

Audiology PRACTICES

THE OFFICIAL PUBLICATION OF THE ACADEMY OF DOCTORS OF AUDIOLOGY®

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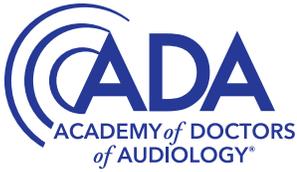
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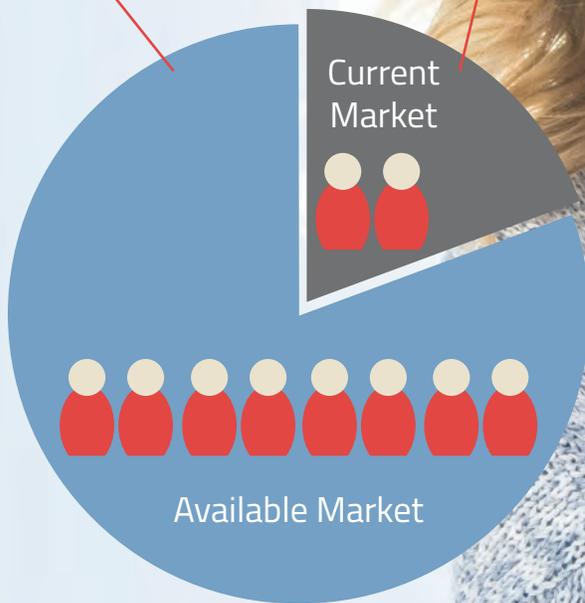
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*As reported in Hearing Health Care for Adults: Priorities for Improving Access and Affordability National Academies of Sciences Engineering and Medicine



AuDacity to Feature New Ideas and Fresh Perspectives on Treating an Aging Population

Not to give away my age...but, as a practice owner and an audiologist for more than 39 years, I am seeing more diversity in terms of perspectives, challenges, and needs in the older adults that I treat these days, compared to years gone by. My "aging" patients range from active, strong, tech savvy, and acutely involved in their care decisions, to those who are frail, isolated, and struggling to manage multiple co-morbidities and even dementia. I am sure most of you see similar trends in your patient population.

With more than 10,000 Americans turning 65 years old each day between now and 2030, and knowing that a large percentage of them will experience hearing and/or balance difficulties, it is more important than ever for us to identify and adopt the best approaches to engage, encourage, and empower older adults and their caregivers to take charge of their audiovestibular health.

I am excited to report that AuDacity 2019 will feature a day of general sessions, focused on important clinical and business considerations and critical aspects related to serving a health-diverse aging population across the spectrum of care.

AuDacity's keynote presentation will be delivered by Esther Oh, M.D., a renowned psychiatrist and geriatrician at Johns Hopkins Medicine, who will discuss cognitive decline, dementia and their relationship to hearing loss. Other featured session speakers include Jeff Weiss, who will help us better understand the active aging consumer and Dr. Lisa D'Ambrosio from MIT Age Lab who will share relevant information that you can put immediately into action from extensive aging research on technology, health care, and a wellness mindset. Other general session topics include dynamic panel discussions on serving older adults at different points along the wellness-illness continuum, interdisciplinary collaborations, and insurance coverage and financing solutions. You can expect to take away lots of pertinent and useful information to apply right away from AuDacity 2019!

Please see page 42 for more information and the full AuDacity 2019 schedule. ADA is grateful for its partnership with the Maryland Academy of Audiology (MAA) and MAA members, which will undoubtedly make AuDacity 2019, the best yet! I look forward to seeing you at the Gaylord Resort in National Harbor, Maryland in November. For more information and to register, please visit www.audiologist.org. ■

Sound Strategies for Mastering the Initial Patient Contact

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The Importance of a Multi-pronged Patient Acquisition Strategy

It's easy to see that behemoths like Amazon, which combines online shopping, low prices and speedy delivery, are utterly transforming the customer experience. Along with Amazon, however, many smaller companies such as Dollar Shave Club and Stitch Fix are also getting in on the action by offering a convenient, hassle-free product at a reasonable price.

What does this rise of web-based subscription-based services portend for audiologists?

We can agree that every customer - no matter what they are buying - likes quality and convenience at a lower-than-expected price. As Thales Teixeira suggests in his insightful book, *Unlocking the Customer Value Chain*, once customers experience a better buying experience with one good or service, they are more likely to embrace this better, often non-traditional buying experience with other completely unrelated goods and services. Take, for example, DoorDash, a food delivery service that makes it easy for customers to get meals from their favorite restaurant delivered straight to their door. It could be only a matter of time before an increasingly larger number of customers expect similar convenience when buying health-related products, like hearing aids.

As Teixeira astutely illustrates, disruptive businesses are always on the lookout for consumer pain points and they will use modern technology (smartphone apps, wi-fi, credit card transactions) to find a gap in the market to create value for customers (and revenue for themselves). For audiologists, one of the potentially overlooked parts of disruptive innovation is that new companies could make the traditional customer acquisition process more convenient for persons seeking help for their hearing. Arguably, we are already seeing that now with the rise of on-line hearing aid retailers (Listen Lively) and Medicare Advantage contractors.

These upstart business models could force audiologists to adapt their traditional linear business model, in which they control the entire value creation process from acquisition to annual follow-up, to a more blended approach where audiologists partner with other outside companies in the customer acquisition process. And, in return for acquiring new customers, some of the revenue generated from the transaction is, in turn, shared. This issue of AP addresses how one such disruptive business model, managed care contracts, requires some difficult trade-offs if audiologists want to meet the needs of a larger segment of the rapidly aging population. ■



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The Power to Practice



Make a Meaningful Impact Through Mentorship

One of the most common requests that I receive from students and audiologists is to help them find opportunities for formal and/or informal mentoring. Most frequently, these requests come from audiologists who are considering practice ownership and would like to talk to a practice owner about opportunities, financial considerations, legal concerns, and potential pitfalls. In other cases, mentees (of all ages and all professional stages) seek very specific input on how to handle a particular situation or issue within their practice or professional landscape. Students often desire to explore different practice settings and learn about the business of audiology.

Every mentoring relationship is unique. Some mentorships are long-term (I know of one approaching a decade), while others may last for only a few email exchanges or phone calls. Finding a mentor with a compatible communication style, availability, and communication preferences is just as important as identifying someone with the experience or knowledge that you seek. Establishing expectations for the level of formality and scope of the mentorship is also important for success.

ADA was founded on the principles of bringing together a community of like-minded audiologists for the purpose of advancing autonomous practice and best clinical and business practices. The most effective way to do that is often through sharing knowledge with peers and future Doctors of Audiology. One of the most surprising things I have discovered over the years in facilitating ADA's formal and informal mentorship pairings is that the mentor-mentee relationship brings tremendous value to both parties. When I get feedback from mentors, it is often because they want to let me know that they benefited as much (or more) from the mentoring relationship than the mentee did! If you are looking for a meaningful opportunity to give back, pay it forward, and grow in your own knowledge, I encourage you to consider mentoring. ADA has several opportunities available including the following:

1. Mentor a student at AuDacity 2019. Starkey Hearing Technologies has graciously agreed to continue its partnership with ADA to fund student scholarships to the AuDacity Conference, to be held beginning November 14th at the Gaylord Resort in National Harbor, Maryland. ADA is currently seeking mentors to connect and engage with students during ADA Lobby Day and throughout the educational and networking events at AuDacity.
2. Serve as an ADA ad hoc mentor. Are you a practice owner? Do you have a special skill or are you an expert in a particular clinical or business area? If so, it is easy to volunteer to be contacted for informal mentoring inquiries.
3. Become a preceptor and give back to the profession by helping to train future audiologists.
4. Join an ADA Mastermind Group to participate in ongoing peer-to-peer mentoring. These small groups meet virtually to share ideas that help each other succeed.

Contact me at 866-493-5544 or at sczuhajewski@audiologist.org for more information or to sign up for any of these mentoring opportunities. ■



THIRD-PARTY REFERRALS

Do they provide enough financial value?

by Austin Singleton, Au.D. and Patty Greene, MA

For the independent provider, the need to maintain a profitable clinic is a daily concern. Even the most successful independents must focus on how to acquire and retain customers, stay competitive, and increase the bottom line. As a result, one of the most important questions to ask when making business decisions is, “How will this affect my clinic’s profitability?” Third-party referrals have been one of the more controversial topics of debate among providers over the past few years. Are they a positive—and have the potential to increase overall profitability—or a negative because they compete directly with the retail business? To answer that question, every independent provider needs to be able to calculate the economic value a third-party referral offers their clinic. To do this accurately, it is important to account for all factors related to profitability rather than only looking at topline revenue per sale. The most accurate way to do this is to calculate the *profit per patient per hour (PPPPH)*. How to perform this calculation is explored in detail later in this article, but first it’s important to understand today’s consumer mentality and why third-parties are attracting them.

Why Hearing Aid Consumers Go Through Third Parties

The internet has played a major role in creating a hearing aid consumer who is more knowledgeable about hearing aid technology, pricing, and the many avenues available for purchasing them. Readily available information and online consumer reviews and recommendations often compete directly with the independent provider’s marketing in attracting consumers to a non-traditional path for purchasing hearing aids. Some of these paths include the provider and some do not. For example, direct-to-consumer options—like iHear Medical, BuyHear and Audicus—exclude audiologists altogether. On the other hand, many third-party referral companies—like TruHearing, EPIC, Hearing Care Solutions, and Hear.com, do include providers in the hearing care process. However, not all third-party companies attract the same types of consumers or operate in the same manner. Some use online direct-to-consumer marketing practices to generate leads, which are then funneled to the providers within their network. Others operate using a managed-care model by partnering with insurers to offer their services to members in the form of a benefit or discount. In both cases, audiologists are paid a professional fee—which varies by company—for dispensing hearing aids to these third-party referrals. Consumers who decide to go through third-parties may do so for some or all of the following reasons: (a) they believe their insurer, or the online channel is a trusted resource for hearing healthcare information and/or services, (b) they are attracted by the promise of saving money on their hearing healthcare, and (c) they believe they will receive the best overall value.

Comparing Profit from a Retail Patient versus a Third-party Referral

Historically, average selling price (ASP) and total number of hearing aids sold have been strong indicators of the financial health of a retail clinic. However, this is no longer accurate because competitive market pressures have compressed margins on hearing aid sales and because not all hearing aid sales are out-of-pocket. Today, many providers work with a mix of hearing aid buyers - third-party

referrals for which a professional fitting fee is paid to the provider and those patients who pay out-of-pocket. These market changes have made it necessary for providers to calculate profit in a new way – profit per patient per hour (PPPPH).

Audiologists who know their PPPPH, will be able to utilize this data to make informed financial decisions to maintain a successful clinic. For example, understanding their practices’ PPPPH can help audiologists determine if third-party referrals are a good financial fit for their practices, the financial impact of offering free hearing tests, or whether to shift their business to a medical model where patients are charged for value-based services, rather than continuing to focus on the income from the sale of a consumer product.

Gathering the Right Data to Measure Profit Accurately

It’s important to note that calculating profit per patient per hour (PPPPH) is not the same calculation or the same numerical value as how much profit your clinic needs to keep its doors open.

To calculate profit from retail patients and from third-party referrals, all factors which influence profitability must be measured and tracked independently for each type of patient. This is because not all metrics apply to both types of patients. For example, there is no customer acquisition cost or cost of goods for third-party referrals but there is for retail patients. Also, it’s important to keep in mind that these metrics will be different for each third-party referral company, therefore, PPPPH must be calculated independently for each third-party company as well. A closer look at what data points must be measured and whether they influence retail profitability, third-party referral profitability or both are shown in Table 1.

Table 1: Data needed to calculate profit per patient per hour

Metric	Definition	Track for retail, third-party or both patient types
Average Customer acquisition cost (CAC)	Annual marketing spend divided by total # of sales opportunities, which include: <ul style="list-style-type: none"> • All patients seen who were tested, screened, demo'd, trialed or recommended hearing aids even if they did not purchase 	<ul style="list-style-type: none"> • Applies to retail patients only • No cost to acquire a third-party referral
Average selling price (ASP)	<ul style="list-style-type: none"> • Average sales price of hearing aids sold in the clinic • Include all price points when averaging 	<ul style="list-style-type: none"> • Retail sales: track ASP • Third party referrals: track average professional fees paid
Average cost of goods sold (COGS)	<ul style="list-style-type: none"> • Average cost to provider for all hearing aids sold in the clinic 	<ul style="list-style-type: none"> • Applies to retail patients only • Providers don't pay for hearing aids sold to third-party referrals
Average closing rate	<ul style="list-style-type: none"> • Of the <u>total</u> number of patients seen in your clinic annually, what percentage buy hearing aids? 	<ul style="list-style-type: none"> • Track independently for both retail and third-party referrals
Average return rate	<ul style="list-style-type: none"> • Of the <u>total</u> number of hearing aids sold annually, what percentage are returned? 	<ul style="list-style-type: none"> • Track independently for both retail and third-party referrals
Average number of hearing aids sold per patient	<ul style="list-style-type: none"> • Total # of hearing aids sold divided by total # of patients who purchased • Note – industry retail average is 1.72¹ 	<ul style="list-style-type: none"> • Track independently for both retail and third-party referrals
Average number of times the patient is seen after the fitting	<ul style="list-style-type: none"> • Average # of visits per patient during the first 12 months, after the initial fitting? 	<ul style="list-style-type: none"> • Track independently for both retail and third-party referrals
Time spent on: hearing exam, fitting visit, follow up visit	What is the average time spent performing: <ul style="list-style-type: none"> • Hearing exam • Fitting visit • Follow up visit 	<ul style="list-style-type: none"> • Track independently for both retail and third-party referrals
Amount paid for: hearing exam, fitting, follow-up visit	What is the average fee you are paid for: <ul style="list-style-type: none"> • Hearing exam • Fitting visit • Follow up visit 	<ul style="list-style-type: none"> • Applies to retail and third party referrals • Track each type independently
Average transaction fees incurred for patient financing	<ul style="list-style-type: none"> • Average fee incurred by the provider for patient hearing aid financing 	<ul style="list-style-type: none"> • Applies to retail patients only • Provider does not incur a transaction fee for third-party sales

As Table 1 indicates, a multitude of factors influence profitability. Although it is not expected that the profit from a third-party referral will be greater than from a retail sale in the first year, many providers who have performed this calculation have been surprised that the profit margin was much closer than expected. Becoming knowledgeable about their specific clinic's data further supported their decision to accept third-party referrals.

Calculating Profit per Patient per Hour

Once the data outlined in Table 1 is gathered, the profit per patient per hour (PPPPH) calculation can be completed. Providers are encouraged to contact their business or financial advisor for assistance with performing the calculation. Alternatively, for providers who wish to perform the calculations on their own, TruHearing has developed a simple-to-use tool, the "TruHearing Financial Calculator." A short video demonstration of the calculator and how one provider uses it in his clinics can be viewed on YouTube titled "TruHearing Financial Calculator."

Providers are invited to contact TruHearing Provider Outreach for a copy of the calculator at 855.286.0550 or provider.outreach@truhearing.com.

For a more in-depth look at managed care, its expansion in the hearing industry and how consumers are driving change, read "Managed Care: Threat or Opportunity" published in *The Hearing Review*, January 2018³. ■

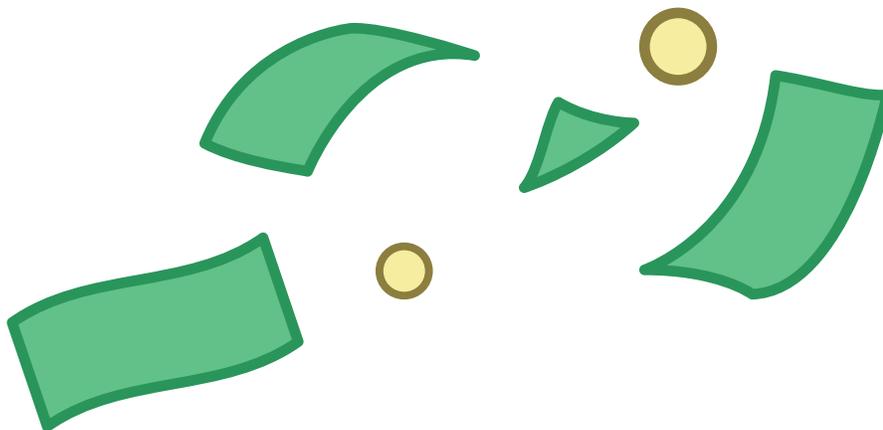
This article first appeared at the Hearing Healthcare and Technology Matter (HHTM) blog in April 2019. It has been republished with permission from HHTM.

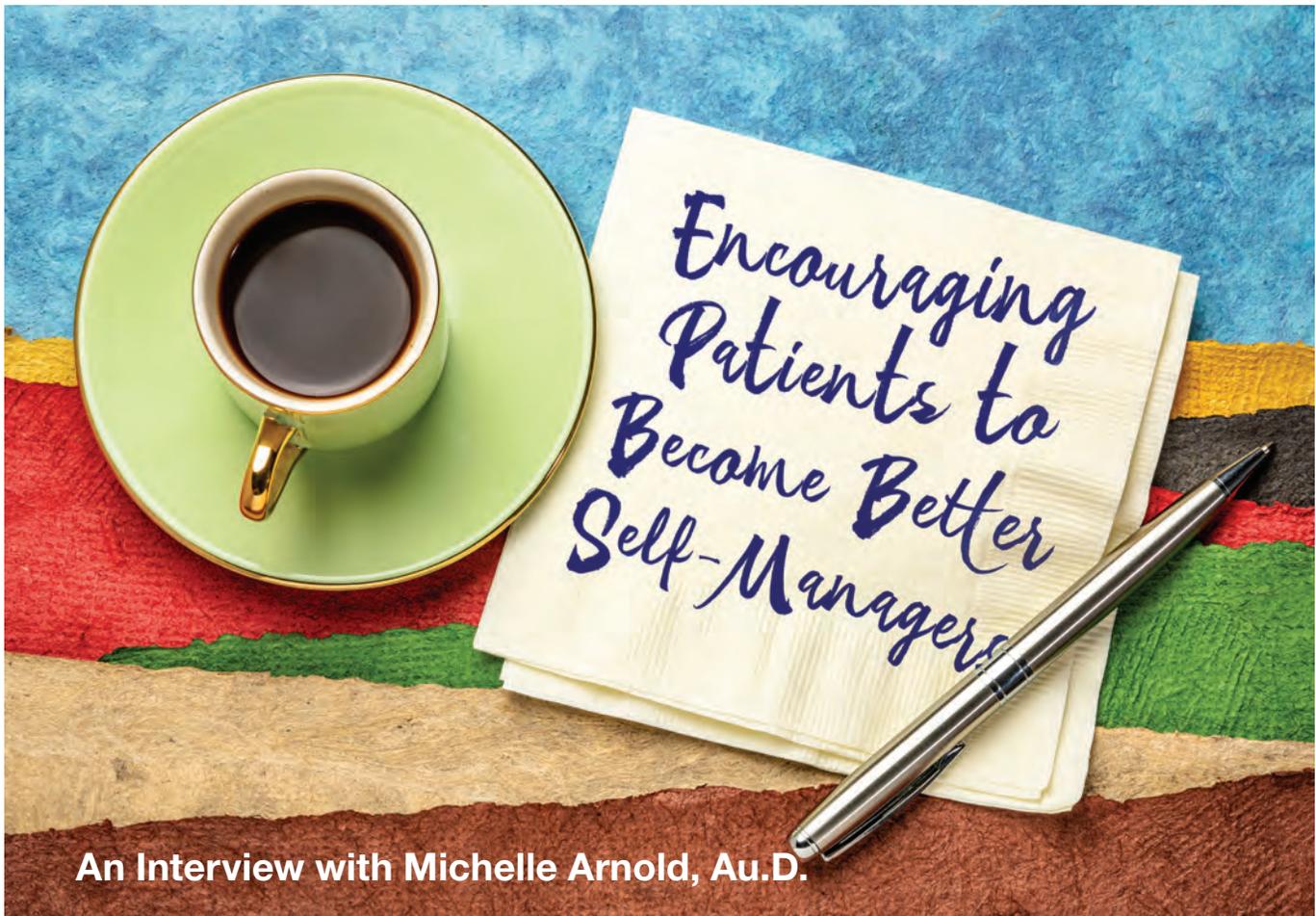
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An Interview with Michelle Arnold, Au.D.

One of the central ironies associated with modern hearing aid use is that as amplification technology becomes more automated and sophisticated, it adds more time and complexity to the fitting process. Anyone who has fitted a pair of hearing aids with direct Bluetooth streaming, near field magnetic induction (NFMI) and user-controlled, smartphone-enabled apps, knows exactly how cutting-edge technology, designed to provide improved patient outcomes, sometimes makes the patient more reliant on the audiologist to “get it right.” One antidote to this dilemma could be the use of self-management skills training.

Hearing loss self-management skills refer to the knowledge and skills people use to manage – as independently as possible – the effects of hearing loss on all aspects of their lives. Moving beyond device mastery skills, teaching individuals to actively identify challenges and solve problems associated with their hearing loss best describes the term self-management. For audiologists, providing self-management skills training could be an opportunity to offer a tangible service that adds value to the traditional bundled service model, or self-management skills training could stand apart from the delivery of a device. Given the likely movement toward more over-the-counter purchases of hearing devices, it’s imperative audiologists offer some type self-management skills training that can be provided to patients who purchased devices elsewhere but are in need of optimizing their use. In addition to a service provision for those buying devices elsewhere, as you will read in this interview with a self-management skills expert, Michelle Arnold, AuD of the University of South Florida, these types of skills should be provided to all patients, regardless of where they may have bought their hearing aids.

To set the stage for Dr. Arnold, let’s get up to speed on some of the essential elements of teaching patients how to be successful self-managers of their condition. Beyond successfully using hearing aids, hearing loss self-management skills encompass maintaining physical and emotional well-being, active monitoring of changes in hearing loss or hearing device effectiveness and

taking an active role in long term care and decision making. In a paradigm that focuses on improving self-management skills, it is the responsibility of the audiologist to help patients acquire these skills.

Self-management skills for adults with hearing loss is defined as the patient independently demonstrating the following behaviors: (1.) Active participation in the goal setting and treatment planning process, (2.) Adherence to an agreed upon treatment plan, (3.) Ability to recognize and manage changes in condition or treatment plan, and (4.) Use of proactive coping strategies when communication becomes challenging or treatment plan falls short of expectations.

When audiologists improve the self-management skills of adults with hearing loss, several benefits are likely to occur: Individuals, who can effectively self-manage their condition, are less likely to show up unannounced in the clinic looking for additional help, they are more likely to keep their scheduled appointments and to experience improved outcomes. All of which help a practice operate more efficiently. To learn more about hearing loss self-management skills and how they can be fostered in your patient, let's turn to my interview with Dr. Arnold.

BT

Tell us a little about your background and how you became interested in issues related to encouraging persons with hearing loss to be better self-managers of their condition?

MA

I am an audiologist and I also have a PhD in Aging Sciences. During my education and training for my AuD, I didn't think a lot about the value of fostering self-efficacy or self-management skills, and those things weren't highlighted in any of my courses. It was my clinical experiences that helped me to realize that self-management is an integral component for success with hearing aids. My research interests are focused on increasing hearing loss awareness and treatment for people from vulnerable populations (i.e., people from low SES backgrounds, people with limited English proficiency, older adults on fixed incomes). I began to look for resources that promoted hearing loss self-management, but the majority of resources weren't suitable from a health literacy standpoint – a concept I was introduced to by delving into the Ida Institute website. At the time I was also tasked with working on self-management materials for a clinical trial planning grant, and I wasn't satisfied with what was available, which led to the development of the Hearing Loss Toolkit for Self-Management®.

BT

Maybe we should step back and look at this issue of hearing loss self-management. Describe for our readers the concept of self-managing a chronic condition and how those principles may apply to work in an audiology clinic?

MA

I think of self-management skills as a reflection of a person's individual self-efficacy. In other words, if a person has high self-efficacy, they feel confident and able to complete tasks or overcome obstacles they perceive as difficult. Self-efficacy is impacted by 4 main learning experiences: (1) mastery experiences, (2) vicarious experiences; (3) persuasive experiences; and (4) emotional arousal experiences. In a clinic setting, self-efficacy can be fostered by providing clients with the different experiences as they relate to the treatment plan. For example, if a person is receiving hearing aids for the first time, providing them opportunities to master hearing aid skills, such as charging the batteries, syncing devices to a smart phone, or cleaning a wax guard, as opposed to simply showing them or demonstrating these skills; these are all mastery experiences. Vicarious experiences can be provided through introducing clients to others who have hearing loss and similar treatment paths – I have a colleague who makes it a point to pair cochlear implant candidates with recent successful recipients so they can observe and learn how they were able to manage the surgery, activation, and follow-up. I think clinicians are probably already providing persuasive experiences, simply by introducing treatment options to clients and telling them that they can be successful. Finally, emotional arousal is impacted by the environment. A rushed, disorganized clinic can trigger negative emotions that will be conveyed then to the intervention, whereas an organized clinic with a calm and empathetic provider will be more likely to foster positive emotions in the client.

BT

What are your thoughts on audiologists offering an unbundled service package that involves helping patients hone their self-management skills? What might that service look like and do you think that type of service package would be valued in a market where people can self-direct their care and buy hearing aids over-the-counter?

MA

I believe that providing clients with the tools to successfully manage their hearing loss shouldn't be de-coupled from the device in an unbundled service package, for several reasons. First, in a rapidly changing professional landscape, where state-of-the-art devices are now available to people with hearing loss at drastically reduced prices compared to what they find in a private practice, the value the clinician will bring to the table is this type of service. I don't believe that private practice will be able to compete with the per-unit prices or manpower of an OTC or big box store anytime soon. What happens when Apple releases an OTC device, and includes the Genius Bar services and classes? Currently, any owner of an Apple device can walk into nearly any mall in the US and attend a Genius Bar course that teaches them how to manage and use their device in a hands-on session – for free. And they hold these sessions EVERY DAY. What about companies like Listen Lively, where a person can receive top of the line technology and follow-up rehabilitation services (including counseling on device use and self-management) for two years – from a licensed AuD – all included in the cost? Pretty much on-demand! Why will a patient want to pay the private practitioner an additional fee on top of an already high ticket price for hearing aids to receive these services when the competitors will be offering them as part of the device cost?

Second, I think that some of the primary obstacles to learning self-management skills are due to a lack of understanding about (1) the negative impacts of untreated hearing loss and (2) a lack of education resources that meet the needs of those with low health literacy. While anyone can have low health literacy, you are much more likely to see this in people from low socio-economic backgrounds. There are already so many cost and access barriers to hearing loss treatment, and these barriers tend to impact those who are probably the most likely to need help with self-management. I find something fundamentally wrong with offering services that I consider necessary for successful hearing loss treatment only to those that can afford to pay for them.

BT

What tools have you developed that a clinician could adapt and potentially use as part of a self-management service package?

MA

Our lab, the Auditory Rehabilitation and Clinical Trials lab (ARCT) developed the Hearing Loss Toolkit for Self-Management®, which is a modular hearing loss education program that can be tailored to the needs of the individual patient. The Toolkit is based on the most current health literacy and patient learning guidelines. Readers can learn more about it in the February 2019 edition of *Seminars in Hearing*.

BT

Turning to your work on help-seeking behavior models, could you familiarize our readers on some of the frameworks used to explain the help seeking behaviors of persons with hearing loss?

MA

I have been lucky enough to have had the opportunity to work with one of the foremost experts in the field in the area of help-seeking for hearing loss, Gabrielle Saunders. Her work (which I collaborate on) encompasses investigating several health behavior models and how they relate to persons with hearing loss. Some of the models include the theory of planned behavior, the health belief model, and the transtheoretical model of behavioral change. The various models seek to predict and explain behaviors related to decisions and actions people make to manage their health, particularly chronic conditions. I highly suggest any readers interested in learning more about the value of applying health behavior models to explaining decisions about hearing loss help-seeking to check out some of her work.



BT

Let's look more closely at the model where you have conducted some research, the Theory of Planned Behavior, tell us about the questionnaire you developed and what it measures?

MA

This questionnaire was developed as part of a larger NIH-funded study where individuals with probably hearing loss are identified at a hearing screening and then followed for 3 years to see what they do (in a nutshell). Do they have a hearing test as recommended? If they have the test, do they follow-up with hearing aids if recommended? Why or why not? Specifically, the theory of planned behavior questionnaire looks at 4 main constructs: intentions to get a hearing test, attitudes about getting a hearing test, how social norms impact the decision to get a hearing test, and a person's confidence that they have the resources and wherewithal to get a hearing test should they want one. We found that the questionnaire reliably differentiates between those who received a hearing test, as recommended, and those that didn't. A measure such as this might be used to tell who might need more counseling or information regarding the negative impacts of untreated hearing loss, or perhaps some motivational interviewing to get at the bottom of why they might not follow through with treatment recommendations.

BT

How might a clinician apply your insights to their own work with patients?

MA

I think overall that shifting focus away from tests and devices and concentrating clinical efforts on meeting the needs of the people sitting in front of you is a great start. Whether it's through providing the best self-management skills training or homing in on addressing the client's individual listening goals, the value of the AuD in the near future will be in providing services – not just diagnostics or devices.

BT

*You mentioned your recent publication in *Seminars in Hearing*, what other work would you recommend to audiologists interested in honing their ability to deliver hearing loss self-management training?*

MA

Sure. Here are some places to start. I was the guest editor of that issues of *Seminars in Hearing*, *Novel Approaches to Fostering Hearing Loss Self-Management in Adults*. It was published earlier this year and you can find it here: <https://www.thieme-connect.com/products/ejournals/issue/10.1055/s-009-42405>.

Also, my colleagues in Australia, led by Elizabeth Convery, PhD, recently published a terrific paper in the *American Journal of Audiology* that looked at the relationship between hearing loss self-management skills and hearing aid benefit. I encourage everyone to read it, as one of the main take-aways is that audiologists can make hearing aid fitting outcomes even better by addressing the psycho-social components of hearing loss. You can find that paper here at this gated site: https://pubs.asha.org/doi/10.1044/2018_AJA-18-0130. ■

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THE RISE OF MANAGED CARE IN AUDIOLOGY WARRANTS A DIFFERENT ECONOMIC MODEL WITH SEPARATE KPIS

by Dan Quall, MS and Brian Taylor, Au.D.

The business of providing hearing services is changing. Unlike days of yore, when a licensed hearing care professional could fit a dozen hearing aids per month and earn a living, today's audiologists are faced with numerous issues that are impacting the top and bottom lines on their profit and loss statements. The availability of hearing aids through big box stores, third party contracts and over-the-counter devices is changing the way audiologists, especially those in private practice are dispensing products and services.

Let's take one of those issues, third party contracts and examine it more closely. We know, for example, that Medicare Advantage programs offering a hearing aid benefit to their members have increased from 47% in 2015 to 73% in 2018 and, given the astronomical numbers of baby-boomers turning 65 every day (10,000 per day in the US), that percentage is expected to increase. Additionally, recent industry reports¹ suggest that by 2023 15% to 20% of hearing aid purchases in the US private market could be partly insured with a third party benefit, and that percentage is expected to grow throughout the 2020's.

To understand both the threat and opportunity facing audiologists with respect to third party contracts, it is helpful to compare the economic model of managed care contracts with the traditional private pay economic model for the commercial distribution of hearing aids. Figure 1 outlines the traditional economic model of the private-pay hearing aid business in which the patient incurs 100% of the out-of-pocket expenses. Using an industry benchmark for retail average selling price of \$2200, Figure 1 shows how the gross revenue per unit is distributed. Note that about 40% of the gross revenue per unit is distributed to the hearing aid manufacturer, while approximately 22% of the gross revenue accounts for acquisition costs accrued by the practice. Although acquisition costs vary widely, conventional wisdom suggests a typical stand-alone private practice spends a substantial percentage on marketing costs such as direct mail advertising, physician outreach, and maintenance of a website – all of which are acquisition costs. At the end the day, the traditional private pay economic model leaves about 35% of gross revenue as a margin for the practice.

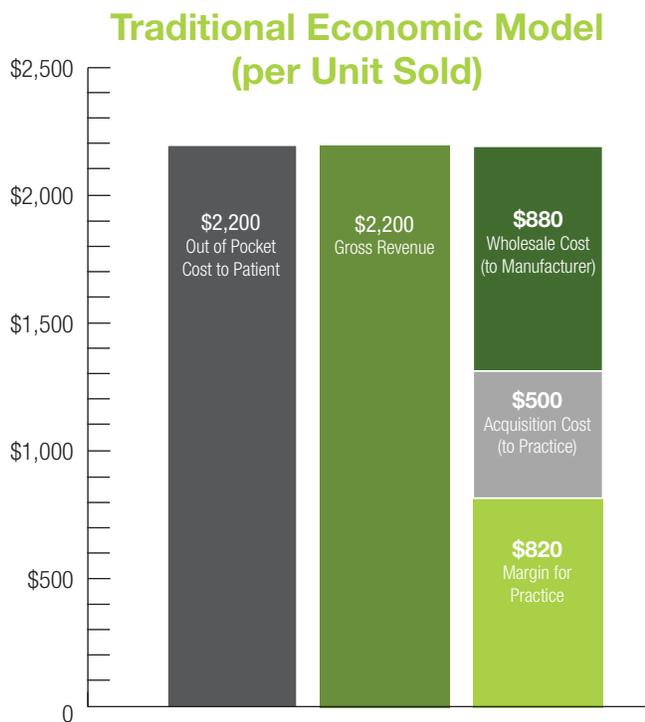


Figure 1. The out-of-pocket private pay economic model: where the money goes

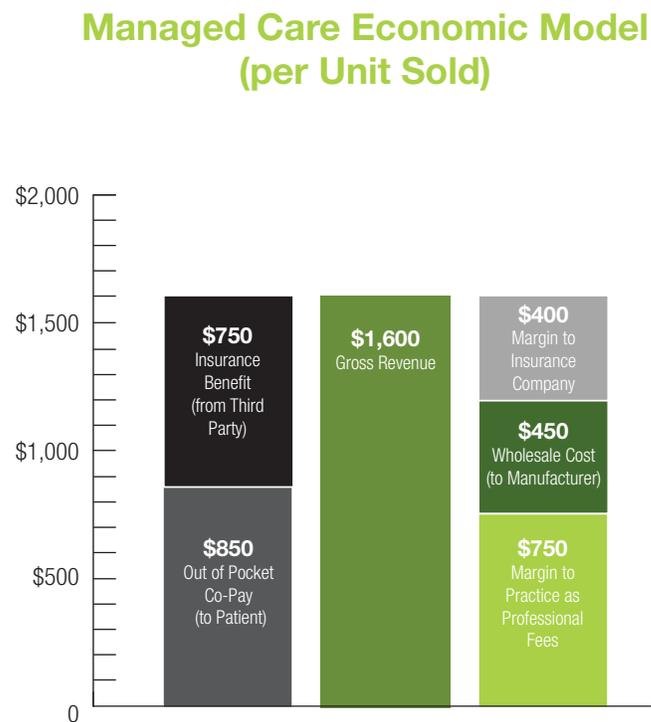


Figure 2. The managed care economic model: where the money goes

This gross margin is then used to pay several costs, including salaries, rent and utilities.

The rise of managed care contracts, with their mandate to control costs and improve utilization of services for their members, necessitates the need for audiologists to manage their business using a different economic model. That model is shown in Figure 2. Note that the patient’s out-of-pocket costs are about two-thirds less compared to the traditional model, with the remaining costs shared by the managed care company (spread across its entire membership in the form of a monthly fee). Also, notice that per-unit gross revenue, on average, is substantially lower than the traditional private pay market. This lower gross revenue number, compared to the traditional economic model, is a by-product of the managed care company’s involvement in the transaction, which is obligated to control costs for their membership. (Without the ability to control the overall costs, and thereby provide their members with a “better deal” on hearing aids, the incentive for consumers to purchase through a managed care contract would be nearly zero.)

As Figure 2 shows, gross revenue is lower in the managed care economic model, providers have zero acquisition costs. Importantly, managed care contracts, with their lower out-of-pocket costs for members, are believed to have the ability to attract new, motivated hearing aid users into a practice.

This is a benefit to all stakeholders in the economic relationship (manufacturers, insurance companies and clinics) as survey data from MarkeTrak 9 suggests that patients with a hearing aid benefit are 20% to 50% more likely to purchase hearing aids if they have an insurance benefit.²

In essence, a managed care economic model asks providers (and manufacturers) for a trade-off. In exchange for access to a pool of new, motivated hearing aid users, providers must give up some margin. It must be noted, however, that the managed care economic model complements, but does not replace, the traditional private pay economic model for hearing aids. Over the next decade or more, these two models are likely to stand side-by-side, each with advantages and limitations for both the patient and the business.

Since managed care contracts use a different economic model to attract patients and distribute revenue, a separate set of key performance indicators (KPIs) are needed to effectively manage this growing part of the business.

Table 1 outlines some of the KPIs that need to be managed in an audiology practice that accepts third party contracts. Each of these KPIs should be compared to similar data from patients that move through the business in the traditional 100% out-of-pocket” route. In addition to managing a different set of KPIs, clinical time spent with each patient, rather

than simply the number of hearing aid units dispensed, must be managed carefully. Given the lower revenue per unit in the managed care economic model, clinicians must be cognizant of how much clinical time they are spending with each patient, and thus must work to optimize their time spent with each patient without compromising quality of care. Now, more than ever, time equals money.

Table 1. Examples of KPIs for a Managed Care Business Model

Managed Care KPIs	Benchmarks
New Patients Per Month	8
Acceptance Rate	85%
Revenue for Practice Per Patient (fitting fee per ear and testing fee)	\$990
Number of Appointments Per Patient Over First Year (post fitting)	4
Time Spent Per Appointment (average)	45

The benchmarks shown in Table 1 serve as rough examples of the types of KPIs that need to be measured in a practice that accepts Medicare Advantage contracts intended to supplement their traditional bread and butter private pay business. Each practice is advised to devise their own set of KPIs that are specific to the needs of the practice. Those shown in Table 1 serve only to make a critical teaching point: Revenue per patient, which is derived from the fitting fee, needs to be measured in relation to the number of appointments per patient and time spent per patient. In the example above, the practice has established the benchmark for appointments over the course of the year at 4, along with a time allotment of 45 minutes per visit. Of course, these are benchmarks and some patients will indeed require more time, but the practice should create and train staff to meet the established benchmarks whenever possible. The use of these KPIs for the managed care side of the business culminate in the all-important use of revenue per hour as a KPI to gauge the financial health of an audiology practice. We examine this KPI next.

REVENUE PER HOUR IS A KPI

The previous section should make it apparent that benchmarking and calculating revenue per clinical hour is an essential KPI in a business that accepts managed care. As the business model changes, and managed care contracts become more widespread, there is a need to change the manner in which we benchmark and measure business outcomes. The standard KPI of gross revenue, units sold and average sale price (ASP), historically utilized to measure success may no longer provide all financial information necessary to make critical business decisions.

Given the current industry trend toward tighter margins, unbundling, and fee for service models, the one financial indicator that bridges both economic models discussed in the first section of this article that providers may consider adding to their financial analytic toolbox of KPIs would be the measure of Revenue Per Hour (RPH).

To understand the relevance of RPH, it is important for clinical managers to recognize how RPH would apply for a traditionally “bundled” hearing aid sale. To make the RPH calculation two data values are required, service time and **gross margin***.

The service vs. time model in Table 2 was developed to understand the total clinic hours spent by a clinician with a typical patient purchasing hearing aids and subsequent services for a five-year period. The following assumptions were made for this model:

- First time wearer of product
- Binaural purchase
- The model represents an “average” or “typical” treatment plan (Some patients require more visits, some fewer)
- A binaural set of hearing aids will require three repairs within a 5-year period. One repair each year after year 2. (based on manufacturer repair rates)
- Repair costs and margins for the out of warranty repairs are not included in the calculation

Table 2. Service vs Time Model

5 Year Model	Appointment Type (time in Hours)								
	Years	Test/HAE	Fit	CHK1	CHK2	6-month Check-up	Annual Check-up	Repair	Total
Y1	1	1	.5	.5	.5	1	-	4.5	4.5
Y2	-	-	-	-	.5	1	-	1.5	6
Y3	-	-	-	-	.5	1	.5	2	8
Y4	-	-	-	-	.5	1	.5	2	10
Y5	-	-	-	-	.5	1	.5	2	12
Total	1	1	.5	.5	2.5	5	1.5	12	40.5

The model shows a total of 17 patient visits with 12 hours of clinician time spent with the patient over five years. Two of the appointments were directly related to the dispensing of the product and 15 were provided as follow-up and continuing service. The model was validated as “typical” for a first-time wearer of hearing aids with more than 30 practice owners in a continuing education class by the author in 2015. Additionally, representatives of Amplifon, in a presentation to the FDA in 2017⁴, reported an average of 15.1 visits for follow-up and check-up appointments (excluding the dispensing appointment) based on analysis of 21,881 patients receiving products in 2010 and receiving continuing services through 2015.

Next, financial analysis must be completed for a bundled sale to obtain the **gross margin** (not the gross revenue) per fitting. In the 2017 survey data from Phonak³, results provided for the median bundled hearing aid sale was reported as \$2,297 monaural or \$4,594 binaural. Assuming a wholesale cost of goods of \$758 per unit or \$1516 for two units (33% COG, use your specific business data) the **gross margin** for this “Advanced” set of hearing aids would be \$3,078.

The RPH for this treatment plan, given new hearing aids are not purchased before five years, would be as follows:

Gross Margin, \$3,078, divided by clinical hours (12) = \$257/hour or \$257 RPH.

A summarization of what we know using this calculation: If a bundled hearing aid treatment plan is dispensed at \$4,594 and the patient follows the typical follow-up and treatment plan, the clinic will have realized **gross margin** of \$257 for each hour spent with the patient.

The next two questions:

- Is \$257 RPH healthy for the clinic?
- Why is this rate important to a clinical manager?

To answer the first question a macro **gross margin** was calculated to determine an aggregate RPH for a full year of financial data. Again, utilizing data from the recent Phonak³ study the following was calculated for a median practice:

Median Gross Revenue	\$510,000
Median Gross Revenue from Hearing Aid sales: 71% **	\$362,100

RPH calculation:

Gross Margin from hearing aid sales: 68% of hearing aid sales	\$246,228
Gross Margin from services and other products: 27.5%	<u>\$140,250</u>
Total Gross Margin for all sales and service	\$386,478
Median Hours reported per clinic	2080
Median Aggregate Gross Margin per hour	\$186 RPH

A summarization of what we know using an annual RPH calculation: Given an office that grosses \$510,000 annually, based on median reported clinical activity, the providers are generating \$186 for each hour spent with a patient for all activities provided by the clinic. The difference between the Gross Margin by product vs. gross margin aggregate is \$71 per hour. This difference is possibly due to lack of efficiency by appointment type, giving away services for no charge, billing inefficiency or some combination of all them.

Of more relevance is our second question. Why is this important? As a hearing healthcare business contemplates inclusion into healthcare/hearing aid contracts or expansion to a multi-disciplinary model, the business manager needs a metric that provides an “apples to apples” comparison of revenue by potential services. Using the RPH metric, we can finally compare our bundled hearing aid service models with other non-bundled services whether it is cochlear implants, tinnitus therapy, balance assessment or a fitting fee. Consider the following example.

Should a clinic sign up in network to accept the following fitting/service fee for contracted hearing aid services?

- Testing fee: \$75
- Fitting fee: \$425 per ear
- Required visits for the fitting fee: Dispensing session, and three follow-up appointments
- Additional appts: \$65 per visit or an annual service contract of \$250

Based on the service model above and assuming a binaural fitting, a calculation of required hours vs. reimbursement for the initial fit and follow-up would look like this:

	Clinical Time	Reimbursement
Test	1 hour	\$75
Fit	1 hour	\$850 (bilateral)
CHK 1	.5 hour	\$0
CHK 2	.5 hour	\$0
CHK 3	.5 hour	\$0
Total	3.5 hours	\$925

The RPH, \$925/3.5hrs, equals \$264 RPH. Compared to an Advance Bundled RPH of \$257 or an aggregate RPH of \$186, this would appear to be excellent. The difference is, however, in a bundled scenario the patient has “pre-paid” for nine additional hours of service, in the future, at a rate of \$257 per hour. The calculation for the contracted services should also be done looking at revenue over five years. That calculation would look like this:

	Clinical Time	Reimbursement
Test	1 hour	\$75
Fit	1 hour	\$850 (bilateral)
CHK 1	.5 hour	\$0
CHK 2	.5 hour	\$0
CHK 3	.5 hour	\$0
5 years	5 hours	\$1250 (5 yrs X \$250)
Total	12 hours	\$2175

The RPH, \$2175/12hrs, equals \$181 RPH. Compared to an Advance Bundled RPH of \$257 or an aggregate RPH of \$186, this would appear to still be reasonable. It becomes even more attractive with the additional value of the “three R’s” provided by a new patient; Repeat business, Related purchases (batteries, repairs, ear wax removal, etc.) and Referrals. When it comes to analysis of contracts it’s not what you are reimbursed, it’s *how much time* is required for what you are reimbursed. This article hopes to provide some of the essential elements of calculating revenue per hour and KPIs that need to be measured in a business that accepts third party contracts. ■

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BUSINESS PLANNING

Setting and achieving business goals are often how we measure success. The tricky part is what happens between setting the goal and achieving it. Growth of a practice and financial success don't just happen overnight. They take hard work and intentional planning. As many business owners know, it is no simple task. Too often, audiologists get caught in the minutia of daily clinic life. Providing patient-centered care, charting, staffing, etc. can take most of our focus. Business decisions get put on the back burner and are made from a place of reaction.

to ROCK your WORLD

by Indira Alvarez, Au.D.

Failure to plan leads to less control of our business environment and ultimately our success. However, if we can flip our approach on its head and be intentional with our business decisions, we will be *proactive* instead of *reactive* and in full control of our environment. According to Clear¹ business professionals who keep goals at the forefront and are purposeful in their business planning, are more apt to have a successful and fulfilling journey to success. So where do we start with intentional business planning and setting goals?

WRITE IT OUT

Did you know that setting a goal doubles the chance of succeeding? If you take it a step further and write out a thorough measurable goal, it is *ten* times more likely to come to fruition¹.

- * Writing goals down makes it easier to remember them.
- * Posting your goals where you can see them, makes thinking about and acting on them part of your daily routine.
- * The process of putting your goals on paper will force you to really evaluate them, strategize for the future, think about your current processes, and start to brainstorm how to attack the goals.

The process of writing out goals can be as simple as utilizing key words, bullet points, pictures, or phrases. For example, if your goal is to take your family to Tahiti, print out photos of that beautiful island to motivate you. There will be times you need a boost of motivation to stay on track. That's when you pull out your pictures and written goals. Getting refocused will recharge you and help you push forward toward the goal, and before you know it, you will find yourself relaxing in Tahiti with your family. When it comes to managing a successful practice, the process is the same. Documentation is a must for success, and this starts with the goals.

PLAN IT OUT

Next, move to documenting the plan to achieve your goals. The journey to achieving goals for practice success may be a tough path and you will likely have to step outside your comfort zone. Your plan is the "owner's manual/users guide" for your practice. It provides the strategic framework and steps to operationalize your goals. It is also there to pull out of the drawer when you need to review or go back a step to stay on track. There are several influential factors that we need to consider when building our plan. These are efficiency, drive, creativity, and mindset.

Your plan will drive the activities and behaviors of your practice. Are you headed straight towards a destination or veering off course? You are the captain of the ship and a solid, intentional business plan will help you to navigate confidently. Having a clear understanding of where you are headed will provide direction and motivation to help encourage your employees to join and work with you to achieve the goals. Your entire team will feel confident that there is a rationale for all of the daily activities in the practice.

Get creative. Think outside the proverbial box and be willing to change current processes. Focus on the end goals with an open mind, to see things differently and find new ways to approach obstacles that you may not have thought of before. Take marketing, for example. Do you market with intention? Do you plan before and analyze after to see if the intended impact occurred? If you intentionally review your marketing and evaluate its success, you can assess whether

As a business coach, I encourage anyone in a position of leadership to have their staff establish personal goals. It is a wonderful feeling as an owner to know what your employees value, and it is a highly effective tactic to work together create goals that will enable each team member to contribute to and to strive to achieve. In my experience, clinics that incorporate and add focus to employee goals, alongside the main business goals, readily succeed because the staff are more engaged and invested in the practice.

a particular campaign should be repeated or if it's time to change the plan and try something new.

WORK IT OUT

Time is money and there are only so many hours in the day. We have all heard those clichés, and while they are both true, if we are efficient with the hours that we are given in a day, we can generate more money with the same amount of time spent in the clinic. By starting with the highest priority goal, or a shorter-term goal, we can reverse engineer the steps to get there and be more effective and efficient in our work. Utilize to-do lists in your practice. As with goals, simply writing down tasks and to-dos markedly increases the likelihood that they will get completed. When you have a plan and a list, you won't find yourself wondering, "Did I accomplish anything today?" You will know exactly what you did and what is left to do.

THINK IT OUT

So far, we have established the pathway to progress through goal-setting, planning, and action. While we are checking off things on our to-do lists, seeing patients, cooking dinner, or even sleeping, our subconscious mind is always thinking and working towards our goals. In fact, your mind is one of the most powerful and influential factors in your success. Taking time daily to focus on your mindset can make a large and lasting impact on your ability to achieve your goals. Believing that you will reach your goals in your mind, will show outwardly in your stride, your attitude, and your affect when speaking to others. People will take notice and you may even have a positive influence on their mindset as well.

COUNT IT OUT

Now that we have covered the basics, let's step it up! Explosive growth is within reach, even in just a few months. To get there, we need one important thing (besides coffee, of course) and that is *data*. You need to know where you are, in order to figure out how to get where you're going. Once you have a starting point, you can track results to measure success. Tracking data allows you to see what is working and where there are areas for improvement. .

At the bare minimum, for a hearing aid dispensing practice, you should know your average per unit selling price (ASP), the number of units dispensed per month, and your help

rate (the number of patients you treated, divided by the total number of consults for the time period, multiplied by 100),

Financial data analysis is imperative. Gross revenue is a marker that is essential to track. Other important data include the cost of goods sold (COGS), expenses, marketing costs, and net income. Accurate recording of this data is crucial so training of staff that will be reporting these numbers is critical. Tracking and planning with incomplete or inaccurate data will move you backwards instead of forwards in the goal attaining journey. Implementing an Office Management System (OMS) makes digitally tracking and analyzing your data much more efficient. If you haven't already, add 'Researching OMS Systems' to your to-do list. There are many OMS products and each of them has merits—your job is to identify the one that best suits your practice.

In the meantime, let's look at a real-world example of exponential growth through data tracking. We will start with calculating anticipated gross revenue for hearing aids using three basic key performance indicators (KPI's): number of patients (or treatable ears), ASP, and help rate. These are easy to calculate and should become, if they aren't already, something you know off the top of your head each month. Onto the math. Imagine that you see four new patients per week, who have a treatable, bilateral hearing loss (8 ears). Your data reflects a \$2100 ASP per unit, and a 50% help rate.

HA Anticipated Gross Revenue Formula

Number of treatable ears X ASP per unit X the help rate or
 $8 \times \$2,100 \times 50\% = \$8,400$ per week or \$33,600 per month.

Next, use this data to establish a new stretch goal (perhaps to hit \$50,000 in revenue a month). How do you get there? Intentionality and reverse engineering. Let's look at three ways you could shift each of these KPIs to attain the new goal.

1. If you increase your patients by just two per week (4 ears) and keep the other two the same, you would increase to \$16,800 a week totaling \$50,400 for the month.
2. If you increase your ASP by \$200 a unit, (yes this does mean possibly increasing your prices), you would increase to \$9,200 a week for a total of \$36,000. Not quite the \$50,000 we're looking for, but this is the easiest KPI to adjust and implement compared to number of patients or help rate.
3. If you increase your help rate from the industry average of 50% to 75% without changing the other KPIs you would increase to \$12,600 a week for a monthly total of \$50,400.

Breaking down your goal and looking at it from different angles can help you decide which route to go in your planning process. If you want to see more patients every week, consider looking at your scheduling, front office intake calls, or marketing. If you want to increase ASP, examine pricing structure. If you decide to increase the help rate, the first step is to review and improve your consult process.

Amplifying Growth

Now, imagine if you took it another step forward and adjusted two or all three of these KPIs, simultaneously? If you implemented all three tactics listed above, you would almost *triple* your revenue, from \$33,600 to \$82,800. Let that sink in a moment. What could you do with an extra \$50,000 per month in revenue? How much faster would you hit your goals? *Stacking*, or implementing multiple things concurrently improves the chances for success. Remember, these were just three of the dozens of data points and KPIs that exist in a practice. The possibilities for growth are virtually endless.

This is the power of planning and reverse engineering. Once you know the impact that changing a measure can have on your business, you can jump right into figuring out how to make it happen. *Focused intention means immediate traction.*

Getting Technical

After your goals are written and you have started the planning process, it is time to look for gaps. (A gap is the delta between the goal you have established, and the actual data collected.) Examine your existing data against your goals to find the deficits, the gaps. If your current revenue is \$33,600 and your goal is \$50,000 you will know the gap, or more realistically the “mini goal” is to increase revenue by \$16,400.

Computer-based spreadsheet and executive dashboard software programs are an asset to this process and provide a visual means to quickly analyze data. Tacking a yearly calendar up on your wall and/or using a white board for jotting down ideas and notes can also be really helpful in terms of staying on top of where to apply resources toward improvements. If you decide to focus on a gap related to the number of patients seen in the clinic per day, then you need to strategize with your team on ways to make this happen. How often do you reach out to your tested-not-treated patients who are in your database? What is your marketing plan for the quarter? Accountability is imperative and getting your staff engaged in these meetings, and strategy sessions will help you stay accountable in this process and keep them engaged as well.

Once you have identified and prioritized your gaps, work backwards to figure out how to close them. Reverse engineering, simply put, is taking your goals and working backwards to break them down into small manageable bite-sized pieces so that you do not become overwhelmed and stay on course.

STACK IT UP

Let's put these goal-achieving initiatives together and consider one final concept that will bring the effectiveness of your planning full circle. When you use the basic concepts of exponential growth to your advantage, it doesn't take a large amount of effort to see big results. Stacking, as mentioned earlier, will increase profit while decreasing the amount of time needed for results. Stacking can be used and applied to all of your goals, just as it is to leverage financial growth. Stacking allows you to use one goal to set you up to hit the ground running with the next goal. For example, if your goal is to increase the number of patients seen by one per week (keeping the same stats from earlier), you would increase your monthly revenue by \$8,400. If you take this profit and invest it into marketing initiatives, you could see an increase to two or three more patients a week, which increases your monthly revenue even more. You could then decide to take the additional revenue and hire a practice manager or community liaison. Both positions can play crucial roles in efficiency and growth for the practice. They, in turn, will provide cost-saving or revenue-generating opportunities. Achieving your first goal has fueled success for future goals, exponential growth, and identifying new goals to strive towards. Success is being stacked.

**SUCCESS IS
BEING STACKED.**

CONCLUSION

Once you change your thinking, plan strategically, and monitor daily activities, you can take the steps to stack success and reach your goals more efficiently. How exciting would it be to always have to set new goals for yourself, your practice, and your team, because you keep crushing the ones you set? Even small incremental shifts in business strategy can have a huge impact. Being in the right mindset and confident in your planning will help you to step boldly forward. You will be ready to take calculated chances and achieve personal and professional growth along the way.

There is no secret formula for success. It is achievable and uncomplicated. Write down your goals, reverse engineer the steps to get there, step beyond your comfort zone, and last, but certainly not least, celebrate your successes. You did it! You built and then rocked your plan. You hit your goal, so take the time to enjoy the victory...and then come up with a new goal to tackle, because you are ready for anything. I did it and you can, too! ■

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ACCESS TO MEDICAID HEARING HEALTH SERVICES FOR ADULTS

POLICIES, PERCEPTIONS, AND PROPOSED RECOMMENDATIONS FOR IMPROVED ACCESS TO CARE

By Stephanie Czuhajewski, MPH, CAE

The following are selected excerpts from a policy analysis, written for course credit at the University of New England.

INTRODUCTION

Access to audiologic treatment services for vulnerable adult populations across the United States is limited by Medicaid coverage policies. The Centers for Medicare and Medicaid Services (CMS) classifies “hearing disorder services” among optional benefits for adult Medicaid beneficiaries.¹ As a result, Medicaid coverage of hearing evaluation and treatment services for adult Medicaid beneficiaries is unreliable and lacking. Currently, only 30 U.S. states provide audiology and hearing aid coverage for this population.^{2,3,4} Even in states that opt to provide adult Medicaid coverage for hearing disorders, patient access to hearing healthcare services is often erratic. Varying levels of Medicaid coverage and state regulatory policies routinely impede provider participation and restrict treatment.

HEARING HEALTH TREATMENT DISPARITIES

Despite the significant risks and costs associated with untreated hearing loss and the promising evidence of the benefits of treatment, only about 25% of those who would benefit from hearing aids are using them, and that rate of adoption has

remained unchanged since 1980.⁵ High costs and poor access to hearing health care services have been identified as two key barriers to hearing care for adults.^{5,6,7} A 2018 study of 1,133 Medicare beneficiaries who self-identified as hearing aid users, identified income as a primary determinant of whether or not they received hearing treatment services.⁸ In all, less than 40% of these hearing aid wearers obtained hearing health services in the previous 12 months.⁸ Further, among low-income, Medicaid-eligible, Medicare participants (dually eligible), 27% of respondents reported “having a lot of trouble hearing with a hearing aid.”⁸

Medicare Part B covers medically necessary diagnostic audiology services. However, hearing aids and much-needed audiologic treatment services such as hearing aid candidacy determination, hearing aid fitting and programming, counseling, auditory rehabilitation services performed in conjunction with hearing aid services, and hearing health follow-up care are statutorily excluded from Medicare Part B coverage.⁹ More than 10 million Americans are eligible for both Medicare and Medicaid benefits, including 45% of non-elderly adults with disabilities and 60% of nursing home residents.¹⁰ These dually eligible beneficiaries often carry substantial disease burdens, and are the greatest cost burden beneficiary segment in both programs.¹⁰

CURRENT MEDICAID LANDSCAPE

CMS provides regulatory oversight and shared financial support for state Medicaid programs. States are required to cover categorically eligible populations including the elderly, disabled, pregnant women, and families with children. CMS also dictates a core set of services that must be covered and regulates certain enrollment and reporting processes. Beyond that, states have considerable latitude in structuring Medicaid benefit coverage and payment models, eligibility requirements, cost-sharing, and administrative oversight.¹⁰

The comprehensive review of state Medicaid hearing aid coverage policies affecting adults across the United States, conducted by Arnold et al. in 2016,² found that coverage variances posed challenges for effective hearing health service delivery along the hearing health continuum.² The authors used a systematic approach to rate each state Medicaid program, based on beneficiary eligibility criteria and coverage of the following: assessment and treatment of hearing loss, allowance for two hearing aids (when two are medically necessary), follow up care, supplies and repairs (including batteries), and the replacement of hearing devices at regular intervals.²

Study data show significant discrepancies among states providing Medicaid coverage for hearing aids and associated services, related to required hearing loss thresholds for coverage, coverage models, amounts, and methods of payment for devices and services.² The study data also indicate a tendency by many state Medicaid programs, to prioritize coverage for hearing aid devices over therapeutic audiology services such as counseling, rehabilitation, and follow up treatments that are usually necessary for patient success with hearing aids. The authors noted that, in several states, service coverage policies were ambiguous, which could pose ethical dilemmas for providers and lead to inconsistent or deficient standards of care.²

A DEEPER ANALYSIS OF COVERAGE FOR FOUR SELECTED STATES

Using data obtained from the Arnold et al. study, *Medicaid Hearing Aid Coverage for Older Adult Beneficiaries: A State-By-State Comparison*,⁴ four states were selected for further analysis: California, Indiana, Massachusetts, and Texas, as depicted in Table 1. Each selected state achieved a rating of either excellent or good by Arnold et al., for quality of adult Medicaid hearing health coverage. Selection criteria for states to examine as part of the policy analysis also included geographic diversity, state government political composition, and the percentage of the non-child Medicaid population in relation to the overall Medicaid population.^{11,12,13,14,15}

Table 1: State Demographics for Selected States

State	Total Non-Child Medicaid Population* (Millions)	Total Medicaid Population (Millions)	Population (Millions)	Political Party Controlling State Government	Percentage of Adults with Hearing Loss	Medicaid Expenditures as Percent of Total State Expenditures	Medicaid Expansion Under Affordable Care Act?
CA	10.02	14.66	39.54	Legislature (D) Executive (D)	12.3%	33.7%	Yes
IN	.58	1.3	6.67	Legislature (R) Executive (R)	18.3%	34.5%	Yes
MA	1.44	1.95	6.86	Legislature (D) Executive (R)	16.3%	28.8%	Yes
TX	1.8	5.07	28.3	Legislature (R) Executive (R)	16%	30.9%	No

*Non-child includes adult, elderly, and disabled.

POLICY DOCUMENTATION

Medicaid coverage for hearing aids, supplies, repairs, and associated audiology provider services for adults in each state was catalogued using Medicaid coverage manuals, provider handbooks, and provider fee schedules from each selected state.^{16,17,18,19,20} Provider reimbursement and authorization requirements were also documented.

QUALITATIVE INTERVIEWS WITH AUDIOLOGY PRACTICE REPRESENTATIVES IN SELECTED STATES

Study participants included a non-probability, purposeful sample of 14 audiology practice representatives, in California, Indiana, Massachusetts, and Texas. Recorded telephone interviews were conducted with each practice representative using a combination of scripted questions and open dialogue to capture audiologists' perceptions about Medicaid coverage of hearing aids and associated healthcare services in their states. Interview recordings were transcribed using Sonix transcription software. Qualitative data was subsequently manually coded, sorted, compared, and grouped into common themes.

RESEARCH FINDINGS: REVIEW OF PROVIDER MANUALS

The analysis of state Medicaid provider manuals, coverage policies, and audiologist fee schedules from California, Indiana, Massachusetts, and Texas revealed significant programmatic coverage diversity. Three out of four states' Medicaid policies contained minimum requirements for treatment that appear inconsistent with published clinical standards and pose barriers to evidence-based hearing care.^{16,17,20} For example, two of the state hearing aid coverage benefit manuals (California and Indiana) contain outdated hearing aid specification requirements that default to analog devices and allow for coverage of programmable and/or digital hearing aids only if certain audiologic conditions are present, and/or if a second prior authorization is obtained.^{16,17} Digital hearing aids, introduced in 1996, and programmable hearing aids, introduced in 2000, are the accepted standard of care today.²¹ Mandating additional requirements for the most frequently used devices is potentially burdensome to patients and audiologists, and provides no additional value to the Medicaid system.

According to the *Texas Medicaid Providers Manual Vision and Hearing Services Handbook*, Texas Medicaid insurance will cover a maximum of one hearing aid for adults diagnosed with a 35 dB or greater loss in both ears.²⁰ Adult Medicaid beneficiaries in Texas are not eligible for binaural amplification, even when it is deemed medically necessary, nor are they eligible for treatment with amplification for unilateral hearing loss under any circumstances.

Evidence-based guidelines require audiologists to assess more than just the measured degree of hearing loss when making treatment recommendations for patients.²² Texas' restrictive eligibility and dispensing requirements do not consider the cause, type, and impact of the hearing loss or associated auditory processing functions unique to each patient, or the patient's potential for success with amplification, based on his environment and communication needs.

Inconsistent coverage directives and requirements for hearing aids and accessories, as well as varied reimbursement schemes for diagnostic and treatment services were found across the state Medicaid programs studied, indicating a lack of consensus regarding the importance and value of audiologic and hearing aid services by state Medicaid policy officials. There were notable discrepancies among states with regard to reimbursement for comprehensive diagnostic testing, hearing aid selection, fitting, and verification services, as well as treatment services including follow-up consultations, auditory rehabilitation, and hearing aid repair services. Hearing aid coverage amounts also varied considerably state to state.

The most consistent feature of policies across states, based on information contained in the policy manuals, is the requirement for redundant referral, medical clearance, and/or prior authorization requirements, which force patients to go back and forth between providers, wasting time and money.

RESEARCH FINDINGS: INTERVIEW RESULTS

Interviews with audiology practice representatives yielded important information and a deeper understanding of the perceptions of providers and administrators, regarding the influence and impact of Medicaid policies on care quality and access to hearing aids and treatment services for adult beneficiaries in their states. Characteristics of the practices and study participants included small practices (defined for this study as practices employing five audiologist providers or fewer), medium practices (defined for this study as practices employing six to 10 audiologist providers), and large practices (defined for this study as practices employing greater than 10 audiologist providers). Practices from rural, suburban, and urban locations were represented. A breakdown of practice characteristics by state can be found in Table 2.

Table 2: Audiology Practice Study Participant Demographics

State	Number of Audiology Practice Representatives Interviewed	Number of Audiology Practices Accepting Medicaid	*Practice/Clinic Size	Location
California	4	1	3 Small and 1 Large	2 Urban, 2 Suburban
Indiana	4	1	4 Small	2 Rural, 2 Suburban
Massachusetts	3	1	2 Small and 1 Large	2 Suburban, 1 Urban
Texas	3	1	2 Small and 1 Large	2 Suburban, 1 Urban

*Small practice is defined as five or fewer audiologist providers. Medium practice is defined as six through 10 audiologist providers. Large practice defined as greater than 10 audiologist providers.

In general, participating audiology practice representatives perceive that state Medicaid policies have a negative impact on access to evidence-based hearing health care for adults with hearing loss. Several themes emerged, from the qualitative interview data, many of which point to Medicaid policy deficiencies that could be administratively or legislatively mitigated.

THEME 1: More than 70% of audiology practice representatives interviewed for this study reported that the practice either does not accept Medicaid insurance for adult patients, or it significantly caps the number of Medicaid patients accepted.

Four of the 14 audiology practices interviewed accept Medicaid insurance for adult patients. One of those four practices reported accepting Medicaid insurance for existing patients but accepting no new Medicaid patients. Two of the four practices that accept Medicaid insurance for adult patients, cap the number of new Medicaid patients scheduled each month. One practice out of 14, reported accepting adult Medicaid patients without any cap or restriction. Three of the four practices that accept Medicaid insurance are either large or multi-location clinics, situated in urban areas. One-quarter of the practices that reported not accepting Medicaid, do accept dually eligible (Medicare-Medicaid) patients for Medicare-covered hearing assessments, but refer those patients to other providers for downstream (Medicaid-covered) services. Three practices reported that they have not considered accepting Medicaid insurance because their providers’ schedules are already filled with private-pay and privately insured patients.



I don't know of any audiology practices in the Houston area taking Medicaid within a reasonable amount of time. I think Medicaid beneficiaries are either putting off hearing aids, or just accepting the fact that it will take a long time to get into a clinic. We don't even know where to refer them.

Audiology practice representative in Texas

Practice participants from three states noted that, based on their own interactions with other practice representatives within their states, there is a shortage of audiology practices willing to accept Medicaid insurance. According to study participant accounts, the dearth of providers treating adult Medicaid beneficiaries, significantly delays and impedes their access to hearing health care resources. In two cases, participants were not aware of any provider currently accepting Medicaid and reported having no place to refer adult Medicaid patients. One practice representative commented that state records of Medicaid-accepting providers are inaccurate, which causes Medicaid patients to routinely waste time contacting practices only to be turned away.

THEME 2: Claims management and administrative burdens pose significant barriers to audiology practice participation in state Medicaid programs.

Six study participants reported that Medicaid paperwork requirements are time consuming for providers and front office staff. Among chief complaints, is the fact that patient eligibility must be repeatedly and frequently reconfirmed for continued reimbursement. The process to obtain prior authorization approval to order hearing aids is also inefficient. Two practices reported not accepting Medicaid because the paperwork to enroll as a provider was too cumbersome. Three practices reported difficulties in keeping up with changes in coverage from managed care programs sometimes affects hearing health benefits and reimbursement midway through a patient's treatment. Two clinics reported that requiring a physician referral prior to the audiologic testing and then a second medical clearance exam prior to dispensing hearing aids is wasting time and creating an unnecessary duplication of services.



Virtually nobody takes Medicaid in Indiana. It's not a mystery. They make you jump through a ridiculous amount of regulation just to file the claim. Then, sometimes it takes six months or more for them to process it. I mean the system's broken. It's completely and utterly broken.

Practice representative from a small practice in Indiana



It (Medicaid) needs to allow reimbursement for the best practices that we (audiologists) can provide. If a patient needs two hearing aids, they should be able to get two hearing aids. You wouldn't give someone a monocle and only let them see out of one eye, would you? Why would you think it is okay to only let someone hear out of one ear?

Audiology practice representative from a Texas practice that accepts adult Medicaid patients

THEME 3: Medicaid reimbursement and coverage policies do not support the delivery of evidence-based care.

One participant reported that reimbursement for follow-up services, post-hearing aid fitting are not covered, so audiologists either end up performing the services for free, or the patient has to go without treatment. Three practices reported that, dictating specific thresholds for hearing loss as a requirement, diminishes the provider's ability to treat patients effectively.

One practice representative commented that the lack of coverage for two hearing aids, even when two are medically necessary, puts audiologists in a bad position, because they want to deliver quality care. One clinic representative noted that hearing aid verification testing is not covered, even though it is recommended for best practices.

Two clinics reported that prior authorization requests are not answered timely, delaying needed treatments for patients. One participant stated that claims must frequently be refiled because the Medicaid administrator loses them or arbitrarily denies them, delaying reimbursement (and sometimes patient treatment), for months, in some cases.

THEME 4: It is easier and more rewarding to go outside of the Medicaid program to help low-income adults with hearing loss.

Three practices, that do not accept Medicaid, have established non-profit organizations for the express purpose of being able to donate hearing aids and services to adult patients in need. Three additional practices reported donating hearing aids and/or offering a sliding scale for those in need, rather than accepting Medicaid insurance. These participants blamed stringent and sometimes archaic Medicaid requirements for patient eligibility and hearing aid specifications. One participant used the word “freedom” to describe being able to donate services and refurbished or donated hearing aids outside of Medicaid. Participants described accepting Medicaid insurance as a “hassle,” a “nightmare,” and “impossible.” None of the Massachusetts respondents indicated a need to create an alternative program or organization, in order to avoid challenges imposed by the Medicaid system.



Everybody used to have straight Medi-Cal. Patients could go to any provider that accepted Medi-Cal. So, there were audiology practices that developed a niche, especially for providers who spoke a second language like Korean. Those practices became known in the community as those who care for poor people. Then, all of a sudden Medi-Cal switched over to this managed care, where you have to be a provider in an HMO group. And, it was impossible to get in there when the corporate-owned practices set up the contract. So, all of these patients were left without a provider who spoke their language.

Audiology practice representative from a California practice that would like to but can no longer accept Medi-Cal because of managed care restrictions



I provide for lower income people, outside of the hassles with the Medicaid system. I just do it my own way in a way where they're getting really good technology and great service. There are a lot of people that fall through the Medicaid cracks. I want them to have good hearing, so I acquire gently used hearing aids, refurbish, and donate them and charge a small fee for services. It's my service to the community.

Practice representative from an Indiana practice

THEME 5: State-specific Medicaid policies affected clinic participation and perceptions.

California: Every California-based clinic representative described California's Medicaid coverage policies as confusing. The lack of clarity results in an increased administrative burden as providers and billing departments investigate questions and problems. Two of the four California-based practice representatives reported that Medicaid managed care organizations (MCO) operate county-by-county, which makes it difficult for patients and providers to participate, because MCOs restrict the provider network or have inconsistent policies from one county to the next.

Texas: All four Texas study participants reported that Texas Medicaid coverage of hearing aids for adults has dramatically decreased in recent years.

Massachusetts: Massachusetts audiology practices have a generally favorable view of the MassHealth Medicaid program. Practice representatives do not believe that MassHealth patients generally have trouble finding providers that will accept MassHealth hearing aid and service coverage. One MassHealth representative reported that about 20% of the patients seen in that clinic are adult Medicaid patients. Two Massachusetts audiology practice representatives reported that MassHealth managed care plans can sometimes pose

barriers to patient access, because patients don't realize that if the audiology practice is not contracted with the patient's specific MassHealth managed care plan, the patient cannot use their insurance coverage there, and must go somewhere that accepts the plan that h/she has. Practice representatives reported that MassHealth patients tend to have a higher no-show rate than other patients and that contributed to the decision by one practice to stop accepting Medicaid patients, even though the hearing aid and audiology benefit is "generous."

Indiana: Three of four Indiana practice representatives stated that the state Medicaid program hearing aid reimbursement does not cover the entire out-of-pocket cost of the hearing aid, if you factor in the shipping costs and the administrative costs to dispense and fit the hearing aid. The representative from the single Indiana audiology practice (in this study) that accepts Medicaid insurance for adult patients, reported that the practice only accepts up to three new adult Medicaid patients per month, because the practice cannot afford to take more.

Audiology practice perceptions, regarding Medicaid coverage for hearing aids and audiology services, shed light on overarching issues that impact Medicaid programs, providers, and patients around the country, and offered specific insight into the most pressing challenges and opportunities to improve access to hearing healthcare for adult Medicaid beneficiaries.

Several of the findings are consistent with other studies that have examined provider participation in state Medicaid programs. Sommers and Kronick²³ reported that state Medicaid physician participation (for all covered services) varies from 40 – 99%.²³ Providers consider reimbursement rates, length of time to payment, and the amount of bureaucratic and "paperwork" requirements when determining whether to accept Medicaid patients.^{23,24}

LIMITATIONS

Study limitations included sparse existing data on the impact of state Medicaid policies on the practical access to care for adult Medicaid beneficiaries with hearing loss. Medicaid policy manuals for traditional Medicaid programs in California, Indiana, Massachusetts, and Texas were examined. State Medicaid managed care plan manuals were not examined in the scope of this study, and may provide information about additional benefits, requirements, and reimbursement policies that could not be documented.

The audiologist practice sample size was low. No medium-sized practices were interviewed for the study. A purposeful sample of practice representatives was used, which may have reduced the variance of practice type. The self-reported perceptions of the practice representatives were subjective and may have been affected by recall bias. Additional research should be conducted to determine the impact of state Medicaid policies on the practical access to hearing aids and associated hearing health care services for adult Medicaid beneficiaries.

ADDRESSING THE PROBLEM OF ACCESS TO MEDICAID HEARING HEALTH SERVICES FOR ADULTS

Ten thousand Americans will turn 65 years of age every day between now and 2030.²⁵ Falls are the leading cause of injury and injury death for older adults.²⁶ A beneficiary with dementia will cost Medicaid roughly 19 times more than a beneficiary who is dementia-free.²⁷ Untreated hearing loss is associated both conditions. Thus, policies promoting early intervention may reduce downstream costs and improve outcomes and quality of life. The prevalence of presbycusis among the older adult population and the emerging evidence about the risks and consequences of untreated hearing loss are beginning to increase awareness



We are contracted with some types of MassHealth managed care options and we're not contracted with others, so there's certainly sometimes a conversation, and it can be difficult because we might be contracted for diagnostic services, but we're not contracted for rehabilitation services or hearing aids and things like that. So, it is really confusing for the patient when they have MassHealth and we still can't help them.

Practice representative in Massachusetts

among health professionals, public health officials, advocacy groups, and policy makers about the importance of early intervention and treatment for persons with hearing disorders. Feedback from the media, the National Academies of Science, consumer and aging advocacy groups, and providers has already begun to stir interest from bureaucrats and policy makers, regarding the need to improve government-funded hearing health care for adults.⁵

Medicaid costs comprise more than one-quarter of state budgets on average and bipartisan solutions are being sought to reduce cost, without sacrificing quality or access. As more states have adopted Medicaid expansion programs, they are becoming more heavily invested in their success. “1115” Medicaid waivers are being used to test policy maneuvers that will streamline services across the board. Two states (Maryland and Washington) have enacted policy changes to add Medicaid coverage for hearing aids and hearing health services for adults in the past 12 months.^{3,4}

Federal legislative initiatives to improve access to hearing health care may affect state Medicaid policies and vice-versa. In 2017, landmark legislation, the Over-the-Counter Hearing Aid Act, put forward by Senator Elizabeth Warren (D-MA) and Senator Chuck Grassley (R-IA) was signed into law, directing the FDA to design a regulatory framework that will negate state laws and allow hearing aids to be purchased over the counter across the United States.²⁸ Legislation has already been introduced in the U.S. House of Representatives in the 116th Congress, which, if enacted will direct CMS to cover hearing aids for Medicare Part B beneficiaries.²⁹ There is a tremendous potential for Medicaid implementation policies to bleed through into Medicare policy, making now the right time to advocate for improvements to both programs.

POLICY ALTERNATIVES

A careful analysis of Medicaid policies related to hearing aid coverage and audiology services for adult Medicaid beneficiaries in four states, and subsequent interviews with audiology practice representatives, isolated specific policy deficiencies, that if remedied, may improve the delivery of hearing health care services and patient access.

The following policy alternatives take into account the improvements to Medicaid coverage policies for hearing health services and hearing aids for adult beneficiaries, suggested by audiology practices, while respecting the budgetary boundaries, incrementalism, and practical limitations that exist in today’s political environment.

- **Policy Alternative 1: Streamline the patient referral, eligibility, and prior authorization processes to speed time to diagnosis and treatment.** Eliminate duplicative visits and allow patients to seek treatment directly from an audiology practice (as they do with dentistry and optometry). Digitize eligibility and prior authorization requests for hearing aids and establish maximum wait times for approval.
- **Policy Alternative 2: Eliminate archaic hearing aid specification requirements and allow audiologists to choose the hearing aid that is best suited to the needs of the patient, within the defined benefit cost range.** Include digital and programmable hearing aids, which are now considered standard technology, as well as over-the-counter hearing aids, if appropriate.
- **Policy Alternative 3: Remove policy barriers that prevent the treating audiologist or physician from rendering care that is consistent with evidence-based practices, supported by medical necessity.** Structure reimbursement models to reward the delivery of evidence-based protocols and successful outcomes.
- **Policy Alternative 4: Allow Medicaid beneficiaries to establish Health Savings Accounts to supplement their Medicaid insurance.** Use a capped match payment to help beneficiaries cover much needed but non-covered services such as hearing aid repairs, batteries, and follow up services.
- **Policy Alternative 5: Remove regulations and barriers to innovation in service delivery.** Allow participating audiology providers to adopt creative service delivery models and technologies, including remote hearing aid programming and telehealth services to reduce patient no-shows and increase the number of patients who can be helped.
- **Policy Alternative 6: Establish incentives and penalties for patients to encourage their attendance at appointments, compliance with treatment recommendations, and responsible stewardship of their Medicaid-funded hearing aids.**
- **Policy Alternative 7: Eliminate regulatory barriers at state borders.** Encourage and allow licensure reciprocity for audiologists in adjoining states who may be able to provide in-person and telehealth services for patients, particularly those near state borders to alleviate provider shortages.

- **Policy Alternative 8: Negotiate pricing for hearing aids directly with hearing aid manufacturers and publish the price list of different models from which providers can choose.** Use the cost savings to increase provider reimbursement for diagnostic and treatment services, including investments in follow up care and counseling.
- **Policy Alternative 9: Establish reliable electronic claims billing processes for participating providers.** Implement claims requirements and reimbursement timelines that are commensurate with the private insurance market. MassHealth provides an excellent model from which other states could draw.
- **Policy Alternative 10: Seek funding, coordination, and support from CMS for a longitudinal research study/demonstration grant to follow patients who obtain Medicaid-covered hearing care, to determine the return on investment in terms of a downstream reduction in Medicaid costs, increased employment, and/or improved quality of life.**

RECOMMENDATIONS

Each of the policy alternatives presented poses limited financial risk and a tremendous opportunity for Medicaid hearing healthcare service delivery performance improvement and improved access to hearing aids and audiology services for adult Medicaid beneficiaries.^{30,27,31,32} Based on feedback from audiology practices, Policy Alternatives 1, 2, and 3 have the most potential for immediately improving access for adult Medicaid beneficiaries to evidence-based hearing healthcare services. Remaining policy alternatives can be floated alongside specific state regulatory and legislative initiatives as opportunities arise to marry high-impact solutions with those that are the most politically feasible. For example, licensure reciprocity and telehealth are becoming normalized and widely supported in some states.

CONCLUSION

Over the past decade, the body of evidence linking untreated hearing loss with increased falls risk and cognitive disorders has increased. Untreated hearing loss contributes to feelings of depression and social isolation. Further, older adults with hearing loss, who do not access hearing health treatment services are more likely to carry and contribute to higher overall healthcare cost burdens than those who access hearing health services.

Cost and convenience have been shown to be key barriers to audiological treatment and hearing aid use. State Medicaid policies restrict access for adult beneficiaries to hearing aids and associated audiology services, despite the fact that the prevalence of hearing loss increases with age. In short, Medicaid coverage does not assure practical access to hearing aids or audiology services. Many audiology practices are not able to adequately serve low-income adults because of Medicaid policy restrictions that hinder audiologist participation in the program.

CMS may look to Medicaid for policy ideas as it considers proposals to provide Medicare coverage of hearing aids and associated services. It is, therefore, essential for the success of patients and the audiologists who serve them, to advocate for improvements to both programs simultaneously. Advocates may be able to better position Medicaid hearing health policies as a problem worth solving—and readily solvable, using a variety of low-risk, high-impact policy solutions. ■

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Think Audiology

BY KIM CAVITT, Au.D.



I am going to take a departure from my usual coding, reimbursement and pricing article and instead share an initiative that puts audiology at its center. Our profession has an identity crisis. The situation is the result of a lack of consumer awareness and understanding about audiology, what it is, what it offers, and how it can positively impact a consumer and their quality of life.

The mission of *Think Audiology* is to stop merely talking about the need for audiology awareness and actually do something about it, through the creation of consumer and audiologist resources.

Think Audiology has two connected, yet separate, offerings and approaches to the awareness issue. First, *Think Audiology* has launched a consumer website and mission to bring attention to the research based evaluation and treatment of hearing, tinnitus and balance conditions and the role audiologists play in assisting the consumer in their journey. The site offers basic information about a variety of audiologic and vestibular conditions and treatment options and provides consumers with unbiased, step by step guidance and resources on how to best address their concerns and their condition. This site is can be viewed at www.thinkaudiology.org. The site focuses on all conditions in our skillset, not just hearing and hearing loss. Many colleagues, including Cliff Olson, Au.D. and Brian Urban, Au.D., have contributed to the *Think Audiology* materials.

Second, *Think Audiology* has created a set of “ads” or images that audiologists can use in their social media and print marketing campaign pieces. These professionally designed ads were created specifically to address all aspects of audiology, not just hearing and hearing aids. The goal is to create a grassroots national audiology awareness campaign and movement. We can accomplish this when audiologists all over the country use the same ads and images in their marketing communications during the same date or window of time. *Think Audiology* will create images for specific awareness initiatives (such as Better Speech and Hearing Month, Healthy Aging Month, Audiology Awareness Month, etc.) and an “Awareness” calendar. We will then suggest the use of certain images or themes for your marketing communications during specific days, weeks or months. We will begin our calendar on June 1, 2019. At this time, all of these materials will be provided at no charge to audiologists and audiology practices.

Think Audiology has a few terms of use. They include:

- The hashtag (#thinkaudiology) or the *Think Audiology* logo will be on every image. The reason for this is simple: we want to consistently expose the public to the word “audiology”. Many of our business names and marketing strategies do not include the word nor specifically address the profession. One of the primary goals of the *Think Audiology* initiative is to change that, one ad, image, blog post, or interaction at a time. We, truly, want folks to Think Audiology.

- *Think Audiology* owns the rights to many of these custom designed images and the *Think Audiology* logo and hashtag. These ads and images cannot be used by manufacturer owned practices or hearing aid dispenser practices. The movement is the promotion of audiology. Use by corporate owned entities and non-audiologists is incongruent to the primary goals of the initiative, which is to promote audiology awareness and the scope of practice of an audiologist. We believe our professional success lies in the practice of audiology, not just hearing and hearing aids.

Ascending Audiologists, who shares our audiology awareness mission, will be our partner in managing access to the *Think Audiology* DropBox account. You will need to join Ascending Audiologists before you can access the *Think Audiology* portal. *Think Audiology* membership in Ascending Audiology is free of charge. You can access Ascending Audiologists and *Think Audiology* ads and images at <https://ascendingaudiologists.com/>. Please contact *Think Audiology* or Ascending Audiologists for more information.

For questions or to learn more or participate in the *Think Audiology* initiative or movement, contact Kim Cavitt at info@thinkaudiology.org.

Dr. Kim Cavitt was a clinical audiologist and preceptor at The Ohio State University and Northwestern University for the first ten years of her career. Since 2001, Dr. Cavitt has operated her own Audiology consulting firm, Audiology Resources, Inc. She currently serves on the State of Illinois Speech Pathology and Audiology Licensure Board. She also serves on committees through AAA and ASHA and is an Adjunct Lecturer at Northwestern University.





HAVE YOU HEARD?

ADA's AuDition—Setting the Stage for Audiology's Future

With the help of ADA member stakeholders, ADA recently made some improvements to the AuDition career connection platform. AuDition is setting the stage for audiologists and audiology students to train, practice, partner, hire, buy, sell, and succeed. It is the only matching system designed specifically for audiologists, Au.D. students, and practice owners. ADA's AuDition system brings audiology's present and future together to achieve mutual goals.

If you are looking for an extern/internship, professional position, partnership, or practice to buy or sell, please visit <https://www.audiologist.org/audition/welcome-to-audition>.

Potential Preceptors: Give back to the profession by being part of the training of future audiologists. If you're not sure where to begin, head over to AuDition, set up your profile, and connect with students seeking an externship! If you're interested in taking on a student extern, remember to click the "Externships Available" tab.

How do I use the ADA AuDition system?

1. Complete your profile (buyer, seller, student, employee, preceptor, partner, etc.).
2. Include your curriculum vitae (C.V.), key practice information, specialties, and a personal statement.
3. Browse opportunities.
4. Contact individuals who have opportunities that interest you.



Name:
Katelyn Witham

Education:
Gallaudet University

Grad Year:
2021

Available Date:
05.07.2020

Interests in Audiology:

- Cerumen Management
- General/Dispensing
- Gerontological
- Pediatric

➤ **Personal Statement**

Hi! I am seeking an externship site within a well-rounded private practice. I am proficient in ASL and clinical sign. Additionally, I am interested in, and have experience, working with special populations (for example autism) and Deaf/HoH individuals.

[Contact Student](#)

Written Recommendation for Hearing Aid Document Now Available in the ADA Practice Resource Catalogue

Visit the ADA Practice Resource Catalogue at www.audiologist.org/audiologists/practice-resource-catalog and take advantage of complimentary members-only documents, located at the bottom of the page, including the recently added Written Recommendation for Hearing Aids, which is required by United Healthcare Commercial Insurance plans who offer hearing aid coverage and benefits. While this form is similar to a medical clearance waiver, it contains the specific language (written recommendation for hearing aids) outlined by the United Healthcare medical policy. This form is provided in a Word format. Other documents that are complimentary for members include:

- Medical Clearance
- Medical Waiver
- Customized Advanced Beneficiary Notice (ABN) - Required
- Customized Advanced Beneficiary Notice (ABN) - Voluntary

Please note, you must be logged in to download the complimentary documents and to take advantage of the member discount on all ADA products.



Volunteer Opportunities Available—ADA Needs You!

Advance your profession and expand your professional network through ADA volunteer service. ADA is currently seeking member volunteers to serve on the following committees: Advocacy & Public Policy, Practice Accreditation, and Member Publications & Resources. The time commitment varies by committee but is typically 1-2 hours each month. Please contact Stephanie Czuhajewski at sczuhajewski@audiologist.org to learn more and find out how you can get involved in these and other ADA service opportunities.

Attend ADA Lobby Day 2019 and #AuDvocate for Your Patients and the Audiology Profession

Make plans to join your colleagues on Thursday, November 14, 2019, for ADA Lobby Day on Capitol Hill. Attendees will be transported from the Gaylord National Resort & Conference Center in National Harbor, Maryland to Capitol Hill, in the heart of Washington D.C., to meet with members of Congress and their staff.

Building off the legislative progress that the audiology community has made in recent years, ADA, along with the American Speech-Language Hearing Association (ASHA) and the American Academy of Audiology (AAA) have joined together for the 116th Congress to work collaboratively on a legislative proposal to improve patient access to audiology services under Medicare Part B. Specifically, we are asking Congress to enact legislation that will:

- Provide Medicare patients with direct access to audiologists, eliminating the physician order requirement. As medical necessity would still be required for treatment, this would not increase cost—it would avoid duplication of services and increase efficiency while preserving safe, effective care.
- Allow seniors to choose from among all qualified providers for audiologic services by directing CMS to reimburse audiologists for the Medicare-covered services that they are licensed to provide under their state-defined scope of practice. These services are already covered under Medicare, when delivered by other providers.
- Classify audiologists as practitioners under the Medicare program, so that they can be most effectively deployed within the Medicare system.

In order to make audiology's voice heard on Capitol Hill, we need as many ADA members and audiology advocates to attend Lobby Day as possible! Please contact Adam Haley at ahaley@audiologist.org or visit www.audiologist.org for more information and to register for ADA Lobby Day.

► **Please contact Stephanie Czuhajewski at sczuhajewski@audiologist.org for more information about ADA, ADA membership, and opportunities for advancing your audiology career through involvement with ADA.**

THURSDAY, NOVEMBER 14, 2019					
8:00 AM - 4:30 PM	Lobby Day				
5:30 PM - 7:00 PM	Opening Reception in Exhibit Hall				
FRIDAY, NOVEMBER 15, 2019					
7:00 AM - 8:00 AM	Breakfast in the Exhibit Hall				
8:00 AM - 8:30 AM	Welcome & President's Address: Ram Nileshwar, Au.D.				
8:30 AM - 9:30 AM	KEYNOTE PRESENTATION: Hearing Loss and Dementia - Esther Oh, MD				
9:30 AM - 10:00 AM	Break in the Exhibit Hall				
10:00 AM - 11:30 AM	Featured Session Sponsored by CareCredit				
11:30 AM - 1:00 PM	Lunch in the Exhibit Hall				
1:00 PM - 2:00 PM	Understanding the Active Aging Consumer: Jeff Weiss				
2:00 PM - 3:00 PM	Aging Research, Technology, Health Care and Mindset of Wellness: Lisa D'Ambrosio, Ph.D.				
3:00 PM - 3:30 PM	Break in the Exhibit Hall				
3:30 PM - 5:00 PM	The Wellness-Illness Continuum: Serving Older Adults At Every Point Along the Way - Panel				
5:15 PM - 6:15 PM	ADA Member Business Meeting				
6:15 PM - 8:00 PM	Special Event in the Exhibit Hall				
SATURDAY, NOVEMBER 16, 2019					
7:00 AM - 8:00 AM	Breakfast in the Exhibit Hall				
8:00 AM - 9:30 AM	TIER 1: Managing Patient Anxiety Part 1	Achieving Financial Success with a Managed Care Program	Custom Ear Molds	TIER 1: A Changing Standard of Care/ Implantable Devices Part 1	Student Track <i>Sponsored by Starkey</i>
9:45 AM - 11:15 AM	TIER 1: Managing Patient Anxiety Part 2	Moving the Needle: State Licensure	Physician Outreach	TIER 1: A Changing Standard of Care/ Implantable Devices Part 2	Student Track <i>Sponsored by Starkey</i>
11:15 AM - 12:30 PM	Closing Lunch in Exhibit Hall				
12:30 PM - 1:30 PM	TIER 1: AI/Machine Learning and Hearing Technology Part 1	Direct-to-Consumer Healthcare Trends	Precepting: What Practice Owners Need to Know - featuring a Student Panel	Pharmacology	Student Track: Owning a General Audiologist Title: Practicing Full Scope
1:40 PM - 2:40 PM	TIER 1: AI/Machine Learning and Hearing Technology Part 2	Using a Subscription Model	Embrace the Change: a How-to-Guide for Dispensing PSAPs	Adding Tinnitus Management	Student Track: HIPAA Training
2:50 PM - 3:50 PM	TIER 1: AI/Machine Learning and Hearing Technology Part 3	Managing Threats and Opportunities	A Critical Review of Audiology Employment	Vestibular Audiology Course	Student Track: Panel on Starting a Practice/ Becoming a Partner/ Preparing to Hold an Ownership Stake
4:00 PM - 5:30 PM	Prepare Your Business for Maximum Sales Value	Telehearing Care for Today's Success	You Got This! Work-Life Balance and Self-Care for Audiologists	Pediatric Audiology Course	Student Track: Custom Molds Student Version
SUNDAY, NOVEMBER 17, 2019 (Additional registration required)					
7:30 AM - 8:00 AM	Breakfast				
8:00 AM - 11:15 AM	Cerumen Management Part 1 Rita Chaiken, Au.D. Jiovanne Hughart, Au.D.	Practice Accreditation Workshop	Balance Workshop Hosted by American Institute of Balance		
12:00 PM - 3:15 PM	Cerumen Management Part 2				

Visit audiologist.org/2019 for the most up-to-date agenda.



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November 14-16, 2019

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Early registration is now available for AuDacity 2019, the premier educational and networking event for audiologists in private practice!



KEYNOTE SPEAKER: Esther Oh, M.D.

Ph.D., is an Associate Professor in the Division of Geriatric Medicine and Gerontology at the Johns Hopkins University School of Medicine. She also holds appointments in the Department of Psychiatry and Behavioral Sciences, and in the Division of Neuropathology. She is also the Associate Director of the Johns Hopkins Memory and Alzheimer's Treatment Center.

Dr. Oh's research is primarily focused on Alzheimer's disease and delirium. Her current projects include: development of biomarkers for detecting early stages of Alzheimer's disease; postoperative outcomes after surgery; and the role of sensory problems (hearing and vestibular function) in Alzheimer's disease.

Visit audiologist.org/2019 to register!





INSIGHTS FROM THE OUTSIDE

The Clinical Care Examination

Insights from the Outside is a group of practicing clinician-owners. They are a diverse group from many medical specialties, including dentistry, veterinary medicine, cosmetic surgery, ophthalmology, audiology and optometry. Uniquely created by CareCredit, the groups' purpose is to capture and share "best practices" to some of the common challenges all health-care business owners face, such as attracting new patients, patient barriers to care, care acceptance, patient retention, social media, team training and empowerment and much more.

This article features ophthalmologist Dr. Ethan Sadri, owner of Atlantis Eyecare, dentist Dr. Howard Ong, owner of Seal Beach Dentistry, and Nola Aronson M.A., CCC-A, owner of Advanced Audiology.



As a healthcare provider, your focus is on identifying health issues and providing solutions. One of the most important stops along the patient journey is the clinical care examination. How do you make this part of the patient journey a positive experience for patients—especially those who may be nervous or skeptical about the need for care?

DR. SADRI I think the most important thing is to make the appointment and overall experience relaxed, positive and educational. Most of the patients I see are afraid of losing their eyesight so you can imagine the level of anxiety is extremely high. To address this we really focus on bedside manner and the patient's mental status. Are they scared? What is their body language saying? After assessing this I'm able to place the patient into one of two buckets—either they're ready to move forward with care or they're not.

MS. ARONSON I agree it's very important to help the patient feel relaxed. One of the first things I do with patients is just sit and talk and give them an opportunity to tell me in their own words why they came to see us. I tell them a little about myself and then we review what they told the front office on the phone and let them add any additional information that might be helpful. Then I share what we're going to be covering during the exam.

DR. ONG To create a positive patient experience in our practice we focus on training based on our practice care philosophy. So that the message the patient receives is the same. Without our systems and protocols, the journey and the patient experience may be vague and that's when patient doubts come into play and trust kind of crumbles a bit.



Is there anything you do with the physical environment to help create a positive experience?

MS. ARONSON I think the biggest way we use the physical environment to help create a positive experience for patients is in our waiting room. It feels like your walking into a comfortable living room. There is coffee, tea, water and snacks of all kinds to help patients relax before their exam.

DR. ONG That's great. We also do what we can to create a comfortable, non-threatening physical environment. But I think what creates a positive experience, ultimately, is how the doctor interacts with the team, and how the team interacts with each other. Patients are always watching us. So a well-orchestrated team will help create a positive experience and instill confidence.

DR. SADRI Our physical environment reflects our desire to make the experience relaxed and informative so we have educational videos playing. Once the patient is in the exam room we try not to keep them waiting too long.



Do you have a system or process when it comes to the clinical examination?

DR. ONG Absolutely. One process we actually nickname “the handoff” and it's where we purposefully position the patient between the doctor and the assistant, whether it's a front office admin person or a chair-side assistant. The goal is to make them feel they're the center of attention. They can look at either one of us as equals in agreement of care. Once we have acceptance, then the front office or admin walks them through the care in sequence.

DR. SADRI We view our system or process in a similar way, in fact we see it as sort of a “well-oiled machine” of technicians and myself.

MS. ARONSON Well, I've been doing this for so long I don't think I have an exact process — but again I start by educating the patient before testing them. I ask questions and we talk about what they will experience. During the test I talk to the patient over a microphone so that they know I'm there and I'm listening to them. Once testing is complete, I go over the results with the patient and get their feedback.



During the clinical examination do you share information and findings with the patient and if so how do you do it?

DR. SADRI In our situation patients often have multiple diagnoses so it's important to slow down and go one by one. Usually I'll have an anatomy chart or video and I'll point to different parts of the eye and explain to them the different disease phase they're being affected by and why it matters.

DR. ONG I agree, We also leverage technology. With our intra-oral cameras and digital X-ray systems the patient can see what we see—so we co-diagnose with them. It's the classic statement “a picture is worth a thousand words.” When we can show patients what's normal and what's not normal the need for care becomes obvious.

MS. ARONSON During the clinical examination I have a graph and pictures of the sounds the patient can't hear and I go over the sounds with them and explain how it relates to their life. For example, testing may reveal that patients have what is called a high frequency hearing loss, which doesn't allow you to hear certain sounds in the English language like unvoiced consonants. Because these sounds are in around 80% of our language — when I show them the graph that has all of the sounds on it they can actually see for themselves which sounds they're missing.



Are there situations when the patient is resistant to your clinical findings or recommendations?

MS. ARONSON Of course you have people who don't want to wear hearing devices. They think that the hearing devices make them old. Luckily in today's world we have hearing devices that are Bluetooth. And Bluetooth is very accepted, especially among the Baby Boomer generation, which is the generation we're working with right now. They get really excited when I tell them about all the features and then I put it in their ear and then they can see how small it is and how it doesn't show and it's not this big thing that makes them look old—or means they're getting old.

DR. ONG Oftentimes those that resist our recommendations do so because initially they feel nothing hurts. But many times in healthcare not much hurts until it's too late or the issue is far along. So we try to encourage patients to move forward by drawing on different experiences they may have already experienced with the dental care they have now and how it got there or other scenarios we can show them.

DR. SADRI In our specialty resistance to clinical recommendations and findings happen a lot. Patients are afraid. They're afraid of cost. They're afraid of getting care. They're in denial. And you have to recognize that and give them time.



Are there any other reasons patients might be resistant?

MS. ARONSON Well, usually if you fit the patient with hearing aids and you give them an in-home trial where they don't feel obligated to have to pay upfront and they have a chance to see how the hearing devices can change their lives they often become less resistant. But price can be a big thing for patients. So we have devices in all price ranges and we offer payment options including the CareCredit credit card and that's something that's a very big thing for patients.



How do you create a culture of trust?

DR. SADRI I think you have to treat everybody like you would want to be treated yourself. Again the goal is to educate and let the patient know we're here to help. If they're not

ready, that's okay. They'll eventually come back. What we've found is when you do it that way, you have a constant flow of patients that trust you and really appreciate the way they've been treated.

DR. ONG Our philosophy is a culture of relationship building and that only happens if we're all engaged with each other and also engaged with our patients. So we take time to just want and visit with the patient. It's important to understand each other's interests and experiences—before we talk about the clinical diagnosis. I think once you've established that engagement, the trust flows naturally. They become a neighbor or a friend and it just rolls from there.

MS. ARONSON I'm very honest and upfront with patients and I don't push anything on them. I always say, "Look, I'm here to help you. I'm not here to sell you anything. I'm here to give you a solution to make your life better. That's all I want from this appointment and that's what you came to me for and that's what I need to provide for you." A lot of times when you give patients an in-home trial they appreciate the fact that I'm loaning them something expensive and I'm not asking them for the money right away. I think they trust more that way, because then they don't feel so tied in.



When the clinical findings are significant, how do you communicate them to the patient and communicate the urgency of care?

DR. ONG Once we communicate what we feel a patient needs, the next step is to kind of bring them along our path or journey to the healthcare choices they require. We call that leading them—leading them to a solution so that they don't have to experience the issues they're experiencing now. So it's important that they understand that we're offering a solution to end their negative clinical findings or bad experiences.

MS. ARONSON When the findings are significant I remind the patient of why they sought out help in the first. If they reported having trouble hearing in meetings at work I'll say, "You told me at the beginning of the exam that you're having trouble hearing in meetings at work. I can help you with that." I also talk about the brain and how it's affected when we are missing sounds and that all of the studies have shown in the last couple of years that you're more prone to

get Alzheimer's and dementia when you don't stimulate your brain. So if a patient is missing all of these sounds it could lead to other problems over time.

DR. SADRI We also try and explain significant findings in ways that relate to the patients everyday life. For example, if they have bad vision, and it impairs their ability to drive it can create any number of issues. So we talk about how it could impact the safety of themselves, their loved ones and others.



What can derail a clinical examination and discussion?

DR. SADRI If the physician is hurried, if the patient is hurried. I find in today's modern age, everyone is distracted. Emergencies happen. If we're late, patients can be derailed. Not being able to get in on time derails an exam. Not being able to communicate – sometimes language barriers can be a problem. Thanks to the advent of things like Google Translate and other apps it's getting better. In fact, recently I scheduled a patient who doesn't speak English. He's from Korea. And we went ahead and booked the appointment and we used an application. So there are barriers but you have to overcome them.

DR. ONG I think patients want to be recognized and they want to be heard. So being flippant about care or being dismissive can derail things pretty quickly. This goes back to one of the main tenets of our practice — they're buying us. They're not buying a crown, they're not buying a dental implant — they're buying us. So making them feel unique and seen and heard by me and my team is ultimately going to stop any sort of derailment.

MS. ARONSON I agree, when you're not actively listening to what the patient is saying and you're just talking all the time. If you start getting nervous about whether or not you're going to make the sale. You have to sit back and you have to be willing to be quiet and not talk for a while and let the patient think about what you just said and come back with a response. If they present objections, you need to know how to handle those objections so that the patient is satisfied with the response. If you don't handle their objections properly, then you're not going to get the sale.



What is the next step you take when the patient doesn't own their healthcare need and leaves the practice without scheduling care?

MS. ARONSON Well, the next step is to call them within 48 hours and try to see if there are any questions you missed or concerns they may have that you can address. Simply asking "Is there something I didn't answer for you? Is there something that you disagreed with? Can open up a dialogue and uncover concerns that weren't shared during the exam. So I think the patient follow up is very important.

DR. ONG I agree. Our training is to follow up with something like "Can we call you in 30 days or in 60 days and revisit this?" We also have a built-in recall system, meaning patients come back every three, four or six months for their routine hygiene visits. So it's an opportunity for us to revisit their care because timing is important for patients, too.

DR. SADRI This happens, so we address it with patients up-front. "It appears that you're not understanding or not ready to hear this or you're afraid. And it's okay. These are all okay things. And I just want to give you some literature. Go read it. Get another opinion if you need to. We're happy to see you back when you're ready because we'd like to participate in your care." ■

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HEAR AND NOW

Early Career AuD Resources



The Academy of Doctors of Audiology offers a variety of resources for early career professionals.

Early Career Listserv: Subscribers can network and discuss issues facing new audiologists through this email-based discussion forum.

Young Professionals Resources: A collection of resources that will help you in your transition from student to professional.

Mentorship Program: What did you do right? What was harder than you expected? What do you wish you could change? As a recent graduate, you are a perfect candidate to help shape the future of audiology by becoming a mentor! Mentee opportunities are also available.

Visit audiologist.org/early for access to these resources and more!

