SPECIAL ISSUE
Overcoming Uncertainty by Creating the Future

Stop Trying to Sell Hearing Aids
And Embrace Your Role as Educator

Pediatric Fitting Protocol From UWO

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The Academy of Doctors of Audiology is dedicated to leadership in advancing practitioner excellence, high ethical standards, professional autonomy, and sound business practices in the provision of quality audiological care.

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Rise to the Challenge

ADA is experiencing unprecedented levels of member engagement and I am absolutely proud to begin my term as ADA president surrounded by a membership body with so much passion, ability and enthusiasm. ADA members have never accepted the status quo and I challenge each of you to continue this tradition by becoming involved, so that we can overcome all challenges and capitalize on all opportunities for the betterment of audiology and the patients we care for.

As 2011 winds down and 2012 unfolds, the emergence, advancement and promotion of unsafe hearing healthcare delivery models poses great concerns for ADA, its membership and most of all the safety of the public we serve. I was extremely heartened to hear the dialogue around this issue at the ADA convention—thoughtful, meaningful discussions that united our members in purposeful action that is affecting positive change.

With your support and collaboration, ADA has established a webpage dedicated to providing information and resources to help audiologists, allied organizations and other healthcare professionals educate patients, consumers and key constituents about the risks of self-serve hearing healthcare. Your response to ADA’s call to action on this issue has resulted in increased scrutiny by governmental bodies and the general public regarding unsound initiatives by insurers and retailers that undermine best practices in hearing healthcare. If you have a passion for advocacy, I challenge you to get involved.

ADA’s year-round and convention mentoring programs achieved phenomenal success this year. This was a direct result of the ADA Mentoring Committee’s leadership, the commitment by ADA student members and ADA mentors to actively participate and share their knowledge with one another. Today, ADA’s student membership stands at 240 (up from 100 in 2010). In response to growing participation and involvement by students, and to ensure that student interests are represented effectively, ADA has for the first time established an ex-officio position on its board of directors to be filled by a student member. ADA will also launch new programs and services for students in 2012, including a student listserv and a virtual student chapter. If you have a passion for student issues, I challenge you to get involved.

Through the leadership of the Education Committee, ADA creates and coordinates practical programming for the convention and beyond. The ADA Business Management Training Program’s first module, Financial Management, was introduced at the ADA convention, and will be available online in the near future. ADA is seeking additional expertise for the development of a continuum of modules that will introduce best business practices in practice management. If you have a passion for developing exceptional learning experiences for audiologists and future audiologists, I challenge you to get involved.

No matter what your passion, there are opportunities to get involved. If you have a passion for enhancing the ADA membership experience, for celebrating the best in our profession, for developing great products and services that your peers will rely on, or for establishing and promoting best practices, then I challenge you to get involved.

Continued on page 61
The Automatic Adaptation Manager in Quantum™ and Moxi™ hearing instruments is different from anything else on the market today. It gently transitions clients from the amplification that feels most comfortable at first fit, to the amplification you know they need to hear their very best. All of this while providing natural sound from start to finish. It’s positively amazing.

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Creating the Future in Uncertain Times

Every time we watch the news or read the newspaper, we are reminded that we are living in a time of great economic uncertainty. Although we cannot predict the future, we can be certain that disruptive technology, like over-the-counter hearing aids, will continue to contribute to this uncertainty. We can also be fairly sure that alternative distribution models, which eliminate the audiologist from the transaction, will continue to exist despite our best efforts to get rid of them.

The key to overcoming the uncertainty of disruptive technology and alternative distribution models is through differentiation of your practice. One way to be different is to make the patient’s interaction with your practice so memorable and enjoyable that individuals flock to your door seeking a transformative, life-changing event delivered by you. By enhancing the patient’s interaction with your practice at these six critical areas of interaction (see Figure 1) you can begin to unlock the secrets of a truly transformative experience for your patient, while commanding a higher average selling price.

Here’s how you can get started. For each of the six interaction stations in Figure 1 ask the question, “How can I make this “touch point” more memorable and meaningful for the patient?” Answering this question is likely to take you outside your comfort zone and should get you thinking about these experience-driven ideas:

- How can I theme my reception area, so that people actually like spending some time there?
- What tests can I use that are more meaningful to the patient, while also accurate and reliable?
- How can I make the process of spending money less painful for my patient?
- How can I make the follow up appointment more engaging to my patient?
- How do I demonstrate results in a way that is meaningful to the patient?

Audiologists cannot take a business as usual approach. As business management pioneer Peter Drucker said, “The best – perhaps the only – way to predict the future is to create it.” Now is the time for audiologists to do just that. Apple says, Think Different. Audiologists must interact different with their patients to excel in these uncertain times.

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Figure 1. The six interaction stations of a patient’s experience in your practice. Based on the work of Shareef Mahdavi of the Premium Experience Network

(e.g., Quick SIN and other tests that provide a higher level of patient engagement)
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HEADQUARTER’S REPORT

Stephanie Czuhajewski, Executive Director

ADA New Year’s Resolution:
Create Phenomenal Member Experiences

During his recent keynote presentation at the ADA 2011 Annual Convention, thought leader Mike Staver, emphasized that no matter what our profession, we are in the business of selling customer experiences. From Harley Davidson to Apple to Nordstrom to Disney, wildly successful organizations understand that it isn’t enough to deliver great products and services (those are minimum requirements). According to Staver, these companies transcend mere customer satisfaction by creating a customer experience that is so fantastic that their customers actually go out and evangelize on their behalf.

Staver also reiterated that we cannot provide exceptional experiences unless we are willing to step outside of our comfort zone to fail, learn, grow and succeed. He noted that when a baby learns to walk he/she falls down many times in the process. The child does not view short-term failure as an insurmountable obstacle to success, but rather as one step in the expected process of achievement.

Staver’s message was directed at audiologists, but his points resonated with ADA leaders and staff as well. There are many great on-paper reasons to belong to ADA—the benefits, services, and educational and networking opportunities are specifically designed to serve autonomous practitioners. But we recognize that unless your membership experience with ADA is also unique and exceptional, the value is lost. ADA’s New Year’s Resolution is to create member experiences that are so phenomenal that we never have to do another member recruitment campaign.

What kind of experience is ADA delivering to you? The first step in creating exceptional experiences is to get feedback on the current environment. To that end, ADA recently held a focus group session, bringing together representatives from ADA’s membership, industry partners, and other key constituencies for the purpose of listening—listening to their current perceptions of ADA and gaining a better understanding of the characteristics that encompass exceptional experiences for ADA members.

As an outcome from the focus group discussion and ADA’s strategic plan directives, ADA will conduct a comprehensive member experience assessment in January. We are seeking the true picture of ADA as you see it, as well as your ideas for how ADA can better deliver exceptional experiences for members. Your participation and input in this electronic member survey will be used to create ADA member experiences that are truly extraordinary.

As we head into 2012, ADA is going to take some risks in an effort to elevate your member experience. We will be revamping committees, introducing new products and services, reshaping advocacy initiatives and creating new opportunities for member engagement. We may stumble and even fall down in the process, but we will be undeterred from achieving ADA’s mission as you have defined it. We remain committed to delivering the information, tools and resources that you need to achieve your goals for your practice and for the profession of audiology, and to delivering an exceptional member experience for you always.

Please contact me at sczuhajewski@audiologist.org or at 866-493-5544 to share your thoughts and ideas.
Stop Trying to Sell Hearing Aids & Embrace Your Role as Educator

If you are old enough to remember the historic frontier days of the Saturday Night Live show, I invite you to take this journey back in time—long before we had ever heard of the war on terror and negative amortization, at time when a housing bubble would most likely conjure up images of the tent fumigation used by exterminators. These are the mid-1970’s, decades before anyone would have ever thought that Yahoo or Google would be a good name for a serious multibillion dollar company, and “Go Daddy” was just a corny expression used by those nonconformist Beatniks of the 50’s. A company called Apple referred to the Beatles recording company rather than the computer company founded in 1976 by Steve Jobs, Steve Wozniak, and Ronald Wayne. If you are unfamiliar with the name Ronald Wayne it is because he sold his share back to Jobs and Wozniak the following year for $800. Wayne was a lot like Pete Best, the Beatles original drummer, who left the band in 1962 thinking it had already reached its potential.

Response Letter from Gregory Frazer, AuD, PhD, ABA, CCC-A, NBC-HIS: click here to view
If these are unfamiliar times for you, know that these are the times in which many of your customers and customers-to-be grew up. Even the slightly older ones certainly know about Saturday Night Live and remember many of the skits and gags that have now become cultural markers for a generation. Let’s tune in to one of the early shows of this TV legend that broke new ground by testing the boundaries of America’s tolerance in parody. In all likelihood, we would be watching our favorite show on a 19” portable TV, in black and white. The idea of a 60” high definition plasma screen was not even a kernel of a thought in the minds of those TV innovators who were basking in the glory of taking us from a vacuum tube to the new transistor TVs.

The particular segment that we will focus on is called Weekend Update. It begins with Chevy Chase portraying a newscaster setting the stage for an editorial feedback on one of the station’s previously broadcasted editorials discussing trends and current events. Enter Gilda Radner as Emily Litella, an elderly woman with an obvious hearing impairment who causes everyone to cringe in anticipation of the potential miscommunications and faux pas that were about to ensue. As was typically the case, Emily would get halfway into her heated rebuttal before the newscaster would interrupt her in order to point out the error caused by her troubled hearing.

In an example of this brilliantly executed comedy skit, Emily was ranting about the absurdity of the station’s editorial promoting a ban on violins being shown on TV. “What’s all this fuss I have been hearing about violins being on television?” she would say with the candor of an old schoolmarm. “Why don’t parents want their children to see violins on television?” “If they only show violins after ten o’clock at night, youngsters will never see them and never learn to appreciate classical music.” With each sentence that Emily spews out she becomes even more enraged; “I say we should have more violins on television…”

At about this time Chase would summon the courage to interrupt her to point out that the editorial was not about banning violins on television; it was promoting a ban on the violence being shown on television. In recognizing the error caused by her hearing problem, Emily would resume the sweet old lady persona that her appearance suggested and admit “that is quite different.” Then she would smile into the camera and deliver the closing line: “Never mind.” The following week she returns with a new tirade declaring: “What is all this fuss I hear about the Supreme Court decision on the ‘deaf’ penalty? It’s terrible! Deaf people have enough problems as it is.”

Although we have come a very long way since the Emily Litella character of Saturday Night Live, our culture has made surprisingly few strides in correcting the stigma that people feel about identifying themselves as having a hearing problem. Unlike most other cultures in the world, ours is a culture that has never accepted the inevitable decline of our senses, our diminishing stamina, nor our changing appearance as we enter the later years of our lives.

We now face a hearing impaired population that would prefer the humiliation of fumbling through life like an Emily Litella—missing the point, smiling and nodding when they should be frowning and shrugging—rather than endure the indignation of an insert into our ear canal that is no bigger than the ear buds connected to the iPods that decorate the ears of today’s youth. Somehow our consumers have become so lost in their vanity and need to conceal the obvious that they would prefer to appear able while remaining disabled.

And as if the absurdity of these misguided priorities weren’t shocking enough, we must also face the fact that our industry actually continues to promote this flaw in our culture. Any time a hearing care professional suggests the need to conceal and hide a hearing aid; they are feeding the dragon that threatens the demise of the dispensing profession. In this matter, we have not really advanced much further than our counterparts of the 1940’s who promised that all inquiries...
for further information about hearing aids would be sent in an unmarked, brown paper envelope.

I recognize the need to accommodate customer preferences, but not at the expense of dispensing professional wisdom in order to right an obvious wrong. In your daily interactions with aging customers, you must set an example by putting health above vanity; function over form. At the very least, you must suggest to all who will listen that true quality of life is a more beneficial objective than the appearance or façade of youthfulness. This may not be easy, however, in an era where sixty year old skin is surgically stretched to its breaking point and tightened eyelids yank hairlines with each blink of the eye.

If we continue to be satisfied with serving less than 30% of the hearing impaired population, we are helping perpetuate a great wrong. This wrong enables an even greater wrong in our culture where people would rather lose the vibrant sound of their life’s symphony than endure yet another telltale sign that they are not in the prime of their youth. And if you, as an audiologist, feel compelled to feed into the need to conceal any suggestion that your customers are less than perfect then you are reinforcing the single greatest obstacle that your industry faces.

In the 1990s, Mayor Rudy Giuliani was asked how he managed to turn around New York City’s soaring homicide rate. He said that they began by cracking down on graffiti, turnstile jumping, and aggressive panhandling by “squeegee men.” His theory held that prosecuting these smaller crimes would send a message that all of New York would be under the same laws and the same level of vigilance. It worked.

We, in the hearing care industry, could take a lesson from Giuliani and begin to send the message that concealment of aging, even hiding disability, is not a higher virtue than enhanced quality of life. The message must declare that it is within our means to keep one of life’s most vital windows--hearing--open for people who may otherwise face the slippery slopes of decline. According to countless studies, the use of hearing aids is associated with reductions in anger, frustration, paranoia, anxiety, and measurable improvements in emotional stability. In a 1999 study conducted by the National Council of Aging, 2,000 people with hearing loss and another 2,000 family members reported that effective use of hearing aids indicated improvement in:

- Relations at home
- Feelings about self
- Mental health
- Self-confidence
- Relations with children, grandchildren
- Sense of safety
- Social life
- Relations at work.

They even reported improvements in their sex lives. And if this message is not clear enough, listen to the wording of their concluding remarks: “Loss of hearing is a serious life issue, a medical condition that is associated with physical, emotional, mental and social well-being. Depression, anxiety, emotional instability, phobias, withdrawal, isolation, lessened health status, and lessened self-esteem have all been linked to uncorrected hearing loss.” Perhaps even more eye opening is the study concluded this year by Johns Hopkins and the National Institute on Aging in which the findings clearly established a link between untreated hearing loss and the early onset of dementia and Alzheimer’s disease. The impact is so profound that they state even mild hearing loss doubles the risk of dementia. Although you know these findings are incontrovertible, your customers have not heard them and even if they have, it is not breaking through.

As a communication expert, I am astonished by how many highly trained professionals, indeed entire industries, have not yet recognized the disparity between what they are transmitting and what is being received by their customers. The average person walking through life with a hearing impairment has yet to become privy to critical information, not because you have not provided it, but because you have not yet broken through their filters with your message.

In the language of communication theory, the bias of your listener continues to obscure the truth of your message. It is not the validity of your claim or the logic of your arguments; rather, it is your inability to overcome the resistance of your listeners that is costing you results. Your customers are not only hearing impaired; they are listening impaired when it comes to considering hearing aids as a solution to their problems. Instead of really listening to what you say, they hear a version of that message after it has been filtered and encoded with their own personal biases.
What are these biases that you encounter with every new patient tested? Two key biases are the most difficult of all to penetrate: first, the desperate hope of being immune to the aging process; and second, the urgency of avoiding being viewed as having a disability. In a culture that is youth obsessed and aging adverse, your customers are culturally trained to cringe at the thought of advertising their own aging process. It’s the same bias that fuels the cosmetic surgery and hair color industries. **Every time you mention the advantages of concealment you are playing into this folly.** I am not suggesting that discrete, subtle hearing aids do not offer a valued feature; I am suggesting that it’s time to stop promoting this feature above the functionality and lifestyle benefits of a good set of hearing aids.

For many people it is not just aging that disturbs their sense of vanity, it’s anything that associates them with disability. Though their hearing disability can be significantly reduced with a good hearing aid, the *image* of disability, as represented by hearing aids, is far more disturbing for them than the actual disability. Overcoming your customer’s biases may seem like a daunting task, but you have one great advantage working in your favor—truth. Once a person truly *experiences* the folly of their bias they can overcome its control over their behavior. It is your duty as a hearing professional to provide a continual flow of facts and truth in order to overcome customer prejudices.

If these two biases are not challenging enough, there exists one more mega-bias to overcome: the bias that older adults have against change. At any age change is challenging, but as we grow older, our desire, or perhaps more adequately stated, our need to stay the same is greater than ever. When a toddler first notices things changing they are becoming aware of their abilities to move around and to express themselves. As we reach adolescence, we perceive change as our ability to gain freedom and handle responsibility. In young adulthood, change may actually take on the form of a willingness to take risks and commit ourselves to new endeavors. At middle age, we start seeing unwanted changes like changing metabolism that encourages weight gain, changing digestive systems that hamper our enjoyment of eating, and changing hairlines, laugh lines, and waistlines. Somewhere along this path, change gets a bad name and staying the same finds a new ring of favorability.

For many older adults change is simultaneously continuous and contentious. It is not necessarily the event or circumstance that is the problem but change itself that they hate. A person who is suffering from “senior onset change overload” will balk at changing from plastic to paper grocery bags. And as a rule of thumb, the more you push the more they resist.

With each of these biases, (1) fear of aging, (2) fear of appearing disabled, and (3) the fear of change, it is best to avoid the confrontational approach. As all three are fear based, they also hold a common solution—understanding. By providing the patient with a greater understanding we are able to dislodge their irrational predispositions. One important caveat is that this kind of illuminating recognition is not usually available in a single encounter. Pre-sale education, emotional support, and professional guidance are among the most valued functions of the hearing professional. Judging from the size of the *tested but not treated* files for most hearing aid dispensing offices, this area could use amplification. It takes more than one visit to create the bond of trust.

Despite their biases, your customers are never able to totally eclipse the truth. No matter how strong their prejudices or how obstinate the consumer, a persistent presentation of the unembellished facts has the ability to wear down the resistance. The presentation of truth must be free of persuasion and without the taint of professional judgment. For a person to go against their biases, it must be the result of their own conclusions and not the “convincing” of family, friends, or your sales interests. Your facts may lead them to the right conclusion, but that conclusion must be perceived as their own.

With all of the electronic communication devices and diversions that have become essential to our survival, i.e. cell
phones, BlackBerries, I-Pads, blogging, tweeting, and Facebook to mention a few, the very pace and character of life has, for the traditional senior, become troublesome. In the midst of such an atmosphere of chaos and disruption is it any wonder that something as simple as a hearing aid might get lost within all of the noise? Especially if a hearing aid is perceived by its potential user as yet another technological device that is outside of their identity, “it’s not me” just might be the single greatest reason for the low utilization rates that plague the hearing profession. The hearing aid industry, unlike other consumer electronics, has not yet elevated the interest of its natural constituents. After all is said and done, it is the interest level of the buyer that ultimately drives the purchase.

Sales people are notorious for trying to sell a product to an uninterested customer. These unproductive dealings between buyer and seller often reposition the buyer even further from a purchase than had there been no contact. It is with this in mind that hearing aids should never be sold; they should be provided. Salespeople typically increase the pressure and persuasion if they are having problems closing the sale. This is the exact opposite formula that a hearing professional should employ. Rather than pressure or persuasion, education and guidance should always be your preferred modes of communication. Older consumers tend to walk away from the pressure of salespeople and they are even more wary of someone trying to put one over on them. Conversely, they embrace authentic education, provided by an expert, about a condition relevant to their personal health.

This non-sales approach should come as good news to you, as most hearing professionals have always been ambivalent about the role of sales in their profession. The shift from selling to teaching requires an alteration of tone in the communication. Selling applies a significant amount of persuasion and promoting while teaching is best delivered with an informative tone and occasional narratives/examples. Whether we are selling or teaching our goal is still to raise the awareness and understanding of our customer to the benefits of what we offer. Teaching is actually a more dignified variation of selling: embellishment and exaggeration.

Elevating the interest of our customers is an involved process, but it always begins with education. The more educated the perception of our consumer becomes, the closer they come to reaching their own conclusion that living with a hearing impairment is outdated thinking. They will eventually recognize that enhancing one’s ability to hear is at least as valuable of an investment as watching Dancing with the Stars in high def with surround sound.

You know the impairments and you know the solutions. Now you must learn to speak about these things in the language of your customers. This requires knowing your customers and having them understand that you know them. You will recognize their trust when they mirror back your understanding of who they are and what they lack. Then, and only then, are they ready for a demonstration of what you can do to help them. Persuasion before this point is counterproductive.

Perhaps most important throughout this entire process is managing unrealistic expectations. The complexity of getting everything just right for the patient can only succeed if you have been careful in your education and preparation efforts. Otherwise, the experience will quickly degenerate into disappointment. One person disappointed with the experience of trying to buy a hearing aid from you will result in countless numbers of their friends not being willing to try.

As a hearing professional, it is the “experience” that you bring to the table that justifies your existence. Buying better hearing cannot be achieved as effortlessly as buying better vision or buying a bigger, better television. It’s a process that begins with easing your patient over their own denial, and concludes with the patient accepting the hearing gains you were able to attain for them. Without this perfected dance between provider and consumer, it is unlikely that your underserved market will ever reap the benefit of what you offer. I mention this because hearing professionals are about to encounter the disruption that all intermediary careers must sooner or later face, that of obsolescence.

In this 21st century, technology is driving the marketplace to simplify the sales process and eliminate human involvement. As Joseph Pine and James Gilmore so aptly postulate in their ground breaking book, The Experience Economy, we may have already passed the peak days of the Service Economy, and are now entering the Experience Economy. In the Experience Economy we go beyond economies driven by raw materials, manufactured goods, and even customized service, to an economy driven by overall experience. In this economy the highest experience is that of transformation where the customer becomes the product. As Pine and Gilmore put it, the customer comes to you and says, “Change me.”
On the surface, this bodes well for those of you who provide an improved experience of hearing. But on closer examination, as we all move from a service economy to one of experience, there is an inevitable devaluation of intermediary services. Anyone who works as an agent, broker, middleman, or even retailer, comes under fire. The forces that are responsible for the decline of the service economy are: commoditization; disintermediation; and automation. The Internet--the greatest force for all three of these modifications--is paving the way to eliminate the human element in traditional buying and selling.

We now buy insurance online without an agent, invest without a broker, and Amazon has long ago put the nail in the coffin for the big bookstore chains. And unless you have been on an extended luxury cruise, you are well aware of the unprecedented and somewhat audacious move made recently by United Healthcare making hearing aids a low cost/high perceived value benefit for their Medicare Advantage members. Whether any of these changes will ultimately benefit the consumer at-large is not the question; we are in the disruptive phase of the trend and its corrective value is yet to be revealed. What is important is to recognize the changing times, and position yourself as invaluable and indispensable. This is done through a constant process of humanization, recognizing at each consumer encounter that an honest relationship is fundamental to providing for the patient and for you.

Beneath the latest hearing innovations and the growing involvement by industry giants such as United Healthcare and Costco, beneath the obstinate hearing impaired who would rather look able yet be impaired, and beneath the culture that rewards the façade and devalues what is real, there is the hearing movement. And just like every previous medical movement throughout history, fixing what stands between patient and wellness will ultimately prevail. But innovation alone cannot carry the ball to the goal. Like any movement it requires leadership: the voice that is heard and recognized as truth. Ironically, the industry that was born to aid the hearing impaired is yet to be heard.

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Editor’s Note

Here are a few clinical tips you can use to bring the wisdom of Mark Goldstein and Duff Reiter to life:

- Get a copy of the book they cite, The Experience Economy, and read it from cover to cover. It provides infinite guidance on how to meet the needs of today’s more demanding consumer as well as reasonable advise on how you can differentiate your practice and command a higher price for your services. In addition to reading this great book, take the time to join the blog of the author of the next article, Shareef Mahdavi. His blog is the Premium Experience Network and his ideas will get you thinking about how to better engage your patients.

- Administer some type of a questionnaire while your patients are waiting to see you. An excellent one is the Characteristics of Amplification Tool (COAT) by Sandridge and Newman. The value of the COAT is that it is “scientifically” gathers information about the preferences of the patient and allows you to target those buying preferences easily during the pre-fitting appointment.

- Use pre-fitting tests like the QuickSIN and Acceptable Noise Level tests to measure the auditory system accurately and in a manner that is meaningful to the patient.

- During the counseling process, be sure to state the facts that support the consequences of untreated hearing loss. Educating your patients to take action now, rather than waiting has a significant impact on their quality of life improvements. This is an absolutely necessary part of the process – sharing your knowledge of clinical evidence with patients.

- Take the time to learn about disease state (or co-morbidity) marketing and how the concept can generate office traffic. Smoking, dementia, diabetes are a few of disorders associated with hearing loss. Since hearing loss is a benign condition, you can leverage the relationship these disorders have with hearing loss to drive more patients to your clinic.
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View eligibility requirements and apply at www.atsu.edu/audiology or email jcapel@atsu.edu for more information.
Over time, everything in life seems to get faster.

Transportation: You can fly across the continental US in 6 hours (rather than drive 5-7 days).

Information: You can send an instant message in a second (rather than a letter taking 3-5 days).

Entertainment: You can watch movies “on demand” (rather than having to go the movie theater).

A SOCIETY ON SPEED

Our entire society is geared towards speed, which is why that as consumers we seem to get more and more antsy when we need to wait in line. Observe the behavior of others (or yourself) at the grocery store checkout, hotel checkin, or while in line at airport security. How many times do you find yourself asking, “why does the wait take so long?” We find ourselves irritated, aggravated and often frustrated because we feel we are wasting our time.

According to CNN, the average patient wait time at the doctor’s office is 24 minutes. In the modern era of “instant everything” where I can get information on my iPhone in a matter of seconds, 24 minutes seems like an eternity (unless, of course, I’m watching an episode of Modern Family and using my DVR to fast-forward through the commercials). What about your audiology practice? Do you make patients wait before they are taken back for an exam or fitting session?

What do you call that front room that patients first walk into when they enter your audiology practice? If you call it a “waiting room,” then you are reinforcing an outdated concept (ie, people's willingness to wait) and introducing what's known as a negative cue into the customer experience for your patients. I use the term customer intentionally to signify that in the modern era, your patients are also your customers. This is true throughout medicine in general, and this is specifically true for all medical providers of elective services where the services aren't covered by insurance or Medicare.
The End of the Waiting Room

In my work with device manufacturers and their customers, Task #1 in improving the customer experience is to change both the name and function of the place formerly known as the waiting room. Step One is to find a name that suits your style of audiology practice:

- lobby, reception, lounge – these tend to be more general in medical environments.
- Listening Post, O-zone, Sensory Village – these tend to be more specific to audiology.

It doesn't really matter what you call it, just call it something that doesn't signify “waiting.”

Step 2 is to re-visit the purpose of that room and how it can be used more effectively by customers prior to an exam (and by their caregivers who may be sitting there during an exam). One of the best frameworks for assessing environments comes from The Experience Economy by Pine and Gilmore. Their 4-E Model contains four specific quadrants that need to be addressed:

- Entertainment - What do you have available to help people have fun?
- Education – What do you have available to help people learn?
- Escapism – What do you offer to allow people to (figuratively speaking) “go” to another place?
- Esthetic – Is that room designed in a way that people would enjoy just sitting and being there?

Anything and everything you put into that front room can serve as a “prop” on the “stage” of your practice. Refreshments, Wi-Fi access, DVD players, iPads, Large Screen television (playing the cooking travel or travel channel, but never CNN), books, games, etc. Your only limit is your imagination.

Indeed, you need to move beyond a rack of brochures, old magazines, and a stark environment badly in need of remodel. Why? Because the expectations of your customer are only increasing when it comes to the level of service you provide and the experience you offer. There are many providers of audiology testing and devices to help people hear better. You are competing in a world that is increasingly difficult for consumers to distinguish among providers. If they view all providers as “the same,” then you are viewed as a commodity and, deservedly so, the consumer will make their decision based primarily on price. But, on the other hand, if you recognize that in order to be perceived as unique and different, you will need to think beyond “doing a good hearing exam and having a decent selection of hearing instruments.” You will need to think very specifically about the overall experience people have when they come to your audiology practice. You will want to recognize that patients can spend that same money on something else – a vacation, home improvement, or new entertainment system. You will want to connect more deeply to their own wants and needs and show them how improved hearing leads to improved lifestyle.

It all has to start somewhere, and I strongly encourage you to begin by creating a better and stronger “first impression” when they arrive at your audiology practice. Goodbye, waiting room.

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By Barry A. Freeman, Ph.D.

The family is sitting around the dining table on Thanksgiving and a grandchild says, “grandpa, please pass the turkey.” Grandpa doesn’t hear the request. Grandma says to grandpa, you need to see my audiologist and have your hearing checked.

This was the scenario I used for a branding and marketing strategy when I first opened my practice in the late 1970s. The goal was to have my practice become the automatic response to persons with hearing loss. When you think hearing and balance, you would think of my practice. Through the years, I applied this concept to building clinical practices. Basically, the theme was trust—Trust your hearing to the audiologists at…Trust your mother’s hearing to the audiologists at…and at a university clinic, Trust your hearing to the Doctor’s who teach it…

Patient Centered Care and Greatness

Jim Collins in the book Good to Great explains that greatness is not a function of circumstance. It must be a way of life with disciplined people working in the practice and actions that are consistent with the brand and image developed for the practice. When grandpa calls the practice for an appointment, the person answering the telephone must respond in a professional manner and be sure to schedule the appointment at a time convenient to the patient and the practice. This requires the practice to have the right people hired and “sitting on the right seat of the bus.”
When I started my practice, I hired "Ann" as my front-line receptionist to answer the phone and manage the general operations of the front office. Ann grew up in the community and, being a small southern town, she knew many of the persons calling for appointments. She was fantastic scheduling appointments and setting a positive professional image for the practice. Unfortunately, because she personally knew most of the people coming to the office, she had difficulty collecting money from them. When it was time to pay, she often would say, "Do you want to pay?" or "Don't worry about paying now, Dr. Freeman will send you a bill." While my appointment book was full, my collections and cash flow were poor. Ann was on the right seat of the bus for scheduling appointments but the absolute wrong seat for collections.

Successful practices not only must have the right people doing the right job, disciplined actions must become a way of life for everyone in the practice. Staff must accept their role in assuring that patients understand what drives the practice and the core principles that make the practice a success. Collins describes this as the "Hedgehog Concept." The practice must define what makes them the best choice for patients like grandpa who, in turn, must believe that the audiologists at this practice are the best in the world at what they do. This should drive your practice and be integrated into your marketing, branding, personnel, and patient care.

The Hearing Industries Association studied persons that were successfully fit with hearing aids and asked what were the most important factors that "delighted" them about their experience in purchasing amplification. While factors such as counseling, verification, professionalism of the staff all were in the top ten, the number one factor that contributed to the delight of these successful hearing aid wearers was the trust and relationship established with the hearing care provider (Rogin, 2009). Patients are less concerned with factors such as cost or price than with the qualifications of the person providing the services.

Creating a Positive Emotional Experience

By defining your hedgehog—what you are the best in the world at and what you are deeply passionate about—you can build a brand that provides a framework to create value for your patients and your employees. Your brand should convey an emotional experience about how you want patients to feel before, during, and after their experience with your practice. The brand includes but is not limited to the name of your practice, its logo, location, office design, and personnel. It generates expectations and values and its key objective is to create a relationship of trust between the patient and your practice.

There was a TV commercial in the 1960s from Oscar Mayer, Inc. where a young child sang a song, “My bologna has a first name, it's O-S-C-A-R…and my bologna has a second name, it's M-A-Y-A-R.” Whose bologna is it? It's his! The child “owns” the bologna.

This should be the goal of your branding. You want patients to "own" your practice. Note that grandma told grandpa to see "my audiologist." The goal of branding should be to have your practice become the automatic response for persons with hearing loss. There is a simple brand exercise that you can do in your practice:

- Label everything that you do in your practice. Is it a product or is it a brand? A product has a functional purpose such as a hearing aid. A brand has a functional purpose plus a value-added. Examples would be that you have been in practice 20 years or that all the professionals in your office have earned their Doctor of Audiology degree.
- List your competencies such as experience and qualifications.
- List your values such as diagnostic hearing and balance services, populations that you serve, special services that you offer.
- Communicate your ‘personality’ such as your involvement in the community, volunteer activities, and/or a special expertise or specialty certification you may have earned.

You now are prepared to write a brand statement and communicate an image and perception to the public that you offer more than a product but, rather, a total hearing experience.

The Front-Line

Grandpa has heard good things about the practice and decides to call for an appointment. This, now, initiates the patient journey and is a point where trust must be reinforced or established. The front-line staff assists in building the trust in the brand and image of the practice by properly answering the phone, responding to patient questions, and carrying the call through to actually making an appointment. It is surprising the number of missed practice opportunities due to an unanswered phone, being placed on hold, or not properly closing the call with an appointment. A shopping study of audiology practices in 1998 for the American Academy of Audiology revealed that 60-70% of persons calling for an appointment were never scheduled and that front-line personnel were uninformed about the culture, brand, and
Despite doing everything seemingly correct, we just cannot get our patients to follow our recommendations for treatment and management. Patients may be more skillful in presenting objections to our recommendations than we are at overcoming those objections. Here are some strategies and recommendations for overcoming patient objections. Simple as they may appear, they can be quite effective for successfully managing patients.

Office Image

When grandpa and the family arrive for the appointment, they must be properly greeted and have a positive impression about the practice. We know that many persons with hearing loss have waited 5-7 years before scheduling an appointment. They are resistant to audiology services and it is our responsibility to instill a sense of trust and professionalism throughout the process. The office furniture, color theme, music, staff appearance, brochures, demonstrations, and hospitality must all connote a sense of quality and professionalism. It is the precursor to successful patient management and overcoming objections by patients to our recommendations. Furniture, for example must be comfortable and durable; Colors such as red can be stimulating and motivating while blues instill calm and tranquility; slower tempo music can be comforting and relaxing; and, coffee and cookies can demonstrate hospitality and friendliness. You can select your office décor to match your brand and image. We have learned from behavioral economists and neuro-psychologists that decision making is influenced by stimulating the pre-frontal cortex of the brain. It is why Costco keeps large screen TVs at the entrance to their stores and Starbucks offers unique drinks and food. They are stimulating the brain centers that influence customer buying behaviors. Remember when we used to pay a lot less for a cup of coffee or purchased a much smaller bottle of ketchup or bag of chips?! Similarly, a well designed audiology office and a friendly staff can set the stage for patient decision making about recommendations for high-end and expensive technology.

Overcoming Objections

Your parents have done what they coode,
They can but bringe horse to the water brinke,
But horse may choose whether that horse will drinke.

—Narcissus, 1602

Yes, we may do a great job branding and marketing; we may be successful in attracting patients to the practice; we may have an attractive office and good office staff; but, sometimes, despite doing everything seemingly correct, we just cannot get our patients to follow our recommendations for treatment and management. Patients may be more skillful in presenting objections to our recommendations than we are at overcoming those objections. Here are some strategies and recommendations for overcoming patient objections. Simple as they may appear, they can be quite effective for successfully managing patients.

Bring a Spouse

Statistics show that patients are much more comfortable in the decision making process when accompanied by their spouse or significant other. When calling for an appointment, the front-line person should encourage the patient to bring the spouse. This is a great way to overcome an objection that may be expressed by the patient during the sales process, “I’ll let you know about purchasing the hearing aids, I have to go home and discuss it with my spouse.”

Patient on phone scheduling appointment: “I plan to come alone.”

Front-line: “It’s fine to come in by yourself if that is your only option. However, your audiologist would value having both of you attend. In fact, there are portions of the examination, for example, where a familiar voice is valuable in determining the best approach to manage your hearing loss. Would it be better to select another time that will be convenient for the two of you?”
Life-Style Assessment

Audiologist: Do you have a problem hearing in a large group?
Response: No

Audiologist: How often do you participate in large group discussions?
Response: Rarely, if ever. I can’t hear well in that situation.

Audiologist: If we could help you, would this be something you’d like to be able to do?
Response: Absolutely...yes

It is quite common to ask patients about their hearing handicap, i.e., do you have difficulty hearing in a group? Do you have a problem hearing at a restaurant? Yet, it is even more important to learn about the patient’s current lifestyle and their goals after treatment. There are standardized lifestyle questionnaires such as the Characteristics of Amplification Tool (COAT) (Sandridge and Newman, 2006). See Appendix 1 for a blank COAT questionnaire. These tools can provide insights that can be applied later in the counseling process.

Grandpa, you told me that you have difficulty hearing your grandson at the dinner table and that is something that you would like to improve. This technology will help you accomplish this.

Explaining Test Results

We should ban the words mild, moderate, severe, and profound from the audiology vernacular (Manchaiah and Freeman, 2011). Nothing leads to objections more than these terms. How often do we hear a patient tell us that they were told that the loss was “only mild” so they will wait until it becomes worse? These terms were probably developed post-WWII for compensation purposes and, yet, they have become a part of our daily counseling with patients. Do the terms really describe the patient’s handicap? Of course not, so, instead of creating a barrier and objection to our treatment recommendations by using these terms, let us agree to ban the terms and explain how the degree of hearing loss interferes with communication and how we can best treat the hearing loss and handicap.

When explaining test results with the visual aid of an audiogram, eliminate this terminology and replace it with “Normal” and “Needs Amplification” as shown in Figure 1.

Introducing Product Prices

Audiologist: Now that we finally have determined your specific hearing needs, your goals, and the style you would prefer, the investment for these hearing aids is $_______. I believe that these instruments will meet the lifestyle goals you (and your spouse) discussed with me. Plus you are getting the latest technology that will fit comfortably in your ear. I’d like to go ahead and order them for you today and set an appointment for you to return next week for the actual fitting with your personal hearing aids.

Grandpa: I can’t afford these hearing aids.

This is a clear objection by the patient to recommendations by the audiologist. However, since you spent time during the initial interview process exploring the patient’s lifestyle and concerns, then you should be able to respond to patient concerns with confidence. The patient is not saying that they are not able to purchase the instruments or that they want less expensive technology. They are asking how you can make these instruments affordable. Perhaps you could offer payment and financing options to make the instruments “more affordable” to the patient.
Grandpa: These hearing aids are expensive.

This is more of a statement than an objection. “You know, you are correct, they are expensive, but this is an investment in your quality of life and you are worth it.” From the lifestyle assessment, you already learned that grandpa was having difficulty hearing his grandchild and hearing in groups. You might respond by saying, “You explained to me that you want to be able to hear your grandchildren and hear better when you are in groups. We selected the hearing aids that will best meet your needs.”

Grandpa: Isn't there something that costs less money?

If you have selected instruments based on the projected lifestyle and hearing needs of the patient, you may find that you are recommending high end technology. After all, if grandpa was your grandfather, wouldn't you want to fit him with the best technology available? If that is the case, then you always can discuss the pros and cons of different levels of technology. For example, you might respond, “yes, there is less expensive technology. There are less expensive styles such as the hearing aids that are more visible and also hearing aids with less digital technology. These would require a lower investment and cost less, but, in my opinion, you will not achieve the same benefit that you will have from these hearing instruments.”

If, however, you are uncomfortable recommending and fitting high end technology, than this will be a more difficult question to answer. The key is to not sell based on price. We learned from the HIA study that cost was not a major contributing factor in the success of patients wearing hearing aids. You should be selling your practice’s brand, your qualifications and expertise, and providing quality hearing care. Hearing aids are just a part of the treatment program. Once you start reducing or negotiating your price, you make your services about price and not about quality. This may undermine your branding and hedgehog principles.

Summary

Consumers are far less influenced by our products and services than they are by the positive elements derived from the total experience. From our branding through to the final recommendations and follow-up, we must build a relationship of trust with our patients. A successful practice is able to differentiate itself from the competition based on the perceived value of care. While you may know that you provide the best quality hearing care in the community, the key is to build a brand and support it so that your patients will agree with you.

References


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Characteristics of Amplification Tool (COAT)

Name: ________________________________________ Date: ____________________________

CCF #: ________________________________________ Audiologist: ______________________

Our goal is to maximize your ability to hear so that you can more easily communicate with others. In order to reach this goal, it is important that we understand your communication needs, your personal preferences, and your expectations. By having a better understanding of your needs, we can use our expertise to recommend the hearing aids that are most appropriate for you. By working together we will find the best solution for you.

Please complete the following questions. Be as honest as possible. Be as precise as possible. Thank you.

1. Please list the top three situations where you would most like to hear better. Be as specific as possible.

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

2. How important is it for you to hear better? Mark an X on the line.

Not Very Important  -----------------------------------------------  Very Important

3. How motivated are you to wear and use hearing aids? Mark an X on the line.

Not Very Motivated  -----------------------------------------------  Very Motivated

4. How well do you think hearing aids will improve your hearing? Mark an X on the line.

I expect them to:

Not be helpful  -----------------------------------------------  Greatly improve my hearing
at all

5. What is your most important consideration regarding hearing aids? Rank order the following factors with 1 as the most important and 4 as the least important. Place an X on the line if the item has no importance to you at all.

___ Hearing aid size and the ability of others not to see the hearing aids
___ Improved ability to hear and understand speech
___ Improved ability to understand speech in noisy situations (e.g., restaurants, parties)
___ Cost of the hearing aids

Appendix 1. The original COAT. The COAT can be administered to the patient prior to their initial hearing aid evaluation or once hearing aid candidacy is determined.
6. Do you prefer hearing aids that: (check one)

___ are totally automatic so that you do not have to make any adjustments to them.
___ allow you to adjust the volume and change the listening programs as you see fit.
___ no preference

7. Look at the pictures of the hearing aids. Please place an X on the picture or pictures of the style you would NOT be willing to use. Your audiologist will discuss with you if your choices are appropriate for you – given your hearing loss and physical shape of your ear.

8. How confident do you feel that you will be successful in using hearing aids.

Not Very Confident

-------------------------------------------------------

Very Confident

9. There is a wide range in hearing aid prices. The cost of hearing aids depends on a variety of factors including the sophistication of the circuitry (for example, higher level technology is more expensive than the more basic hearing aids) and size/style (for example, the CIC hearing aids are more expensive than the BTE instruments). The price ranges listed below are for two hearing aids. Please check the cost category that represents the maximum amount you are willing to spend. Please understand that you are not locked into that price range. It is just very helpful for us to know your budget so that we can provide you with the most appropriate hearing aids.

___ Basic digital hearing aids:    Cost is between $2000 to $2499
___ Basic Plus hearing aids:    Cost is between $2500 to $2999
___ Mid-level digital hearing aids:    Cost is between $3000 to $3999
___ Premium digital hearing aids:    Cost is between $4000 to $6000

Thank you for answering the questions.
Your responses will assist us in providing you with the best hearing healthcare.
Choosing an Accountant, Attorney & Other Consultant for Your Practice

BY GRANVILLE Y. BRADY, JR., Au.D.

NOTE: The information contained in this article is based on the author’s lectures at the Arizona School of Health Sciences course Business Development and Accounting. It is meant for educational purposes only and is not intended to give a legal or accounting advice which can be done only by a licensed attorney or CPA.
Given the extraordinary demands of the private practice and clinical audiologist it is imperative to understand the value of using consultants to enhance your practice.

This article focuses on what the audiologist needs to know when hiring an accountant, lawyer, insurance agent or other consulting professional. I will share several rules on how to select and utilize consultants in your practice. Let's get started with rule #1.

It might seem obvious, but the first rule is to avoid, if possible, hiring family or a friend. Cousin Harry may be a terrific accountant who works for a large firm, but he might not fit the needs of a small audiology practice for the following reasons:

1. His specialty may not be consistent with this type of practice. A corporate accountant may know little about the complexities of a small business.

2. Harry may be hard to fire if the audiologist decides to get another accountant. It is not uncommon for a first time practice to change consultants as the practice grows. By retaining a non-relative, the audiologist can make changes if necessary.

3. A relative may not want to take the audiologist as a client. It is difficult for a family member to refuse to help kin, but face it; the audiologist may not be the type of client the accountant likes. The audiologist may ask too many questions and expect services at a discount or at no cost.

4. It is not a good idea for relatives to know the audiologist's business.

5. It might be better to ask cousin Harry whom he'd recommend for the practice.

**Questions to ask when interviewing an accountant.**

Interviewing a consultant is similar to interviewing a potential employee. After all, the accountant is likely to be working for the audiologist throughout the duration of the practice and will know a great deal about the audiologist's professional, financial and, to some extent personal life.

1. Does he/she have a CPA? In most states, corporate taxes cannot be prepared by someone who is not a licensed accountant (PA) or CPA. Check the credentials.

2. Does he/she know about small business accounting? Some accountants specialize only in taxation. The audiologist will need someone who has experience in helping a small business grow.

3. Will he/she back the audiologist up in an audit?

**Personal Observation**

True accounting nightmare:

A friend whom I will call Ted and his wife, Jane had a small take-out food service that picked up food from the restaurant and delivered it to the home. They hired many drivers whom they considered to be non-employees or independent contractors
according to federal guidelines. When one of the drivers applied for Unemployment Insurance, it triggered an investigation of the Ted and Jane's business practices. The state investigator came into Jane's office and asked to see all her records, which she supplied. Ted and Jane were found to be guilty of not paying worker's compensation and unemployment and were fined thousands of dollars by the state that alleged that the drivers were employees.

The day before the state investigator came in Jane called her accountant who reassured her that this was no big deal. The accountant did not want to be there and advised Jane to handle it by herself.

The audiologist will likely be audited or investigated sometime during their career. Be sure that the accountant will stand by the audiologist. Never open financial records to anyone without having an accountant or lawyer present. Investigators cannot go on a “fishing expedition”. They must ask for specific information and cannot simply peruse the audiologist's files looking for violations. There are two exceptions: if the files are seized by court order and if the IRS seizes the audiologist’s records.

4. Do not expect the accountant to lie for the audiologist. He/she will not back the audiologist up if the owner takes money out of the company, cooks the books or plays illegal tax avoidance schemes. The role of the accountant is to prepare information given to him/her. The accountant will help the audiologist set up the financial books and, depending upon the level of service, may act as bookkeeper for an additional fee. In the beginning, the owner should take on as much of the record keeping as possible to save some money and to get a better handle on the practice.

5. The practice owner may want the accountant to do the personal taxes as well. If the practice owner is a sole proprietor or an “S” corporation, the funds will flow in and out of the personal taxes.

6. Do not ask the accountant to manage the owner's finances. He/she will help the audiologist keep things straight, but should not tell the owner where to invest or what to buy. If an accountant offers to handle the owner's financial investments, the audiologist might want to look elsewhere.

7. Will the accountant grow with the owner's practice?

8. Does the audiologist like the accountant and understand what he/she is talking about? Accountants, like audiologists have their own brand of “accountant speak”. Ask to have anything the audiologist doesn’t understand explained in lay terms. The owner should be comfortable with the accountant.

9. Are the fees within reason and what do they include? Generally, the fees are for tax preparation. If the audiologist wants P&L statements, audits or representation at investigations, there will be additional charges. Ask if the accountant will give a discount for preparing all of the owner’s business and personal taxes.

10. Ask for references or referrals. Accountants are bound by their code of ethics not to divulge information about one client to another. So if the audiologist has a colleague who is a successful practitioner, ask who he/she uses. Successful people usually travel around with other successful people. If the practice owner has a mentor, he/she is usually glad to recommend someone.

11. Know what an accountant does before hiring one. Ask what financial record keeping systems he/she uses and what software the audiologist will need to purchase to keep the financial records.

Personal Experience

Early in my practice, the two accountants in the firm we retained offered to invest a small inheritance for me with the promise of a 20% return. So I gave them money for that purpose. Their scheme was to invest in builders who were putting up housing units. Based on a 30-day turnaround, the “loans” were paid at a rate of interest that was much higher than normal. When I realized what was happening, I immediately asked for my money back and went with another accountant who handled my books and not my money.

12. Does the accountant have sufficient staff? If the audiologist is interviewing an older accountant, does he/she have an associate to take over when he/she retires? Is the office staff helpful when the owner has a question? Just as
an audiologist does not have to answer questions about the size and type of hearing aid batteries when a patient calls, the accountant’s assistant may be the best person to speak to when the client has a question.

When to Retain an Attorney

Unless the owner has a large practice or a very complicated estate, the audiologist does not need to have an attorney on retainer. The audiologist will probably hire one on an hourly basis to review leases, contracts and other material.

Real Estate and Leases

As in the case of accountants, attorneys may specialize. If the client has a complicated lease agreement or is constructing a building, a lawyer who is well versed in real estate might be consulted. Real estate law rarely involves litigation and is usually confined to contracts, closings and appearances before planning and zoning boards. Bear in mind that professional practices must conform to the local land use laws. If the audiologist wants to start a home-based practice, he/she will need to find out if that is a conforming use. Since zoning laws vary from one jurisdiction to another, the audiologist needs to find out what the local zoning laws are.

The attorney should be aware of current land use laws and how they apply to the audiology practice. If the owner plans to renovate an existing building, a construction permit will be needed. In cases where the building has been constructed before 1965, it will not conform to the BOCA codes and the audiologist may have to put in ADA acceptable restriction-free lavatories, elevators and other expensive amenities for the public. The attorney should be able to walk the audiologist through this and represent the client at planning/zoning board meetings. It is wise to establish a set fee, rather than retain the attorney on an hourly basis since planning boards often take a long time to grant a variance.

Personal Experience

I was vice chair of my local planning board for several years. The most frustrating part of going into practice is the permitting process. An audiologist may need electrical, plumbing and construction permits to renovate an office. An architectural rendering may be needed if there is a façade change. Signage is a particularly testy issue with planning boards and the audiologist may not be able to place a bright neon sign saying “MID ATLANTIC HEARING CENTER—DR. GRANVILLE BRADY”. In general, the owner should plan about 3-6 months in advance depending on what renovations need to be made. Just because the audiologist buys a building or a piece of land is no guarantee that the land use laws will permit the use for an audiology practice.

Likewise, an attorney should review the audiologist’s lease. In places that are a buyer’s market and there is a glut of commercial real estate, the practice owner can often negotiate terms regarding length of lease and what renovations the landlord will make to the lease holding. In a seller’s market, where professional office space is tight, leases are pretty much boilerplate and the audiologist’s attorney may not have much leeway.

Most of audiology practices occupy rent low-end space of 1000 square feet or less. The leases should be pretty much standard. Ask the landlord for time for attorney review before signing it.

Employment & Consultant Agreements

If the audiologist is going to work in a physician’s office, a written agreement between the physician and the audiologist should be subject to attorney review. Be careful of restrictive covenants that may block the audiologist from practicing in a certain geographic area if the relationship with the physician sours out. Restrictive covenants are hard to enforce if they are too restrictive, and the attorney should be consulted before executing the agreement.

Personal Observation

A physician colleague (ENT) was in practice with another ENT. He decided to leave the practice and set up shop, but the owner of the practice had a restrictive covenant that prevented the doctor from opening a practice within a 7-mile radius. Since the restriction was not unreasonable and did not prevent the doctor from pursuing his livelihood, the court upheld it.

As the audiologist expands the practice, additional staff may be required. A letter of agreement, detailing how much the new employee will be paid and the basis for compensation (bonus based on sales) along with other considerations such as payment for attaining the Au.D., benefits, etc. should be subject to attorney review. However, don’t promise an employee that he/she will have a job as long as the audiologist is there. Employees are “at will” employees who may be terminated at the discretion of the employer unless they are subject to tenure laws e.g., school based audiologist.

Most state labor laws require the employer to offer the same benefits equally to any and all qualified employees, subject to some restrictions. This includes any health or pension benefits that are enjoyed by the owner must be extended to employees.
For example, the employer can impose a reasonable vesting period before the employee is granted benefits but the owner-employer cannot deny access to them. Some practitioners prefer to hire part timers because they are not usually covered the same way as full time employees. An employee may waive the benefits and elect to receive compensation instead.

**Document & Contract Review**

Since the audiologist may be required by law to have written agreements with patients for hearing aids and services and, of course, HIPAA, the owner should retain an attorney to review all of the pertinent documents. This includes contracts with HMO plans and public sector agencies as well.

**Defense & Litigation**

If the practitioner is summoned to appear before the state licensing board, he/she will need to be represented by legal counsel. Everyone reading this article is a highly competent audiologist who would never knowingly break the law. However, it is possible that someone will file a complaint that cannot be resolved administratively. In that case, the audiologist may be asked to appear before the licensing board. In New Jersey, the appearance is voluntary, but if the audiologist does not appear, this is considered grounds for suspension of the license. Appearance before the licensing board is considered a quasi-judicial hearing but licensees are not allowed discovery because the board has filed no complaint. The appearance is for investigational purposes only and no complaint may be filed if the licensee is exonerated. In short, the licensee is being asked to cooperate in an investigation of the audiologist’s practices related to a specific charge but does not have the protection of certain constitutional rights. Most states operate this way. Even though the audiologist is not required to be represented by an attorney, it is advisable to bring one into the hearing.

**Personal Experience**

I was president of the NJ Hearing Aid Dispensers Examining Committee for 10 years. We rarely brought someone in for a hearing since most complaints were handled administratively and most of them resulted in no action taken against the dispenser. Prior to scheduling an appearance, a licensee was informed that this was a hearing and that charges may or may not be filed as a result. I always asked the licensee if he/she had an attorney. In cases where the charge was serious, I recommended that licensee retain legal counsel even if it meant postponing the hearing. I did this for two reasons: (1) to protect the licensee from unwittingly divulging information that may be self-incriminating and (2) I always preferred working with the attorney because the issues were not taken personally and we were able to resolve the matter without confrontation and emotional outbursts.

Malpractice is another area that most of us do not think will happen. Although buying malpractice insurance is beyond the scope of this article, the audiologist need to be protected against a lawsuit. The audiologist’s insurance carrier will retain legal counsel; however the audiologist will need to cooperate and supply the attorney with a list of expert witnesses who can testify on his/her behalf.

**Incorporation**

Finally, the audiologist will need an attorney to help set up the practice. If the audiologist incorporates, the attorney will set the corporation up with the appropriate books, permits and licenses. It is important that the audiologist encourage the attorney and accountant to work together. In my experience, both play a vital role and the audiologist, as the newly minted private practitioner; heed the advice and counsel of both the lawyer and accountant.

**Selecting a Banker**

The new owner will need to set up a bank account for checking and savings and as a depository for credit card transactions. There are two types of banks generally. Savings banks work with personal accounts, make small loans, administer checking accounts and provide for personal real estate mortgages. Savings banks are usually limited in the number of branches and types of services offered.

Commercial banks are set up to handle business transactions. They administer small business loans (SBA), handle business checking accounts, lend money to small and large companies and administer credit card transactions, for which they charge a fee. In general, commercial banks charge for every service rendered except for large depositors who can negotiate better terms for checking and credit card fees. It is best to shop around for the best deal when looking for the credit card discounts. Some banks will charge up to 5% of the amount charged while other banks give a better discount. In general, VISA and Master Card are the two best charges to accept. American Express is more expensive.

**Insurance Brokers**

The audiologist must have insurance. There are two types. One is for the audiologist’s business—called a BOP (business owner’s policy) that has liability protection in case someone falls in the audiologist’s office. The audiologist might look at
adding business interruption insurance in the event there is a fire, flood or other catastrophe. Be sure to have the policy reflect the replacement costs of equipment if it is stolen or damaged since new equipment can be much more costly to replace than the original item. If the audiologist owns the building and property, do not over insure the value of the land since land is rarely destroyed in a fire. The building, however, needs to be insured for the replacement costs in case it must be rebuilt after a fire. In a partnership practice, “key man” insurance will provide the survivor with money in case one of the principals dies or becomes incapacitated. If disability insurance is purchased, be sure that it specifies that the disabled person cannot work as an audiologist.

Most small agents do not handle malpractice insurance. The audiologist will need to contact a professional association for information. Since the insurance and HMO’s will not offer a contract unless the audiologist has malpractice coverage, this is a priority. The limits of liability should be set at least at $1 million per occurrence and $3 million aggregate. The experience rating for audiologists is still very good and the premiums are reasonable. However, if the audiologist plans to fit deep canal devices provide VNG and Electrocochleography or any other service that is invasive; the premiums may be higher than normal.

**Actuarial Services & Pension Planners**

Some pension plans, such as defined benefits require the audiologist to retain an actuary to set up the plan, which is administered by a brokerage firm. The defined benefits plans are complicated and have generally been replaced by the SEP retirement plans. Both are acceptable for deferring compensation until retirement.

I have attempted to outline some of the areas that the practice owner will need to consider when going into business. As the owner of a practice, the audiologist has a team of experts available to help manage the organization and avoid problems before they arise. A good practitioner has good consultants on the team. The consultants the audiologist retains should know each other and have free access to discuss ways to help maintain and grow the practice. Treat the audiology practice the way we treat the child with auditory processing problems: the best way to handle them is with a team approach.

**When it’s Time to Say Goodbye**

There may be a time when the practice owner decides to replace the consultant. There could be several reasons for firing an accountant or attorney. Among the reasons are: malfeasance, poor workmanship or escalating fees that seem unreasonable. In the last case, when the fees escalate, it might be a good idea to discuss the matter before looking for another consultant. We are all aware that costs rise but in a slow economy, raising rates may be a sign that the consultant does not value your business any longer. Most state laws prohibit abandonment, but if the owner’s account is too small or if the owner demands unreasonable time or services, the consultant might find that it is better to increase the fees or let the account go.

Before firing any consultant, it is wise to locate another one who will fit the practice's needs at a reasonable rate. Once the owner has agreed to hire a new accountant or lawyer, a letter to the previous one asking that all records be turned over is sufficient. Or the owner might ask the new consultant to reach out and obtain the records. One caution however: it might not be wise to change horses in midstream. If the lawyer or accountant is involved in an audit, lawsuit or other serious matter, letting him or her go could be devastating. Unless an issue has become too contentious to resolve equitably, it is better to wait until the matter is settled to replace a consultant. In all cases, be sure to obtain the records to turn over to the new consultant.

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Granville Brady received his Au.D. from Arizona School of Health Sciences. He is a licensed Audiologist in NJ and holds CCC-SLP/A. Since 1984, Dr. Brady has owned and operated a private practice with offices in Clifton & East Brunswick, NJ. He has been active in government as Finance Chairman for the Borough of Somerville, NJ where he was responsible for the development and implementation of a $12 million municipal budget. Dr. Brady was treasurer of the Audiology Foundation of America (AFA). He currently serves on the board of directors of KMM, a transportation management agency in Middlesex County, New Jersey.
Since 2008, Juliette Sterkens, Au.D., has facilitated the placement of hearing loops in more than 100 venues in Wisconsin and I have facilitated around 50 in Illinois. You may be asking yourself, “Why would these two doctors of Audiology, both owners of successful private practices (with the daunting pre-requisite of being chronically over-extended), be willing to take the time to do this?”

From my perspective, hearing loops are the only thing I have ever done where patients come in without an appointment on a Monday morning just to thank me for being able to hear for the first time at their place of worship once the loop is installed.

Hearing loops are the only thing I have ever demonstrated where patients display a look of astonishment, and then a wide grin when they switch to their hearing aids’ telecoil and can hear every word of the dialogue on the waiting room television despite the fact that it’s inaudible to everyone else.

Hearing loops are the only thing I have ever provided that allow my patients to hear better than those with normal hearing, who are present with them in the same venue. What a juxtaposition that is! When I was recently using a telecoil at a newly installed Roman Catholic Church, I could hear the priest break the host, whisper a “thank you” to the altar boys, and quietly request that a mother reposition her baby closer to the baptismal font.

I am distressed over the fact that telecoils, which interface with hearing loops, haven’t been promoted by hearing aid manufacturers. I suspect that hearing aid manufacturer’s advertising misleads the public into thinking that hearing aids are the end-all solution to every hearing concern. I am also certain that hearing loops compete with manufacturer’s proprietary television solutions. Finally, I am confident manufacturers believe the consumer wants cosmetics—small, small, small—over every other feature.
I think they’re wrong. What consumers want is to hear, hear, hear in every environment. But you know, and I know, that while it is the hearing aids manufacturers responsibility to sell hearing aids, it is the audiologist’s responsibility to manage hearing loss. Ultimately, dispensing audiologists are the ones that are culpable.

**Marketing of Hearing Loops**

As members of the joint HLAA/AAA *Get in the Hearing Loop* Task Force, Juliette and I have compiled a comprehensive marketing plan that will allow you to begin looping your own community. Some of the information that may be of interest to you includes:

- A copy of the initial consumer seminar hearing loop mailing I sent to my database (that garnered 50 attendees—some of them my patients’ pastors). The seminar room was looped and patients were encouraged to have their telecoils enabled via a no charge office visit prior to attending the presentation
- Printed brochures and/or handouts to interested parties when loop information is requested
- The announcement about the loop and explanation of how it functions for the church bulletin and/or newsletter
- Statements to incorporate when standing at the pulpit during the loop dedication
- Editorials to be placed in the local newspapers regarding the access that hearing loops provide for those members with hearing loss

A hearing loop PowerPoint presentation is available to AAA members on the Academy’s website, as is information about telecoils and hearing loops for consumers.

**The Difference Between FM Infrared Listening Systems, Bluetooth Transmission, and Hearing Loops**

David Myers, Ph.D. has provided reams of information about hearing loops on his website (www.hearingloop.org). At this website, you can also review notes I compiled regarding the performance of hearing with wireless Bluetooth streaming compared to induction loops. Dr. Myers’ comparison of FM and infrared listening systems with hearing loops can be viewed in Table 1. The bottom line is that hearing loops are inexpensive, hygienic, operate on a universal frequency, don’t use any battery drain, are not manufacturer-dependent, and most important to audiologists, they deliver customized sound to most efficiently mirror the individual hearing loss. The biggest advantage, though, is that hearing loops, being directly hearing aid compatible, are much more likely to get used than any system that requires people to take the initiative to obtain and wear special, often conspicuous, equipment.

**Information about Television Loops**

Fellow ADA member, Bill Diles, Au.D., has now looped over 1800 homes and continues to do so at a rate of 10/month. His “How To” article can teach you how to install a room loop yourself (Diles, 2006). Our practice has hired a journeyman carpenter who wears hearing aids with telecoils to install hearing loops for our patients. He travels with a demonstration loop in his van, lays it out as a sample, checks the reception and interference personally, and charges the patients directly for the pre-agreed upon onsite visit. If the patient agrees to proceed, he then charges an additional fee for installation and immediately installs a room loop from his van inventory. Our practice then forwards an invoice to the patient for the actual loop (some of our patients have up to three television loops installed).

**The Link between Hearing Loss and Dementia—Why It’s Pertinent to the Hearing Loop Cause**

Remensnyder, 2011 includes relevant information to possibly limit the risk of dementia in the patients we serve. New research from Johns Hopkins and the National Institute on Aging has documented that seniors’ risk of dementia is two-fold for those with mild hearing loss, three-fold for
those with moderate hearing loss, and five-fold for those with severe hearing loss. Lin, et al, (2011a & 2011b) attribute the increased risk to the probable etiology of the strain of decoding that robs the brain of cognitive processes such as working memory in combination with the well recognized social isolation secondary to hearing loss. Since it is our responsibility, as audiologists, to provide our patients audibility everywhere, hearing loops are an integral part of the solution to overcome the effects of hearing loss and dementia.

Prevalence of Hearing Loops

The task force has estimated that there are more than 1000 looped places of worship nationwide. The Michigan State Sports Arena is looped. Some tour buses are looped. The NYC subway system is looped. A senior high rise in Arizona has looped all the living rooms and master bedrooms prior to occupancy. Theatres, opera centers, and performance venues are getting looped. And even a Whole Foods check-out lane and some restaurant tables in Sarasota, FL are looped. So far, three airports are looped as well. Audiologists must continue to advocate for more buildings and rooms to be looped.

Patient Hearing Loop Satisfaction Surveys

Hearing Loop satisfaction surveys have revealed incredible consumer satisfaction levels as noted in Figure 1. In an era of evidence based practice, this data suggests that audiologists would be wise to routinely recommend telecoil use along with induction loop systems.

Table 1. The advantages of loop systems relative to FM and Infrared systems

<table>
<thead>
<tr>
<th>Advantage</th>
<th>Loop Systems</th>
<th>FM Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Require no pick up/return of portable receiving units and headsets</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Require fewer portable receiving units (and batteries)</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Operate on a universal frequency (FM systems operate on differing frequencies, requiring receivers for each venue)</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Are inconspicuous: No need to visibly announce “I am HOH!”—an invisible solution to an invisible problem</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Work in transient situations (can serve the HOH at ticket counters, teller windows, drive-through stations, airports, etc.)</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Entail no hygienic concerns regarding ear buds</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Are hearing aid compatible: Do not require putting ALD on/off (e.g., church sermon/singing)</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Provide flexible use: Can allow either direct listening (M=mic) or loop broadcast (T=telecoil) modes, or both</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Deliver personalized in-the-ear sound . . . customized by one’s own hearing aids to address one’s own hearing loss</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Are, therefore, much more likely to be used . . . and to be increasingly used, once installed.</td>
<td>✓</td>
<td>✗</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HLAA/AAA SURVEY</th>
</tr>
</thead>
<tbody>
<tr>
<td>556 People Answering Question</td>
</tr>
<tr>
<td>&quot;Are you more satisfied with your hearing aid(s) and/or CI(s) after using them with a hearing loop?&quot;</td>
</tr>
</tbody>
</table>

Figure 1. Results of one unpublished survey of hearing loop satisfaction reported by end users.

How Patients Become Loop Advocates

Approximately 85% of my patients, who are vacillating between purchasing a hearing aid with, or without, a telecoil, purchase the latter after listening to my office waiting room’s looped television. Remaining stalwarts are encouraged to take demos with telecoils to a local looped venue. And, of course, those statistics just reflect patients who are on the fence. The vast majority of new patients who have seen me at the pulpit or have spoken to someone who wears telecoil-enabled hearing aids at a looped venue arrive with a telecoil mandate prior to requesting any other hearing aid feature.

Keep in mind that currently three states, New York, Florida and Arizona, mandate that hearing health care professionals discuss the dual functionality of the hearing aid’s telecoil with the consumer.

Current and new patients may be offered a one page “How to get more from your hearing aids in a hearing loop” handout with a list of all local hearing loop installations on the back page. This encourages patients to not only try out hearing loops, but also it serves to inform local ministers and venue operators that hearing loops can now be found in many places. This encourages adoption of the technology and sometimes inspires competition.

Patients are also routinely offered a reprint from the “Let’s Loop America’s Worship Centers” article that appeared in Technology For Worship Magazine by David Myers, PhD.
reprint can then be shared with church council members, family members and friends or mailed to family out of town.

Loop just one venue and loops will beget loops. The July 2, 2010 Chicago Tribune’s front page coverage of the hearing loop that is present at my personal place of worship lead to installations all over the country.

Hearing Loop Advocacy Cards

Dr. Sterkens has put together a loop advocacy card that patients can drop one off at venues at which they have experienced poor audibility. The card explains how hearing loops work, documents that the listener was unable to hear in the venue, and provides a contact number. Figure 2 shows an example of the front and back side of a “loop advocacy” card.

Leaving a Legacy

The facilitation of hearing loops leaves a legacy to your patients that outlasts your practice ownership.

Our practice provides a certain number of loop drivers to our patients’ places of worship and/or senior citizen gathering rooms on an annual basis. It is called “targeted philanthropy.” We donate both the hearing loop and the loop driver/s but make it clear that installation is the responsibility of the venue.

Venues are selected based upon the lack of audibility secondary to poor acoustics specific to the venue as well as the number of the patients in our practice who use the facility. We track the information when patients come into the office for routine hearing aid checks and when we take a new patient case history.

The following criteria must be met in order for us to reimburse the facility for the hearing loop and driver/s:

- The hearing loop sign must be displayed in all facility advertising
- The hearing loop sign must be displayed on the facility’s website
- An audiologist must be present (preferably at the pulpit if it is place of worship) at the Loop Dedication to answer questions and explain the technology to those assembled (I have been known to be present at 5 Masses on a Sunday morning)
- The loop sign must be present at all services including weddings and memorials

Summary

Hearing loops have provided me a sense of purpose and a sense of satisfaction and have not just invigorated my practice, but have invigorated my life.

Mark Ross’ mandate that “When it comes to hearing better, passivity is not an option” should be the audiologists’ mantra. 

Continued on page 61
Close to ten years ago, David Myers, Ph.D., a social psychologist from Hope College and a hearing aid user, experienced a hearing loop while attending a service at Iona Abbey in Scotland. This experience was so transforming, that upon returning to the U.S. he launched, with community support, an initiative to introduce hearing loops to Holland, MI. Now, almost a decade later, hundreds of hearing loops can be found in places of worship, senior centers, meeting rooms and conference centers in western Michigan.
It was late 2008 when I heard Dr. Myers speak at a Wisconsin HLAA meeting. This lecture proved career transforming to me. As an audiologist in private practice for nearly 3 decades, I have worked to give my clients the best hearing possible, though understanding in reverberant and large meeting places continued to be an elusive goal. Suggestions that my patients use FM or infra-red assistive devices were rarely acted on.

Listening that fateful day to Dr. Myers’ story, I realized why most hearing aid users are so reluctant to seek help and that I could perhaps bring hearing loops to my community with the help of my retired engineer husband.

My initial local hearing loop promotion has now evolved into state and nationwide loop advocacy work and a desire to educate audiologists about the benefits of hearing loops to our patients as well as our audiology practices. The purpose of this article is to give the busy practitioner an overview of hearing loops, telecoil variables, and how a mutually beneficial relationship with an audio professional/hearing loop installer might be established.

The IEC Hearing Loop Standard 60118-4

Induction loop systems used in Europe and many other countries are required to meet the established international standard IEC 60118-4 as developed under the auspices of the IEC (International Electrotechnical Commission). This IEC standard defines the strength of the magnetic field, frequency response, and methods of measuring these requirements. It also specifies the maximum levels for electromagnetic background noise. For more information on this standard see www.efhoh.org/documents_presentations/.

Currently there is no regulatory organization in the U.S. that has set a hearing loop standard. Therefore it made sense for U.S. hearing loop manufacturers and hearing loop vendors of European equipment to adopt the European IEC standard for hearing loops. Compliance with this standard allows the same hearing aid user to worship at Ione Abbey in Scotland, attend a basketball game at the Michigan State University Breslin Center, enjoy a performance at the Opera House in Sydney, Australia, or hear their granddaughter perform in a play at Alberta Kimball auditorium in Oshkosh, Wisconsin --all by merely switching their hearing aids to the telecoils **without ever having to make a volume adjustment**!

Thus, potential audio-video (AV) installers of hearing loops should be asked whether they have been trained in IEC standard hearing loop engineering and installation and whether they own the necessary equipment to verify that the loop meets this standard. Proper hearing loop installations will prevent dissatisfaction with uneven, poor quality installations and will delight users with clear, strong input wherever they choose to sit.

Following each and every hearing loop installation in my community we attend the worship services, lectures or performances with a T-coil equipped hearing aid and field strength measuring equipment to verify that the hearing loop sounds clear and is set loud enough. If needed, we also offer to the venues tips on hearing loop signage and accessibility to the loop system.

**How does the IEC hearing loop standard relate to the telecoils in hearing aids?**

In the most basic form, a hearing loop system consists of a loop of wire placed around the perimeter of an area and connected to an amplifier. An input signal is provided to the loop amplifier which drives an audio current through the loop in the form of a strong alternating current. As the alternating current from the amplifier flows through the loop it creates a magnetic field within the looped area and “induces” in the telecoil exactly the same signal that was picked up by the microphone feeding the amplifier. This magnetic field is a vertical magnetic field and, as such, requires that the telecoil be positioned mostly vertically in the hearing instrument for maximum induction. The strength of this magnetic field is measured in mA/m.

The IEC standard requires that the loop be capable of transmitting:

- A 100-5000Hz frequency response to a pink noise test signal
- A 1000Hz test tone does not vary more than +/-3dB in field signal strength in all of the seated area
- The average signal strength is 100mA/m with headroom for signals up to 400mA/m. Note that the 100mA/m signal corresponds to a 70dB SPL acoustic sound input and 400mA/m to 82dB SPL acoustic input

The average magnetic hearing loop signal of 100mA/m should therefore elicit an acoustic signal in the ear of the listener that corresponds to 70dB SPL input.
ANSI Standards and Telecoils

The ANSI spec sheets for the hearing aids should help the audiologist choose the best telecoils for use in a hearing loop. Fortunately many manufacturers position the telecoils vertically, which is the optimal telecoil position for hearing loop use. Another important hearing loop consideration is ensuring there is an equalized microphone and telecoil response. This means that the telecoil gain and frequency response matches the gain and frequency response characteristics of the microphone. Both conditions: a vertical telecoil orientation within the hearing aid and a matched microphone and telecoil response will ensure that the end user will hear well in an IEC adjusted hearing loop. Putterman (2010) confirmed that switching from a 70dB acoustic input to a 100mA/m magnetic input (the average magnetic signal strength in the hearing loop), results in similar SPL levels in the user’s ear.

Telecoil performance can at times be unclear to audiologists since critical information is often lacking on the hearing aid specification sheets. For example, not all hearing aid manufacturers offer information about the positioning of the telecoil in instruments and some spec sheets only offer a telecoil strength value and lack a complete frequency response curve.

The ANSI SPLITS (Sound Pressure Level for an Inductive Telephone Simulator in ANSI 3.22-2009) test can be used to measure the strength of the telecoil. It’s important to note, however, that a horizontally located telecoil in the hearing aid often provides a much stronger response in the test box than what is obtained in an induction loop system. This mismatch between telecoil response in the test box and telecoil performance in the hearing loop is because the ANSI SPLITS test measures the telecoil response at the so-called “sweet spot” setting. This may mean that the instrument is positioned horizontally or at an angle to ensure the most magnetic field pick up – and therefore not the way it is worn on the ear.

Hearing loop advocates recommend that each telecoil be tested with the SPLITS and the SPLIV test (one that measures the telecoil in a vertical/as is worn on the ear position and found in the ANSI 3.22 Annex C-11). Hearing aid manufacturers would be wise to include the curves for the typical acoustic (60 or 70dB SPL) and magnetic signal inputs (31.6 or 100mA/m) specified in the IEC hearing loop standard with the instrument in a vertical position in one graph. The ANSI standards committee was petitioned to make this change in the ANSI hearing aid tests, however, such a change can require years to take effect, yet it is critical information for audiologists who need to choose effective telecoils for use in hearing loops.

Finding Hearing Loop Installers in your Area

What if there is no local audio company in your community trained in hearing loop installation? You may be able to obtain installation services from one of the national companies that install hearing loops over the country, but developing local expertise will ensure that hearing loops will be installed in many of your local venues.

When I started my hearing loop advocacy in my area, I formed a loop installation company with my husband, a retired engineer. Initially, I planned to bring the technology to my local community for the benefit of my patients and practice. It soon became clear that the AV professionals would be the key to furthering hearing loop installations in Wisconsin. A few phone calls to audio engineers quickly convinced them of the benefits to our clients, and they often agreed that the FM assistive listening technology, although well intentioned, usually ends up sitting in the back of sanctuaries, unused, with dead batteries, malfunctioning and/or unhygienic looking earphones.

Once the word got out, a growing number of audio and video firms quickly recognized that adding hearing loop installation services made good business sense in Wisconsin. In the past 2 years over a dozen audio engineers have been trained.
by hearing loop manufacturers in proper IEC standard hearing loop installation techniques.

AV specialists benefit from working with local audiologists since we often are familiar with the venues and places of worship that could benefit from a hearing loop. We keep a log book in my office of the different places of worship and meeting venues and list the clients who frequent the locations. This allows us – with their permission – to bring members of the same church in contact with each other, which improves their loop lobbying ability. Audiologists are also the professional of choice to introduce hearing loops during a service or by giving community speeches on the new hearing loops once installed. Few AV professionals know much about hearing aids and telecoils and would much rather leave the introductions up to audiologists. See Sterkens, 2011 for more information.

Guidelines about Programming and Configuring the Hearing Aid Telecoils Taking into Account Social, Environmental, and Hearing Concerns

It is important to familiarize yourself with the telecoils in the instruments you handle and understand how the microphone and telecoil sensitivity can be modified in the hearing instrument fitting software.

Depending on the degree of loss and the hearing loop application a telecoil-only program is suggested for clients who use open-canal (RIC) instruments. If used in situations where listening to one primary speaker is all that is required (which is usually the case in a lecture hall or place of worship) the telecoil-only setting is usually sufficient. A combination microphone-telecoil (MT) setting is recommended for watching TV in a home loop where some conversation needs to be possible with a spouse or other person while watching TV, thus, the hearing aid user can participate in conversation while listening to TV. For those hearing aid users with greater than moderate to severe hearing losses, those who typically utilize a closed ear mold, two hearing loop programs are usually offered: one that includes a blended MT program and one for telecoil only. If the listening situation has their frequent companion sitting on one side or another (e.g., at a movie theater, church, bingo, etc.) an “MT” program on the “direct speech listening” side, and T-only on the opposite ear is recommended. This latter setting reduces background noise pick up in the loop listening situation.

What patients are saying about hearing loops

One client, a retired attorney wrote:

“Loop technology has dramatically improved my hearing. I cannot say enough good about it. The elimination of background noise means that I don’t have to sit in the front row all the time. I can actually watch the power point screen instead of staring at the speaker’s face for lip reading cues. My husband and I can watch television together again because we have our own separate sound systems...I heard of this technology from a friend - not my audiologist. Since my first ‘AHA Moment’ of listening to the clear amplified sound provided by the T-coil, I have been trying to spread the word about this remarkable technology...Hearing impaired people deserve to know about this technology and have more venues looped. It will enhance their quality of life - just as it has for me.”

Improving patient communication in challenging listening situations (such as churches and auditoriums) begins with the audiologist’s ability to become an advocate for the installation of loop systems. Beyond simply installing induction loop systems and selecting hearing aids with telecoils, it is critical that telecoils have the property orientation within the hearing aid and are programmed properly in order to optimize their performance with hearing loops. In addition, audiologists must work with AV engineers to ensure hearing loops are installed properly and, once the loop is installed, work with the facility to raise awareness about the importance of hearing loops for their hearing impaired clients.

References


Dr. Juliëtte Sterkens, an audiologist in private practice since the 1980’s has received the Wisconsin Audiologist of the Year, The American Academy of Audiology Presidential Award, and the hearing industry Larry Mauldin award for her hearing loop advocacy on a local, state and national level. She is reaching out to audiologists, hearing aid users, parents of children who use amplification and/or cochlear implants, A/V professionals, designers and architects, clergy and other public venues. She serves on the HLAA/AAA Hearing Loop Task Force. Her work has led to over 120+ hearing loops in her community and other areas of Wisconsin, a number she expects to double by 2012. She can reached via jsterkens@new.rr.com.
Application of
The University of Western Ontario Pediatric Audiological Monitoring Protocol
(UWO PedAMP)

By Marlene P. Bagatto, Au.D.

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Background

The primary goal of Early Hearing Detection and Intervention (EHDI) programs is to provide effective intervention by six months of age to maximize the infant's natural potential to develop language and literacy skills (Joint Committee on Infant Hearing [JCIH], 2007). Intervention with hearing aids is a common choice among families and pediatric audiologists have access to scientifically-based strategies and clinical tools to ensure the hearing aids are fitted appropriately to the infant (e.g., Bagatto, Scollie, Hyde & Seewald, 2010). Outcome evaluation is a key component of the pediatric hearing aid fitting process, however, there is little research related to what a typical outcome might be for an infant who wears hearing aids and how to systematically track the child's auditory development and performance over time. This is in part due to the lack of well-normed and validated outcome measures available for use with infants and children who wear hearing aids. Supporting outcome evaluation for pediatric patients who wear hearing aids could be addressed by a well-validated, clinically feasible monitoring protocol to track auditory development and performance. Known clinical tools with good normative properties, validity, feasibility, and utility would support the development of an evidence-based outcome evaluation guideline for pediatric audiology programs. Additionally, indicators to track clinical process outcomes, such as the appropriateness of the hearing aid fitting, are needed so that the functional outcomes can be appropriately interpreted.

Recently, the University of Western Ontario Pediatric Audiological Monitoring Protocol (UWO PedAMP) was developed (Bagatto, Moodie & Scollie, 2010; Bagatto, Moodie, Malandrino, Richert, Clench & Scollie, In press-a). This outcome evaluation guideline consists of several tools that aim to measure auditory-related outcomes in infants and children who have permanent hearing loss and may or may not wear hearing aids.
The guideline includes tools that assess the following dimensions: 1) subjective assessment of early auditory development; 2) subjective ratings of auditory performance in daily life; 3) acceptance and use of hearing aids; and 4) effectiveness of service delivery. The caregiver-report functional outcomes are supported by each child’s hearing aid fitting information (i.e., real-ear-to-coupler difference (RECD), Speech Intelligibility Index (SII)). Caregiver-report functional outcome tools were targeted in the first version of the UWO PedAMP because objective measures of speech detection and recognition may be difficult to obtain in cases of children with complex factors (e.g., difficult to test due to developmental level). Coincidentally, it is these same children who may also present assessment and/or management difficulties more generally. Focusing on objective strategies as the primary strategy for outcome evaluation, therefore, is not likely to be successful on those very cases in which outcome measures are needed the most. Caregiver reports (i.e., subjective outcome measures) can be completed by the parent regardless of the child’s developmental level and provide rich and important real-life information that can support the more objective tests that clinicians may perform as well as being more applicable to children with complex needs. Therefore, this initial work focused on the evaluation of subjective outcome evaluation tools that assess auditory-related behaviors in infants and children. This article will describe the outcome evaluation tools included in the UWO PedAMP Version 1.0. A description of how the guideline is administered as part of a complete pediatric hearing aid fitting protocol will be provided in the context of a case example. The UWO PedAMP has been implemented with children of varying ages, developmental abilities and degrees of hearing loss and the impact of these variables on outcome have been presented elsewhere (Bagatto et al, In Press-a).

**Development of the UWO PedAMP**

Using a knowledge-to-action (KTA) approach (Graham, Logan, Harrison, Strauss, Tetro, Caswell & Robinson, 2006) a critical review of available outcome evaluation tools for infants and children aged birth to six years within the category of caregiver-report questionnaires was conducted (Bagatto, Moodie, Seewald, Bartlett & Scollie, In Press-b). This allowed for an appraisal of the current tools to eliminate the need for developing new tools. Through the critical review process, there was an attempt to include tools with good statistical properties and available norms and avoid tools that were too lengthy or complicated in favor of those that had good clinical feasibility and utility (Andresen, 2000).

Following the critical review, the UWO PedAMP was developed and members of the Network of Pediatric Audiologists of Canada were invited to review the proposed outcome evaluation tools and provide objective and subjective feedback regarding the components of the guideline (Moodie, Bagatto, Seewald, Kothari, Miller & Scollie, In Press). Their feedback was also requested regarding barriers and facilitators to implementing outcome evaluation tools within the contexts in which they worked. This provided an opportunity to use an engaged community of practice with a shared understanding of the knowledge and clinical needs. It also allowed the authors of the UWO PedAMP to strike a balance between creating an evidence-based guideline, which can be rigid and complex, with a more actionable, flexible guideline through the development of clear and specific tools (Bhattacharyya, Reeves & Zwarenstein 2009).

**Content and Clinical Application of the UWO PedAMP**

The UWO PedAMP consists of the:

- Hearing Aid Fitting Summary
- Aided Speech Intelligibility Index (SII) Normative Values
- LittleEARS’ Auditory Questionnaire (Tsiakpini, Weichbold, Keuhn-Inacker, Coninx, D’Haese & Almadin, 2004; Copyright MED-EL, 2004)
- Parents’ Evaluation of Aural/Oral Performance of Children (PEACH) Rating Scale (Ching & Hill 2005a; Copyright Australian Hearing, 2005)
- Ontario Infant Hearing Program (OIHP) Amplification Benefit Questionnaire

The UWO PedAMP is intended to be used with children with permanent childhood hearing impairment (PCHI) from birth to age six years who wear hearing aids. Monitoring children with PCHI who do not wear hearing aids is also considered an important use of the UWO PedAMP. The proposed use may change as the guideline evolves through systematic evaluation and clinical implementation. Information about where each tool can be located is found in Appendix A.

Clinical application of the UWO PedAMP will be explained in this document through the use of a case example: David was identified with a moderate rising to mild bilateral sensorineural hearing loss and fitted with binaural hearing aids when he was eleven months old. The reason for the delay in hearing aid fitting was due to parental indecision in the early stages. David was born full term and does not have any other medical issues besides hearing loss. The following sections...
describe each outcome evaluation tool in the UWO PedAMP and provide results for the case example.

**Hearing Aid Fitting Details**

Evidence-based pediatric hearing aid fitting protocols were followed in order to ensure that David’s hearing aids will positively impact his ability to develop auditory skills in daily life (e.g., American Academy of Audiology [AAA], 2003; Bagatto, Scollie et al, 2010). Outcome evaluation is designed to be completed following the hearing aid verification stage of the fitting process as it allows one to measure the impact of the fitting. Since positive outcomes infer good hearing aid fittings, it is important to monitor factors associated with 'typical' hearing aid fittings as part of the UWO PedAMP. Monitoring hearing aid fitting details allows the clinician to determine whether an *individual child’s fitting* is providing a typical degree of audibility. In addition, this information provides monitoring *at the level of the program* as a whole. The brief fitting details gathered in this protocol will help to determine, for example, the typical rate at which RECD measures are made, or the typical amount of audibility provided by hearing aids. Health care programs that receive government funding are increasingly being pressured to document that the services are of high quality. As part of the UWO PedAMP, two tools have been provided to monitor hearing aid fitting details and include: 1) the Hearing Aid Fitting Summary; and 2) Aided SII Normative Values. Used together, they provide helpful information for the audiologist, caregivers, and health policy-makers about the hearing aid fitting as part of this outcome evaluation guideline.

Simulated (or predicted) real-ear measurements of hearing aid performance are the preferred method of verification for infants and young children and are recommended by several pediatric hearing aid fitting protocols (e.g., AAA 2003; Bagatto, Scollie et al, 2010). The real-ear performance of the hearing aid is predicted from coupler measures of speech inputs using the infant’s RECD (Seewald, Moodie, Sinclair & Scollie, 1999). The hearing aid’s maximum power output (MPO) is verified using narrowband stimuli. Functional outcome evaluation of the hearing aid fitting will be measured through the use of questionnaires within the UWO PedAMP. In this guideline, the aim is to minimize the time needed to capture the hearing aid fitting details. For this reason, the exact fit-to-targets at each frequency and test level are not documented. Instead, the fit-to-targets are assessed by the clinician and the overall amount of audibility provided for low and moderate level speech (via the Speech Intelligibility Index [SII]) and whether or not key protocol elements were monitored. A complete Hearing Aid Fitting Summary includes details about the RECD (Measured, Predicted, Used other ear values, Previously measured) and the MPO as well as SII values for soft and average speech inputs (zero to 100).

The SII is a value representing the proportion of speech that is heard by the listener through the hearing aids (American National Standards Institute [ANSI] S.3.5 1997). It is an acoustic measure, not a behavioral prediction. This means that the SII represents the audibility of speech, and is not a prediction of speech recognition scores. The SII provides a value that clinicians, caregivers, and teachers can use to conceptualize the proportion of speech that is available to the child. SII values are provided from hearing aid verification systems (e.g., Audioscan Verifit®, Interacoustics Affinity®) for various speech inputs. If a clinician has performed multi-level speech-based real-ear verification of the young child’s hearing aids, the associated SII values for these measurements would also be provided.

Recently, normative data relating the specific SII values for acceptable hearing aid fittings became available (Moodie 2009, 2010). These were derived from pediatric fit-to-target data from 161 ears. From these data, the SII values were extracted to develop norms by pure-tone average (PTA) for use in the UWO PedAMP (see Appendix A). Tracking this
clinical process outcome is important for interpreting scores on the functional outcomes such as the LittLEARS and the PEACH. The hearing aid fitting details and SII values for David's hearing aid fitting are summarized in Figure 1. It can be noted that the RECD and MPO were measured and the SII values for an average speech input were 91% for the right ear and 90% for the left ear. This indicated typical audibility in both ears for David's degree of hearing loss (PTA Right = 33.8 dB HL, PTA Left = 36.7 dB HL). SII values for a soft speech input also indicated typical audibility in both ears.

**The LittLEARS Auditory Questionnaire**

The purpose of the LittLEARS Auditory Questionnaire is to assess the auditory behavior of infants with PCHI who wear hearing aids or cochlear implants (Tsaikpini et al, 2004; Coninx, Weichbold, Tsiakpini, et al, 2009). The 35 items in the LittLEARS questionnaire assess auditory development during the first two years of hearing in the real-world and tap into receptive and semantic auditory behavior as well as expressive-vocal behavior. The questions are listed in an age-dependent order and are in a yes/no format. The total of all ‘yes’ answers provide a score that can be compared to average and minimum age-dependent values. These values are provided in one-month age categories based on normative data (Coninx et al, 2009).

A longitudinal intervention study was conducted using the LittLEARS as part of the UWO PedAMP (Bagatto et al, In Press-a). Through this work, it was reported that caregivers and clinicians found it feasible to complete clinically (Moodie et al, In Press). In addition, the questionnaire has been shown to be sensitive to other medical issues besides hearing loss (Bagatto et al, In Press - a). The LittLEARS has been shown to be useful for monitoring the progression of auditory development in infants and young children who have normal hearing and aided PCHI. As part of version 1.0 of the UWO PedAMP, the LittLEARS can be used for children from birth to approximately 48 months of age, depending on their score on the tool. A close look at the items on the LittLEARS and the PEACH, which has items more appropriate for older children, indicate a stopping rule was needed to make the application of these tools feasible to utilize in a clinical population. Therefore, when a minimum score of 27 or better is achieved on the LittLEARS, the child’s performance is considered to be at a ceiling score. If ceiling is reached, the tool should no longer be administered. Instead, the clinician can begin to administer the Parent’s Evaluation of Aural/Oral Performance in Children (PEACH), either at that appointment or at the next follow-up visit. Children who are younger than 24 months of age and achieve the ceiling score on the LittLEARS may not yet be in the developmental range of the PEACH. The clinician may want to continue to administer the LittLEARS until the child is 24 months of age, or interpret low scores on the PEACH knowing the child may not yet be within the developmental range of the tool as supported by recent work (Bagatto et al, In Press – a).

At David's hearing aid fitting appointment, David's mother completed the LittLEARS Auditory Questionnaire to obtain a description of his auditory development without experience with hearing aids. The total ‘yes’ score of 14 was plotted to intersect at age eleven months and revealed that David was not meeting auditory development milestones for his age without hearing aids (Figure 2). After three months of hearing aid use (David was 14 months of age), the score on the LittLEARS was 20 indicating that he was meeting minimum auditory development milestones for his age when wearing the hearing aids. Another hearing aid review appointment

![Figure 2: LittLEARS score sheet for Case Example: David. The solid line indicates the minimum expected score, the small dashed line indicates the average expected score and the large dashed line indicates the maximum expected score from the German-derived norms. Circles represent the LittLEARS Score (y-axis) plotted by the child’s age in months (x-axis). The open circle is the unaided score and the filled circles represent scores in the aided condition. Scores in the non-shaded region indicate the child is meeting auditory development milestones for his age and scores in the shaded region indicate the child is not meeting auditory development milestones for his age. David was not meeting minimum auditory development milestones for his age prior to being fitted with amplification. While wear the hearing aids, David’s scores improved to where he was showing progress and meeting auditory development milestones for his age.](image-url)
revealed responses on the LittlEARS that totaled 30 at age 19 months. This score was plotted on the LittlEARS scoresheet (see Figure 2) and indicates that David was meeting auditory development milestones for his age after about 8 months of hearing aid use.

**Parent’s Evaluation of Aural/Oral Performance of Children (PEACH)**

The PEACH in its original diary form is conducted using a structured interview format and has questions that address quiet and noisy situations, as well as hearing device and telephone usage (Ching & Hill 2005b). The PEACH Diary requires caregivers to observe their child for at least one week and record their observations for the 13 scenarios over that time period. They are also asked to rate the frequency of each behavior and provide examples of when the child did or did not exhibit a particular response. After the observation period, the audiologist meets with the caregiver to address each item in a face-to-face interview. The interview is structured in order to solicit detailed information from the caregiver, rather than yes/no answers.

This observation and interview process required for the PEACH Diary was found to be heavy in administrative and respondent burden as reported in a research study (Golding, Pearce, Seymour, Cooper, Ching & Dillon, 2007) and through the Network of Pediatric Audiologists of Canada (Moodie et al, In Press). A Rating Scale version of the PEACH (Ching & Hill, 2005a) has been made available and includes most of the scenarios from the original PEACH Diary (Ching & Hill, 2005b). The PEACH Rating Scale appears to be more acceptable by clinicians and caregivers because the respondent and administrative burden have been reduced (Moodie et al, In Press). The PEACH Rating Scale has been selected for use in version 1.0 of the UWO PedAMP, with children who have attained ceiling performance (i.e., total score of 27 or greater) on the LittlEARS Auditory Questionnaire. The instructions ask caregivers to recall their child’s behavior in everyday life over the past week and rate their child’s hearing performance across a range of hearing and communication scenarios. The nature of the rating scale allows it to be answered by the caregiver during an appointment with guidance from the clinician. The overall score is summed, along with summed scores for the quiet and noise subscales. Each sum (overall, quiet, noise) is converted to a percentage. An accompanying score sheet was developed as part of the UWO PedAMP and provides assistance with interpretation of individual scores (see Appendix A and Figure 3).

The PEACH assesses functional auditory performance in quiet and noisy situations. Using the newly-developed score sheet, scores can be compared to scores derived from children with PCHI who wear hearing aids. This tool can assist in identifying whether a child is or is not performing typical auditory behaviors. Results to date indicate that the PEACH Rating Scale is appropriate for use within the UWO PedAMP with children who wear hearing aids after they have met a certain criteria on the LittlEARS Questionnaire (Bagatto et al, In Press-a).

Since David’s recent score on the LittlEARS exceeded 27, the PEACH Rating Scale was administered at his next follow-up appointment (22 months of age) where new earmolds were provided. Audiometry was repeated using the new earmolds coupled to insert earphones and the RECD was measured using the new earmolds. Upon verification of the performance of the hearing aids, it was noted that the SII values for soft and average speech inputs were not significantly different from previous assessments. The MPO was measured in both ears. Responses from his mother on the PEACH revealed that David was demonstrating typical auditory performance in both the Quiet (91.7%) and Noise (70.0%) subscales (see Figure 3). His overall score was 81.8%.

![Figure 3: PEACH score sheet for Case Example: David. The PEACH percentage scores (y-axis) are plotted within each subscale (x-axis) for this case example. Results indicate the David is demonstrating typical auditory performance while wearing the hearing aids.](image)
Strategies to support the child’s acceptance of the hearing aids were discussed with David’s mother. A summary of each outcome measure within the UWO PedAMP and administration guidelines are provided in Figure 4.

Summary

The UWO PedAMP consists of several outcome evaluation tools that assess auditory development (LittleEARS) and performance (PEACH) in children with hearing loss. It also includes tools to track important hearing aid fitting details as well as an index of the appropriateness of the hearing aid fitting (e.g., SII) to assist with the interpretation of scores on the functional outcome questionnaires. Finally, this outcome evaluation guideline includes a tool that assesses overall service delivery and caregiver satisfaction with hearing aid services for their child. The OIHP Amplification Benefit Questionnaire provides a way to measure how an EHDI program is doing overall. The use of the KTA process framework and The Network of Pediatric Audiologists of Canada facilitated the development of the UWO PedAMP. The end result of this process is a guideline that is balanced in statistical properties as well as in clinical feasibility, utility and acceptability. The UWO PedAMP can be used in the final stage of the pediatric hearing aid fitting process where it facilitates the evaluation of the impact of the hearing fitting. Access to visual tools to permit rapid scoring supports clinical feasibility and implementation on a regular basis. The UWO PedAMP will evolve through clinical implementation, and a continued community of practice is considered important for its success.

References


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Appendix A: Location of Questionnaires

<table>
<thead>
<tr>
<th>Questionnaire / Outcome Tool</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Aid Fitting Summary</td>
<td><a href="http://www.dslio.com">www.dslio.com</a></td>
</tr>
<tr>
<td>Aided Speech Intelligibility Index (SII) Normative Values</td>
<td><a href="http://www.dslio.com">www.dslio.com</a></td>
</tr>
<tr>
<td>LittIERS Auditory Questionnaire</td>
<td><a href="http://www.earfoundation.org.uk/shop/items/98">http://www.earfoundation.org.uk/shop/items/98</a> Other languages direct from MED-EL. Tel: +44 (0) 1226 242 874</td>
</tr>
</tbody>
</table>
The word synergy is derived from the Greek word \textit{synergos}, meaning “to work together.” It describes the effect of a collection of different elements working together to produce results not obtainable by any of the elements alone. Synergy can be the ability of a group to outperform even its best individual member. This is why the term is often associated with the slogan, “the whole is greater than the sum of its parts”. But it would be more accurate to say that synergy refers to effects that the parts cannot achieve alone, effects that are interdependent without necessarily being better. Thus synergies demonstrated by “the whole” arise more from the relationships and interdependencies between “the parts” than from the individual characteristics of those parts. The unique characteristics of “the whole” that distinguish it from the individual components are called emergent behaviors. Here is an example of an emergent behavior, which results from the unique relationship of two common elements. When the light metal sodium and chlorine gas, two elements that are normally poisonous to humans, are combined they form sodium chloride (table salt) with new properties, which in moderate amounts, are beneficial to humans. But the properties of table salt (emergent behavior) cannot be understood in terms of the properties of its constituent elements; the parts lose their identities and combine to create a new substance. The synergistic effect of the relationship of two otherwise poisonous substances results in a desirable emergent behavior: the creation of the very beneficial compound, table salt.

**Why Should I Care?**

Over the last 20 years our industry has seen the progression of technology move from fully analog hearing aids to instruments with completely digital signal processing. New fitting tools and new ways of thinking about hearing aid fitting have advanced in lockstep with the technology along the way. We started with trimmers and screwdrivers on analog products. Then we moved to fitting software on programmable and digital instruments. Now digital products have become ubiquitous throughout the world and clinicians no longer worry about our customers walking off with our screwdrivers to fix their own glasses. In fact, if you have been fitting hearing aids for 10 years or less, you probably didn’t even grasp the humor in that last sentence. The point here is that the confluence of personal computers, digital hearing aids and more recently wireless programming has led to desirable emergent fitting behaviors which yield better results than we could have achieved in the past and nobody is lamenting the lost glories of the “good old days”.

The synergistic impact of faster computers, advances in miniature chip technology and wireless programming have been two-fold. The first emergent behavior, on the part of manufacturers, is to develop instruments for each new generation which are consistently more complex and flexible than the last, but which also require more time to fit and to troubleshoot. The second emergent behavior, on the part of clinicians, is to rapidly embrace the latest technological gadgetry, while being simultaneously repulsed by the increased complexity, requiring forever more time to learn, to fit and to troubleshoot complaints. Emergent behaviors are always different. But they are not always improvements. A perfect case in point is our current fascination with the a la carte menu approach to fitting software. It is this approach which has probably spawned more “fitter fatigue” through unnecessary complexity than anything else we have done with digital hearing instruments in the last 10 years.
A LA CARTE MENUS AND FITTER FATIGUE

The a la carte menu approach works as follows. Manufacturers are rewarded for creating novel technologies or even for spawning variations on a common theme. Take microphones for example. Most hearing aid users reside in relatively quiet listening environments as much as 80% of the time. They prefer an omnidirectional microphone for such situations. They are in noise or in speech and noise type environments, for which a directional microphone may be beneficial, less than 20% of the time. Yet their single biggest complaint is that they cannot function in noise. Manufacturers naturally respond by developing: fixed directional systems, adaptive directional systems, multiband adaptive systems, split omni/directional systems and so on. It is quite likely that one of those directional systems will prove more efficacious than the others for any given individual in their unique listening environments. But nobody can really say which system will be best for each individual in any one or more of their listening environments. Since we cannot provide specific individual direction we put the onus of discovery on the shoulders of the clinician by making all of our directional microphone selections available all of the time in a handy drop down menu box. The manufacturer is then let conveniently off the hook while reinforcing the notion that, “you the clinician are closest to your client and best suited to decide what they should wear. Here is a lovely a la carte menu from which you may select whatever you desire.” If only it were that simple.

The problem with the a la carte approach is that it is not confined to microphones. Fitting software screens are currently filled with a plethora of drop down boxes, pop-up windows and drag and drop menu selections for everything from manual program choices to noise cancellers, speech enhancement, phase cancellers, transient noise limiters, wind noise managers, etc. Furthermore, every one of those parameters comes with a range of strength settings; 1 - 10, off-mild-moderate-maximum and so on. The clinician must wade through a myriad of program choices, features settings and parameter adjustments during every fitting. And every time some new feature gets developed it adds to the complexity and time required to learn the software and undertake the fitting in an already time-constrained clinical setting. Thus the emergent behavior that results from the interaction of these factors is a form of fatigue and paralysis in clinicians. They haven’t the time to do thorough evaluation and adjustment of a range of parameters on all clients and settle instead with leaving most settings at the manufacturer’s defaults in the hopes that they will be the best first choice. It is exactly this a la carte approach of leaving everything up to the discretion of the time-constrained clinician rather than optimizing parameters together during development that leads to fitter fatigue. What is less obvious to the clinician is the effect it has on the engineers who are designing and implementing these new features.

A LA CARTE’S IMPACT ON PRODUCT DEVELOPMENT

Consider the evolution of the current generation of digital hearing instruments. The devices we fit today did not spontaneously spring fully formed with all sorts of directional microphones and adaptive features out of a test box one afternoon at an Audiology Now! convention. Over a period of years layer upon layer of more sophisticated and complicated technology has been painstakingly added to the body of hearing aid features. One of the pitfalls of this genesis is that we treat each new innovation as if it were a thing unto itself that exists somehow adjacent but distinct from every other hearing aid component. Unfortunately, this viewpoint is fundamentally flawed. Every component in the instrument must work and play well with every other component with which it interacts. Not only must each feature perform a task, it must do so without interfering with the tasks performed by all of the other features. Furthermore, when the performance characteristics of each feature and the interactions between different features are understood the synergies created will encourage the most desirable emergent behaviors from the hearing aid. But that is not what happens in the a la carte approach. This is what happens when every possible parameter is available at every conceivable strength setting all of the time.

When several features are running as if they were adjacent but distinct, as in the a la carte approach, a clinician may choose to put each parameter into any one of (n) states. For example, the fitting software may make; n = 3 microphone states (omni., fixed dir. & adaptive dir.), n = 4 noise canceller states (off, mild, moderate, maximum) or n = 4 speech enhancement states (off, mild, moderate, maximum) available and freely adjustable in up to say 4 listening programs. This means that the clinician could choose from up to 3 x 4 x 4 x 4 = 192 unique sets of feature combinations on one ear during one fitting. Not only does this level of granularity frustrate the clinician, it severely hampers feature development. This is the process by which this occurs.
Ideally new features are designed to provide the greatest potential benefit. Assuming that making a desirable feature such as a noise canceller, directional microphone or speech enhancement stronger will make it better, such features are initially designed to operate at their maximum capacity. Significant benefits are often measurable for each individual feature in this state. However, it does not end there. The new feature must also be integrated with all of the other features in the instrument. It is at this point where synergistic interactions between the new feature and the existing features can cause undesirable emergent behaviors to occur. For example, an adaptive directional microphone may work optimally when designed to provide a very narrow target area and aggressive reduction of sounds in the nulls. Similarly, most hearing impaired individuals may desire aggressive noise cancelling of up to 10 dB or 12 dB to obtain their preferred listening comfort in noise. Taken individually each feature yields the best performance at its most aggressive setting. But once they begin to work together in a single hearing instrument their combined gain reduction impact becomes additive and very undesirable at the most aggressive settings. The synergistic effect of combining these two features at individually desirable settings is an overly aggressive gain reduction for both speech and environmental sounds. The emergent behavior on the part of the wearer is to complain that the hearing instrument shuts down in noise and that they struggle even more to understand speech in noise than they did before. Even a less aggressive fixed directional setting may be too strong when added to aggressive noise cancelling.

The emergent behavior on the part of the hearing aid developers is two-fold. The first is the aforementioned a la carte approach that shows up in the fitting software. If enough levels of strength settings are provided for each feature the developers hope the clinician will somehow be able to choose the correct distribution of settings across the range of parameters so as to provide the optimal performance in the listener’s specific environments. This approach has the previously described baggage attached to it. Also, taken alone such a solution may not work for another reason. It is possible that the synergies between any two or more adaptive features can create an undesirable emergent behavior regardless of how they are set. For example, a noise cancelling algorithm that reduces gain in bands that are dominated by noise may be desired by a listener to promote comfort. Whereas a speech enhancement algorithm which boosts gain in channels dominated by speech may be preferred to improve the clarity and ease of speech understanding in the same environment. Individually they provide benefit. But running simultaneously, acoustic artifacts and distortions may occur as they pull the gain in adjacent bands in opposite directions. Given a noise canceller that can provide 12 dB of gain reduction in one band and a speech enhancement algorithm that can provide 10 dB gain increase in an adjacent band it is not hard to see how both algorithms running at once could yield uncomfortable and unnatural sound quality. The developer’s reaction to these artifacts will be to reduce the strength of one or both algorithms until there is no possible combination of settings available to the clinician which could yield an undesirable emergent behavior. Herein lies the product developer’s dilemma.

**DEVELOPMENT THAT MINIMIZES SYNERGIES**

The strongest speech enhancement setting may provide significant speech clarity benefit with mild or moderate noise cancelling. Or the strongest noise canceller setting may provide optimal comfort in noise without artifacts in the presence of mild or moderate speech enhancement. However, when the strongest speech enhancement is combined with the strongest noise canceller setting the emergent behavior may be distortion and artifacts. Since the a la carte approach does not limit clinician’s options to avoid the strongest settings for both features at once, the developer has no choice but than to reduce the strength of each at the maximum setting. Thus a negative synergy that only creates problems at one pair of parameter settings (maximum and maximum) forces a reduction of the potential benefit at all other possible settings. Unfortunately, it gets worse. Not only can an undesirable emergent behavior occur when the noise canceller and speech enhancement interact at the wrong settings. But such an effect is possible when any combination of two or more features interact with each other. That includes, all of them, noise cancellers, speech enhancement, adaptive directionality, wind noise managers, transient limiters and on and on. In every case, the developer must compromise performance to minimize undesirable emergent behaviors which can occur because of the wide open nature of the a la carte approach. When every feature is allowed to interact freely with every other feature at all possible settings, product developers have no choice but to reduce the effectiveness of all features to avoid undesirable artifacts that may occur at only a few possible extreme choices.

**USING SYNERGY IN HEARING AID DEVELOPMENT**

In the examples above the emergent behaviors caused by the convergence of the synergies between hearing aid features
and a less than optimal “a la carte” fitting approach were far more of an enemy than an ally. But it is also possible to take advantage of synergies by carefully controlling the relationships between select adaptive features to achieve a desirable and predictable emergent behavior. The first step is simple, eliminate the a la carte fitting approach. It is not the range of possible settings available for each feature that causes the trouble. It is the fact that each feature (noise canceller for example) can exist in any one of many possible states relative to all the other features (microphones, speech enhancement, etc) at any point in time. However, the problem of undesirable emergent behaviors, such as distortion and artifacts is often a component of a small subset of extreme settings of one or more features. The artifacts can be eliminated without reducing the effectiveness of any individual features by keeping all of the interacting features in a known state relative to all of the others. In this way it is possible to avoid the clusters of parameter settings that create problems.

If the noise canceller and the speech enhancement provide benefit in all combinations except where both features are at their maximum setting then the occurrence of undesirable artifacts can be eliminated by adjusting both features simultaneously such that they can never both achieve that state simultaneously. In other words, if an adjustment to one of the features automatically leads to simultaneous complementary adjustment of the other. Then both features will always exist in a known state relative to one another. The same can be true for greater numbers of features. For example, complementary adjustment of gain, microphones, noise cancellers and speech enhancement are already possible using the SmartFocus™ control in most Unitron hearing instruments. SmartFocus was designed to avoid the pitfalls of the a la carte fitting approach. As mentioned above, hearing aid features are not toned down by developers because they fail to work well at aggressive settings, but rather because of negative interactions between features at specific settings leading to undesirable emergent behaviors. The idea with systems like SmartFocus is to eliminate these negative interactions and design in positive emergent behaviors by taking advantage of their synergies; optimizing all of the features simultaneously to achieve specific performance goals. In this case, the emergent behavior creates a new performance goal that was not achievable with any of the individual components that make up SmartFocus.

The emergent behavior that SmartFocus was designed to provide is that of a single control that offers a range of adjustment on a continuum between two perceptual constructs, comfort and clarity. If you can agree that for any situation encountered by a hearing aid wearer there is a desirable balance somewhere between hearing with complete clarity (possibly sacrificing some comfort) and listening in total comfort (when clarity is not essential), then it should be desirable to have a single control with which to adjust your hearing aids to achieve it. A noise canceller or a gain reduction may improve comfort, particularly in noise. Speech enhancement or appropriate microphone configurations may also provide better clarity without making many listening situations any more comfortable. But no one of those features truly does both. However, all of their adjustments may be linked together under a single control such that all four features are in known states relative to one another at every position on that control. Thus, as the control is modified in one direction or another, each feature is carefully adjusted relative to the other three so as to achieve greater comfort or greater clarity as desired. Furthermore, since all of the features always exist in a known state relative to the other three, the maximum strength of each feature does not have to be diminished to avoid artifacts. Instead the relative settings across each feature are optimized at every position of the control such that the artifacts are always avoided. Thus, the control is optimized to utilize the synergistic relationships of “the parts” so as to provide the beneficial emergent behavior of “the whole”, a simple comfort or clarity adjustment. The outcome is superior to that achievable using the a la carte approach because the component features under adjustment can provide maximum benefit without being toned down to control for artifacts that may occur at only a few settings. Figure 1 is a schematic depicting the comfort – clarity settings of the four features combined on the SmartFocus algorithm. The end user may adjust the SmartFocus

![SmartFocus™: Overall Combined Effect](image)

**Figure 1.** The synergistic effect of the four features of SmartFocus (microphone strategy, digital noise reduction, spectral enhancement and gain) at three different user settings: neutral, maximum clarity and maximum comfort.
New 2012 CPT Code and Code Descriptions for Audiologists

This guidance was compiled in collaboration with and authored by representatives of the Academy of Doctors of Audiology (ADA), the American Academy of Audiology (AAA), and the American Speech-Language-Hearing Association (ASHA).

Effective January 1, 2012, there will be a new OAE Current Procedural Terminology (CPT®) code, 92558, to describe evoked otoacoustic emissions screening and new code descriptors for two existing OAE codes, 92587 and 92588, to clarify the otoacoustic emissions evaluations.

The CPT code descriptors set forth below appear in the 2012 CPT Manual under the heading: Special Otorhinolaryngologic Services, Audiologic Function Tests. The new code descriptors will guide the audiologist in how to correctly select the appropriate OAE code and file an OAE claim. When determining how to select the correct code, an audiologist should base his or her decision upon the purpose for performing the test and the diagnostic capability of the test equipment (i.e., the number of frequencies performed).

Background

The Centers for Medicare and Medicaid Services (CMS) had previously identified CPT code 92587 for review due to rapidly growing utilization. In calendar year 2011, this service was surveyed by the audiology specialty societies. After reviewing the survey data, the specialties concluded that more than one service was being represented under this code. As a result, three codes were created. CPT 92558 was created to describe automated OAE screening; CPT 92587 was clarified to describe the procedure commonly used to determine the presence or absence of auditory disorder as a follow-up to screening or as an objective verification of disorder; CPT 92588 was clarified to describe the procedure used for “cochlear mapping” commonly aimed at fine-resolution monitoring of cochlear function. Services billed on or after January 1, 2012, must be coded with one of these three codes as described below.

CPT Code Descriptions and Guidance

CPT 92558 Description: Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis.

Guidance: CPT 92558 should be used when an automated pass/fail screening is performed, via a fixed number of frequencies at a single intensity level, when administered by support personnel, an audiologist, or a physician. This procedure has been designated by CMS to be a non-covered service under the Medicare program.

It is important that audiologists consult the specific guidance that will be provided by regional and federal payers such as Medicare Administrative Contractors (MACs) and Medicaid, as well as guidance from their private third-party payers. Some third party payors may dictate the use
of specific codes, modifiers, and coverage determinations specific to the state or location where the service is performed.

**CPT 92587 Description:** Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report.

**Guidance:** CPT 92587 is to be used when 3-6 frequencies are tested bilaterally and includes the interpretation of the test, with a reporting of the results in the patient's medical record. If you perform both distortion product and transient evoked otoacoustic emissions, you may seek additional reimbursement using the –22 modifier in conjunction with CPT 92587. Again, audiologists should be aware that third party payors may dictate the use of specific codes, modifiers, and coverage determinations specific to the state or location where the service is performed.

CPT 92587 is a global procedure code comprised of both a technical component (TC) and professional component (PC). If the audiologist is performing the procedure, providing the interpretation of the results and making a report of the results in the patient's medical record, this code should be reported without a modifier.

Under the Medicare program, otoacoustic emissions testing may be performed by a technician, who is working under the direct supervision of a physician. Testing performed by a technician should be reported using the TC modifier. Audiologists should be aware that services performed by a technician which are billed under the NPI of an audiologist are not covered under the Medicare program.

**CPT 92588 Description:** Comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report.

**Guidance:** CPT 92588 is to be utilized when a minimum of 12 frequencies are tested bilaterally and includes the interpretation of the test, with a reporting of the results in the patient's medical record. If fewer than 12 frequencies were performed, file the claim with CPT 92587.

CPT 92588 is a global procedure comprised of both a technical component (TC) and professional component (PC). If the audiologist is performing the procedure, providing the interpretation of the results and making a report of the results in the patient's medical record, this code should be reported without a modifier.

Under the Medicare program, otoacoustic emissions testing may be performed by a technician, who is working under the direct supervision of a physician. Testing performed by a technician should be reported using the TC modifier. Audiologists should be aware that services performed by a technician which are billed under the NPI of an audiologist are not covered under the Medicare program.

**Read More**

For further information, please review the CMS Transmittal governing audiological services at: https://www.cms.gov/transmittals/downloads/R84BP.pdf

The CMS website also has a general page for audiology services, which includes additional guidance, at: https://www.cms.gov/PhysicianFeeSched/50_Audiology.asp

**Notes**

*Consult your otoacoustic emissions equipment manufacturer or equipment service provider to learn the diagnostic capabilities of the OAE equipment. Your ability to utilize a specific code may be restricted by equipment limitations (e.g. you may not bill using CPT 92588 if the required minimum 12 frequencies can not be met by the equipment used).

*The code descriptions are listed in the 2012 CPT Codebook out of numerical order (e.g., 92586 is immediately followed by 92558, which is followed by 92587 and 92588 and so forth) in order to keep all three OAE codes together as an easy reference for audiologists and other professionals seeking reimbursement under these codes.

**The Revised Advanced Beneficiary Notice (ABN) goes into effect January 1, 2012**

As of January 1, 2012, audiologists must be using the ABN dated March 2011. The form dated 2008 will no longer be valid. There are no substantative changes to the form from the 2008 version other than the change of effective date. Please go to http://www.cms.gov/BNI/02_ABN.asp#TopOfPage to locate a copy of the new form and the instructions on completion.

**HIPAA 5010**

HIPAA 5010 applies to all practices who submit their claims electronically. The conversion deadline is January 1, 2012. Please contact your office management software and medical claims clearinghouse vendors to ensure that they are HIPAA
5010 compliant. Payers will not be accepting or processing claims after January 1, 2012 if they are not transmitted via HIPAA 5010.

**Medicare Fee Schedule 2012**

The 2012 Medicare Fee Schedules are now available for review from your Medicare Area Contractors (MAC). These fee schedules go into effect January 1, 2012. It is strongly recommended that you consult the MAC website for your area and review the fee schedule and its modifications. Here are some of the issues worth noting:

Unless Congress acts as they have done in previous years, all audiology services are slated to be reduced by 27.4% of their current 2011 value.

- **Otoacoustic emissions:**
  - Code 92558 was not assigned a payment rate because it is a screening code it is assigned an “N” status by Medicare meaning it is not considered covered for Medicare patients. CPT 92558 may require appending a -33 modifier when the procedure is preventive in nature and part of a newborn hearing loss screening program. See [http://www.ama-assn.org/resources/doc/cpt/new-cpt-modifier-for-preventive-services.pdf](http://www.ama-assn.org/resources/doc/cpt/new-cpt-modifier-for-preventive-services.pdf).
  - For 92587, currently the conversion factor is scheduled to be reduced by about 27 percent for 2012. However, we expect that legislation will likely be enacted to prevent this massive reduction in payment. Under and assumption that the 2012 conversion factor will be the same as the current 2011 rate, the national nonfacility payment rate for Code 92587 is $28.20 of which $18.01 is assigned to the PC and $10.19 to the TC.
  - For 92588, the national nonfacility payment rate using the 2011 conversion factor is $42.81 of which $28.20 is assigned to the PC and $14.61 to the TC. The 2012 conversion factor would result in a $31.09 total payment but, again, congress is expected to avert such a cut as they have in previous years.

- **Physician Quality Reporting Initiative**
  - For more information, please consult [https://www.cms.gov/PQRS/](https://www.cms.gov/PQRS/).
  - This program continues for 2012 with a .5% bonus payable for all allowed charges associated with this reporting. The codes available for 2012 are:
    - #188 Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear
    - #189 Referral for Otologic Evaluation for Patients with History of Active Drainage From the Ear Within the Previous 90 Days
    - #190 Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss
    - Referral for Otology Evaluation for Patients with Acute or Chronic Dizziness (number not yet available)

**Medicare Enrollment Revalidation Pushed Back to March 2015**

All audiology who enrolled in Medicare prior to March 25, 2011 will be required to revalidate their enrollment. The purpose of this re-enrollment process is to institute screening tools in an attempt to prevent and reduce Medicare fraud. The original deadline for completion of this process was March 2013, but, due to the depth and breadth of this process, the deadline has been extended to March 2015.

Audiologists have begun receiving a letter from their Medicare Area Contractor (MAC) requesting that they re-enroll. Do not re-validate until you receive your letter. Please try to re-validate via the PECOS system ([https://pecos.cms.hhs.gov/pecos/login.do](https://pecos.cms.hhs.gov/pecos/login.do)) as allowed as it will simplify and expedite this process. In your letter, MACs will provide you with information on the steps to completing this process PECOSs and submission of signed certification letter) and your deadline for completion (60 days from date letter dated). Failure to complete this re-validation process within the allotted time frame can result in your claims being rejected for payment by Medicare.

Audiologists are not required to pay the $505 application fee as this is exclusive to equipment providers. Please contact your MAC for guidance, prior to submitting the $505 payment, if your clinic provides and submits claims for cochlear and/or auditory osseointegrated implant replacement processors.

If you are unsure if you have received your enrollment re-validation, please consult [https://www.cms.gov/medicareprovidersupenroll/11_revalidations.asp](https://www.cms.gov/medicareprovidersupenroll/11_revalidations.asp) for more information.


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Kim Cavitt, Au.D. is currently owner of Audiology Resources, Inc., which provides comprehensive operational and reimbursement consulting services to hearing healthcare clinics, providers, buying groups, and manufacturers. She also serves as the Co-VP of Governmental Affairs for the Illinois Academy of Audiology and is a member-at-large on the ADA Board of Directors.
Why social media marketing?

Today more and more customers want to hear from a far more powerful resource: each other.

Facebook has over 800 million users. Twitter generates over 50 million messages a day. It has never been easier to spread the word about your business in an instant.

Social media marketing taps into the power of organic communities to sell and promote your business. News, offers, and recommendations are shared instantly through groups of friends.

These “friend-of-friend” networks are deep, fast, and free.

How can DemandStreet help?

For all ADA members who sign up for the comprehensive social media package, DemandStreet will:

- Establish your business’ presence on FACEBOOK and TWITTER
- Provide a DEDICATED CLIENT SERVICE REP to handle all requests
- Generate INTERESTING, RELEVANT, and ENGAGING CONTENT
- Embed Facebook and Twitter LINKS ON YOUR WEBSITE
- Design IN-OFFICE DISPLAYS to encourage clients to “Like” your Facebook page via text message
- Assist with creating TARGETED FACEBOOK ADS and PROMOTIONAL CAMPAIGNS to attract new clients and leverage word-of-mouth referrals
- Email QUARTERLY NEWSLETTERS that you create to all of your patients.

How do I sign up?

To sign up for DemandStreet’s comprehensive social media package, please visit www.demandstreet.com and click the green “Sign Up Now” button.

The ADA has partnered with DemandStreet to provide all members with a comprehensive social media package to help grow your business. This $199 value is free for all ADA members who sign up before December 31, 2011.
**HAVE YOU HEARD?**

**The ADA Convention Rocked the Boat**

November 3-5, 2011 marked the 2011 ADA Annual Convention, where more than 550 audiologists and hearing industry leaders converged to learn, network and engage in a meaningful dialogue about the “rough water” issues facing the profession of audiology today.

During the opening session, ADA President Dr. Bruce Vircks reported that ADA’s student membership has topped 230 members, now comprising more than 20 percent of overall ADA membership. He announced several new ADA student initiatives including:

- The creation of an ex-officio position on the ADA Board of Directors to be filled by a student member
- The implementation of an ADA student listserv
- The development of a Virtual ADA Chapter to be “owned” and operated by ADA student members
- The development of education and training activities designed specifically for Au.D. students

“We will have no future without talented, inspired audiology students,” said Dr. Vircks, “and we believe their continued involvement will serve as a bellwether for the success of ADA and the audiology profession.”

During the opening session, Dr. Vircks also announced that ADA is in the process of developing an online mechanism that will match practice owners seeking an exit strategy with young practitioners seeking practice ownership. More information coming soon!

This year’s convention featured 26 regular sessions and three pre-convention workshops including the long-awaited launch of the ADA Business Management Training Program, which is designed to equip audiologists with the tools and training needed to effectively manage the business components of a private practice. Module 1: Financial Management, which debuted at the conference, will be offered online in the near future.

Find out what all of ADA’s friends and fans were doing at the convention here: www.facebook.com/AcademyOfDoctorsOfAudiology

Miss a course? No worries—order your ADA 2011 course CD today for only $125 and you will have access to the full set of audio recordings and slide presentations from all of the regular sessions at the convention. Relive the sessions you enjoyed and discover the sessions that you missed. Visit www.audiologist.org for more information.

**ADA Needs Your Passion & Expertise**

Calling all Members! There are numerous issues affecting your practices and our profession! Your input and insight can take ADA to the next level and help guarantee that ADA continues to lead the profession of audiology through advocacy and education. Please take the opportunity to get involved as a volunteer leader of ADA. There are service opportunities available in a wide variety of interest areas, with varying time and talent commitments required. Please take the following link to complete your 2012 volunteer interest form: www.audiologist.org/ada-2012-volunteer-sign-up.
Outstanding Audiologists Recognized at ADA Convention

The theme of this year’s convention, *Rock the Boat: How to Practice, Manage and Lead in Rough Waters*, was certainly evidenced by the outstanding audiologists who were recognized for their significant contributions to the profession of audiology.

During the 2011 Opening Session, the following awards were presented:

ADA presented James McDonald, Sc.D., Au.D., with the Joel Wernick Award to commemorate his outstanding educational contribution within the profession of audiology and hearing science.

“Jim’s service to Au.D. students and his excellence as demonstrated by and through the voice of the students, makes Jim most deserving of this award.”

ADA presented John Balko, Au.D. with the Leo Doerfler Award for his dedication to providing outstanding clinical services in his community.

“John provides services to more than 150,000 residents in more than 1,000 residential care facilities in five states, and his commitment to the profession of audiology is further exemplified by his service to audiology organizations.”

ADA presented Tabitha Parent Buck, Au.D. with the David Goldstein Award to recognize her significant contributions to the audiology profession by promoting the transformation of audiology to a doctoral profession with the Au.D. as its distinctive designator. This award, established by the Audiology Foundation of America (AFA), was presented at the ADA convention for the first time by Dr. David Goldstein, for whom it is named.

“Tabitha is a tireless worker for the transformation of the profession, who has devoted her efforts in the organizational, practitioner and academic realms. She has been a remarkable advocate for the autonomous practice of audiology.”

Please contact Stephanie Czuhajewski at sczuhajewski@audiologist.org for more information about the ADA Awards Program.

Continued on page 62
I have been an audiologist for about 15 years, working in manufacturing, clinical consulting, and private practice during that time. I currently own a practice in Shoreview, MN – a northern Twin Cities suburb – which is primarily geriatric focused, although it is my goal to offer pediatric care within the next two years. I also contract with two educational cooperatives, the state school for the Deaf, and two charter schools to offer educational audiology services. This keeps me busy enough that I brought in a second audiologist earlier this year to work in the clinic! In the clinic, we have focused primarily on hearing-related services, although I have a background in tinnitus management and vestibular medicine as well. Finally, I do a monthly podcast for audiologists called AudiologyTalk. In this program targeted to audiologists, we discuss current news and events and typically speak with an expert in some area of our profession. This has allowed me to merge my first profession of radio broadcasting with my work in audiology.

AP: Tell us a little about your professional journey and how you ended up in private practice.

JC: I began my career in manufacturing, working for two manufacturers and a local special equipment distributor. I left manufacturing to form a consulting business with a colleague and a marketing specialist. That was a big learning curve and an experience I will never forget! Our first big client walked away the week after the three of us gave our notice to our employer. It was also an eye-opener in terms of running your own business. I was an accounting major early in college, but this was the first opportunity that had to directly apply by knowledge of business. As with everything else, what you learn in books rarely transitions smoothly to how things work in the real world!

I later left that company to strike out on my own. I opened a private practice (my current setting is a second iteration of that practice) and spent my time between clinical practice and consulting on my own. At one point about three or four years ago, I found myself traveling so much that I was missing my kids growing up. I made a decision to focus more fully on the practice in an effort to reduce my travelling. I still travel around the state quite a bit to serve the various schools, but my life is a bit more balanced (although none less busy!) and I get to spend more time with my family now.

AP: Can you speak to your ideas on professional autonomy and what it means to you in your current position?

JC: I believe the professional autonomy is a crucial goal for audiology. I am rather strong willed, to put it politely, and I honestly would never allow myself to be in a position where I practiced any other way. However, as a profession we cannot expect to achieve many of our goals without autonomy. These include recognition as a doctoral profession, a primary care provider for hearing and vestibular care, and even – to address a very current concern - recognition as a vital part of the rehabilitative process for those individuals with hearing loss. If we do not constantly strive to practice autonomously, we never will. I still remember the time when members of our
profession petitioned the federal government to be recognized as a doctoring profession. I felt for those brave colleagues, who must have felt rather sheepish when they were rejected because our own literature did not support the facts they were presenting. The group who reviewed the request reported that we did not act like a doctoring profession. All our publications talked about “assess” and “manage” – nowhere did we ourselves talk about “diagnosing” and “treating.” We need to remember lessons such as this because it reminds us that our own actions need to support our goals. We will not be recognized as autonomous care providers, as a doctoring profession, or anything else just because we say we are. If we do not look like we are capable of practicing autonomously, then no one outside the profession is going to want to grant us that status.

There are other audiologists who do a wonderful job of practicing autonomously. These colleagues typically become recognized for such conduct and earn the respect of other healthcare providers in their area. However, I also know audiologists who are not allowed to report results of their own evaluations to their patients! This is the polar opposite of autonomous practice. However, as long as we have this kind of disparity amongst our colleagues, our road to autonomy will be that much more difficult, if not impossible.

**AP: What has been your greatest lesson learned from your experiences as a business owner?**

**JC:** There are so many! Anyone wanting to go into business for themselves must be ready with a bucketful of perseverance, humility (I know many people would find that a surprise, coming from me!), fortitude, and support from family and friends. A truckload of money doesn’t hurt either! You are the last to be paid and you can usually count on your earnings being less than you forecast. It is not an easy road, but it can be a rewarding one when you build something that is yours. I truly believe that certain people are driven to be in practice for themselves – I don’t honestly think I could work for someone else for a prolonged period of time – and some people are more comfortable working with the security of knowing they are NOT the last to be paid, that the decisions ultimately are someone else’s responsibility, and that they can walk away at any time.

Nonetheless, I think the most valuable lesson that I may have learned about business ownership is to recognize and direct your business where the opportunities truly are. I think that every single time that I have tried to force my business in a specific direction because it is what I wanted to do, I have failed. However, when I have recognized where the opportunities are and taken advantage of them, I have usually improved my revenues, grown my business, and moved closer to my definition of success in what I am doing.

No matter what your goals or what is causing an audiologist (or anyone, really) to open his or her own business, maybe the most important attribute is brutal honesty. I don’t want to scare people away from private practice (!), but you need to be willing to be extremely honest with yourself in terms of your motivations, your capabilities, and what it will take to achieve your goals. If you are not very honest with yourself, the outside world will be happy to show you the error of your ways! Surround yourself with good people who have done this before, such as your accountant, your attorney, and even a mentor. Establish methods to track every bit of relevant data there is so that you can forecast, track, and adjust. Then make sure you use that data to periodically reevaluate what you are doing. Be flexible and be willing to admit that you may be on the wrong path – and then correct it. Most of all – we are in a people business. Take extra good care of your patients! You may be struggling financially, overworked, and unsure about your future. However, if you can stick it out through all that, the care that you provide to your patients will drive your business forward. Your patients will spread the word (don’t be afraid to ask them to do so!), referring physicians will hear about you (send them copies of reports!), and media will look to you as an expert resource. Ultimately, these are the things that will move your business in the right direction.

**AP: If you could advise a new graduate deciding on a professional setting, what advice would you give them?**

**JC:** The advice I typically give to students is to utilize their days in training to gain exposure to as many different experiences as possible. Only then can you be sure about the direction you want to pursue professionally. Of course, that doesn’t guarantee that any audiologist will not change specialty areas during his or her career. However, that doesn’t help someone who has recently graduated! I would encourage any new graduate to find a setting which matches his or her professional interests. If you enjoy working with children, find a pediatric setting. If you don’t enjoy working with them 24/7, find a private or medical practice which sees children to a lesser extent. Audiology is a diverse profession with many possible settings and specialties. I believe that any audiologist should find personal satisfaction in the work they are doing. That will drive you to keep learning (hopefully for your entire career!),
improve your skills, and provide the best possible care for each and every patient.

The other advice I would give a new graduate is to always remember that learning doesn't stop after school is completed. You have a foundation in audiology, but there will always be more to learn and you should never stop trying to learn more about your profession. Subscribe to journals, join state and national academies, attend their conferences, and take advantage of online seminars. You have joined a wonderful profession that helps a great many people every day. Arm yourself with as much knowledge as you can so that you can provide the best possible care to every patient you encounter.

AP: What do you like best about being an audiologist?
JC: Audiology brings together a number of attributes that resonate with me. I enjoy all things technical, I enjoy helping people, and I need to have variety in my work. Audiology offers all those things that appeal to me. However, the thing that drives me is making a difference in someone's life. When I see a patient who is leading a better life because of the care I gave them or I see a student who is excelling in school partly because of the services I have provided to them, all the time and effort and hard work and dedication become worth it.

AP: Tell us about your most memorable patient.
JC: This is always a difficult question because there are so many! I do remember a patient a number of years ago who had one of the most debilitating cases of tinnitus I have ever encountered. He was considering leaving his job, didn't want to go outside his home and could not speak to anyone about his condition, including his own family. After the first two appointments, I had decided to recommend that he seek additional help from a psychologist as he was undoubtedly on the road to serious depression. However, when he returned for the third visit, he was already showing an improvement in his outlook and emotional state because of the counseling I had provided. Within an incredibly short amount of time, he had opened up to his family and co-workers about his condition, reported subject improvement in tinnitus, and displayed a much improved emotional state. To see that profound an improvement in someone's life and to be responsible for any part of it is truly an awesome experience. Cases such as his remind us of why we became audiologists.

AP: Was there any one person in your life that was influential in your career choice/path?
JC: I honestly don't know whether there was any one person who was singly influential in my career. As far as in my career choice, we can all thank (or boo) the speech pathology instructor who left the program my senior year in college. He was the only individual who had any interest in voice and professional speakers – my early interest in speech-language pathology. Once he left that program, the only thing in which other faculty were interested were kids in schools. I had zero interest in that area as a speech pathologist, so it caused me to look around a bit and reassess what I really wanted to do.

In my years as an audiologist, I have been fortunate to have access to many leading colleagues and others because of my years in manufacturing and consulting and my involvement in professional organizations. Although I could not identify one person who was singularly influential for me, I was able to assimilate the knowledge of leading audiologists all through the first years of my career and later apply that knowledge to clinical practice and business management.

AP: When you are not busy seeing patients or running your business, what are some things you like to do in your spare time?
JC: The first answer that comes to mind is, “spare time???” The next is “sleep!” But seriously, one of the great joys of my life is my children. I still travel enough that I look forward to each and every moment that I get to spend with them. I also have a lot of fun producing AudiologyTalk each month. It can be a tremendous amount of work sometimes to put out a quality program, but it is something that I thoroughly enjoy and I hope that comes through when Dean Flyger and I are talking.

We made a commitment to ourselves early in the process that we would not take ourselves too seriously and that we would not allow the program to consume our lives (particularly not until the point where we actually have consistent sponsors!). I think we have stayed true to that and it continues to be something that we enjoy doing each and every day. I get to play golf about once every two years and play on our church’s softball team. Most of my spare time, however, is spent working for the various academies and charities to which I give my time. That also can be a lot of fun producing AudiologyTalk each month. It can be a lot of work sometimes, but it is also truly a labor of love and a way that I feel compelled to give back to the profession which has given me so much.

AP: What’s one thing you want other audiologists to know about your practice or how you take care of your patients?
JC: I believe we touched on a lot of my clinical and business philosophy earlier, but one thing about which I am adamant is that our focus is singularly and squarely on the needs of our patients and what we need to do to meet those needs. I believe that patients have a right to expect our best effort to address their needs, that we will do it in a professional, respectful and compassionate way, and that we will do everything in our power to utilize the latest methods and tools to help them realize the best possible outcomes. We run our clinic very much in the medical model. We have a high level of transparency, we
follow medical models, we market our services and our outcomes, and we try to make sure that our patients know we are here first and foremost to take care of their needs.

**AP: What do you want patients to remember about your practice after they leave an appointment?**

**JC:** It is my single goal that patients leave our office believing that they received the best possible care from an audiologist who did everything possible to address their condition. I made a comment on a recent episode of AudiologyTalk that I occasionally find myself counseling a patient about possible ways to address hearing loss and am met with, “so I guess I need a hearing aid. Do you have those here?” I realize that some people may be horrified to think about that, but I can always say “yes” and move on with the counseling and treatment. However, that says to me that I have been so focused on making sure I have properly diagnosed the hearing loss, on describing results and impact of hearing loss, and on providing thorough counseling and guidance to the patient that I did not have time to come across as someone who is just trying to sell hearing aids.

I know this is difficult issue for many of our colleagues. We have too often been lumped in with hearing instrument dispensers and we are all sensitive to it. However, we have an opportunity to conduct ourselves as doctoring professionals. When we put our patients’ needs first, when we focus on treating a condition – treating a person – and not a device, we become that which we strive to be: a doctor of audiology. Someone who has expertise unsurpassed by any other discipline. Someone who is recognized as the primary provider of care for disorders of the ear. If we conduct ourselves accordingly, patients will see it and remember.

**PRESIDENT’S MESSAGE**

**Continued from page 3**

If you have a passion for advancing your profession, I challenge you to get involved in ADA. How? Visit the volunteer section of the ADA website at www.audiologist.org/ada-2012-volunteer-sign-up and commit to serve your peers and your profession. There are a variety of volunteer openings with varying levels of required commitment that meet a wide-range of interests.

ADA is unique among professional audiology organizations in that it is wholly dedicated to serving the interests of autonomous professionals. In keeping with the ADA spirit and philosophy, ADA initiatives have always been, and will continue to be, member owned and driven. I look forward to working with all of you to make ADA and audiology even better in 2012!

**INVIGORATE YOUR PRACTICE WITH HEARING LOOPS**

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**References**


**Linda S. Remensnyder, Au.D. is President and Owner of Hearing Associates, P.C., a private practice in Audiology established in 1980 with multiple office sites in the Northern Suburbs of Chicago. She received her professional doctorate in Audiology from the University of Florida and was the first Doctor of Audiology in Illinois. Dr. Remensnyder served on the Board of Governors of the American Board of Audiology and was appointed to the HLAA/AAA Get in the Hearing Loop Joint Task Force in 2010. The Better Hearing Institute (BHI) profiled her practice in their Audiologists Changing Their Communities Series with a focus on her Audiologic Rehabilitation Classes and Patient Empowerment. In April, she received the 2011 Presidential Award from the American Academy of Audiology “in grateful appreciation for her significant contributions to the American Academy of Audiology and the profession of Audiology.” She is an active proponent of Hearing Loops and serves as the Spokesperson for the State of Illinois.**
SYNERGY IN THE EVOLUTION OF HEARING INSTRUMENTS

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algorithm from the neutral position, which is established at the initial fitting by entering the audiogram thresholds and other information in the fitting software, with a manual control (remote or on-board wheel/lever) or the algorithm may be allowed to automatically switch to either the comfort or clarity setting, depending on how the input signal is classified by the hearing aid’s signal classification system.

IN SUMMARY

The real purpose of this article is to describe of the current state of hearing instrument development and fitting while providing a glimpse of the future. The narrative was written employing the concept of synergy. It has been the trend of the industry to provide all new hearing aid features to the clinician with a range of adjustment. But negative synergistic relationships between those features required that the range of adjustment be minimized to avoid artifacts and distortions at some subset of their settings. However, some manufacturers have begun taking advantage of synergistic effects by optimizing whole sets of features together under a single control. Since all features in the set are always in a known state, it is possible to avoid artifacts while actually extending the range of adjustment rather than by reducing it. This leads to a novel (emergent) behavior in the form of higher level control of perceptual constructs such as direct adjustment of sound quality on a continuum from total clarity to total comfort. Thus the developers improve performance by utilizing synergies rather than optimizing them out of their fittings.

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DISCLOSURE: AP Editor Brian Taylor is employed by Unitron.

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United Healthcare (UHC) Update

ADA shares your concerns regarding “benefits”, hearing “devices” and hearing “testing” that UHC has made available to UHC plan members and the general public. On October 31st, in collaboration, ADA and AAA sent joint letters to United Healthcare and hi Health Innovations regarding their online hearing healthcare delivery initiative. Please visit www.audiologist.org/news/internet-hearing-healthcare-delivery.html to view those letters.

ADA has established a web page, which will serve as a repository of information for members: www.audiologist.org/news/internet-hearing-healthcare-delivery.html. As promised, ADA has established this page so that members can share information and resources from around the country and collaborate more effectively on advocacy efforts. We are seeking any information that you can provide about formal mobilization efforts in your state to address this issue, so that we can compile this information and push it back out for all members to share.

Please send ADA links, documents and other resources in a web-compatible format and we will include it in this repository. Send information to sczuhajewski@audiologist.org. You may also post updates to the ADA Connect listserv.

ADA has been in communication with other organizations including AAA, IHS, ASHA, and AAO-HNS to ensure collaboration in information sharing regarding the UHC initiative. We will continue to keep you updated with the latest information, tools and resources to ensure the safe delivery of hearing healthcare to patients.

The Academy of Doctors of Audiology Warns Consumers Against Obtaining Hearing Aids Without Proper Diagnosis, Treatment and Counseling

(lexington, Ky.)—The Academy of Doctors of Audiology (ADA) urges consumers who suspect that they have hearing loss to seek treatment from a licensed audiologist or other hearing healthcare professional to ensure the proper diagnosis and treatment of hearing loss, and to identify potentially serious underlying medical conditions. Further, ADA reminds consumers that hearing aids are not always the recommended course of treatment for hearing loss.


ADA Members: You are encouraged to copy this press release, customize it with relevant information pertaining to your state or region, and use it to disseminate this important information to patients and consumers in your area.
Our passion for the pursuit of excellence has resulted in a significant step forward in the evolution of the Phonak Spice Generation.

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SPECIAL ISSUE
Overcoming Uncertainty by Creating the Future

Stop Trying to Sell Hearing Aids
And Embrace Your Role as Educator

Pediatric Fitting Protocol From UWO