peer-reviewed papers, has presented nationally mostly on various vestibular topics including concussion, is a reviewer for fifteen journals, and provides patient care.

Humanitarian Award

Awarded to an individual who has made significant voluntary and/or philanthropic contributions to under-resourced communities through provision of audiology or ear and hearing services, philanthropic development of educational programs, and/or other service-oriented activities. Work that is done in conjunction with the nominee's employment is usually not considered as being relevant for this award.



Nora Stewart, MA

Nora Stewart began working in the hearing health-care industry in 1996. In 2000, she and her husband built a successful private practice in Fort Wayne Indiana. In 2011, they founded the HearCare Connection, a not-for-profit clinic providing hearing assessment and hearing aids for under-served individuals in their community. HearCare Connection is supported through grants, donations, corporate sponsorship, and volunteerism providing services on a sliding-fee and reduced-fee basis. The program empowers recipients of its services to give back to their community through volunteer work in a model referred to as the "circle of giving." To date, HearCare Connection has helped nearly 400 individuals and has inspired more than 4,000 hours of volunteerism in the local community. Nora also serves as the Chief Vision Officer of the Enthéos Audiology Cooperative, an organization that helps audiologists to give back to the local and international communities.

Samuel F. Lybarger Industry Award

Awarded to an individual who has made important contributions to research or engineering achievements within the field of audiology. He or she should have been, or should be, employed by a company or corporation in the hearing health-care field but must have made contributions that extend beyond their service to the company.



Ora Buerkli-Halevy

Ora Buerkli is receiving the Academy's Samuel F. Lybarger Industry Award in recognition of her outstanding contributions to the field of audiology over the past 30 years, extending beyond her service to Phonak. As Vice President of Global Audiology for Phonak, she has acted as a passionate link between teams at the company and the scientific and clinical audiological communities internationally. She was among the first to initiate controlled clinical trials of product performance — now the standard in our field. Through her leadership, and by leveraging the resources of Phonak, she significantly contributed to transforming clinical practice internationally and to improving the quality of life of those who have hearing loss.

Outstanding Educator Award

Awarded to an individual who has made significant contributions to audiology through his or her dedication and skill to the education of students of audiology. The individual may be a clinical or academic educator but should be a faculty or adjunct faculty member of a credentialed AuD program in the U.S.



Jenny Weber, AuD

Jenny Weber, AuD, has made significant contributions to the field of audiology through her dedication and focus on excellence as an educator, clinical supervisor, and mentor of audiology students. Dr. Weber serves as program coordinator for the Audiology Speech-Language Sciences Department for the University of Northern Colorado. She has successfully integrated her robust teaching and research interests to prepare her students in amplification, diagnostic audiology, aural rehabilitation, pediatric assessment, and habilitation. Her colleagues and students consider Dr. Weber to be the ultimate professional and role model through mentoring, volunteering, and research.

Marion Downs Pediatric Audiology Award

Awarded to an audiologist for exceptional contributions in pediatric audiology either as an educator, clinician, or scientist.



Susan Scollie, PhD

Susan Scollie, PhD, is recognized as a global leader in pediatric amplification, particularly related to her work at the University of Western Ontario. Dr. Scollie has continued to refine the Desired Sensation Level (DSL) Version 5.0, originally developed by Dr. Richard Seewald. At Western University, she leads the child amplification laboratory team to develop, implement, and evaluate evidence-based protocols for the Ontario Infant Hearing Program. She has presented nationally and internationally and has published numerous articles on topics related to DSL, verification, and pediatric concerns of amplification.



The global website for hearing healthcare leaders

The website for hearing industry leaders throughout the world with continuously updated quality content and audiology news from around the planet.



- ✓ MARKET INSIGHTS
- ✓ PRODUCTS
- ✓ EVENTS
- ✓ AWARENESS
- ✓ RESEARCH...



@AudioWorldnews

www.audiology-worldnews.com

THANK YOU TO OUR CORPORATE PARTNERS

PLATINUM



GOLD



SILVER



AMERICAN
ACADEMY OF
AUDIOLOGY



The 2018 JAAA Editor's Award

These awards will be presented to Dr. Gaffney and Dr. Schafer on Thursday, April 19 at the Honors and Awards Banquet during AAA 2018. The award is given annually to one or two members of the editorial board of the *Journal of the American Academy of Audiology (JAAA)* for outstanding contributions to the peer review of the journal. Awardees Gaffney and Schafer were chosen by editor-in-chief Gary P. Jacobson, PhD.




Erin C. Schafer, PhD

Dr. Schafer is a professor and the director of Graduate Studies in Audiology at the University of North Texas, where she has been a faculty member since 2005. She received her PhD in communication sciences and disorders from the University of Texas at Dallas in 2005. Her research programs on the assessment and (re)habilitation of adults and children with hearing loss and auditory disorders have produced 61 peer-reviewed publications, four textbooks, 59 national and international podium presentations at conferences, and \$528,000 in external grants and gifts. She is the past president and journal editor for the Educational Audiology Association, board member for the Auditory Implant Initiative, and serves as a reviewer for 17 professional journals. Dr. Schafer was honored with the University of North Texas Office of Research and Innovation Teacher Scholar Award in 2017 and the Cheryl Deconde Johnson Award for Outstanding Achievement in Educational and Pediatric Audiology in 2013.



Patricia Gaffney, AuD

Dr. Gaffney is currently an associate professor at Nova Southeastern University (NSU) in Ft Lauderdale, Florida. She earned her bachelor's degree from the George Washington University and her doctor of audiology from the University of Pittsburgh in 2005. She joined the audiology department at NSU in 2007. At NSU, she teaches the introductory vestibular class, vestibular lab, the advanced vestibular class, and a vestibular specialty course designed for advanced students who wish to specialize in vestibular diagnostics and treatment. She also teaches amplification I and II and accompanying labs. In addition to teaching, she sees patients in the NSU audiology clinic and is also the director for the NSU inter-professional fall prevention clinic. Dr Gaffney has presented at various national and state meetings on various topics including vestibular, amplification, and professional issues. Dr Gaffney also maintains memberships in several organizations and volunteers for various committees. 



New Members of the American Academy of Audiology

Maha Al-Sulaiten MD
Sara Bachinski, AuD
Stefanie Behnke, AuD
Tara Bodziak, AuD
Amy Cavallo MA
Alexa Del Tufo, AuD
Nicole Derda, AuD
Troy Dyer, AuD
Chamutal Efrat
Amy Escamilla, AuD
Paul Groesbeck, AuD
April Hubbard, AuD
Tracey Hudson MS
Deepak Kumar AuD
Justine McDermott, AuD
Jennifer Mock, AuD
Donald Parr
Christine Pickup, AuD
Christina Rasmussen, AuD
Macy Schott, AuD
Faith Sikorski, AuD
Abby Smith, AuD
Thomas Strini, AuD
Stacy Szymkowski, AuD
Riki Taitelbaum-Swead PhD
Barbra Timmer PhD
Kimberly Tullock MA
Michael Vekasi MS
Adam Waters, AuD

ACADEMY PARTICIPANTS SUPPORT OUR PROFESSION

The Academy's Loyalty Media Programs offer organizations the opportunity to connect with Academy members and the audiology community.

You can find participants featured here in *Audiology Today* magazine, on our Web site (www.audiology.org), and at Academy events. Consider supporting the companies that support your association.

Current Loyalty Media Program companies include:



For more information about the program, contact Alyssa Hammond at ahammond@networkmediapartners.com.

Advertiser Index

American Hearing Aid Center, LLC www.ahac-online.com/	39
Amplivox www.aplivox.us	31
Auditec, Inc. www.auditec.com	23
Audiology World News www.audiology-worldnews.com	101
CaptionCall, LLC www.captioncallprovider.com	C2, 1
Clearwater Clinical-Shoebbox Audiometry www.shoebbox.md/going-mobile	27
Ear Technology Corporation www.eartech.com	7
Eosera Inc. www.earwaxmd.com	42, 43
FYZICAL Therapy and Balance Centers www.AuDBalance.com	34
Hamilton CapTel www.hamiltoncaptel.com	French Gate Cover, 54
HearUSA Careers.hearusa.com	28
Interacoustics US www.interacoustics-us.com	15
Maico Diagnostics www.maico-diagnostics.com	5
Oticon, Inc. www.oticon.com/connectclip	C3
Otodynamics Ltd www.otodynamics.com	49, 50
Otometrics/Audiology Systems www.audiologysystems.com/otosuite	10, 11, 20
On-Trend: Sprint CapTel/ZPower, LLC Professionals.sprintcaptel.com , www.zpowerhearing.com	60
Prestige Brands, Inc. www.debrox.com	24
Sennheiser Electronic GmbH and Co. KG www.sennheiser.com/set880	16
Signia www.signiausa.com/purecharge	C4
Sonic www.sonici.com	36
Sprint CapTel Professionals.sprintcaptel.com	2
Widex USA, Inc. www.widexpro.com	9
ZPower, LLC www.zpowerhearing.com	61
Academy Products and Services	
AAA 2018 Annual Conference www.aaaconference.org	66, 67
AAA 2019 Annual Conference www.aaaconference.org	30
ABA at AAA 2018 www.aaaconference.org	81
Academy Corporate Partners www.audiology.org	102
Academy Research Conference www.AcademyResearchConference.org	59
ACAE at AAA 2018 www.acaeaccred.org	84
Advocacy www.audiology.org/advocacy	89
eAudiology www.eaudiology.org	91
Foundation Lectures at AAA 2018 www.aaaconference.org	76
HearCareers www.hearcareers.org	83
SAA Conference www.aaaconference.org	79
Student Upgrade www.audiology.org	71

OTICON | Opn

Hands-free connectivity from iPhone® and Android™ to both ears, and more



Works with
**any modern
smartphone**



Made for



iPhone



iPad



Works with
Android™

Introducing ConnectClip

ConnectClip is a wireless accessory that transforms Oticon Opn™ hearing aids into a wireless, hands-free headset to stream clear, high-quality sound to both ears from modern smartphones and many other devices.*

Uses efficient 2.4 GHz Bluetooth Low Energy (BLE) technology with OpenSound Navigator™ to transmit speech that's free from unwanted noise. ConnectClip can also be used as a remote microphone in noisy settings and as a remote control.

Learn more on oticon.com/connectclip

* ConnectClip works with all smartphones with Bluetooth from 2010 onwards, including Android™ and iPhone®. Apple, the Apple logo, iPhone, iPad, and iPod touch are trademarks of Apple Inc., registered in the U.S. and other countries. Android is a trademark of Google Inc. The Android robot is reproduced or modified from work created and shared by Google and used according to terms described in the Creative Commons 3.0 Attribution License.

oticon
PEOPLE FIRST

Replicating nature.

Signia Nx with OVP™ for the most natural own voice and highest acceptance.



NEW
Pure Charge&Go Nx

Pure Charge&Go Nx: Own Voice Processing (OVP) is now rechargeable!

Signia Nx, the world's most advanced hearing aid platform, is now rechargeable. Introducing Pure® Charge&Go Nx, a lithium-ion inductive charging hearing device that also provides the most natural own voice for highest acceptance* with its patented Own Voice Processing, OVP.

Now you can provide our best sound quality and our best hearing performance, even in loud environments, without compromise in a rechargeable solution.

Patients can enjoy natural hearing all day long on a single charge without fussing with batteries as well as direct streaming of high quality music, phone calls, and TV via *Bluetooth*® low energy.

For more information, visit signiausa.com/purecharge or contact your Signia Sales Representative at (800) 766-4500.



Pure Charge&Go Nx with charger

* 2017 "First Fit Study" conducted at Hörzentrum Oldenburg examining the effect of own voice processing on spontaneous acceptance after first fit of hearing aids. The *Bluetooth*® word mark and logos are owned by the Bluetooth SIG, Inc. and any use of such marks by Sivantos is under license. Other trademarks and trade names are those of their respective owners. Copyright © 2018 Signia GmbH. 1/18 SI/18328-18