

THE OFFICIAL PUBLICATION OF THE ACADEMY OF DOCTORS OF AUDIOLOGY®

Audiology PRACTICES

INSIDE THIS ISSUE

Pricing in Hearing Healthcare

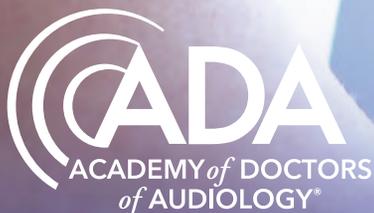
Stop Trying to Sell Hearing Aids

Modernizing Hearing Health Space

Audiogram Needed to Fit Hearing Aids?

The Risks and Rewards of Private Practice

Customization is the Antidote for Automation



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Features

8 Pricing in Hearing Healthcare: Which Race are You Running?

AMYN M. AMLANI, Ph.D.

14 Stop Trying to Sell Hearing Aids and Get Busy Guiding Consumers with Hearing Difficulties to Action

TERRY MACTAGGERT

20 Modernizing Hearing Health Space: Moving Past the First Fit Approach

DONALD HAYES, Ph.D.

22 Is the Audiogram Needed to Fit Hearing Aids?

BRIAN TAYLOR, Au.D.

24 Be Careful What You Wish For: Thinking Through the Risks and Rewards of Private Practice

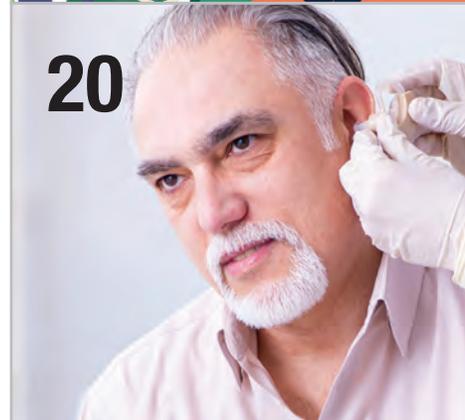
CHANDACE JEEP, Au.D. AND NICOLE KOVEL, Au.D.

32 Customization is the Antidote for Automation

BRIAN TAYLOR, Au.D.

37 Go Figure: Customizing Gain Leads in Optimal Results

BRIAN TAYLOR, Au.D.



The in-laws are here

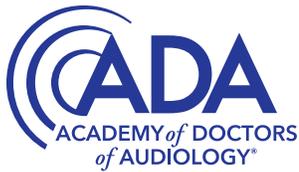
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Moxi Move R shown at actual size. *Singh, Kreuger, Besser, Wietoska, Launer, Meis (2018). A Pre-Post Intervention Study of Hearing Aid Amplification: Results of the Emotional Communication in Hearing Questionnaire (EMO-CHeQ), IHCON 2018.



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Departments

President’s Message	5
Deb Abel, Au.D	
Headquarter’s Report	7
Stephanie Czuhajewski, MPH, CAE	
The Source	38
Tele-Audiology Resource Guide	
Remote Hearing Aid Evaluation, Fitting and Management by Audiologists	
Up to 11	48
Have You Heard	

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We are here to support you.

As the global situation with COVID-19 continues to evolve, we greatly appreciate everything you're doing to help your patients, staff, and communities.

We are committed to you and look forward to continued partnership as we collectively navigate these uncharted waters. Our teams are already working on strategies to help your business recover and rebuild when we get to the other side.

Here are some steps we are taking:

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- It's clear that many individuals may face financial difficulties in the coming weeks and months. We are committed to helping people get the care they want and need without delay due to cost concerns. This could include waiving fees or evaluating credit limits to help with additional, necessary purchases.
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Stronger Together

As I write this in early April, the world is changing in ways only an Orwellian novel could read. Just a month ago, students were anxiously awaiting the completion of their 4th year assignments and planning graduation parties to celebrate becoming Doctors of Audiology. The audiology community was making plans to congregate at the American Academy of Audiology Conference in New Orleans, and ADA volunteers were making visits to Capitol Hill to discuss the Medicare Audiologist Access and Services Act with Congressional staff and Members of Congress.

Instead, the coronavirus (COVID-19) pandemic has disrupted these activities, and our entire lives, in ways that we could not have imagined. Some of you are sick or have loved ones who have become ill or passed away from this virus. Some of you have had to close your doors as required by your state and local governments. Some of you have maintained a limited schedule, and some of you are serving your patients with drive up services and drop boxes, or via telehealth. Some of you are working from home while teaching school for your children, and some of you are not working at all. Whatever you are doing today, it is likely vastly different than what you could have imagined, just one month ago.

ADA leaders and staff are committed to using whatever resources we have available to assist members during this unprecedented time. While you may be physically distancing, please know that you are not alone. We are together. First and foremost, rely on your ADA community as a place of support and solidarity. With the help of members and volunteers, ADA has developed clinical, professional, and business resources to help you make sense of the CARES Act, telehealth options, and state-by-state resources related to national and state clinical and operating guidelines.

As we are all tasked with making tough decisions every day to “flatten the curve” to stop the spread of COVID-19, during this uncertain time, we will all work together to make the best decisions for ourselves, our practices, and those whom we serve and love with the information available. There will be loss of many things, including many lives. I encourage you to focus your time and energy on the things that matter most, including your health and wellbeing. And, please let me and the ADA team know if we can help you navigate any challenge to make you or your practice whole again.

Finally, I would like to take a moment to remember a dear friend and our collaborative colleague, Neil DiSarno, PhD, who recently passed away after a long and valiant battle with cancer. This gentleman and gentle man had an easy smile and exuded a sense of warmth when you saw him. In his role with ASHA, I had the chance to work with him on several professional issues over the years. He was one of THE most collaborative and kindest audiologists I have had the honor of knowing. I am sure that those of you who knew him will agree. It was all about the profession for him and we can honor him by reflecting on a life that truly impacted students and colleagues, and of course, the profession that he loved. Rest in peace, Neil.

Thinking of you all, with all the challenges we have facing us in the weeks and months ahead. May you find the strength in what is important. May we find the strength, resolve and fortitude from each other. We are stronger together. ■



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The Power to Practice



ADA Strategic Plan Initiatives Must be Designed to Support Members in 2020 and Beyond

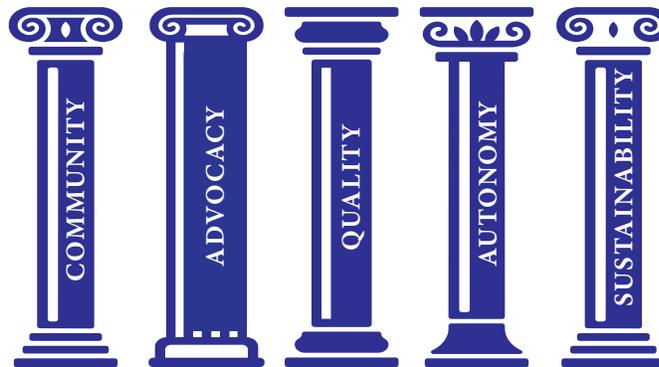
As ADA and its members face mounting health, clinical, and economic challenges, as a result of the coronavirus (COVID-19) pandemic, it is important to ensure that our strategic goals flex to meet the evolving needs of practices, students, and audiologists.

ADA's Mission: To Advance practitioner excellence, high ethical standards, professional autonomy and sound business practices in the provision of quality audiologic care.

Vision: To ensure practitioner ownership of the profession of audiology through the advancement of autonomous practice models.

With the input of ADA members, the following strategic pillars have been identified: Community, Advocacy, Quality, Autonomy, and Sustainability.

ADA Strategic Plan Pillars



Community: Create Opportunities for peer-to-peer education, professional advancement, and networking.

Advocacy: Implement public policy initiatives that advance ADA's mission and member interests.

Quality: Promote evidence-based business and clinical practices.

Autonomy: Expand opportunities for ownership of the audiology profession through the development of autonomous practice models in any chosen practice setting.

Sustainability: Facilitate member access to the tools, resources, and relationships that will foster success for their practices and the audiology profession.

The ADA mission, vision, and strategic goals have never been more important to members and the profession. Over the next few months, ADA will assemble steering committees for each of these pillars to ensure that the objectives developed are consistent with ADA member needs now and over the next 18-24 months. *If you are willing to participate on one of these steering committees, please contact me at sczuhajewski@audiologist.org.* ■



PRICING IN HEARING HEALTHCARE

Which Race are You Running?

by Aryn M. Amlani, Ph.D.

PART 1 Market Segmentation

In hearing healthcare, *price* continues to be a hot-button topic of discussion among consumers, providers, advocacy groups, legislators, professional organizations, and manufacturers of consumer electronic products and traditional hearing aids. The fundamental issue is that consumers and their supporters believe the costs associated with and the value received in treating impaired hearing are misaligned. This disparity is one reason that impaired listeners do not adopt or delay adopting amplification technology, despite its positive effects on improved quality of life. However, rather than focusing its value-proposition of enhanced service delivery, the supply-side of the market is hedging a bet that **reduced** retail prices will entice a marked uptick in impaired listeners purchasing amplification technology.

Don't believe me? Then consider, at a minimum, the continued acquisition of independent practices by hearing aid manufacturers to create large-scale vertically integrated retail, competitive outlets as a means to compete on price with large-scale Big Box retailers. Also, consider the forthcoming direct-to-consumer (DTC) supply of over-the-counter (OTC) devices that will be available directly—and at lower retail prices than most traditional hearing aids—to impaired listeners with milder hearing losses without the need to interact with a licensed professional. These examples of market competition based on reduced price is known as the “Race to the Bottom.”

The examples of competition, based on price, support the evolving transition of hearing healthcare from a predominately provider-based market segment—predicated on professional interaction that, in theory, substantiated a high retail cost—to a multi-segmented, retail model within the healthcare space. The purpose of this blog is to share the developing retail segmentation occurring in the market. In Parts 2 and 3 on this topic, the reader will be informed on how profitability is affected in these segments.

Market Segmentation in Hearing Healthcare

Figure 1 displays the pyramid-shaped segmentation taking form in the hearing healthcare space.

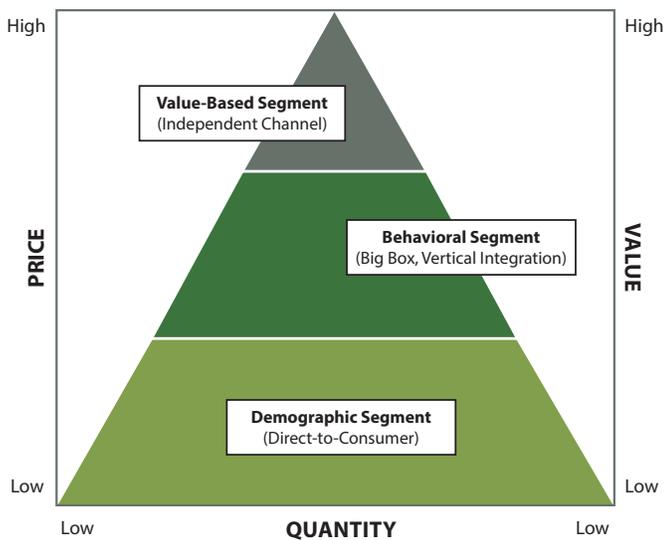


Figure 1. Market Segmentation Occurring in Hearing Healthcare

Demographic Segment

The base of the market, or the *Demographic Segment*, will consist primarily of DTC products; namely, OTCs and PSAPs (i.e., personal sound amplification products). Here, products are marketed and distributed directly to consumers based primarily on price (e.g., \leq \$1000) and degree of hearing difficulty (i.e., mild-to-moderate), with little to no professional support. *A priori* estimates indicate that a large number of individuals with mild-to-moderate hearing difficulty will resort to these products in lieu of traditional hearing aids. For practice’s that engage in the dispensing of DTC products, profitability in this segmentation will be minimal, at best, because of the practice’s inability to capitalize on retail markups associated with the product itself. A practice’s opportunity to supplement or recoup profits in this segment is available through itemized professional service offerings, such as verification, validation, and communication training.

Behavioral Segment

The middle and largest segment of the market, as seen in Figure 1, is the *Behavioral Segment*. This segment consists of traditional products and associated services delivered to listeners mainly through retail outlets (e.g., Big Box, vertical integrated chains). This segment is considered “behavioral” given the average listener’s purchasing behaviors related to product and service acquisition that stems primarily on price. The Costco Model is considered the gold standard in this market segment.

The behavioral segment appears to be steadily growing, as some practices in the independent channel have elected to delve into reducing their cost of goods (COGS) in order to

lower retail prices. The ability for an independent practice to offer products and services at lower retail prices is often viewed positively, as practice’s feel the need to remain competitive with Big Box and manufacturer-owned retail chains. This perception is not without fault. Specifically, participation in this segment—or in the demographic segment—is a threat to a practice’s brand and its profit. Competing on price creates a brand image associated with terms such as “discounted,” “bargain,” “cheap”, and “economical.” None of these terms is correlated with the perceived value expected in a doctoring profession.

As we’ll address later in this article, practices that participate in reducing retail pricing could be limiting their profit opportunities and, perhaps, more importantly, making themselves vulnerable to being cannibalized by the demographic segment. (Note: A similar outcome is expected for those practices whose revenue stream is heavily dependent on third-party reimbursement.) Simply stated, being cheap and being good do not go together, and reversing this perception is a monumental task.

(Note: The reader should note that the commentary in this article is not directed to practices that negotiate lower COGs and offer products and services at non-reduced retail prices, while providing the highest level of patient care.)

Value-Based Segment

At the top of the pyramid resides the independent channel (Figure 1). Note that this segment—called the Value-based Segment—is the smallest of the three discussed and has seen a considerable decline in growth over years due to manufacturer acquisition (i.e., vertical integration) of independent practices and a declining pipeline of graduates interested in becoming independent practice owners. While this segment is by no means immune from being cannibalized, it is the segment in the market that is considered to provide the greatest value to the consumer with respect to service delivery. As such, most practices in the value-based segment do *not* attempt to compete on price. In fact, value-based practices tend to command higher-than-average retail prices for amplification technology and associated professional services. In many cases, these practices also offer expanded diagnostic and treatment services in areas such as balance, tinnitus, and central auditory processing.

The market for hearing healthcare is evolving into a multi-segmented, retail-based market. The evolving market is predicated on increasing affordability and access through a reduction in retail price (i.e., the base and behavioral segments in Figure 1), with the expectation that a prolific

number of impaired listeners will utilize amplification products. Practices that intend to compete on price, instead of service delivery, are enrolling themselves in the race to the bottom. This race is fraught with risk associated with a diminished brand and an increased likelihood of reduced or cannibalized profit opportunities.

PART 2 Consequences of Reduced Retail Pricing

In this section, we will highlight how practices that participate in reducing retail pricing run the risk of decreased profit opportunities by means of market and brand cannibalization. First, let's examine the concept of market cannibalization.

What is Market Cannibalization?

Market cannibalization is the reduction in sales volume, sales revenue, or market share caused primarily by:

- (1) the introduction of a new product by the same producer;
- (2) lowering/discounting prices of a product; and
- (3) a saturation of the same retail companies in close proximity.

Examples of (1) and (3) above, respectively, include Apple's introduction of the iPad and its negative affect on the sales of the MacBook and Walmart's decision to close profitable stores due to direct competition with its own stores.

Economics of Lowering/Discounting Price

In hearing healthcare, there is a notion that reducing retail price of a product results in an uptake in adoption that yields to an increase in gross revenue. To quantify the effect of reducing retail price, we utilize the economic principle of law of demand.

Let's leave the world of audiology for a moment and explore the law of demand for pencils. Below is an example of a retail outlet that sells pencils. Table 1 displays that this outlet sold four different levels of pencils at varying prices (i.e., P), totaling 235 units (i.e., Q) for fiscal year 2018, yielding a gross revenue (i.e., R) of \$122.50. This demand function is graphed in Figure 2.

Prior to fiscal year 2019, the owner of retail outlet elected to reduce prices by \$0.05 for all four pencil levels. The owner's notion was that reducing prices would yield an increase in units sold and, in the end, an increase in gross revenue. At a minimum, the owner hypothesized that the market would increase organically by 3%, or 7 additional units (i.e., 235 x

Table 1. Retail outlet data for fiscal year 2018. Key: Q = quantity sold; P = price, and R = gross revenue (i.e., $Q \times P$).

FISCAL YEAR 2018				
	Q (Unit)s	P (\$)	Demand	R (\$)
	90	0.25		22.50
	65	0.50	-0.48	32.50
	50	0.75	-0.65	37.50
	30	1.00	-1.75	30.00
Total	235			122.50

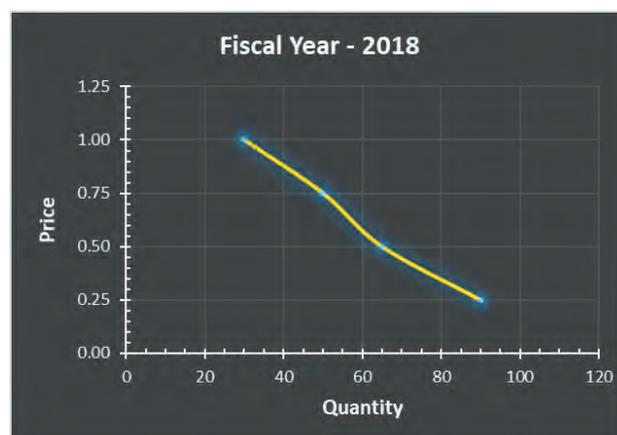


Figure 2. Demand function for data shown in Table 1.

3%), to 242 units. What the owner had failed to realize was that the market yielded an inelastic demand. Results for fiscal year 2019 are shown in Table 2 and Figure 3.

(Note: The hearing aid industry has an inelastic demand. To that end, an inelastic demand indicates that lowering price will *not* result in an appreciable increase in the number of units sold and increasing prices will *not* result in a marked decrease in the number of units sold. In addition, increasing total revenue in an *elastic* market requires reducing price and increasing total revenue in an *inelastic* market dictates increasing price.)

When comparing the data between fiscal years 2018 and 2019, note that the total number of units increased from 235 to 242. The data further suggest that in fiscal year 2019, 16 *more* units (i.e., 171 units compared to 155 units) were sold than in fiscal year 2018 for the two lowest price points. For the two highest price points, a *decrease* of 9 units (i.e., 71 units compared to 80 units) was seen between fiscal years 2019 and 2018.

Table 2. Retail outlet data for fiscal year 2019. Key: Q = quantity sold; P = price, and R = gross revenue (i.e., Q x P).

FISCAL YEAR 2019				
	Q (Unit)s	P (\$)	Demand	R (\$)
	99	0.20		19.80
	72	0.45	-0.41	32.40
	47	0.70	-0.97	32.90
	24	0.95	-2.14	22.80
Total	242			107.90

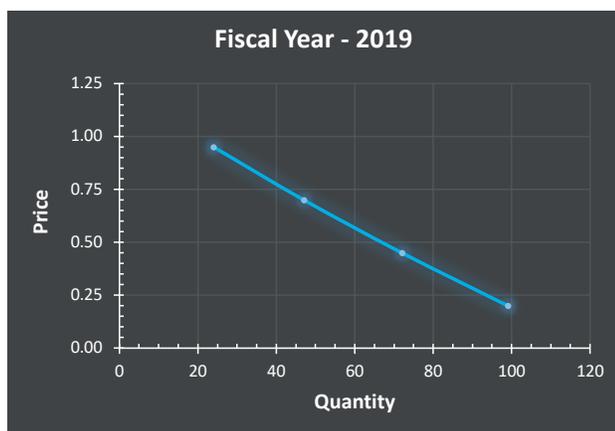


Figure 3. Demand function for data shown in Table 2.

Despite the increase in units sold for fiscal year 2019, total gross revenue yielded \$14.60 *less* than the total gross revenue in fiscal year 2018. Stated differently, this retail outlet yielded an average transaction of \$0.52 per unit sold (i.e., \$122.50/235 units) in fiscal year 2018 compared to an average transaction of \$0.45 per unit sold (i.e., \$107.90/242 units) in fiscal year 2019. In this example, the practice cannibalized its own gross revenue by reducing prices. A similar effect on total gross revenue is often seen in hearing healthcare when practices attempt to provide the market with reduced hearing aid prices.

Effect of Reduced Retail Pricing on Purchase Intent

Price-quality inference theory^{1,2} predicts that consumers often perceive prices as an indicator of quality. That is, consumers use price as a perceptual compass of quality. When a retail outlet lowers its price, the consumer perceives that the product or service being purchased has a diminished quality. Simply stated, quality perceptions influence purchasing intent more so than price.^{3,4} At the same time, higher quality

also means that consumer demands an exceptional experience during the purchase process.

Effect of Reduced Retail Pricing on the Multi-Segmented Market in Hearing Healthcare

Part 1 of this article revealed that the market was transitioning from a provider-based market segment to a multi-segmented retail model, the latter of which is shown in Figure 1. Independent practices in the value-based segment who elect to compete on reduced retail price not only diminish their brand, but often transition from the top of the pyramid to the middle and bottom where they are electing to compete with retailers in the Big Box and vertical integration channels, as well as with the direct-to-consumer retailers, respectively. For those independent practices who participate in the reducing pricing game, their downward transition—or race to the bottom—creates self-induced competition against corporations with greater brand awareness, and perceptually unlimited resources and marketing budgets.

So far, the reader was made aware of the impact of reducing price on (1) total revenue, (2) consumer purchase intent, and (3) the downward transition within the segmented market pyramid. For practices to sustain their place in the market—given the predicted compression of traditional devices as the direct-to-consumer market evolves—it would be wise to stay in their lane (i.e., operate in the value-based segment) instead of playing “chicken” with retailers in the behavioral and demographic segments.

Next, in Part 3, we will evaluate the impact of third-party reimbursement on this market pyramid and its effect on the race to the bottom.

PART 3 Implications of Health Insurance on Consumer Demand

In Part 3, we address the principles of health insurance and its effect on consumer demand, and then apply these principles to hearing healthcare.

Why Do Consumers Purchase Health Insurance?

Fundamentally, consumers purchase economic goods (i.e., physical object or service) to satisfy a need. *Health*, however, does *not* fit the definition of an economic good; it is neither a physical object nor a service. Instead, health is a condition or state. Consumers, therefore, demand other economic goods or services—for instance, pharmaceuticals and medical care—to meet their desired health state. Stated differently, consumers do not value medical care directly; instead, they value medical care because it improves (or maintains) their health and quality of life.

To achieve healthy living, many consumers acquire health insurance. Health insurance is any program—public or private—that provides protection to a consumer equally whether healthy or sick. The demand for health insurance is predicated on: (1) future health is uncertain (i.e., probability of sickness), (2) magnitude of potential economic loss, and (3) risk aversion. These points are described below.

Presume that consumers were able to foresee their entire health future (i.e., absence of uncertainty). They could financial plan accordingly to cover the costs of future medical expenses (i.e., potential economic loss). Because knowledge of the future is known, uncertainty is an essential consideration (i.e., planning for the future) in the demand for health insurance.

When the individual becomes sick, insurance is utilized to lessen future uncertainty (i.e., the unanticipated expenses associated with medical services and income loss). That is, insurance engenders a smaller gap in terms of risk. In the private and public markets, the degree to which a consumer perceives risk will determine whether they enroll in insurance and supplemental insurance, respectively, and which medical protections to acquire. Consumers who are risk averse (i.e., prefer certainty to avoid risk) are more likely to purchase insurance and pay a higher premium for increased protection. Consumers who are risk seeking (i.e., willing to assume risk) and risk neutral (i.e., insensitive to risk) are less likely to purchase insurance, and if they do, they purchase insurance with lower premiums with a lower degree of protection.

Health Insurance and Demand for Hearing Healthcare

In today's hearing healthcare market, insurance programs—both private and public—often limit the provider's ability to render diagnostic and treatment options to the consumer. The limited options can include non-coverage of test procedures, non-coverage or limited coverage of amplification technology, and limited follow-up visits. Research suggests that limiting demand-side options increases the inelastic demand, which constrains the average individual from moving forward with improving (or maintaining) their health and quality of life.⁵ From the supplier-side, limited insurance coverage prohibits the provider from making the most of their scope of practice, which can also influence negatively the practice's brand and revenue stream.

With respect to the occurring market segmentation in hearing healthcare (see Figure 1), the following assumptions should be considered with respect to health insurance and demand:

1. Consumers who lack hearing health protection and who are risk averse will:
 - a. Strongly consider options in all three tiers, with purchase intent based primarily on value and not price.
2. Consumers who are enrolled in health insurance that includes hearing health protection and who are risk averse will:
 - a. Strongly consider options in the value-based segment, with purchase intent based primarily on value and not price. If the perceived value displayed by the provider does not meet the expectations of the consumer, interest could potentially shift downward to the behavioral and demographic segments. Here, the intention is to improve the state of well-being, even at the cost of utilizing personal resources.
3. Consumers who lack hearing health protection and who are risk seeking or risk neutral will:
 - a. Consider options in the demographic segment, followed by the behavioral and value-based segments. For this consumer type, decisions are based primarily on price as opposed to value.
4. Consumers who are enrolled in health insurance that includes hearing health protection and who are risk seeking or risk neutral will:
 - a. Consider options in the value-based segment, with purchase intent based primarily on price and not value. If the criterion of price is not met, the likelihood of expending personal resources is small. This consumer type is the least likely to move forward with improving their hearing healthcare.

Use of a Clinical Application to Determine Risk

In order to improve patient flow and conversion rates in hearing healthcare, providers should become keenly aware of consumer demand towards the willingness to accept health-related risk. To that end, Amlani⁶ provided readers with a resource that

quantified risk preference as it related to purchase intent. As the landscape in audiology continues to evolve, and as the number of options for treatment of hearing difficulties expands, having such a resource will aid the provider in managing consumer motivation. This resource can also be used by the provider to self-evaluate and reflect on whether their demeanor is impacting consumer demand.

Pricing in hearing healthcare in a complex matter with several variables. The values and needs of the business must be balanced with the demands and behaviors of helping seeking individuals. This article provides data-driven insights to help audiologists and business managers develop their own effective pricing strategy. ■

Amy M. Amlani, Ph.D., is Director of New Practice Development at Audigy, a data-driven, management group for audiology and hearing care, ENT group, and allergy practices. Prior to this position, Dr. Amlani was an academician for 18 years, where he educated future Doctor of Audiology professionals and directed a research laboratory funded primarily from extramural grants and corporate sponsors.

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STOP TRYING TO SELL HEARING AIDS AND **GET BUSY** GUIDING CONSUMERS WITH HEARING DIFFICULTIES TO **ACTION**

by Terry Mactaggert

SIX years ago, I wrote an article, published in *Audiology Practices*, arguing that significant change should be anticipated in the hearing health marketplace. A combination of new technologies, major demographic trends, and emerging consumer attitudes towards their well-being basically guaranteed that development. Disruption of the traditional business model would occur as a result of those forces as well as the immense opportunity of unfulfilled demand perceived to be available by many outsiders, some of whom already had had millions of customers. The article went on to describe in more detail the new, less expensive devices that would be marketed, the additional channels that would make them available as well as the Internet becoming the major communication source for persons seeking help with their hearing and communication. Since then, I have written several blog posts (see <https://hearinghealthmatters.org/innovationsinhearing/2018/navigating-road-ahead-part-4-hearing-triage/>) describing this inevitability in more detail. Since these posts, more than a year ago, several key questions remain: How far-reaching will this disruption become? How will the industry adapt?



Let's address these questions. The Direct to Consumer (DTC) revolution for hearing instruments is underway and gaining traction. The U.S. Food & Drug Administration (FDA) mandate to specify the terms under which the new class of over-the-counter listening devices will become available will, of course, be a game changer. There is already plenty of evidence that such devices are available at retail and via the Internet.

Turning, potentially tipping, points like this have affected many industries and the variety of responses is instructive. Some enterprises have been sluggish and ended up disappearing. Others have been more agile and adaptive, changing their proposition and continuing to thrive. Whether the hearing aid segment of the hearing health landscape remains dominated over time by relatively few players is open to question. There is little doubt that others, in some cases, with much larger scale and far greater reach, will enter the arena.

This juncture creates an opportunity to consider deeply what should happen (a values question) as well as the size of the stakes (an economic question). We have argued for some time that hearing loss is the largest untreated chronic health condition in our society, and that the numbers typically quoted—37 million plus in the United States—are significantly understated (NIH, 2016). For example, a recent study (Sawyer, et al 2020) from the United Kingdom (UK) found that 40% of adults between the ages of 50 and 89 years have a measured hearing loss, but do not report any difficulty with their hearing (Sawyer et al 2020). These figures, from the US and UK, indicate hearing loss and its long-term consequences are not taken seriously by the public. Indeed, data collected by my company, Summus Hearing Solutions, supports this fact: The public is generally unaware of the debilitating effects of hearing loss.

Regardless of the precise number, there is no question that many more individuals are left out of the assessment and treatment process than are accommodated by it. And, given what we now know about the hazards of ignoring hearing loss and the problems of late diagnosis, that abandonment (a word deliberately chosen to underscore my point) should be considered unacceptable. As practitioners with the most experience in dealing with hearing issues, audiologists should be cultivating ways to overcome this indifferent, “so many on the sidelines” conundrum.

Why not begin by thinking boldly? Assume there are at least seventy million people in the U.S. and Canada with self-perceived communication difficulties and/or varying degrees of permanent hearing loss - sensorineural patterns within the normal range through profound degree of hearing loss. How might they be tested and empowered to take control of their hearing health?

Too often, the industry starts with a solution - a device, usually with a number of services bundled with it. Compare that with what the contemporary consumer wants: An accessible, reliable and private way of measuring their hearing. When it comes to other types of self-assessment, however, most of us have become suspicious of providing personal information before the need is evident and the service provider is trusted.



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A credible self-screening tool must not only be easy to use and reliable, but audiologically valid – that is, the consumer is informed about his or her hearing status and the implications for any next steps that are warranted. Some of the basics include establishing the interpreted result as a baseline, informing one's family physician and maintaining a vigilant stance for the future.

Finally, to the extent that a product or service could be helpful, such advice can then be offered. A minority (our data sets indicate that an average of 30% of those 45 years of age or older) will test with a sensorineural hearing loss, the more advanced of whom (including many “mild” and “moderate”) should consider



Figure 1: The help seeking journey for the person with hearing difficulties in Medicine 3.0

a remedial device, such as a quality PSAP or starter hearing aid and many of those are becoming aware of some degree of hearing change. Another 15%-20% will have indications of a conductive change where, if the condition is persistent, their pharmacist and doctor are obvious sources of medical support. Most will display normal patterns and levels where coaching about frequent updating is appropriate.

Figure 1 describes the paradigm of test → interpretation → implications for action → potential solutions. It is the essence of Health Tech and personalized medicine and represents an enormous shift towards Medicine 3.0. For those unfamiliar with the term, Medicine 3.0, it is a health-related extension of the concept of Web 3.0 whereby the users' interface with the data and information available on the web is personalized to optimize their experience. A primary goal of Medicine 3.0 is to use consumer technology, such as social media and smartphone-enabled apps, to actively engage persons with hearing difficulties in their ability to self-direct their own care.

The meta issue, directly related to the application of Medicine 3.0 within the profession of audiology, can be stated quite simply: How can tens of millions more consumers become engaged in the hearing health process? There is not one answer, but rather a constellation of related steps involving a number of players and technologies. The outcomes remain speculative as the process, by definition, will be incremental with learning and adjustments required at each step.

A good starting point is to ensure that the overriding message is consumer, rather than product oriented – focused on how to create value by providing timely information, education and guidance rather than a “fix” via a hearing device. Sensorineural changes can begin at birth or be acquired at a relatively young age (particularly now with the “gaming and earbuds generation”) rather than suddenly appearing at age 60 or older. Even when exacerbated by noise, ototoxic medications and/or one or more disease states, such changes

usually worsen gradually. Pattern recognition algorithmic routines can detect early changes within the normal range thereby identifying younger as well as older people that are entering their “hearing journey”. The cohort of those who should be concerned about their hearing sensitivity is very broad and will benefit from early identification. We do this with sight and blood pressure; why not hearing?

We have found a receptive audience among this much larger target group. When testing is provided in an accessible, efficient, and private fashion with no strings attached, most people regardless of their age, are interested in participating. This receptive audience is prepared to take guidance, providing it is well explained and not biased towards a particular solution. When adequately prompted, there is often an appreciation of the widespread nature of the problem. Those with signs of hearing loss appreciate they are in good company – there is nothing unusual or abnormal about acknowledging and dealing with the condition.

Another key involves recognizing that the industry as it stands now cannot alone solve the problem of poor uptake of treatment options and lack of awareness that hearing loss is a consequential problem, if left untreated. Even if concerted action was taken by every audiologist and hearing instrument specialist, the proportion of those impacted would fall well short. Natural biases and business-traditional imperatives, among many, and the dominant brick-and-mortar distribution infrastructure, with limited reliance on the Internet, assures that the problem of poor uptake and lack of awareness among most of the population will remain unresolved. Adding thousands of family physicians and pharmacists would clearly help, although a continuing campaign with enough incentives would need to be created to sustain their efforts. Existing hearing health providers will need to evolve and receive help from other healthcare professions if the goal of greater awareness among the public is to be entertained.



HEARING HEALTH PROVIDERS WILL NEED TO EVOLVE & RECEIVE HELP FROM OTHER HEALTHCARE PROFESSIONALS...

Reducing regulations and creating an environment where individuals are empowered to seek knowledge as well as what next steps make sense is vital. The industry, with more of a 21st century face, can provide an important part of that engine, providing much greater reliance on the Internet is assumed. Adoption of hearing health as a priority by governments and public health agencies is also essential. Greater testing of school-age children, for example, with educational extensions for parents about their child's and their own well being would be additive. Leveraging corporations and their insurers is also part of the mix. The influence of new players, those offering less expansive hearing devices and including at least a few of the FAMGA (Facebook, Apple, Microsoft, Google, Amazon) technology group, each with a stake in healthcare can be enormous, as well.

Some of these drivers are already underway, although most are motivated by appeals to their audiences or members to acquire product. Whether the net effect is to turn on or off most consumers, receiving these messages remains to be seen. What is certain is that awareness of hearing and hearing health issues is increasing and will likely continue to do so.

Making it simple for consumers to test themselves reliably and follow the Health Tech process to a logical conclusion is also a requirement. There are many tests available, most via the internet, beyond those provided by in-house by industry professionals. Many of the protocols followed are of dubious quality and almost none, if any at all, offer reliable interpretation. The presence of "Click-Bait" (i.e. You've been tested and need a (expensive) hearing aid!) is all too evident, even with some of those that offer "professional" intervention along the way.

What is needed is a simple application widely available on the Internet via thousands of websites that can be accessed with a browser or QR code, using any connected device, any time from anywhere, particularly from home. Such a medium would provide an interpreted test and explanatory report for the user at a minimal, if any, cost. A further comfort would be the assurance that personal information required to report would not be stored, much less shared, unless the user wished it to be for follow-up evaluation or support. We can anticipate such an innovation to become available soon.

So, what else might we do short of letting market forces alone confront the problem as important as those forces can be?

The industry itself can provide part of the solution. Adopting more of a counselling stance (and likely charging for it), partnering with physicians and pharmacies, and using the Internet to a much greater extent to extend reach are all part of the equation. So is offering more devices at a wider range of prices as is unbundling and making related services transparent to clientele. ■

Terry Mactaggart is the President and CEO of Ultimate Kiosk Inc. and Summus Hearing Solutions Inc., AI-enabled software companies with proprietary technologies aimed at capitalizing on opportunities in international hearing health. He has substantial experience with private venture creation, financing and growth as an investor, consultant, director, chairman and president of a number of companies – both privately owned and publicly traded – as well as of a private equity fund. A broad international perspective has been gained from these activities as well as from his leadership of The Niagara Institute and his time with the World Bank. Terry has a BA (Political Science and Economics) from the University of Toronto and an MBA from Stanford University. He can be reached at terry.mactaggart@bell.net.

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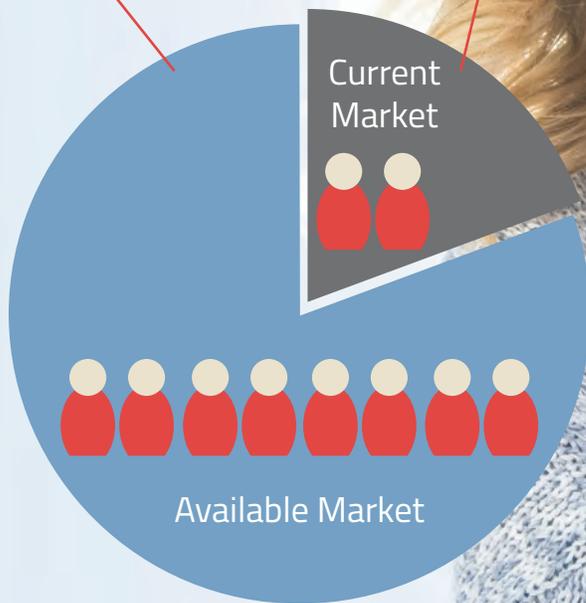
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*As reported in Hearing Health Care for Adults: Priorities for Improving Access and Affordability National Academics of Sciences Engineering and Medicine



By Donald Hayes, Ph.D.

Modernizing Hearing Health Space

When Joe Sweet decided to pursue curling to improve his cardiovascular health, he did not expect to find out that he also suffered from hearing loss. He was unable to hear what the skip was saying, making it difficult to excel in the sport and socialize with his colleagues. The gradual hearing loss Joe experienced was compounded by the fact that every time he tried a hearing aid, it was either uncomfortable, too loud, or itchy. These hearing devices all ended up in Joe's bedside table, while outside he continued to suffer in silence.

Joe isn't alone. Approximately one-third of people in North America between the ages of 65 and 75 suffer from some degree of hearing loss. For those older than 75, that number is approximately one in two.¹ Perhaps even more alarming is the fact that 80 percent of those suffering from hearing loss are not wearing the proper aids and devices² that could provide drastic improvements to their hearing experience.^[ii]

In the midst of an industry-wide transformation, a new first-fit strategy is needed to see higher adoption numbers of this critical adaptive technology.

Hearing aids are evolving from medical devices to wearable consumer electronics with technology advancing to include Bluetooth connectivity, TV and music streaming, and secure data logging. These new offerings have expanded the prospective client base and made the hearing aid shopping experience more rewarding for those struggling to cope with hearing loss.

However, audiologists still face obstacles when it comes to fitting patients with these devices. While the primary goal of a hearing aid is to optimize a patient's hearing, the historic fitting process fails to take into consideration the innate tension between wanting to give a person the best speech intelligibility and the reality of what they are ready to hear.

Traditionally, when a patient is fitted for a hearing aid, the audiologist aims to create the most optimal fit. This will maximize speech intelligibility, providing enough amplification to hear both high-pitched and low frequency sounds right out of the box.

The problem they face is that hearing loss has a gradual onset occurring over many years. The longer a person has significant hearing loss, the more they have adapted to a diminished auditory world. It is hard for them to accept the sudden application of appropriate amplification because it is so much louder than how they remember everything being. When you are dealing with a patient who has never worn a hearing aid but suffers from hearing loss, the sudden jolt to their auditory system is alarming and can deter them from wearing a hearing aid in the future. This is how they end up back on the nightstand.

The consequences of an improper fitting experience can be devastating. Those experiencing a loss of hearing may be forever deterred from properly addressing the issue. Poor hearing health can impact an individual's physical well-being as well as their socio-economic level.

A recent study³ conducted by researchers at Johns Hopkins found that untreated hearing loss increases the risk of dementia by up to 50 percent, compared to those without hearing loss. The study also found greater incidents of slips and falls, high blood pressure, and cardiovascular disease. Depression rates also increased by 40 percent, in five years, for adults suffering from hearing loss.^[iii]

Hearing impairment also triggers structural changes in the brain. The average person loses their hearing over time, but there is enough redundancy within the brain to fill in the blanks when that person can no longer understand every



Moving Past the First Fit Approach

word in a sentence. When a little hearing sensitivity is lost, we work just a bit harder to piece together the pieces we do hear and fill in the blanks based on the context of the discussion. Each time our hearing sensitivity drops a little more, we will again work just a little harder to piece it together, but with slightly less information. Eventually, hearing loss reaches a point where the brain can no longer fill in the blanks, forcing people to exert a great deal of their energy and brain power on listening and impacting their well-being.

Unaddressed hearing loss can also pose significant socio-economic concerns. According to a study by the Better Hearing Institute⁴, adults with hearing loss are more likely to be unemployed and, on average, earn approximately \$12,000 less annually than those without significant hearing loss. The estimated cost of lost earnings to the United States economy is \$122 Billion, which results in an estimated \$18 Billion of unrealized federal taxes.^[iv]

Audiologists and healthcare professionals need to rethink the “first-fit” approach to hearing aids.

Adapting the “first-fit” experience to be more reflective of a patient’s gradual hearing loss experience is an alternative that healthcare professionals should consider when fitting patients for new hearing devices. Pursuing a gradual transition allows the auditory system to receive, process, and accept sounds that have been missing for an amount of time. The starting point begins with comfortable, natural sound and enough amplification to provide benefit that is not jarring or overly loud. Over the next few days, as the wearer adjusts to the slowly increasing amplification the devices slowly adjust upwards to the appropriate level that maximizes speech clarity. This gradual transition encourages the wearer to use the devices regularly without rejection due to over-amplification.

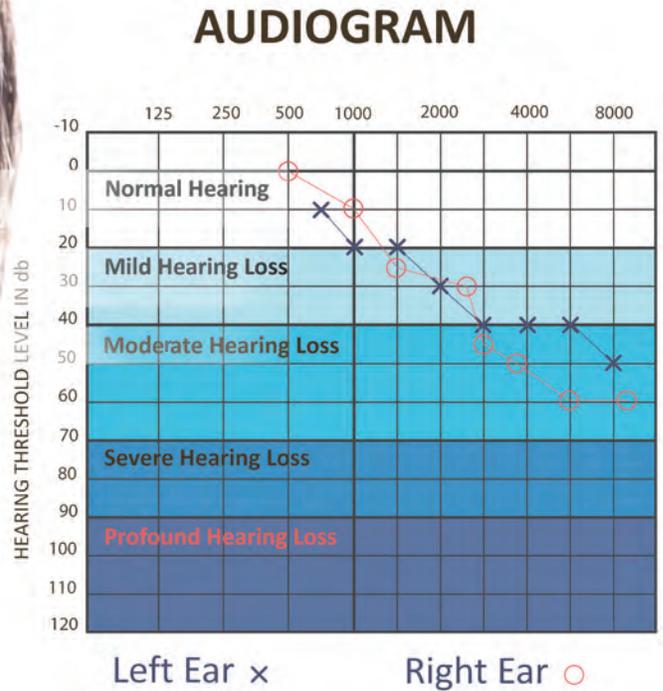
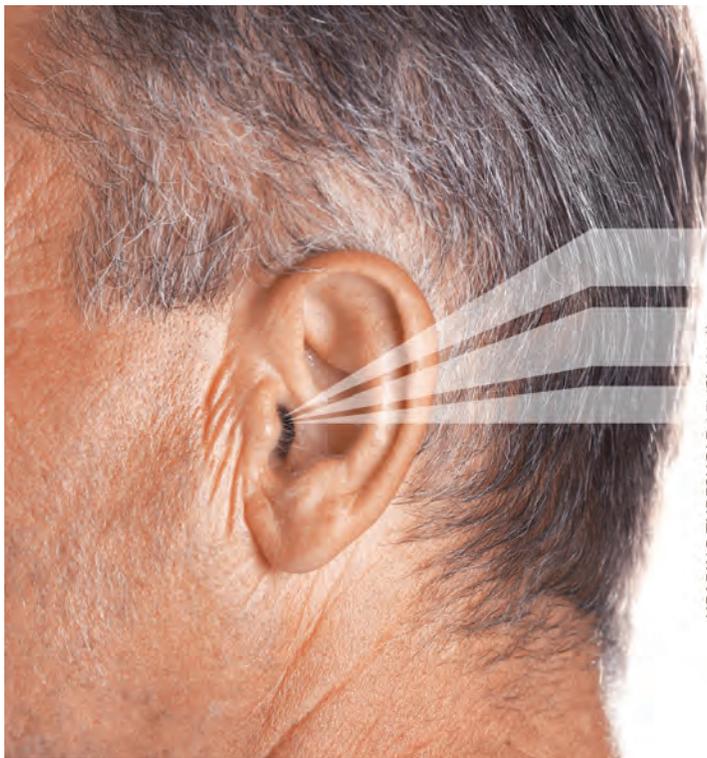
Factors that must be considered in this revamped “first-fit” approach include calculating the average hearing loss each year, a person’s age and the amount of experience with amplification to determine how much overall gain a patient should receive. Over the span of approximately one month, the hearing device will adapt to the patient’s changing auditory needs, eventually reflecting an industry standard fitting target for the greatest long-term benefit.

The industry is slowly moving towards this “first-fit” approach, with companies like Unitron prioritizing a more gradual shift in hearing device capabilities using its Discover platform. But, with the senior population in North America expected to double by 2036, it is paramount for health care providers to embrace new technologies that will improve hearing health and reduce the associated physical and socio-economic impacts.■

Don Hayes, Ph.D. is Director of Clinical Research at Unitron.

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Is the Audiogram Needed to Fit Hearing Aids?

By Brian Taylor, Au.D.

All clinicians can agree that comfortable, natural sound from hearing aids is a reasonable first-fit starting point for anyone wearing them. However, does the audiogram need to be part of the equation when it comes to the first-fit starting point? That notion is being called into question by scientists involved in the creation of self-fitting hearing aids.

Although most clinicians don't complete all the steps outlined in many best practice protocols, they have relied on the prescriptive method to fit hearing aids for more than 30 years. Now, that process, which requires, at a minimum, clinicians enter a patient's hearing thresholds into computer-based fitting software is being challenged.

In a paper published January 31st at the open access journal, Trends in Hearing, researchers demonstrated adults with mild-to-moderate hearing loss could select hearing aid parameters similar to those derived from a vetted prescriptive approach, such as NAL-NL2.

In their study, conducted at Northwestern University's hearing aid clinic, a group of 75 adult patients with mild-to-moderate hearing loss were split into two groups. One group wore hearing aids with acoustic parameters, selected by an audiologist following conventional best practice prescriptive fitting methods and the ability to adjust gain-only in the device, while the second group wore a device allowing them to directly self-adjust many of the hearing aid's acoustic parameters using a smartphone-like interface.

After the entire group of 75 participants were initially first fit using conventional prescriptive methods and allowed to wear the prototype hearing aid for about one week as a practice session, they returned to the clinic for some fine-tuning, and then split into the two groups. The "audiologist selected" group left the clinic for a 30-day at-home trial with gain set to closely match

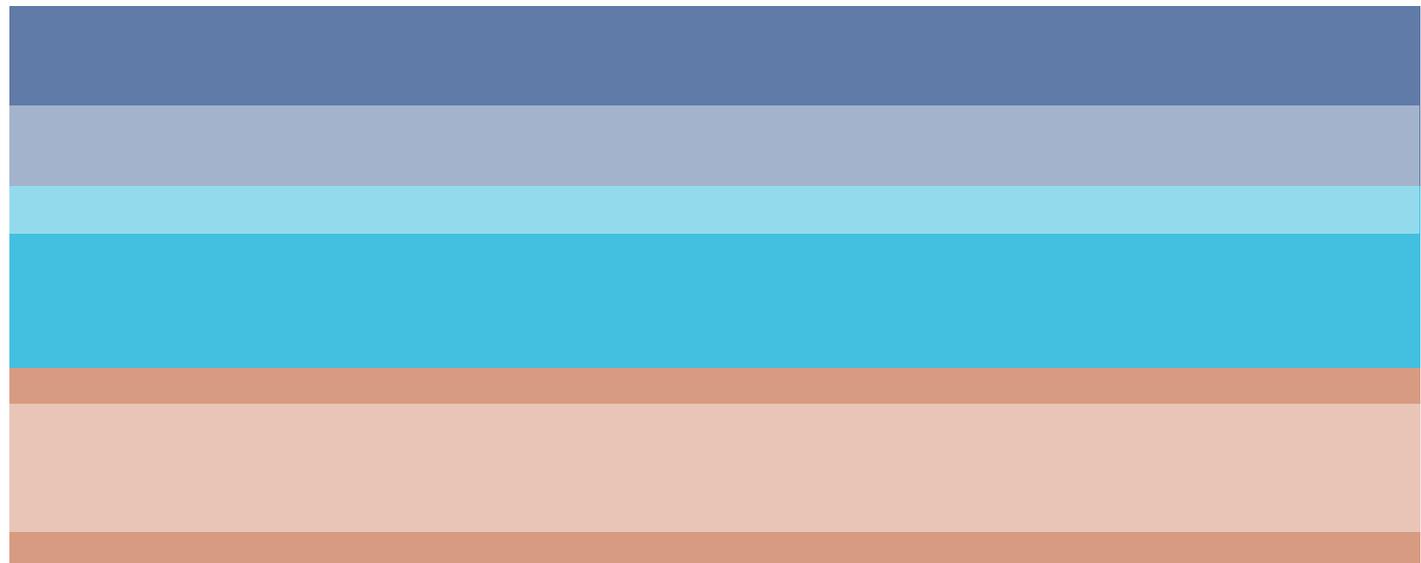
their prescriptive target and the ability to adjust gain-only (+/- 8 dB) using the smartphone-like interface. In contrast, the “self-fit” group left the clinic for the 30-day at-home trial with a starting point of 0 dB insertion gain (REIG) and the ability to self-adjust two sliders on the smartphone-like interface that were tied to compression, gain and frequency response parameters of the hearing aid. During their at-home trial, both groups were able to randomly report, using a real time assessment feature on the hearing aid, their satisfaction with sound quality during various types of listening situations. At the same time, the researchers were able to record the participants’ hearing aid settings when they made their self-reports.

At-home use of the devices showed, regardless of the group, that participants with greater hearing loss selected greater amounts of gain, with the “self-fit” group selecting slightly lower amounts of gain compared to the “audiologist-selected” group. Further, preferred gain levels for both groups were remarkably similar. The deviation from the initial prescriptive starting point in the clinic was calculated two different ways: Overall gain and gain per band. The gain selected by the “self-fit” group was within 1.8 dB for overall gain and 5.6 dB per band, on average, compared to the gain selected by the audiologist at the initial fit in the clinic.

While wearing the devices, participants were able to make A/B comparisons between their own self-selected parameters and those selected by the audiologist, during the initial fit in the clinic. Both groups preferred their own self-selected settings more than the settings they received during the initial fitting in the clinic, but the preference for their own self-selected fitting was stronger for the “self-fit” group. Following the at-home trial, a series of standardized measures of outcomes were conducted in the clinic on all participants following their at-home trial, including the APHAB, SSQ-12 and aided QuickSIN. The average scores on these outcome measures did not differ between the two groups, as both groups derived benefit from their respective fitting approach.

Given the similar preferred gain settings and outcomes between the “self-fit” and “audiologist-selected” groups, the researchers surmise that adults with mild-to-moderate hearing loss, when provided user-friendly tools, can successfully fit their own hearing aids with minimal or no involvement from an audiologist. Also, it’s worth considering that the fitting method employed in this study possibly could be used by patients with severe or asymmetrical hearing losses – groups that were not included in this study, but nevertheless should not be precluded from such a fitting approach, simply because they have more complex hearing loss.

Considering the remarkably similar outcomes between the two groups in this study, consumers may soon have a choice between two different fitting procedures: one driven by the clinician, using traditional threshold-based principles, and another that places the control firmly in the hands of the wearer. Audiologists must be poised to work with both types of persons with hearing loss: those who want in-person assistance and those that choose to self-direct their care and begin the process of improved communication by self-fitting their own hearing aids. Indeed, evidence is emerging that both approaches lead to successful outcomes. ■



BE CAREFUL WHAT YOU WISH FOR

Thinking Through the Risks and Rewards of Private Practice

By Chandace Jeep, Au.D. and Nicole Kovel, Au.D.



Although considered one of the most challenging endeavors in the hearing health care field, starting a private practice can be one of the most rewarding accomplishments for an audiologist. The ability to make decisions and provide treatment that directly influences the quality and standards of care delivered to a patient is often a coveted career choice for clinicians. However, private practice comes with a multitude of obstacles to overcome, hardships, start-up costs to pay, and common mistakes to avoid. This article, geared mainly toward doctoral students and recent graduates, provides a candid review of the essential topics related to stepping away from a salaried position and buying a private practice.

Buying an existing or starting a new private practice is like launching any other small business and is subject to the same statistical analysis as any other newly established business venture. According to the U.S. Small Business Administration, roughly 50 percent of new businesses fold within five years of coming into existence. Audiologists, however, who plan well, secure proper funding and remain flexible in the ever-changing climate of healthcare, face a better overall chance of achieving long term private practice success.

When assessing your appetite for private practice, it helps to have some frank and honest information available to better gauge your willingness to assume the career risk the often accompanies self-employment. After all, given the current shortage of audiologists in many regions of the country, it could be far easier to take a salaried position with an existing organization, where the steady pay and opportunity to advance are appealing. This article overviews many of the common concerns and factors associated with becoming a self-employed audiologist. Every audiologist buying or starting a practice faces two primary categories of financial obligations: (1) start-up costs, the expenses incurred when initially establishing a new business; and (2) continuing costs, the expenses required to maintain and operate a private practice.

START UP COSTS OF A PRIVATE PRACTICE

The path towards establishing a private practice is different for everyone with varying factors (such as personality, location, specialty) playing an important role in affecting the overall cost to setting up and running any health care-related business.

Consultants estimate that the cost to launch a private practice ranges from \$10,000 to more than \$100,000 – an estimation that includes the money needed for rent, insurance, equipment, and living expenses for the first few months.

AVERAGE START-UP COSTS

Audiologists pay initial fees for registering a small business; business entity formations (such as PLC versus LLC); and/or trademarking a business name – all of which vary on a state-by-state basis. These aforementioned fees are in addition to the various state, county and other localized government fees that audiologists are required to obtain in order to practice in a state.

Malpractice insurance is one of the first items an audiologist should obtain, as medical professionals are required to have it before the processing of insurance credentialing paperwork can take place. The average cost of malpractice insurance depends on the location (state) of a practice.

The cost of renting or leasing office space varies and is determined by location and size by square feet. Leasing and renting space for a practice is generally a multi-year financial commitment. Some experts believe the ideal size of a private practice facility is 900 to 1500 square feet.

When applicable, improvements or renovations to existing office space can cost between \$15,000 and \$50,000 – depending on the space. For example, some practices may require additional space to store equipment, such as probe microphone equipment. These costs typically run about \$40-\$60 per square foot.

The purchase of basic office equipment and furnishings includes an up-to-date computer system, printer/ copier/ fax machine, filing cabinet with lock, telephone and voicemail, and furniture (for the audiologist's office, waiting room and patient rooms).



Prices are dependent on an individual's office space and needs. It is not necessary to purchase new equipment when initially establishing a private practice. Gently used equipment can be bought for half the original cost and can be upgraded or replaced as a practice and revenue grows.

Average high-end costs for furniture, equipment, copiers, computers, and telephones can range from \$50,000 to \$65,000. A first-class practice management computer system can cost upwards of \$20,000, while some are available for less than \$10,000.

Sales and marketing costs allow an audiologist to establish a presence within the community, and to build a patient base, he or she may pay for newspaper ads, flyers, postcard mailers, radio spots, TV commercials, and social media ads. Since most individuals locate and research health care providers by conducting an Internet search, an online presence is also essential, such as purchasing a domain name and setting up a website. Business cards and letterhead are both valuable for the start-up of a practice, as well as for ongoing advertisement.

Retaining a consultant or advisor is optional and typically costs an average of \$5,000 annually, but their guidance and advice can streamline the transition from school graduate (or salaried clinician) to a health care business owner. Rather than pay a flat fee for a consultant or advisor, new business owners can opt to join a buying group in which a percentage of each hearing aid purchased from a manufacturer can be placed into an account that pays for the consulting services. Buying groups are plentiful and provide useful services, but any prospective owner must carefully consider the monthly or yearly hearing aid unit commitments that might be involved with membership. This is essentially a loan extended to the owner repaid through the purchase of devices with a modest per unit upcharge. An onerous hearing aid unit commitment can easily get in the way of proper or ethical patient care, as the new owner feels an obligation to recommend the hearing aids that will fulfil her unit commitment, rather than the hearing aids that might be most appropriate for the patient.

Tax and legal advisors, such as attorneys and accountants, are also optional yet serve as a long-term investment for the success of a private practice which helps audiologists to avoid costly mistakes. The fees and services they provide vary.

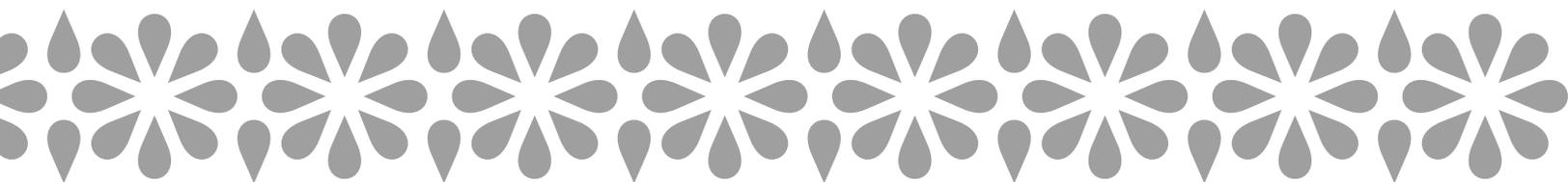
CONTINUING EXPENSES

In addition to start-up costs, there are several continuing costs that are typically paid on a monthly or annual basis. Average continuing Costs include: Office rent and utilities paid on a monthly basis—gas, electricity, telephone service, and internet connection needed to run a business. Office supplies and medical materials, from copy paper to clinical supplies, are purchased on a continuous basis in order to maintain the administrative and clinical duties of a private practice – and is oftentimes a monthly expense.

Insurance plays a vital role in providing multiple levels of protection for both a clinician and small business owner and must be renewed and paid on a scheduled basis. In addition to liability/malpractice insurance, other types include an audiologist's own health and disability insurance; and property insurance for the office space.

Private practice owners are responsible for the bi-weekly payroll, annual salaries, periodic bonuses and yearly benefits of their staff, which may include writing checks for an administrator, assistant and/or other health care workers. It is estimated that an administrator or audiology assistant should be paid a rate of \$12 to \$20 per hours, possibly higher in some regions of the country. Additionally, business taxes must be paid every year and include the additional payment of self-employment tax – traditionally the responsibility of employers of salaried clinicians.

Optional expenses to consider include monthly living expenses, travel expenses, professional development (such as continuing education and licensure requirements), and membership dues. Also, the marketing of a private practice is a continuous effort. For many, websites, blogs and online networking can attract patients. Some audiologists choose to hire a professional to maintain a Facebook business page, engage with the public on Twitter, or write blog posts related to their field of expertise. Hiring someone to create your creative marketing output should be approached with caution. Although hiring a marketing expert to handle this task saves time, it's critical that your marketing message reflects your standards and values. Patients and prospects are savvy and can spot an inauthentic or phony marketing campaign from miles away.



THE TIME COMMITMENT FOR OWNERS OF A PRIVATE PRACTICE

Starting a private practice comes with some of the same type of demands associated with establishing a small business, and a lack of planning is the downfall for any new enterprise. In addition to the time commitment it takes to earn an audiology doctorate degree, audiologists with an interest in establishing a private practice must also devote time to planning for their future business well in advance. It's advisable to start during their fourth year in an AuD program, as it can take at least upwards of six months to set up a private practice.

The time an audiologist spends organizing a business plan is one of the most important investments made towards the success of his or her practice.

Experts say 80 percent of new businesses fail because the owners overlooked the appropriate steps needed to develop a successful business strategy and goals. There are also many steps outside of the control of an audiologist that can take time to complete. For example, audiologists planning to accept insurance as a form of payment from third party payers must sign up with companies and local insurance panels by filling out the appropriate paperwork and undergoing the credentialing (or enrollment) process. This can last many months and varies with each company.

Devoting at least six months to the start of a healthcare practice is essential to avoid falling into a "position of urgency." The waiting period alone for the time-consuming credentialing process can take up to six months for a company to verify the legitimacy and experience of the audiologist.

States and insurance providers must determine if an audiologist and their private practice meets their requirements. During the credentialing period, an audiologist's state license and other qualifications are confirmed.

Overall, a private practice does not blossom overnight, and the process involves taking financial risks and making cost-effective decisions in the beginning stages. It often takes at least two years before an established private practice starts to see increasing profits. It is not uncommon for some audiologists to lose money until a client base and steady referral network are established.

OBSTACLES ASSOCIATED WITH OPENING A PRIVATE PRACTICE

Audiologists opening a private practice do not have the luxury of concentrating solely on the clinical side of health care but must also create a sustainable balance between caring for patients and running a business. Audiologists seeking self-employment must comprehend and execute standard business practices.

Along the path of establishing, managing, financing and growing a private practice, an audiologist typically encounters the following obstacles:

1. **A Higher Level of Responsibility:** As a salaried employer, audiologists are not responsible for the accounts receivable; maintaining IT equipment; the inventory of supplies; business taxes; record-keeping; and administrative duties, such as staff hiring and termination. Owners of a private practice often deal with collecting past-due payments, billing patients, mediating staffing conflicts, upholding patient safety, and managing the overall business. Their level of responsibility goes beyond assuming the role of a clinician.
2. **Must Build from Scratch:** Hospital or ENT-based audiologists gain instant access to patients as a perk for being an employee, while owners of a private practice must start from the ground up establishing their own business and building a patient base.
3. **Hiring an Appropriate Staff (Team):** Audiologists face the challenge of recruiting and hiring staff members that fall in line with the mission, values and vision of their private practice. Employees are an investment, and hiring the wrong fit can become costly. And, in the early stages of the business, to save money, you might have to go it alone for a while, by swallowing your pride, answering your own phone, and booking appointments.
4. **Choosing the Right Technology:** Technological advancements in healthcare, such as the electronic health record (EHR), provide self-employed audiologists with many options for improving the overall quality and efficiency of patient care. The key is to select business solutions prevalent to a practice's area, which also require the least amount of transition or upgrades in the future.



5. **Healthcare Reform:** Large changes will center in third party reimbursement focus on exploring a “value-based reimbursement” approach with various methods being tested out, such as shared savings, bundled payments, per member per month payments, and pay-for-performance models. Audiologists in private practice must carefully each new insurance contract and weigh their involvement in each contract.
6. **Unexpected Expenses and Financial Losses:** Revenue for a private practice takes a hit whenever unintended expenses arise, such as a piece of equipment needing to be replaced, burst water pipes causing damage to the office, computer system shut downs, or an overall economic downturn in the community. Increases in local competition and the emergence of a nearby multi-specialty practice or big-box retailer can also threaten the income stream of a private practice.
7. **Threat of Being Sued:** Although rare, audiologists must prepare themselves for the possibility of a malpractice suit. Not only does the process of legal action translate into the threat of financial repercussions but can also create ‘bad press’ that damages the reputation and patient confidence of any medical professional.
8. **No Guarantees with Income:** As a salaried employee, audiologists know exactly when and how much money they will be paid, while a self-employed audiologist earns varying levels of income on a monthly basis – which is dependent on a multitude of factors, such as the number of clients seen, payroll demands, fluctuating expenses, unforeseen expenditures, and the timeliness of reimbursements. Audiologists in private practice also lose income when they take vacations or sick leave, unlike their salaried counterparts.
9. **Managing ebbs and flows in the business cycle:** Like any business, private practices also experience ebbs and flows in office traffic that can affect revenue. For example, if you live in Minnesota, your practice may experience a slow time when many older folks head south. And, just about every practice experiences the lowest number of referrals and fewest patient appointments every December when patients are less likely to visit a practitioner close to the holidays.
10. **Managing slow time:** If you’ve spent time in an ENT practice, it is likely you struggled to find the time to fit hearing aids. When you step into a private practice, the rhythm and flow of patients can be must different. Inevitably there will be slow times in your daily schedule. These are good times to network with other medical professionals and strength your brand within your community.

REWARDS AND BENEFITS OF A MEDICAL PRIVATE PRACTICE

Without question, the autonomy that private practice owners have is one of the largest rewards associated with establishing an independent business. This plays a role in making the following benefits possible for self-employed audiologists.

1. **Be Your Own Boss:** Holding the top position, private practice owners do not answer to administration, office managers or other executives that often affect the work environment and role of an audiologist in a salaried position. There is no one pushing them to increase the number of patients seen per day, or how to run their daily operations. Private practice owners are able to exercise a higher level of creativity. They set their own hours, designate their own vacation time, and determine the next steps for furthering their business goals.
2. **Build a Respected and Trusted Business:** The ability to run a practice as an audiologist sees fit allows them to create the atmosphere and quality of services they’d like to provide patients, such as offering a more relaxed, laid-back, family-oriented environment.
3. **Control Who You Work With:** Audiologists typically review the applications of office staff for their private practice, which means they have better control in outfitting the office with suitable, highly motivated workplace personalities. When



conflicts arise with office staff, private practice owners have the power to discipline or dismiss, when necessary.

4. **Greater Ability to Increase Revenue:** Unlike working for an employer, audiologists in private practice are able to increase revenue by accepting more patients, extending hours, as well as offering weekend and evening appointments. Solo practitioners can also increase their income by providing ancillary services, such as the audiologists who conducts tests for a local ENT practice.
5. **Decision-Making Freedom:** From choosing to accept a particular insurance carrier to ordering a new piece of cutting-edge equipment, audiologists running their own practice have the power to make important decisions regarding office dynamics and the quality of patient care they provide. Self-employed audiologists can also swiftly respond to new treatments, emerging medical trends, and the need to make office-wide changes.
6. **Help Patients in Need:** Solo practitioners are also in a position to make decisions that affect the affordability of care without having to answer to higher management, such as avoiding unnecessary procedures or making an effort to better understand the cost differences of various treatment options and prescriptions which can lower out-of-pocket expenses for patients.

THINGS YOU MAY NOT HAVE THOUGHT ABOUT

In addition to start up costs, on-going expenses and various pros and cons, there are a few other considerations for those thinking about plunging into self-employment.

1. **Determine a Practice Strategy:** According to Heather Hill-Spaine, of Real Psych Practice LLC, medical professionals should narrow the focus of their practice, as she says it's been her observation that a lack of practice specification increases the chances of a practice not surviving its first 18 to 36 months. Hill-Spaine says that identifying the types of patients a health care professional wishes to serve and the kinds of services they'd like to offer can make shaping and building a private practice much easier to achieve. Specifically, Hill-Spaine suggests assessing population(s) and communities to serve; drawing from special training and experiences regarding disorders and conditions; acknowledging unique or personal connections to the community; and amplifying the things that set a health care provider apart from those who provide the same or similar services.
2. **Obtain Adequate Business Training:** A common misconception regarding the establishment of a private practice is that expert health care knowledge and skills translates into a health care business that will automatically thrive. However, audiologists who lack sufficient training and entrepreneurial knowledge face an increased risk of failure. An audiologist must learn business strategies, design, and implementation as it relates to running a private practice. In addition to buying groups, those interested in pursuing private practice can network with Academy of Doctors of Audiology members or professors at their local AuD program who might have experience in this area.
3. **Work with a Business Advisor or Consultant:** Healthcare business experts are trained to guide audiologists through the process of launching and running a private practice. Although the average cost for their services is in the \$5,000 to \$7,000 range, advisors and consultants assist self-employed practitioners with:
 - a. The accounting and legal aspects of a private practice
 - b. Obtaining the proper insurance for practicing and running a business
 - c. Recruitment and training of employees
 - d. Billing, coding and other reimbursement issues





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- e. Implementing office essentials, from phone lines to digital record systems
 - f. Addressing government regulations and compliance issues
4. **Create A Solid Financial Plan:** One of the most important steps an audiologist must take before starting a practice is to establish a well-planned financial strategy with business projections. For example, it is suggested to create estimated statements that demonstrate financial scenarios for the best-, worst-, and most likely outcome for a private practice. An audiologist must draw from their specific circumstances, such as location, office size, staff size, intended fee schedule and specialty, to arrive at these approximations.

Strategic financial plans not only provide audiologists with a blueprint for starting their business, but the information and projections help secure business loans and funding from banks and lenders. Banks and investors also review net income (profit and loss) statements; balance sheets; and estimated cash flow statements for monthly, quarterly and yearly expenses and revenue.

COST VS REWARD OF PRIVATE PRACTICE

A private practice owner encounters a great deal of decision-making which plays a significant role in the success and future of the business. For starters, audiologists must assess whether launching a private practice is economical and financially feasible according to their personal circumstances, including geographic location and level of local competition for medical clinic or retail stores. Then, audiologists must figure out how they will cover start-up and ongoing expenses until their business starts to turn a profit. While some dig into their savings, others take out a loan from a lender. It is also not uncommon to see an audiologist hold a ‘day job’ to help fuel their own business.

Having an understanding of all the costs involved in running a private practice is essential, including how much it costs to see a patient per visit and the cost per diagnosis, as well as establishing a fee schedule that not only covers these costs but is also profitable in the long run.

Another way to create a balance between the start-up costs and rewards for a private practice owner is to make business decisions that reap benefits in the long-term. Audiologist who desire to own a private practice must create a healthy balance between patient care and thinking like a ‘businessperson.’

In conclusion, opening a private practice is a significant investment an audiologist makes in their future. The opportunity is ideal for a medical professional wishing to reap the benefits of owning a business and treating patients as they best see fit. In addition to the high level of financial risk and responsibility, the process of launching a private practice also involves a substantial commitment of time and money. Those who succeed in their respective fields enjoy a high level of autonomy and a potentially rewarding, not to mention lucrative career.

“You will need to wear multiple hats – one being a physician (what you were trained to do in medical school) and the second being a business manager (which is not taught in medical school),” says Debs. “Embracing both roles is critical in order to succeed in private practice.” ■





Customization IS THE ANTIDOTE FOR **AUTOMATION**

By Brian Taylor, Au.D.

If you followed the unveilings at CES 2020 in January, it's apparent that hearing aids continue to morph into consumer audio devices, as a growing number of consumer audio devices transform into hearing aids. Because these devices have multiple functions, they can be classified as hybrid devices. That is, they can be used to stream music, talk on the phone, track biometrics, and amplify speech. Obviously, a greater number of choices, spread across a wide range of price points, is a positive development for consumers with hearing loss, especially for millions of people with hearing difficulties who don't want or value interventions delivered by audiologists. According to a recent MarkeTrak 10 article by Brent Edwards, published in *Seminars in Hearing*, about 7% of Americans have no measured hearing loss but perceive hearing difficulty, and another almost 8% of Americans have measured hearing loss and perceive no hearing difficulty. Both of these groups are unlikely to see themselves as hearing aid candidates and could embrace some type of do-it-yourself, off-the-shelf solution.

The convergence of hearing aid and consumer audio technology might be appealing to these two groups for different reasons. For those with no measured hearing loss but perceiving hearing difficulty, hybrid devices, with their multitasking capability can be used as a situational hearing aid in challenging listening places, encountered a few times each week. In contrast, those with measured hearing loss and perceiving no hearing difficulty, family and friends can encourage them to try an amplification device from the comforts of home without scheduling an appointment with an audiologist.

The emergence of hybrid devices will enable more people to opt to self-direct their own care—the ability to self-assess, self-diagnose, self-treat and self-manage one's own condition with little to no direct involvement with a licensed professional.

Let's explore some of the underlying reasons driving the trend toward self-directed care. A closer look tells us there are two trends driving some individuals to self-direct their care. At the center of each trend is the smartphone, smartphone-enabled apps and a wireless internet connection, which, together, form a user-friendly self-directed care system.

DEMOCRATIZATION OF TECHNOLOGY

Many of the tests and procedures conducted in the clinic by audiologists can be placed in the palm of the consumer's hand, allowing them, with smartphone and machine-learning apps, to self-screen for possible ear disease, self-test their hearing or even self-fit hearing aids. These are all part of a larger movement aimed at democratizing all of healthcare. Even if a patient chooses to make an appointment for a comprehensive hearing assessment, the standard test battery can be completed by a non-audiologist using automated equipment. If you're an aging Baby-boomer or Gen Xer who has grown up experiencing the marvels of both modern medicine and Madison Avenue marketing, there's a good chance you find this new-found ability to self-direct your own health care incredibly appealing.

DECOUPLING OF THE BUYING PROCESS

Until recently, if you have hearing loss and decided to purchase hearing aids, the entire sales and service acquisition process took place in a fairly linear manner, as outlined in Figure 1. All components of the buying process typically occurred with the same clinic, under the same roof. In a sense, persons with hearing loss were hostage to the location in which they decided to do business. The costs of switching to a new provider meant developing new personal relationships with new service providers, an often times consuming and stressful process.



Figure 1. The traditional linear buying process with five key phases, delivered by the same clinic

Now, thanks to modern technology, each phase of the buying process can be delivered by a different clinic or service provider and each of the five phases, importantly, can be delivered either face-to-face or virtually, using webcasting, video chatting or some other form of computer-based communication. Figure 2 and Figure 3 show two examples of a decoupled buying process, in which the consumer with hearing challenges acquires a different component of the buying process from three different entities.

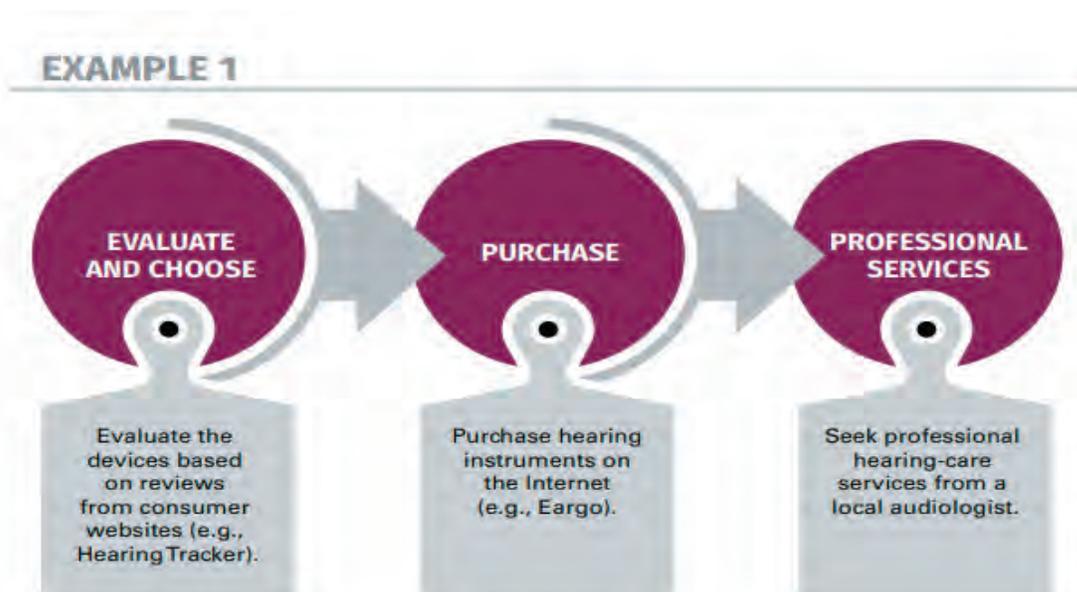


Figure 2. An example of the decoupled hearing aid buying process

EXAMPLE 2

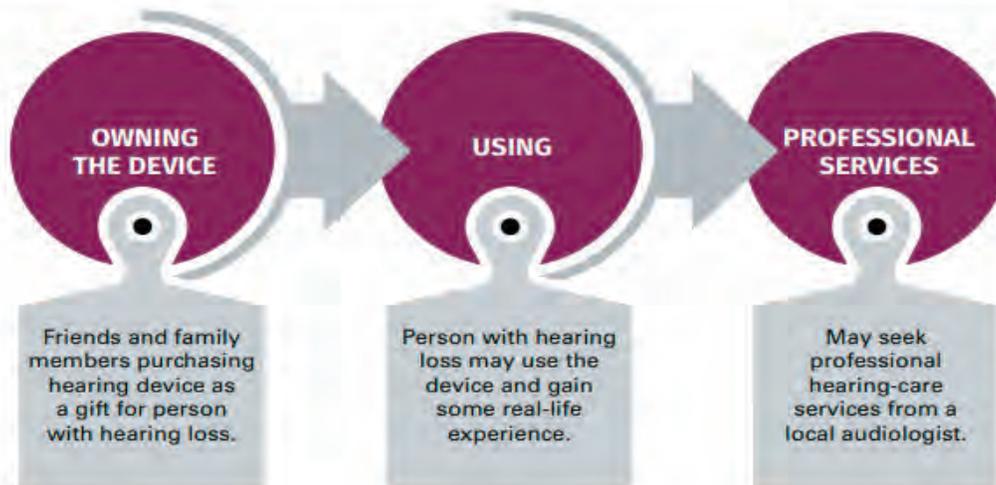


Figure 3. Another example of the decoupled buying process

Given the nature of hearing loss that's gradual in onset, its accompanying social stigma and the natural inclination to procrastinate intervention for a chronic condition, both the democratization of technology and the decoupling of the buying process enable consumers with hearing challenges to dabble, test drive and experiment with various assessment tools and treatment options in a low-risk manner from the comforts of home or with the help of family and friends.

The democratization of technology combined with the decoupling of the buying process means consumers can choose when and what parts of the buying process they want customized by an expert professional. And, in contrast, they can decide when and what aspects of the buying process they want standardized/automated. You can think of the choice between customization and standardization/automation as one that lies on a continuum, like the one shown in Figure 4. For every component of the buying process, from evaluation to on-going service (See Figure 1), the consumer with hearing challenges can decide if it's worth the time and money to have all or some aspect of the buying process customized. Customization, it would seem, of all or some part of the buying process more likely leads to an optimal outcome. On the other hand, an automated or standardized one-size-fits-all process, which saves either time or money, more likely leads to an outcome that might be "just good enough."

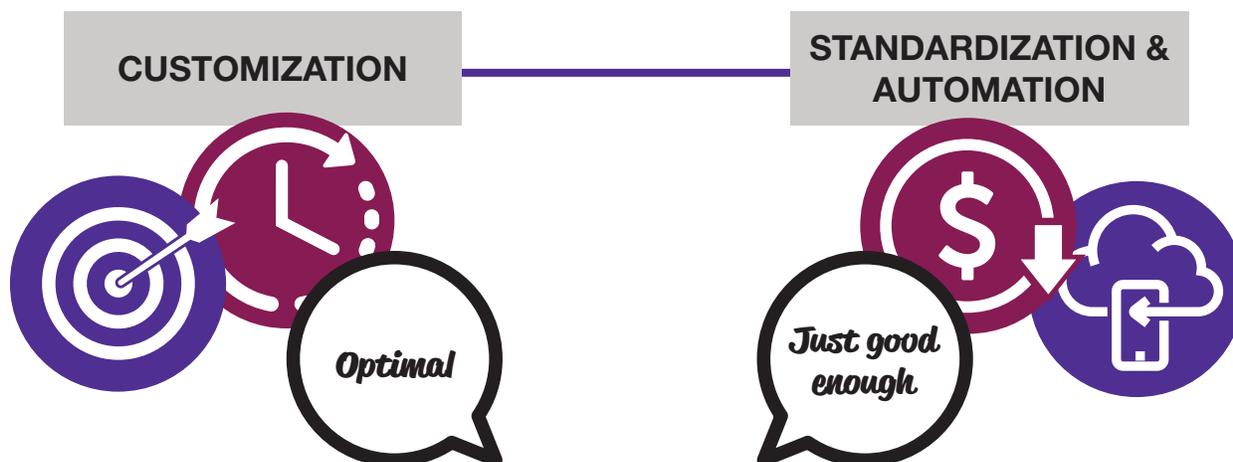


Figure 4. The Customization-Standardization/Automation Continuum. Customization takes more time but it's more individualized and more often leads to an optimal outcome. Standardization and automation require less time, tend to reduce cost for the patient and more often lead to an outcome "just good enough" for the patient.

Clinicians may soon even practice in a world where customers with hearing challenges begin the process in the clinic with a face-to-face visit. After an initial intake, the clinician and consumer mutually decide if the rest of the buying process should be automated or standardized with little or no further direct involvement from the professional.

Today, clinicians are already grappling with providing services on this customization – standardization/automation continuum. There are several components of the clinical delivery process that can be standardized or automated, thus saving considerable time, but possibly sacrificing an optimal outcome. Every clinician uses a standardized procedure to measure hearing thresholds and speech understanding ability – components of a standard assessment that can be completed with automated equipment in the clinic today. And, many clinicians rely on first fit algorithms as a starting point in the fitting process and don't use probe microphone measures to customize the fitting. Any test, procedure or interaction in the clinic with a patient can be placed somewhere on this continuum.

It seems clear that if hearing care professionals want to remain relevant for most consumers with hearing challenges, they must identify ways to customize as many parts of the buying process as possible. Furthermore, it makes sense to provide this customization in an ala carte format, allowing consumers the ability to choose what they want customized. Below are some examples of how hearing care professionals can differentiate their practice through customization for each of the stages of the buying process. Each of the components below could be an unbundled fee for service provided by an audiology practice.

I. EVALUATE: CUSTOMIZE INFORMATION GATHERING AND TREATMENT GOALS

Gather as much information as you can about the person's auditory system and the underlying non-audiological factors that contribute to their handicapping condition. Use scaling questions to gauge the patient's perception of hearing loss and their willingness to take action on a treatment. In addition to standardized tests like the Quick SIN, use established questionnaires like the Revised Hearing Handicap Inventory Screening to ascertain the patient's self-reported emotional and social factors affecting communication ability.

Finely tailored information gathering leads to the development of bespoke treatment goals that can be recorded on the COSI or Patient Expectation Worksheet. Gathering detailed information about the *person* (not just their auditory system) and devising individualized treatment goals cannot be easily replaced by machine-learning algorithms or standardized tools found on an app or website. This information gathering is a humanistic skill provided by conscientious professionals.

2. CHOOSE: CUSTOMIZE TREATMENT OPTIONS

One of the tenets of patient centered communication is that the consumer with hearing challenges and the service provider are working *together* to identify treatment goals and options. By using a patient decision aid, like the one shown in Figure 5, clinicians can educate consumers about a full range of options, including options that may be "just good enough." It is the responsibility of the clinician to educate the consumer about the pros and cons of every potential treatment option, even those that may be sub-optimal.

Effective decision aids show more than device options but can include the option of doing nothing or forgoing the use of a device and trying some type of stand-alone aural rehabilitation or auditory training program. Patient-centered communication means the provider is clearly articulating the pros and cons of each option based on the information gathered during the evaluation.

3. PURCHASE: CUSTOMIZE THE FITTING

Regardless of where a consumer may have purchased hearing devices, professionals have an opportunity to provide quality control measures to ensure the physical fit and acoustic parameters are optimized. One proven strategy is to use a scientifically validated prescriptive target and verify the match of that target with probe mic measures. A 2018 study by Valente and colleagues indicates that squeezing an extra 5 to 8 dB out of the fitting, getting the first-fit starting point closer to an individualized prescriptive target, improves speech understanding by upwards of 20%. The challenge for clinicians, of course, is that they don't always have familiarity or access to fitting software that allow them to make these necessary adjustments on devices purchased elsewhere. A challenge that could be addressed by changes in FTC hearing aid regulations.

OPTIONS FOR HEARING TREATMENT

	Near Normal		Moderate		Very Challenging
YOUR OPTIONS	Minimal Action	Personal Sound Amplification Products (PSAPS)	Hearing Aids	Hearing Systems	Baha and Cochlear Implants
PROS	Annual hearing checks are low maintenance and low cost. Maintaining healthy hearing ensures best overall health.	Inexpensive, over-the-counter option for people with little to no hearing loss that may help to amplify sound.	Hearing aids are considered the gold standard of treatment for hearing loss. Proper fit, follow-up, and counseling from an audiologist results in high satisfaction with devices and improved quality of life.	Better signal to noise ratio, remote microphones, wireless streaming to TV and phone, adjustments and programming.	Cochlear implants are an effective long-term solution for treating hearing loss
CONS	Untreated hearing loss can lead to a variety of negative health conditions, including depression, cognitive decline and dementia.	Inadequate fit and follow-up often leads to dissatisfaction with the product. Low quality technology leaves a lot of room for improvement with your hearing.	The upfront cost can be a concern for patients. Luckily, financing options are available.	Need to carry additional accessories on hand, some hearing systems have limited range.	Surgery is required for implantation.

Figure 5. An example of a patient decision aid used to customize treatment options

4. USE AND ON-GOING SERVICE: CUSTOMIZE SELF-MANAGEMENT PLANS

More than simply teaching patients how to use their hearing aids, clinicians can customize an individual’s self-management plan. People with chronic conditions, like hearing loss, benefit from learning how to be independent communicators and problem-solvers. Since the condition cannot be cured but can be effectively managed, the goal of the professional is to devise a self-management plan, targeting key areas of improvement for the individual. A self-management plan focuses on improving one of the three components of self-management: 1. Knowledge of the condition and treatment options, 2. Actions that improve the patient’s condition, and 3. Psychosocial issues resulting from the hearing loss that need to be overcome or addressed through long range planning and support from a professional.

An individualized self-management plan is an iterative process, which means that it is likely to change over time. Therefore, at least once a year the consumer and provider should sit down together (in person or virtually) and update the plan by modifying goals and communication strategies.

These are four examples of how audiologists, relying on patient centered communication skills, can customize any link of the buying process for individuals who have the choice of self-directing their care. As a larger number of routine clinical tests, procedures and products become automated and democratized, it is imperative for audiologists to excel at the humanistic ability to tailor all components on the buying process in an ala carte manner. Customizing the consumer’s purchasing experience can be the antidote to automation. ■

Customizing Gain Leads in Optimal Results

This installment of Go Figure shows results of a 2018 study from Mike Valente's lab at Washington University in St. Louis. Using a double-blind, randomized crossover design 24 adult participants with mild-moderate, downward-sloping bilateral hearing loss were fitted with hearing aids for the first time. The 24 participants were split into two groups: One fitted to a closely matched NAL-NL2 prescriptive target and verified with standard probe microphone measures, and the other group fitted to the manufacturer's proprietary first-fit algorithm without probe microphone verification measures. .

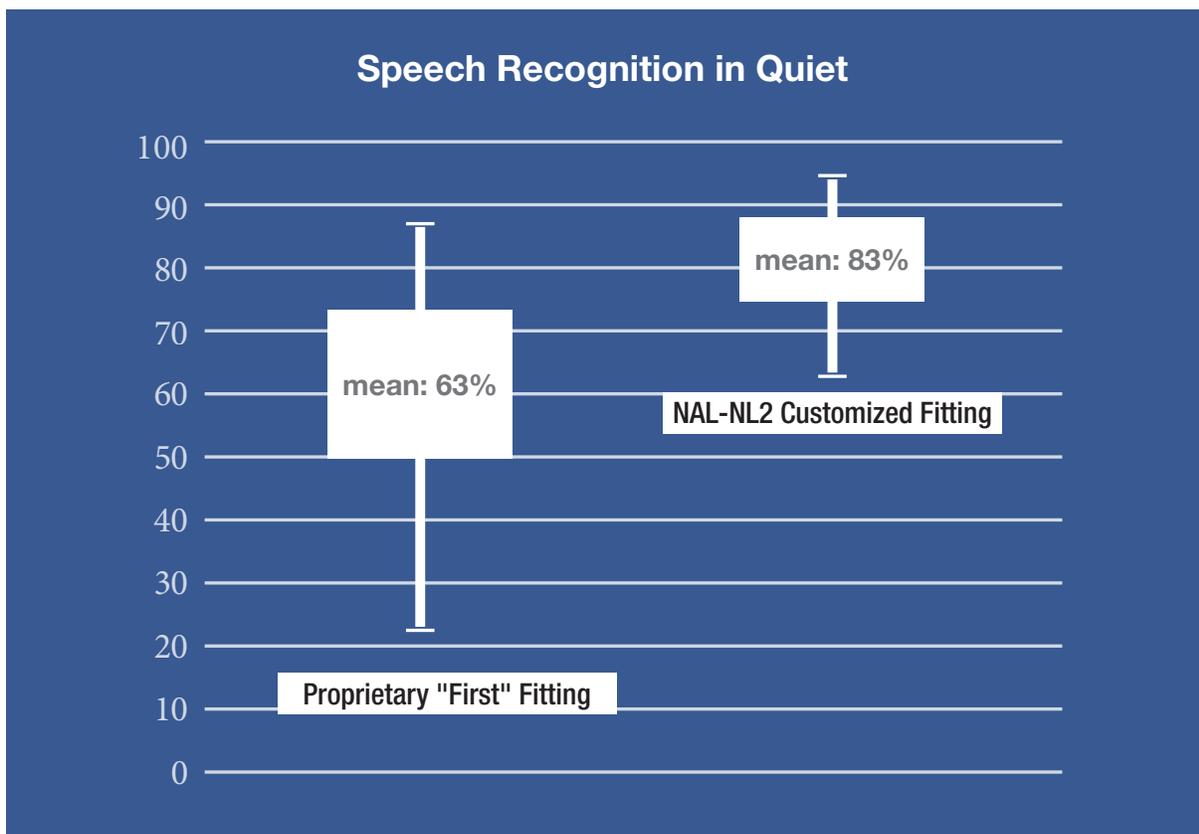
All 24 participants wore the hearing aids for about three weeks. Following this time frame, they returned for follow-up testing, including speech recognition in quiet and in noise (HINT), subjective responses for the Abbreviated Profile of Hearing Aid Benefit (APHAB) and the Speech, Spatial and Qualities of Hearing (SSQ) questionnaire.

The group fitted to the NAL-NL2 target and verified with probe microphone measures outperformed the "first-fit" group on all outcome measures. Perhaps the most fundamental point taken from the study is outlined in the figure. It shows the group fitted and verified to the NAL-NL2 target had almost 20% better, on average, speech recognition scores relative to the "first fit" group.

If you are wondering if it's worth the time to chase after five to ten dB of gain in the ear canal (and not simply rely on first-fit algorithms), the results of this study clearly show that, yes, it is worth the time to customize gain. Getting closer to the prescribed target is likely to achieve significantly better speech recognition ability for most patients.

You can find the complete article here:

Valente M., Oeding K., Brockmeyer A., Smith S., and Kallogjeri D. (2018) Differences in Word and Phoneme Recognition in Quiet, Sentence Recognition in Noise, and Subjective Outcomes between Manufacturer First-Fit and Hearing Aids Programmed to NAL-NL2 Using Real-Ear Measures. *J Am Acad Audiology* 29, 8, 706-721. ■



Tele-Audiology Resource Guide

BY KIM CAVITT, Au.D.

PROCEDURES WHICH MAY BE ABLE TO BE PROVIDED VIA TELEHEALTH WITH EXISTING TECHNOLOGIES (IF TELEHEALTH PROVIDED BY AN AUDIOLOGIST IS ALLOWED BY STATE LICENSURE)

- Ensure that all of the requirements of the code are met.
- If in your scope of practice and allowed by licensure, individuals can be charged privately for non-covered telehealth services.
- Coverage more likely to exist if the procedure was covered as a face to face interaction.
 - No coverage if provided to Medicare beneficiaries as audiology is not covered for the provision of telehealth.
 - Coverage may exist through state Medicaid programs and private insurances.
 - Please be cautious in accessing an individual's third-party hearing aid coverage and benefits for the services indicated with an asterisk. You could, potentially, exhaust an individual's third-party hearing aid coverage and benefits by accessing those benefits for any service. Please consult individual payers for guidance and be transparent with the individual as to the risks of accessing their benefits for evaluation and service, rather than product.
 - Also, if your practice offers a bundled hearing aid delivery or an unbundled delivery with a service plan option, please proceed with caution regarding all of the codes with an asterisk. If your practice does not currently bill individuals or payers for these services in face to face interactions, your practice needs to consider the ethics and optics of charging for these services, in this environment, via telehealth. Individuals may have already paid for this service in their bundled delivery or service plan.
 - 92531: Spontaneous nystagmus test, including gaze.
 - 92507: Treatment of auditory processing disorder; individual.
 - *92590: Hearing aid examination and selection; monaural.
 - *92591: Hearing aid examination and selection; binaural.
 - *92592: Hearing aid check; monaural.
 - *92593: Hearing aid check; binaural.
 - 92630: Auditory rehabilitation; prelingual hearing loss.

- 92633: Auditory rehabilitation; postlingual hearing loss.
- 92700: Unlisted otorhinolaryngological procedure.
 - Used to classify procedures that do not have CPT codes.
 - Common procedures to consider:
 - Communication Needs Assessment.
 - Tinnitus management.
 - Auditory prosthetic device orientation, counseling, troubleshooting and service.
- 96127: Brief emotional/behaviorial assessment, with scoring and documentation, per standardized instrument.
 - As allowed by state licensure laws.
- 97129 : Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks), direct (one-to-one) individual contact; initial 15 minutes).
 - As allowed by state licensure laws.
- 97130: Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks), direct (one-to-one) individual contact; each additional 15 minutes (list separately in addition to code for primary procedure).
 - As allowed by state licensure laws.
- S9445: Individual education, not otherwise classified, non-physician provider, individual, per session.
- S9446: Individual education, not otherwise classified, non-physician provider, group, per session.
- S9981: Medical records copying fee, administrative.
 - Can be billed with units.
 - State medical records policies dictate what can be charged.
- S9982: Medical records copying fee, per page.
 - Can be billed with units.
 - State medical records policies dictate what can be charged.
- V5008: Hearing screening.
 - Same as 92551.
- *V5010: Assessment for hearing aid.
 - Same as 92590/1.

- *V5268: Assistive listening device, telephone amplifier, any type.
- *V5269: Assistive listening device, alerting, any type.
- *V5270: Assistive listening device, television amplifier, any type.
- *V5271: Assistive listening device, television caption decoder.
- *V5272: Assistive listening device, TDD.
- *V5273: Assistive listening device, for use with cochlear implant.
- *V5274: Assistive listening device, not otherwise specified.
- *V5281: Assistive listening device, personal FM/DM system, monaural (1 receiver, transmitter, microphone), any type.
- *V5282: Assistive listening device, personal FM/DM system, binaural (2 receivers, transmitter, microphone), any type.
- *V5283: Assistive listening device, personal FM/DM neck, loop induction receiver.
- *V5284: Assistive listening device, personal FM/DM ear level receiver.
- *V5285: Assistive listening device, personal FM/DM, direct audio input receiver.
- *V5286: Assistive listening device, personal Bluetooth FM/DM receiver (streamer.)
- *V5287: Assistive listening device, personal FM/DM receiver, not otherwise specified.
- *V5288: Assistive listening device, personal FM/DM transmitter assistive listening device.
- *V5289: Assistive listening device, personal FM/DM adaptor/boot coupling device for receiver, any type.
- *V5290: Assistive listening device, transmitter microphone, any type.
- *V5265: Ear mold/insert/disposable, any type.
 - Per mold (billed with units).
 - Dome.
 - Insert.
- *V5266: Battery for use in hearing device.
 - Should be billed as multiple units unless advised against it by the payer (Medicaid).
- *V5267: Hearing aid or assistive listening device/supplies/accessories, not otherwise specified.
 - Billed as separate line items.
- *V5299: Hearing service, miscellaneous.
 - Extended warranty.
 - Accessory or FM support and service.

**PROCEDURES WHICH MAY BE ABLE TO BE PROVIDED VIA TELEHEALTH WITH SPECIAL EQUIPMENT OR TECHNOLOGY
(IF TELEHEALTH PROVIDED BY AN AUDIOLOGIST IS ALLOWED BY STATE LICENSURE)**

- Ensure that all of the requirements of the code are met.
- If in your scope of practice and allowed by licensure, individuals can be charged privately for non-covered telehealth services.
- Coverage more likely to exist if the procedure was covered as a face to face interaction.
 - No coverage if provided to Medicare beneficiaries as audiology is not covered for the provision of telehealth.
 - Coverage may exist through state Medicaid programs and private insurances.
- Evaluation and Management Codes, new patient:
 - 99201
 - 99202
 - 99203
- Evaluation and Management, existing patient:
 - 99211
 - 99212
 - 99213
- Evaluation and Management, consultation codes:
 - 99241
 - 99242
 - 99243
- Telephone Assessment and Management Service:
 - 98966
 - 98967
 - 98968
- Online Digital Evaluation and Management Service:
 - 98970
 - 98971
 - 98972

REMOTE ASSESSMENT

- Ensure that all of the requirements of the code, and its associated procedure, are met.
- For hearing aid dispensing, confirm if any test requirements exist for your state.
 - iHear (FDA approved): <http://www.ihearmedical.com/ihear-test/> and <http://www.prweb.com/releases/2016/01/prweb13147729.htm>

- National Hearing Test: <https://www.nationalhearingtest.org/wordpress/>
- Audicus: <https://www.audicus.com>
- Jacoti: <https://www.jacoti.com/hearingcenter/>
- Music Acoustics: <http://newt.phys.unsw.edu.au/jw/hearing.html>
- Nuheara: <https://www.nuheara.com/online-hearing-assessment/>
- Lively: <http://www.listenlively.com>
- Starkey: <http://www.starkey.com/online-hearing-test>
- Widex: <https://www.widex.com/en-us/hearing-loss/online-hearing-test>
- Resound: <https://www.resound.com/en-us/online-hearing-test>
- Miracle Ear: <https://www.miracle-ear.com/hearing-test>
- Spinach Effect: <http://www.hearingkiosks.com/>
- Ultimate Kiosk: <http://www.ultimatekiosk.com/site/home>
- ShoeBox: <https://www.shoebox.md/>
- Kuduwave: <https://kuduwave.com/>
- Otohub: <https://www.otohub.com/>
- Ototronix: <http://www.ototronixdiagnostics.com/otogram.html>
- Auditdata: <https://www.auditdata.com/>
- Quadrio: <http://www.quadrio.in/hearing-solutions/quadiometer>

APPLICATIONS (EMERGENCY AMPLIFICATION)

- Available on mobile phones.
- No FDA regulations.
 - EarMachine: <http://www.earmachine.com/>
 - EarSpy: <http://www.earspyapp.com/>
 - Fennex: <https://www.fennex.io/> (turns AirPods into amplifier)
 - HearingOS: <http://www.hearingos.com/>
 - Jacoti: <https://www.jacoti.com/>
 - Mimi: <https://mimi.io/en/behind-mimi/>
 - Petralex: <http://petralex.pro/>
 - Volume Boost
 - Hear Boost
 - Search “hearing aid” in app store and you will see many additional options.

Questions? Please contact Kim Cavitt at kim.cavitt@audiologyresources.com or 773-960-6625 (text or call).

A hand is shown in the foreground, reaching out towards a row of wooden blocks of varying heights. The blocks are arranged in a line that recedes into the background, creating a sense of depth. The background is a dark, textured wooden surface.

There are **STEPS**
we can take to reduce
or prevent falls!

#thinkaudiology

See an audiologist today!

think  audiology
Hear More. Fall Less.

Remote Hearing Aid Evaluation, Fitting and Management by Audiologists

We are in the midst of a national health crisis and most audiologists have closed their clinics in an attempt to follow professional, state and federal guidance. We now expect to be home for the entire month of April, at the very least.

So, what hearing aid related items and services can we provide via telehealth? For some, many services are available. For others, no services are available. It is extremely dependent on state audiology and hearing aid dispenser licensure laws and consumer protection and telehealth regulations. It is also influenced by any executive or emergency orders or proclamations from the governors of your states.



A few general rules of thumb: Audiologists can only provide telehealth to individuals who are currently residing in the state(s) in which the audiologist is currently licensed to dispense hearing aids, either their audiology and/or hearing aid dispensing licensure. Medicare does not cover any audiology procedures or services provided by an audiologist via telehealth. As a result, all testing and evaluation would be private pay. Finally, you cannot bill a patient for telehealth services that you do not charge for in face to face interaction OR you have bundled into your current hearing aid delivery.

Please view the guidance at https://www.audiologist.org/_resources/documents/webinars/2020-03-23-Town-Hall-COVID-19.pdf for more detailed considerations and codes. In determining what can be provided via telehealth, you need to find answers to all of the following questions:

GENERAL QUESTIONS

1. Is telehealth allowed in your state? You can learn more about this at <https://www.asha.org/uploadedFiles/State-Telepractice-Policy-COVID-Tracking.pdf>. There are still some states where telehealth is not allowed.
2. Does your current malpractice and business insurance cover care provided via telehealth?
3. Do your payers or third-party administrators/networks IN YOUR STATE allow for coverage of hearing aids and related services delivered by drop-off/mail and fit by telehealth?
4. Who, in your patient population, would you be legally allowed and/or comfortable evaluating, fitting and managing via drop off/mail and fit by telehealth?
 - a. Loss and damage replacements?
 - b. Existing users?
 - c. Pediatrics?
 - d. New users?

- e. Private pay?
 - f. Managed Care?
5. Do patients, in your state, have to complete some form of telehealth acknowledgment or authorization form?
- a. If yes, how will you get this signed form forwarded to you?

EVALUATION QUESTIONS

1. Does your state have requirements as to what constitutes an audiogram (in order to fit hearing aid in your state)?
 - a. Can you meet those requirements via telehealth or via an online or app evaluation?
2. Does your state have test environment requirements for hearing testing?
 - a. Can you meet those requirements via telehealth?
3. Does your state have requirements as to the age of the audiogram?
4. Has the patient already received a compliant audiogram within the age requirement?
5. What type and level of testing can you provide via telehealth OR via an online or app option?
6. For those who typically charge for this visit, how do you monetize and collect payment for this visit?

COMMUNICATION NEEDS ASSESSMENTS OR HEARING AID EXAMINATION AND SELECTION

1. Are you a bundled or unbundled hearing aid delivery? You cannot charge someone for a service via telehealth that you would not charge them for in a face to face delivery.

ADA's Practice Resource Catalog: The Tools You Need for Your Practice



ADA's Practice Resource Catalog offers a comprehensive library of off-the-shelf forms, office forms, bills of sale, HIPAA compliance documents, and guidance materials. These materials can assist audiologists and their staffs with practice operations, compliance, and patient management.

Visit audiologist.org/prc for more information!

2. Has this service already been provided?
3. What type and level of this service can you provide via telehealth?
4. How will you get state required medical clearances or medical waivers signed and forwarded to you?
5. For those who typically charge for this visit, how do you monetize and collect payment for this visit?

HEARING AID FITTING

1. Are you a bundled or unbundled hearing aid delivery? You cannot charge someone for a service via telehealth that you would not charge them for in a face to face delivery.
2. Does your state have requirements as to what must be included in a hearing aid fitting?
 - a. Do these requirements have to met at fitting or can it be met in follow-up visits (at a later date)?
 - b. Can these requirements be met via telehealth?
3. Have the aids already been ordered? Are they sitting on your shelf?
4. Will they be pre-programmed by you or the manufacturer?
5. How will you get the aids to the patient?
6. What type and level of this service can you provide via telehealth?
7. How do you get the state required bill of sale/hearing aid receipt signed and forwarded to you?
8. How do you monetize and collect payment for this visit?
9. Can this be billed to and covered by a third-party?

HEARING AID FOLLOW-UP

1. Are you a bundled or unbundled hearing aid delivery? You cannot charge someone for a service via telehealth that you would not charge them for in a face to face delivery.
2. What type and level of this service can you provide via telehealth?
3. How will you handle returns for credit? Exchanges?
4. For those who typically charge for this visit, how do you monetize and collect payment for this visit?

I firmly believe that remote evaluation, hearing aid fitting and management may be a viable option for some patients over the coming months. I recommend folks explore these options if they are looking for a potential revenue stream.

If ADA members have further questions or would like to learn more, please contact Kim Cavitt at kim.cavitt@audiologyresources.com or 773-960-6625 (text or call). ■

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.

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Required Credentials

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 YES, I agree to abide by the Code of Ethics. _____ Associate _____ Au.D. School: _____
License #: _____ License State: _____ License #: _____ Graduation Date: _____
Au.D. School: _____ Graduation Date: _____

PAID

Employment

Business Setting: Private Practice ENT Office Hospital/Clinic Educator School System
 Community Agency Government Hearing Industry Consultant Retired Other

Payment Information

\$350 Fellow \$300 Associate \$50 Student \$50 Web Subscription \$525 Lifetime \$95 Assistant \$1000 Bundled Practice
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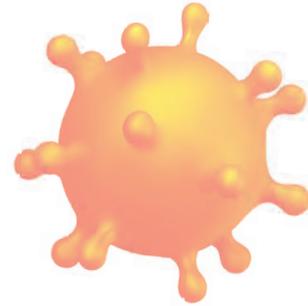
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HAVE YOU HEARD?



Special Message from ADA Leaders

The coronavirus disease (COVID-19) pandemic has created unprecedented challenges for ADA members as citizens, parents, caregivers, clinicians, and business owners. Our first priority is the health and safety of every ADA member and stakeholder and that of your patients, colleagues, friends, and families.

As small business owners and employees, ADA members are the backbone of the American economy, and also among the most vulnerable to financial impact of the COVID-19 pandemic. ADA and its leaders are committed to delivering the most useful, relevant, and accurate information, so that you can make the best clinical and professional decisions for you and your practice during this unprecedented time.

CARES Act Information for Small Business Owners: Good Places to Go for What You Need to Know

On Friday, March 27, 2020, President Trump signed the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act into Law. This \$2 trillion package includes various relief programs and among them is assistance to small businesses, such as audiology practices, in response to the COVID-19 pandemic.

For the most up-to-date information, please visit www.home.treasury.gov and www.sba.gov.

Please visit the following link to view the ADA CARES Act Town Hall Webinar and download the handouts: <https://www.audiologist.org/item/town-hall-legislative-update-cares-act>.

ADA urges audiology practice owners to seek guidance directly from their attorneys, accountants, bankers, and business consultants to help ensure the best possible course and outcome for their businesses.

The Families First Coronavirus Response Act (FFCRA) Took Effect April 1st: Employer and Employee Information Released by DOL

The Families First Coronavirus Response Act (FFCRA) requires private employers with fewer than 500 employees to provide emergency paid sick leave and emergency FMLA leave to eligible employees. Employers are required to notify their employees of these benefits and to post the information in a conspicuous place within the premises.

The most up-to-date guidance from the U.S. Department of Labor can be found at the following link: www.dol.gov.

The ADA COVID-19 Telehealth, Reimbursement, and Compliance Town Hall Webinar and Resources Now Available

The ADA COVID-19 Telehealth, Reimbursement, and Compliance Town Hall webinar, featuring Kim Cavitt, Au.D., is now available for on-demand viewing at the ADA COVID-19 Webpage: <https://www.audiologist.org/audiologists/covid-19-resources>.

CARES Act Authorizes HHS Secretary Broad Waiver Authority on Telehealth

Passage of the CARES Act provides the U.S. Department of Health and Human Services (HHS) with the authority to waive statutory requirements for telehealth services identified under Section 1834(m), during the COVID-19 public health emergency. As such, CMS could, at its discretion, expand the list of providers that can be reimbursed for telehealth services for Medicare Part B beneficiaries to include audiologists.

ADA Requests 1135 Waiver to Allow Safer Medicare Patient Access to Audiology Services

On Friday, March 27, 2020, ADA submitted a request to CMS Administrator, Seema Verma, MPH, seeking a 1135 Waiver to remove the requirement that Medicare beneficiaries obtain a physician order prior to seeking treatment from an audiologist and to add audiologists to the list of providers who are authorized to perform telehealth services under the Medicare program. View the request letter on the next page.

MAASA Legislation Would Make Much Needed Medicare Improvements

The Medicare Audiologist Access and Services Act (MAASA), H.R. 4056 and S. 2446, would make much needed improvements to Medicare statute, alleviating some the challenges now faced by patients and providers.

Today's Medicare rules impose unnecessary burdens and risks for beneficiaries seeking audiologic care.

- Medicare Part B beneficiaries are currently required to obtain a physician order prior to seeking treatment from an audiologist. This requirement is inconsistent with evidence-based practices in the delivery of audiologic services and places undue burdens upon beneficiaries, ordering physicians/providers, and the Medicare system, particularly when healthcare systems are overcapacity.
- Because audiologists are classified by Medicare as suppliers, they are left out of important telehealth provisions that would allow continuity in care, every day, and particularly during healthcare crises. Providers who are classified as practitioners under the Medicare program are already authorized to provide telehealth services, without the need for special waivers or considerations that create unnecessary distractions during emergencies.
- Medicare recognizes audiologists as diagnosticians only. Therefore, audiologists cannot be reimbursed for the Medicare-covered treatment services that they are licensed to provide. These restrictions detrimentally limit the use of telehealth delivery of audiology services for Medicare beneficiaries and creates unnecessary barriers to treatment.

ADA and its members have long advocated for legislation to modernize Medicare and streamline patient access to audiology services. **Congress should pass MAASA as soon as possible to make much needed and permanent fixes to mitigate these problems.**

MAASA will make important improvements to the Medicare Program. If enacted MAASA will:

1. Remove the physician order requirement and allow Medicare beneficiaries to have direct access to audiologists;
2. Reclassify audiologists from suppliers to practitioners; and
3. Allow audiologists to be reimbursed for the Medicare-covered treatment services that they are licensed to provide under their state licensure laws (in addition to diagnostic services).

Contact your members of Congress today and urge them to pass MAASA as soon as possible so that audiologists can be better utilized in the critical months and years to come--and so that Medicare beneficiaries have improved access to evidence-based hearing and balance care.

Please visit www.chooseaudiology.org for more information and to contact your Members of Congress.

State Laws Prohibiting Audiologists from Providing Telehealth Services Must be Updated for Any Federal Improvements to Apply

It is important to note that even if Medicare laws are changed to allow audiologists to provide telehealth services, audiologists will not be able to do so if prohibited by state law. If your state does not allow audiologists to provide telehealth services, please work with your state audiology organization and/or independently to request an emergency policy change.



Academy of Doctors of Audiology

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tel 866.493.5544 | fax 859.271.0607 | web www.audiologist.org

March 27, 2020

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma,

Thank you for all you are doing in response to the coronavirus pandemic. We appreciate all of your efforts to rapidly update and adjust Medicare policies to keep our country and its citizens safe and well served. As you know, the President declared a National Emergency under the National Emergencies Act on March 13, 2020, therefore allowing the Centers for Medicare and Medicaid Services (CMS) to issue Section 1135 waivers to temporarily or waive certain requirements of the Medicare program.

The U.S. Centers for Disease Control and leading health experts from the Administration's Coronavirus Task Force have demonstrated that social distancing can help prevent the spread of the coronavirus and all diseases such as the flu, which are similarly transmitted. Unfortunately, current Medicare policy with respect to hearing and balance health care encourages the exact opposite of social distancing for our most vulnerable citizens.

Current Medicare Part B policy requires beneficiaries to obtain a physician order before seeing an audiologist and also prohibits audiologists from providing services via telehealth. These requirements are inconsistent with evidence-based practices in the delivery and efficiency of care. The physician order requirement is unique to the Medicare Part B program only, even though audiologists are responsible for determining medical necessity. The Department of Defense, the Veterans Health Administration, and Federal Employees Health Benefit system plans do not require a physician order for beneficiary access to covered audiology services. Most private insurance plans and Medicare Advantage plans similarly allow direct access to audiologist services.

Therefore, we urge you to exercise your authority under Section 1135 to modify the requirements of the Medicare program to eliminate the physician order requirement for audiology services and to also allow audiologists to provide Medicare-covered services via telehealth.

Thank you in advance for your consideration. Please feel free to contact me at 330.495.0293 or dabel@audigy.com. Wishing you continued good health.

Sincerely,

Debbie Abel, Au.D., President

The Power to Practice

CMS Announces Expansion of the Accelerated and Advance Payment Program for Medicare Participating Health Care Providers and Suppliers

On Saturday, March 28, 2020, the Centers for Medicare and Medicaid Services issued a notice of Expansion of the Accelerated and Advance Payment Program for Medicare Participating Health Care Providers and Suppliers, to assist providers facing hardships related to being asked to delay non-essential procedures, healthcare staff unable to work due to childcare issues, and other disruptions in reimbursement.

According to the CMS statement, “Accelerated and advance Medicare payments provide emergency funding and addresses cash flow issues based on historical payments when there is disruption in claims submission and/or claims processing. These expedited payments are typically offered in natural disasters to accelerate cash flow to the impacted health care providers and suppliers. In this situation, CMS is expanding the program for all Medicare providers throughout the country during the public health emergency related to COVID-19. The payments can be requested by hospitals, doctors, durable medical equipment suppliers and other Medicare Part A and Part B providers and suppliers.”

To qualify for accelerated or advance payments, the provider or supplier must:

- Have billed Medicare for claims within 180 days immediately prior to the date of signature on the provider’s/ supplier’s request form,
- Not be in bankruptcy,
- Not be under active medical review or program integrity investigation, and
- Not have any outstanding delinquent Medicare overpayments.

Medicare will start accepting and processing the Accelerated/ Advance Payment Requests immediately. CMS anticipates that the payments will be issued within seven days of the provider’s request. Please visit the following link for more information: <https://www.cms.gov/newsroom/press-releases/trump-administration-provides-financial-relief-medicare-providers>

ADA 2020 Student Business Plan Competition and Webinar Series Now Open

Attention ADA Students—Do you have an entrepreneurial spirit and a desire to create your own destiny? Does your future include private practice ownership?

If so, it’s time to get down to business and get your business plan ready, polished and perfected for the ADA 2020 Business Plan Competition. The deadline to complete the intent to participate is June 1, 2020. Contestants must be ADA student members in good standing and 2nd, 3rd, or 4th year students at some point during the 2020 program year.

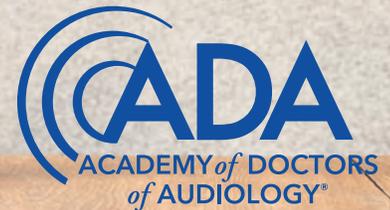
Finalists will receive an all-expense paid trip to the AuDacity Conference, November 2-4, 2020 at the Gaylord Texan Resort in Dallas, TX, where they will present their business plans in person. The Grand Prize Winner will receive a \$5,000 ADA cash grant to be used to advance business objectives and enhance business and leadership skills.

Please visit www.audiologist.org for complete rules and to register.

► **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.**

Contact Your Legislators!

Urge them to support the **Medicare Audiologist Access and Services Act** (H.R. 4056/S. 2446)



The Medicare Audiologist Access and Services Act of 2019 (H.R. 4056/S. 2446) will remove unnecessary barriers, allowing patients to receive appropriate, timely, and cost-effective audiologic care. This legislation can improve outcomes for beneficiaries by allowing direct access to audiologic services and streamlining Medicare coverage policies so that audiologists can provide the full range of Medicare-covered diagnostic and treatment services that

correspond to their scope of practice. The legislation would also reclassify audiologists as practitioners, which is consistent with the way Medicare recognizes other non-physician providers, such as clinical psychologists, clinical social workers, and advanced practice registered nurses.

Support the future of audiology!

Contact Congress today and express your support for H.R. 4056/S. 2446.

Visit chooseaudiology.org/support and contact your congressperson today!



AuDACITY

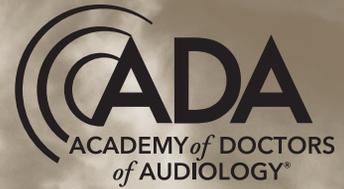
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