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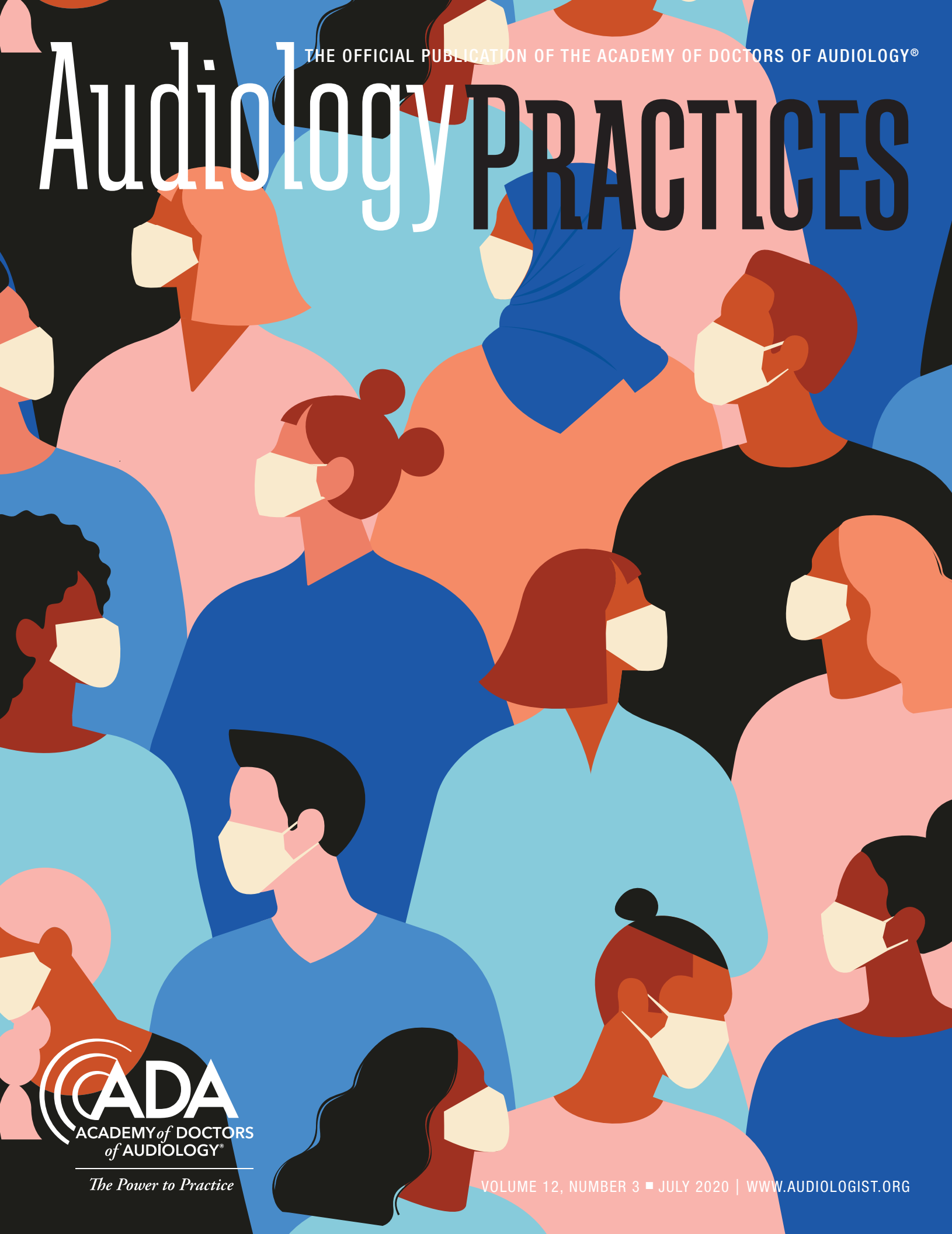
Audiology PRACTICES



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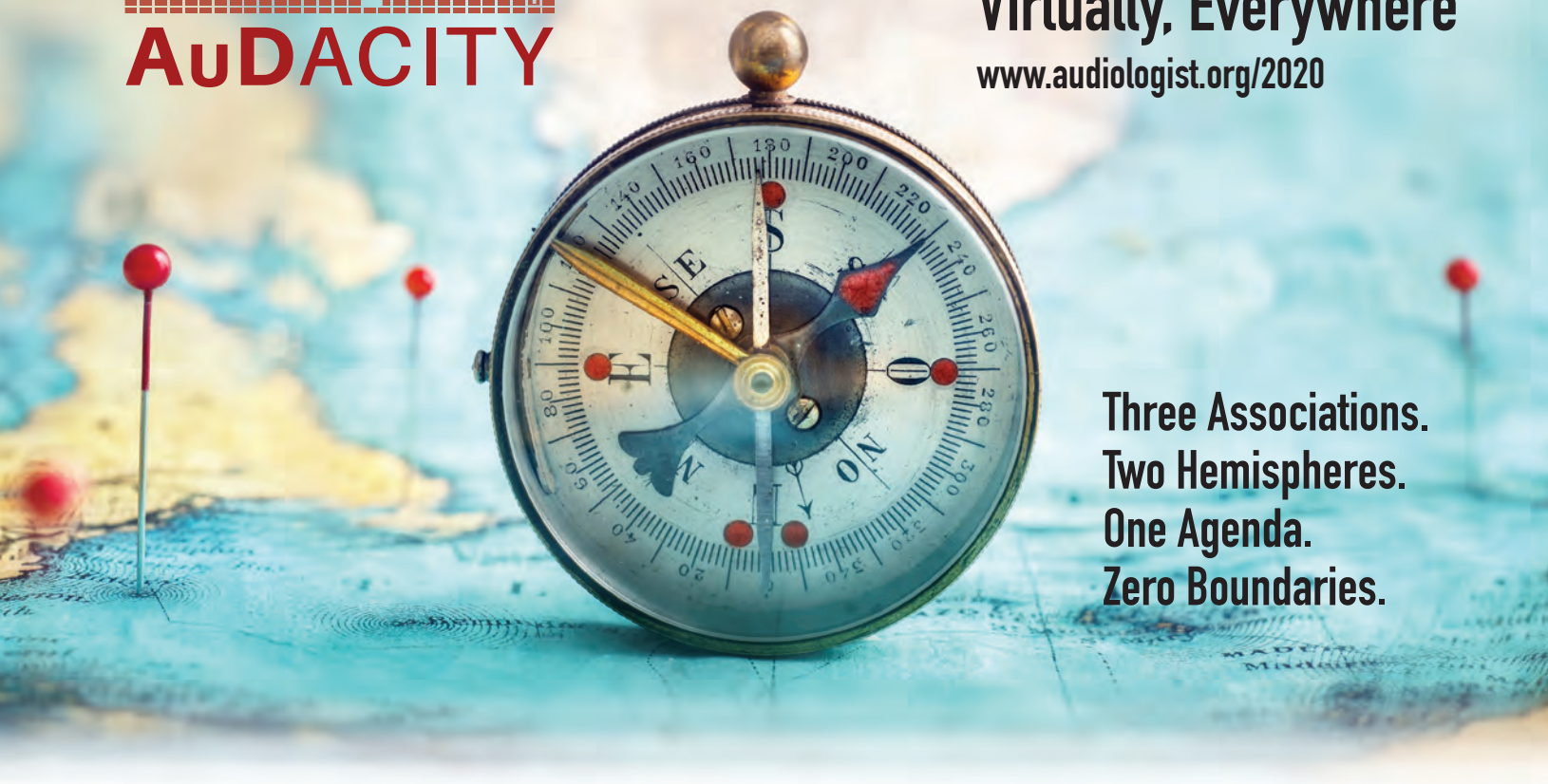

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On October 16-17, 2020, the Academy of Doctors of Audiology (ADA), the Independent Audiologists Australia (IAA), and the Independent Audiologists New Zealand (IANZ) will bring together audiologists, students, and industry leaders from around the world for a shared virtual experience that will allow participants to learn and network in unexpected and delightful ways.

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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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Deb Abel, Au.D.

Brave New World

All things are difficult before they are easy.

—Thomas Fuller, writer, churchman, historian

The above quote was at the end of a daily email I received last month, and I found it to be very appropriate way to begin this President's Message, during these tumultuous times. With any disruptive change, such as those wrought by COVID-19, it takes time and effort to get into new a rhythm. Mr. Fuller's statement can also be readily applied to recent national events that have caused us to take a difficult and uncomfortable look inward as we see and hear what is happening as a result of systemic racism and social injustices in the United States. In June, the ADA Board of Directors examined our organizational composition and initiatives and made a commitment to improve diversity and health equity as part of ADA strategic plan goals, in ADA and its programming, and within the profession. ADA is not content to merely make a statement, but intent on making impactful change. Stay tuned. We will be calling on members for dialogue, input, and help.

In the last edition of Audiology Practices a long three months ago, COVID-19 was making its impact known to the world and of course to ADA members. Many of you had your offices close or you were creating opportunities to care for your patients in ways you likely never thought possible with drop off and curb services. Telehealth came into play more predominantly, and for those who had the devices that could be adjusted remotely, they were utilized successfully and appropriately all while navigating state licensure law regulations, which seemed to change nearly daily. COVID-19 has impacted us in so many ways professionally and personally and for those of you who have contracted this devastating virus or who have had family members who have, I hope that there has been an uneventful and complete recovery. Audiology Practices editor, Dr. Brian Taylor has included some compelling pandemic perspectives from the frontlines in this issue (see p. 10).

ADA has also been impacted, by the pandemic and has pivoted to adapt to a socially distanced environment. While we won't be meeting in person in Dallas this fall, as originally planned, AuDacity 2020 WILL be an amazing meeting and we WILL be together. AuDacity's virtual platform will enable members to enjoy incredible speakers, including speakers that we would never have been able to bring to a face-to-face meeting. There will be opportunities to visit with vendors, meet new colleagues from the United States, Australia, New Zealand, and anywhere in the world, and to visit with old friends that you so look forward to seeing! AuDacity will attract colleagues who have never attended AuDacity and will show them why ADA is an incredible organization that always keeps our members in the forefront and always has their backs.

Continued on page 52

Contact Your Legislators!

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

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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!

Brian Taylor, Au.D.

Technology Alone is Not Enough to Traverse the Digital Divide

Since the early '90s, the Hearing Instrument Association (HIA) has published its quadrennial MarkeTrak survey. It provides audiologists with a glimpse of how hearing aid owners and non-owners view the strengths and shortcomings of hearing aids and professional services. Over the past 30 years, the MarkeTrak survey is not more than a couple of papers, summarizing the data and authored by an HIA representative. In contrast, the latest survey, MarkeTrak 10 (MT10), is a series of a half dozen papers published in Seminars in Hearing, all authored by independent researchers. As usual, it is a treasure trove of information for conscientious audiologists.

One of the more remarkable findings, published in the MT10 series of papers, is one authored by Dr. Erin Picou of Vanderbilt University. Unsurprisingly, her paper suggests a growing number of hearing aid owners report wireless capabilities in their hearing aids. This wireless, Bluetooth-enabled technology enables wearers to improve the sound quality of cell phones and lower the signal-to-noise ratio of many listening situations through the use of a remote microphone or TV streamer, directly connecting to their hearing aids and accessed through a smartphone app. According to the MarkeTrak 10 survey, 54% of wearers report their hearing aids have this wireless capability, a nine-point increase from the MarkeTrak 9 survey. Interestingly, the survey found that one in five current hearing aid owners did not know if they had wireless technology in their hearing aids.

Audiologists know quite well that wireless, Bluetooth-enabled technology is highly effective, particularly for improving speech intelligibility in noisy listening places or on the phone. The MarkeTrak 10 survey findings, however, indicate that just because hearing aid owners report they have wireless capability, it does not mean they use it.

In addition to the 20% of owners who do not know if they have wireless capability, Picou also reports that many of the key features, that accompany wireless technology on-board a hearing aid, are simply not used. Picou found 68% of hearing aid owners reported they did not have a downloadable smartphone app compatible with their hearing aids, 79% reported they did not have a TV streamer, and 80% reported they did not have a companion microphone. I think we can agree, based on these survey results, wireless capability in a hearing aid is woefully under-utilized – even though many hearing aid owners report they have it.

The good news here is that a small number of patients, who have taken the time to learn how to use these wireless features are helped by them – a lot. The survey determined that the 15% to 20% of owners who possess these wireless features use them every day and find them to be highly beneficial.

These results remind us that no matter how cool or how effective AI-based or Bluetooth-enabled technology becomes, it is the relationship between the person with hearing loss and the audiologist that drives much of the outcome. Indeed, a compassionate provider, willing to take the time to teach and empower the hearing aid owner to use wireless technology, is just one example that demonstrates audiologists cannot be replaced by automated processes or computer algorithms. ■

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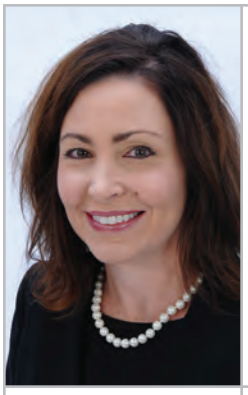

Meet the AuDacity 2020 Conference Team

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WORKING "VIRTUALLY" DAY AND NIGHT TO MAKE YOUR CONFERENCE EXPERIENCE AMAZING

Plans for AuDacity 2020: Forge Ahead and Forge Ahead Down Under are moving along! Over the past few months, I have had the pleasure of collaborating with Dr. Louise Collingridge, my brilliant counterpart at the Independent Audiologists Australia (IAA) to put together preliminary logistical plans for this virtual event. Volunteers from ADA, IAA, and the Independent Audiologists New Zealand (IANZ) are preparing an exceptional educational program (see p. 51 for a preliminary agenda).

AuDacity's interactive virtual platform is imaginative and intuitive, and will allow attendees to learn and network in tangible exhibit, reception, and educational spaces. The ADA conference team is fully immersed in identifying and developing the educational, entertainment, and engagement opportunities that will most delight attendees, sponsors, career fair participants, and exhibitors.

It is my pleasure to introduce the ADA Conference Staff Team. Our goal is to help you make the most of your AuDacity 2020 experience..

Please contact me at sczuhajewski@audiologist.org, or any member of the ADA team, if you have any questions about AuDacity 2020, or if we can assist you in any way. Stay tuned—a complete digital demo of the event space will be available soon. ■

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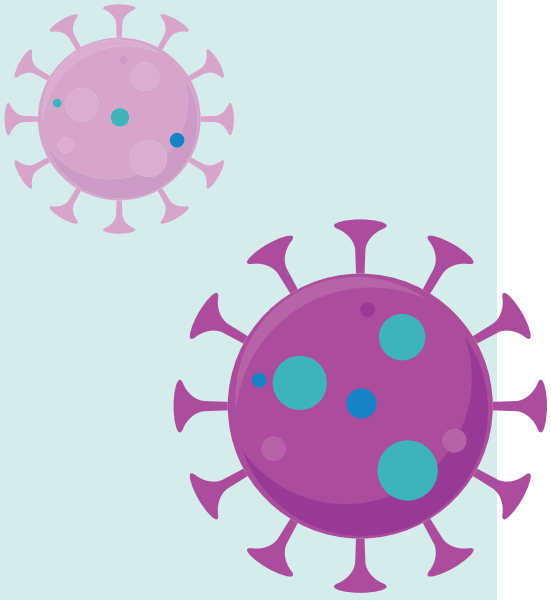
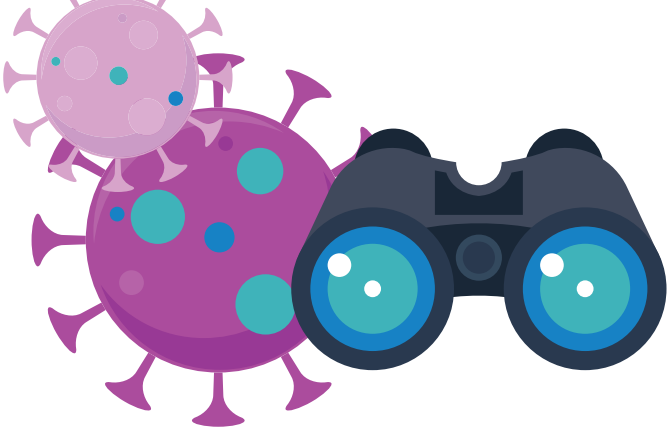
Audiology & COVID-19



By late February, most of us had heard of the novel COVID-19 virus (SARS-CoV-2), but at that moment we didn't fully realize the scale and scope of what was about to soon overwhelm us. As I deplaned for what would be my last business trip for the foreseeable future, on March 9, the effects of COVID-19 were beginning to sink in. The plane was barely half full, everyone had hand sanitizer at the ready, a few people were wearing face masks, and the line in the airport restroom just to wash your hands was out the door and around the corner. At that time, during what turned out to be the early phases of this crisis, many of us thought the newly imposed social distancing orders would last a few weeks, and we would resume business as usual quickly. Most of us, unfortunately, had yet to wrap our head around the magnitude or duration of this crisis.

Here we are, more than ten weeks later. Even though, in many areas of the United States, lockdown restrictions have been eased, the profession of audiology is likely to never be the same again. As we grapple with an uncertain future, as many of us cope with furloughs and other unpaid time away from our businesses, it is helpful to remember that there are millions of people around the world who need our help. They need our help to navigate the emotions associated with hearing loss and they need support and guidance as they move toward to take action to improve their communication ability. People need our help to select appropriate hearing devices and to learn how to use them. They need our insights on how to be effective communicators and problem solvers as many of them grow older and cope with other serious chronic conditions.

Perhaps one silver lining, created from this pandemic, is we have learned that many audiology services can be delivered, at least in part, with remote telehealth technology. Audiologists can still provide the care our patients deserve, in ways that that minimize their vulnerability to COVID-19. This article examines, from multiple perspectives, how COVID-19 is likely to change the profession of audiology and how persons with hearing loss acquire services.



A View from Private Practice

by Judy Huch, Au.D.

Immediate Changes and Adaptations for the Next 3-6 Months

Our business, Oro Valley Audiology, has always fallen under essential in our state (Arizona), but in early March 2020 there was little guidance about how to proceed. One major change that we made immediately was to control patient flow within our building. We have a standalone office which has one door for in/out for public traffic. We locked the front door, moving to curbside emergency and in-house only for dome removals.

We continued to have a "soft closure" for the next 5-6 weeks. During that time, we studied guidelines from the U.S. Centers for Disease Control and Prevention (CDC), the Occupational Safety and Health Administration (OSHA), and state guidelines to figure out what personal protective equipment (PPE) we would need and for what situation. I served on the Entheos Audiology Cooperative Task Force for Infection Control and, with the help of Dr. AU Bankaitis, we updated the infection control manual to include a COVID-19 section. We anticipate that audiologists and other staff will be using PPE such as masks, shields, and gloves for the foreseeable future.

In addition to the use of PPE and enhanced sanitation procedures, we updated our chairs to be of a material which would be easier to clean, spaced seating in our lobby, increased scheduling spacing in between patients, all of which will be protocol moving forward as we see spikes in viral infections in the future.

Installing a drop box and pick up locker system has been working well for the office to ensure a low-touch policy. At one point, we had 150 people on our waiting list to get back into the office as we were booked 4-5 weeks out before the pandemic hit. We have hired another audiologist who will start next month to help us catch up. We took the time to develop better protocols for aural rehabilitation classes, tinnitus therapy, central auditory disorder marketing, Cognivue screening for cognitive health, the production of videos for education, and database clean up. We are now introducing services online, thru telehealth, social media, and adding Zoom classes.

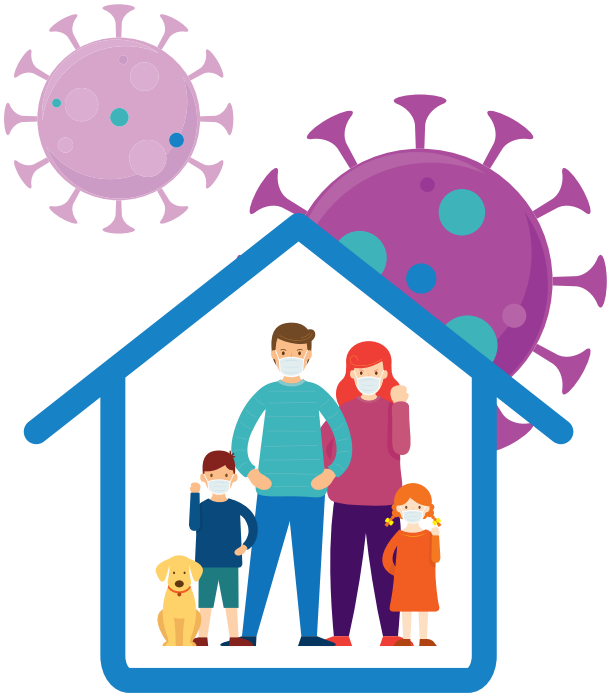
Long Term Changes Next 2-3 Years; Different Scenarios

I see consumer behavior polarizing even more extremely than in the past. There will be those who see audiology as product driven and buy devices online, with little or no service-added value. On the other hand, there will be those who see audiologists as service driven and value our expertise in tinnitus, dizziness, aural rehabilitation, and cochlear implant mapping.

There is space for both perspectives, but the only way for private practices to survive (and thrive) is to find areas they excel at in service. My advice is to quit worrying about your competition and make yourself better! We will need to clean and service all types of devices and charge for our expertise. The pandemic has taken away our fear of telehealth and there is absolutely a place for this in the future. However, we should never underestimate the power or value of treating people in person.

Being flexible and figuring out quickly what 2 or 3 options to offer to our patients is important, so that we can avoid overwhelming them, but provide options that are specific to their needs at the same time. It is a balancing act that requires agility. Those who want to stay with "how they have always done things" will find it very frustrating to move into the future.

Judy Huch, Au.D. *is the owner of Oro Valley Audiology, a private practice, in Tucson, AZ since 1998. She is a presenter and has been published in trade journals, OpEds, and numerous online outlets with her focus on Audiology Healthcare and Services, Private Practice, Tinnitus Counseling, and Giving back to the Community she lives in. She has two sons, a Marine and a senior in high school and a very patient husband.*



A Changed Business

by Geoff Cooling

Many of us have by now accepted that our business will change dramatically during the pandemic. However, I think most of us have focused on the simple mechanics of continuing to see patients, rather than the impact of the epidemic on business levels. I understand that, but I think we need to look at the broader context of the effects of this event on the people we serve and our businesses.

I believe that this pandemic will dramatically change our business levels and therefore may lead to a very different delivery model. There are several reasons for this, and I have coined the phrase motivation/fear ratio for want of a better term.

Motivation

The driver of the motivation to begin the journey to better hearing is most often the ability to hear in social situations. People feel left out of the conversation. Eventually, the motivation to do something builds and they, or their loved ones, make an appointment to see us.

What Social Events?

Social events, typical of our cultures, are on hold for some time. Social distancing, the act of keeping as far away from someone else as possible will continue for quite a while. Even if respective governments order the use of masks, they will continue to use social distancing as a requirement. What then will be the motivation to get hearing aids? Even if social events begin anew before the end of this crisis, how many will attend?

Afraid to Socialize?

The longer this goes on, the more ingrained the habit becomes. The restrictions that we live under and the underlying fear of this virus may change the outlook of many people. This crisis is having a direct psychological effect on all of us. It may be the case that people will begin to fear crowded spaces and continue to do so until there is a cure or a vaccine.

This pandemic could have a dramatic impact on social interaction and outlook moving forward and for years. It could certainly have that effect on older people who know they are at heightened mortality risk. The underlying fear, whether conscious or not, will further work to keep the motivation low. If there isn't a massive problem with your hearing, why risk another trip out?

Seminal Events

I have brought this up elsewhere, and someone rightly pointed out that Americans are a resilient bunch, citing the after effects, or lack thereof after other seminal events in our history. Singular societal events such as 9/11 or the assassination of John F. Kennedy had an impact on societal psychology, but those effects tended to fade over a short period.

The difference, I believe, is that in general, those events are distant to broader society, and while there is an emotional effect, there is little or no intimate experience. To a certain extent, that is why we see protests in some areas of America to reopen businesses. The people involved understand what is going on, but they have no intimate experience with the issue. The disease event has not affected them so far, but the economic impact has.

A Very Different Prospect

The COVID-19 pandemic is very different from seminal events that have gone before. Neither time nor initial impact constrains this event. It is not a single seminal event over one day; it will go on for a long time. As this disease continues to affect us in several waves, more and more people will have an intimate experience with it. The death toll will continue to increase and areas, where there has been little impact, will begin to see that change.

Consider the emotional impact to a community of the release of restrictions—the death of several members of that community and the re-introduction of restrictive measures. Consider the emotional and societal impact of repeated cycles over an eighteen-to-twenty-four-month period? Unfortunately, there is little study evidence available to understand how pandemics have affected societal norms historically. The one article I could find was not hugely encouraging.[1]

That Motivation/Fear Ratio

I believe that many of the people with mild-to-moderate hearing problems, which have been responsible for incremental increases in the sales of hearing aids, will no longer be motivated or may well fear to attend our clinics. We could see a return to the historical precedent of people with moderate-to-severe hearing loss being the only ones who search out our services, mainly because the motivation/fear ratio is different in that demographic. Even then, fear may spur them to search out solutions that don't involve face-to-face appointments or unnecessary trips out of the house.

An Unpalatable Choice

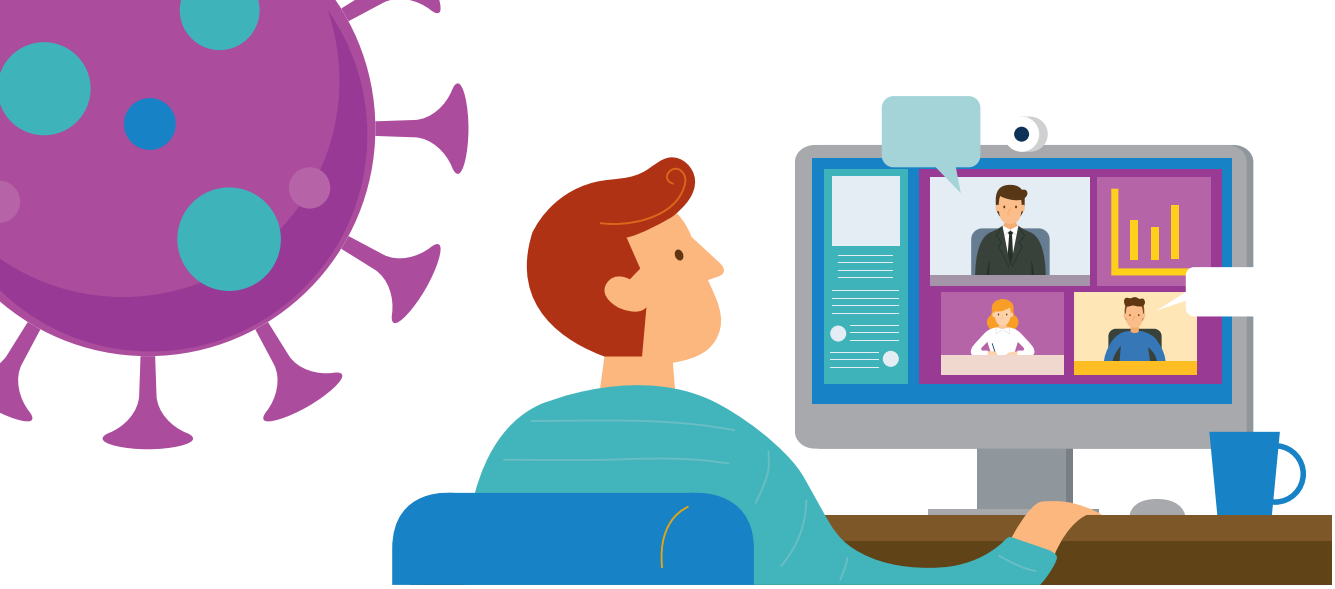
Let us begin to assess the use of the remote provision of hearing solutions. While many within the profession, myself included, are aghast at the trade-offs inherent in such a provision model, we need to be cognizant of the consumer, and their specific wants and needs. It may be the case that many consumers want remote services. It may well be the case that the availability of remote service provision could change the motivation-fear ratio for many people, including the mild-to-moderate cases I mentioned earlier.

While ensuring consumers understand the active measures that we are undertaking in our clinics to ensure that they are safe will help, I am not sure if that will be enough to overcome fears for any but the most urgent or exceptional cases. For the rest, we will have to look at strategies that make it easier for them to access hearing care from home.

For some of us, that may be unpalatable, and I understand that it goes against the grain for many of us. However, we have to be realistic. We have to ask ourselves whether we can accept that we need to look at non-traditional methods to survive, or whether we would prefer going out of business. I honestly think the choice may be that stark for many audiology practice owners going forward.

Geoffrey Cooling *is an Irish Hearing Aid Audiologist and Co-Founder of Audiology Engine and Hearing Aid Know.*

[1]Vox, CEPR Policy Portal, Pandemics and social capital: From the Spanish flu of 1918-19 to COVID-19: https://voxeu.org/article/pandemics-and-social-capital



Growth in Alternative Care Models

by Sophie Brice

Here in Australia, COVID-19 has seen clinic visits drop right across healthcare as more and more people seek out and become aware of telehealth alternatives.

In the years I have delivered tele-audiology services, I have seen uptake increase from a well-researched 'techie' group, to curious but less-confident consumers. I expect this uptake to fast-track over the next few months as COVID-19 causes people to more carefully plan their in-person interactions.

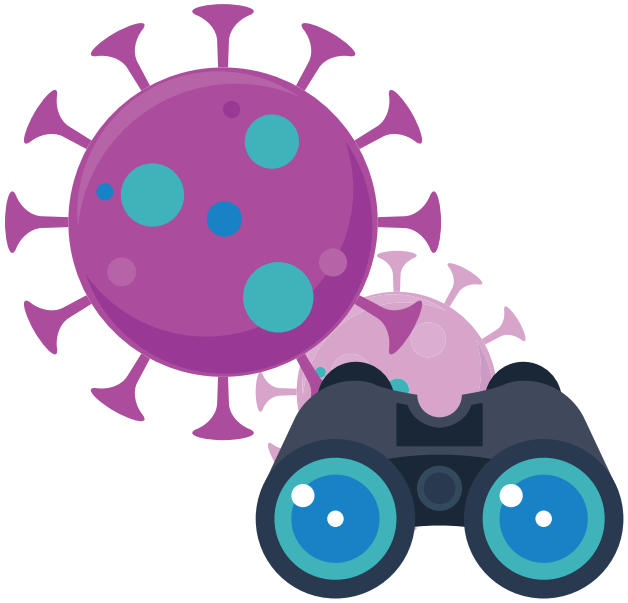
As people start to explore their hearing care options and learn about online services like tele-audiology care, the challenge is discerning what is being offered, especially whether they will receive fully vetted and qualified care remotely. It is up to audiology providers to clearly outline and develop a support service that works for their practice and revolves around consumer needs. So, in the short term, I predict a positive trend in awareness and inquiry for consumers and clinics into how tele-audiology can work for them.

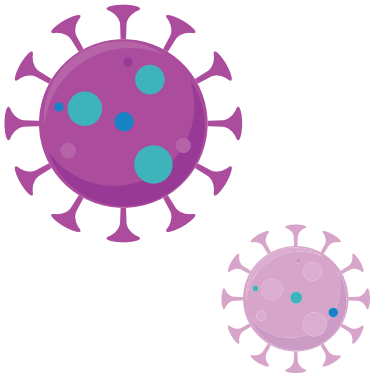
Possible Long-term Changes in Consumer Behavior

I predict that one of the lasting impacts of COVID-19, for hearing care professionals, will be that telehealth is an expectation. The new normal. When using tele-audiology, the hearing care professional is essentially invited into the environments that people want help with most. Both the responsibilities and quality of hearing care are actually heightened rather than compromised. Because of this, I predict a greater appreciation and acceptance of the need for tele-audiology for providers and consumers.

I believe that tele-audiology is a vital tool for hearing care, not a threat, and I am excited that the conversation is now getting much bigger and more inclusive.

Sophie Brice *is a Digital Health Lead at Swinburne University of Technology, alongside developing and delivering Tele-audiology services at Blamey Saunders hears. Curriculum development, educator, researcher and author in Teleaudiology and related practices for hearing and health care professionals.*





A View from the Hearing Industry

by Brandon Sawalich

The COVID-19 pandemic has reminded us that hearing is critical for clear communication. For 53 years, this has been Starkey's sole focus. During these challenging times, many people are realizing that they are struggling to hear everything during this 24/7 news cycle.

While it may take some time for our industry to settle in to a "new normal", we expect that demand for hearing health products and services will increase. As long as patients feel that practitioners are following CDC guidelines for care, they will return to hospitals, clinics, and retail shops. The role of the audiologist is essential to optimal outcomes, and we are working with our partners to ensure that they have access to PPE and the latest information. .

What long-term change in consumer behavior might be seen over the next 2-3 years?

If there is a "silver lining" to these very unfortunate times, perhaps it is that the role of the professional has taken on increased significance.

We foresee increased use of telehealth in the long term, not as a substitute for face-to-face care, but to augment that important patient-provider relationship for minor adjustments that do not require an in-person visit. We are optimistic that emerging generations will not be as stigmatized by hearing loss and hearing aids, and instead will seek products that provide outstanding hearing benefits and a gateway to health and wellness. We are optimistic for the future, while acknowledging that it will not be business as usual.

Brandon Sawalich *is the President of Starkey Hearing Technologies, leading a global team of more than 6,000 employees, with 26+ facilities worldwide. He also currently serves as the Chairman of the Hearing Industries Association (HIA).*

COVID-19 and the Electronic Mediation of Speech

by Nancy M. Williams, MBA

How does the COVID-19 pandemic impact the consumer-patient experience with hearing loss? A crucial change is that social distancing results in a significantly greater proportion of speech being mediated by electronic devices. This new element in the consumer-patient's experience suggests important opportunities for hearing care professionals (HCPs) to update their service model and for hearing aid companies to consider new feature-functionality.

When people observe social distancing, phone calls, video calls and videoconferencing become the predominant medium for spoken human communication. Speech mediated by electronic devices replaces much of in-person interactions. People hold work meetings, "quarantinis," even memorial services over video.

Yet people with hearing loss often struggle over video. Poor internet connections cause the speaker's voice and lips to become unsynched. Speakers turn away from the camera mid-sentence or their lips slip below the camera line. As a result, speech degradation caused by electronic mediation, as opposed to speech-in-noise, takes center stage as the primary hearing challenge.

In the near term, HCPs can remain relevant by providing services to help patients succeed with video calls. HCPs may recommend videoconferencing resources, such as this excellent knowledge base. Of particular help would be to show patients how to activate captioning features on the videoconferencing platform of their choice.

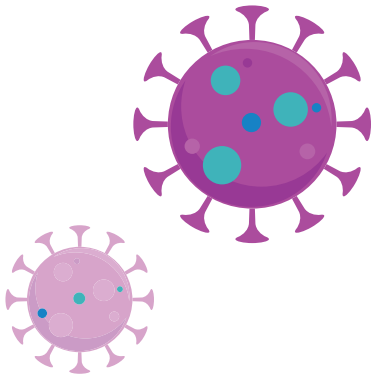
Public health experts predict that we are in for "at least another 18-24 months of significant COVID-19 activity, with hot spots popping up periodically in diverse geographic areas." In other words, expect intermittent social distancing for the next two to three years while the country builds up immunity. The exceptions of essential workers—about 28% of men and 33% of women—combined with people who chose to flout social distancing requirements will not be significant enough to eliminate the impact on society. In fact, in states with relaxed requirements, some people will continue to take precautions by maintaining social distancing. A prime example will be the hearing industry's core customer, people aged 60 and older, given their higher risk of mortality.

In a world of periodic social distancing, consumer-patients will have even a tighter relationship with their smartphones and personal computers. Apps which provide customized amplification by frequency range may become more appealing for people with hearing loss. Contributing to apps' appeal will be their convenience and also affordability in what could be an extended period of economic downturn.

The pandemic may also drive increased penetration and use of earbuds. In the home, earbuds enable multiple members of the household to conduct video calls at the same time; at work, earbuds will most likely become more socially acceptable for minimizing noisy distractions. As in the case of apps, consumers may find an all-in-one solution, an earbud which also provides hearing personalization, to be more convenient than a hearing aid. This is particularly true of those with mild hearing loss. To remain competitive, hearing aids will need to keep pace with earbud feature-functionality.

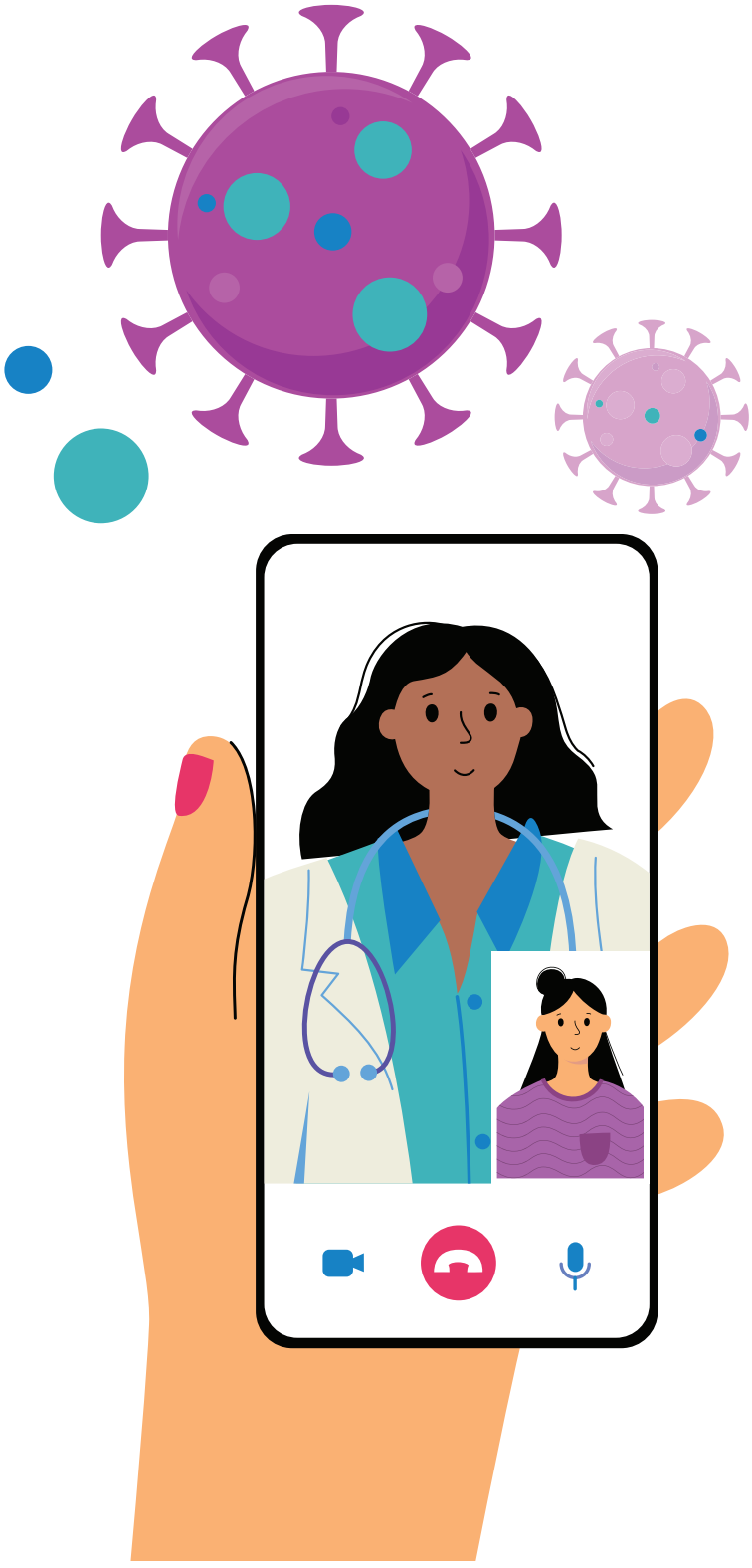
With the prospect of ongoing and periodic social distancing, the shift of a significant portion of in-person communications to phone and video calls will be a multi-year phenomenon. Both HCPs and hearing aid companies will need to adapt to a consumer-patient experience which is moderated more than ever by smart phones and PCs. The industry's recent innovations in online hearing tests, direct ordering, and remote fittings demonstrate the kind of flexibility needed to succeed in this new world wrought by COVID-19.

Nancy M. Williams *is President of Auditory Insight, the strategy and marketing consultancy for the hearing healthcare industry. She advises leaders of pharma and device companies how to transform hearing healthcare with effective engagement strategies and innovative models of care. Adept at breaking through conventional molds to create value, she has generated over $120M in new revenue in public and privately-held companies. Prior to founding Auditory Insight, she created and ran the patient engagement business for HPOne, working with Medicare Advantage payers to close care gaps through patient outreach. Nancy holds an MBA from Harvard Business School and a BA from Stanford University in Quantitative Economics, both with distinction.*



Change is a Certainty

by Dan Quall, M.S.



One certainty provided by the COVID-19 virus is change. The pandemic has brought forward a number of issues that we must address for the consumers of our products and services. One looming question is, "How will consumer behavior change?"

As we re-open our practices what can we expect in the next three-to-six months, as well as on the horizon, two-to-three years from now?

Near Future (3-6 months)

The number one issue consumers should expect from their healthcare providers, in the near future, will be safety. Given the population many audiologists serve (older adults with sensorineural hearing loss) they are treating patients at high risk for serious health consequences, including mortality if the virus is contracted. The new normal will require continuous monitoring of employee health and a strong infectious disease protocol that says to the patient "you are safe here". This messaging starts with the clinic website and pre-appointment communications. It continues upon arrival to the clinic, throughout the service protocols, and finally, it must become part of the treatment plan… "Here is how we treat you to limit exposure to the virus". Safety will be priority one.

One of the safest ways to treat our patients will be through remote care. Tele-medicine and tele-audiology will become a significant part of how we treat consumers. The adoption rate for remote programming of hearing aids, pre-pandemic, was below 10% according to several manufacturer sources. This number will increase significantly as follow-up visits and adjustments for hearing aids can be accomplished without a face-to-face encounter. In the banking industry, mobile deposits were growing a rate of less than 5% annually pre-COVID-19. That number jumped to 55% in one month as consumers adapted to electronic deposit -- people do adapt. In our profession, in the near term, there will be a learning curve for professionals and for consumers. Some patients may be unable to easily navigate the technology hurdles for this type of interaction. This will mean longer training times in the short term or the need to interact with the patient's care givers to allow this appointment type to take place.

The near-term consumer will, most often, also be cautious. They are faced with two issues. The virus and what its economic fallout will mean to them financially. The good news is the majority of our patients are retired and have predictable income streams; they haven't lost a job. That being said, they will be cautious about large expenditures until they

understand the full impact of the economic downturn. To address that issue, we believe consumers will be interested in subscription and/or finance programs with monthly payments they know will fit their budget. It will allow them to get into new solutions and treatments, without a significant hit to their cash position. Additionally, service plans and extended product warranties could be very attractive as the cautious consumer tries to extend the life of their current devices.

Given the home quarantine consumers have faced across the nation, we need to anticipate a high number of consumers (or their care givers) have been surfing the internet. In the near-term, consumers will likely have many questions about internet offers for product. Professionals need to anticipate these questions, be familiar with internet product offerings, and most importantly, be able to discuss the value of getting services through a local medical professional.

Do not ignore the consumers who will want to use their insurance benefit. The market will probably not bounce back right away and professionals need to look at how they fill their schedules. Discussions with two of the third-party hearing aid benefit provider companies indicate that, while their referral numbers are down, they are not seeing the same level of decrease experienced with private pay patients. The insurance-invested group of consumers have already purchased a benefit and will want to utilize it to save cash. The third-party benefit providers, meanwhile, need locations to send patients, because many offices have been closed during the crisis. Now is the time to evaluate these programs and determine which are a good fit for your clinic.

On the Horizon (2-3 years)

Telehealth will most likely be the biggest and perhaps the best thing to emerge from the pandemic. Consumers are experiencing the convenience of healthcare from the comfort of their homes. Providers and clinics are discovering the efficiency and effectiveness in using technology to prioritize patients and provide excellent treatment remotely. The consumers of the future will expect this kind of service to continue and it should. This could be a great windfall for the profession of audiology and the industry of hearing aids as we settle into the COVID-19 era. We will have the ability to interact daily with more patients in a more convenient manner. Access to care will increase with the remote care model-- this is a good thing.

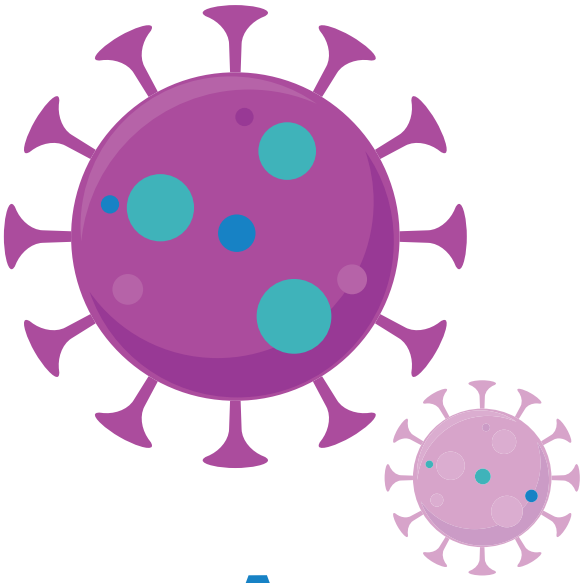
State and federal laws governing the utilization of telehealth will most likely be relaxed to provide better access for consumers to all medical professionals. This could impact current legislation for direct access to audiology. Additionally, state hearing aid and audiology licensing regulations will need to be changed to allow for the delivery of services across state lines. This could take place in the form of a national registry for reciprocity or low-cost registration fees by state. For the consumer, this will mean even more access to care via telehealth.

Over the Counter (OTC) hearing aid product definition guidelines by the FDA have taken a backseat to the virus. Those close to the issue anticipate its completion in 2021. These products will become more prevalent and will most likely be utilized by a younger age cohort. Home quarantines will have revealed a higher incidence of communication issues. This younger population will use technology to access care. This will further accentuate the need for remote care channels and the use of audiology techs or assistants to interface and cultivate future hearing aid candidates.

As consumers adapt to a world of remote care, avenues for the internet sale of products will increase. To counter this, the manner in which we reach out to our patients will change. The services we provide will shift to management of a chronic disease state, sensorineural hearing loss, using technology based patient monitoring. The hearing device itself, still being a critical part of the treatment plan, will simply be a part of the management of the chronic health issue and not the single treatment modality.

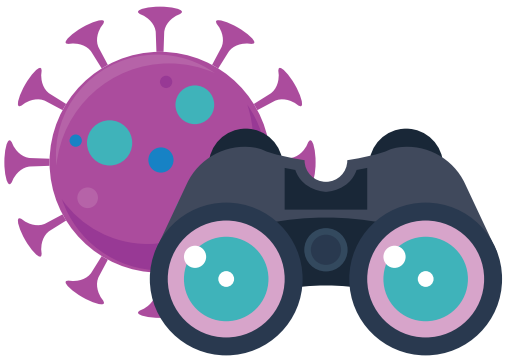
Due to the government expense for the COVID-19 Crisis and sub-sequential economic downturn, legislative initiatives to include hearing aids into Medicare will most likely fail due to budget constraints. However, insurance for hearing aids through Medicare Advantage programs should continue to grow because the programs are paid via personal expenditures. The growing trend the industry experienced prior to COVID-19 should be accelerated as consumers invest in Medicare Advantage programs to ensure coverage for any health issues they will encounter in the future. Hearing aids, eyeglasses, and dental services will continue to be an important value in these insurance plans.

Dan Quall, MS, CCC-A *is the Director of Strategic Initiatives for Fuel Medical Group.*



A Consumer's View

By Shari Eberts



Disruption and chaos are often catalysts for change, innovation and creativity. COVID-19 is likely to be no different. The pandemic has already forced a number of changes in hearing care that are likely to remain in the short and long term. Many of these are positive steps that will provide more flexible and varied treatment options for people with hearing loss and the clinicians that care for them.

1. Telehealth has arrived. Telehealth has been accelerated and is proving a viable option for hearing care when executed well. The availability of captioned video platforms and remote programming of devices support these initiatives. Telehealth will likely remain a potent option for patient care beyond the pandemic, particularly for patients with mobility issues and for those who live in remote areas.

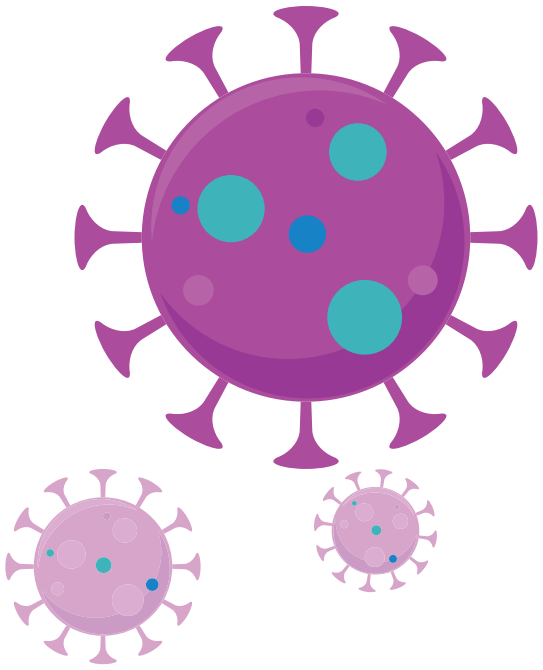
2. The use of alternative forms of hearing devices will increase. With hearing aid repair more challenging and more time consuming, patients are likely to experiment with alternative options when faced with a broken device. This will lead to a greater acceptance of over-the-counter type devices like Bose Hearphones, amplifier apps like Ear Machine and speech-to-text apps like Live Transcribe or Otter.ai. Hearing aids may become one of the tools people use to help them hear, rather than the one silver bullet that is prescribed for all situations.

3. Patients will take more responsibility for their own care. Partnering in hearing health care will become more typical as audiologists rely on patients to clean and maintain their devices from a distance. This will generate confidence on both sides as patients feel more capable in managing their own care and audiologists feel more comfortable letting them do so.

4. Aural rehabilitation and counseling services will gain importance. Patients will need advice and support adjusting to the new normal of post-pandemic life. Masks and physical distance rules will create new hearing challenges for many. Audiologists will become critical partners in figuring out the tricks that make communication possible for people with hearing loss in these new circumstances.

Shari Eberts *is a hearing health advocate, writer, and avid Bikram yogi. She is the founder of Living With Hearing Loss, a blog and online community for people living with hearing loss and tinnitus. She also serves on the Board of Trustees of Hearing Loss Association of America. Shari has an adult-onset genetic hearing loss and hopes that by sharing her story she will help others to live more peacefully with their own hearing issues. Connect with Shari: Blog, Facebook, LinkedIn, Twitter.*

Delivery of Medical Care, Including Hearing Care, Likely to be Forever Changed



by Andrew Bellavia

It is my personal belief that the pandemic has changed forever the way medical care of all kinds is delivered by accelerating trends that were already beginning. Chief amongst them is the use of remote consultation and care delivery. We were already moving in that direction to support people for whom travel was difficult or who lived far from their providers. For example, the U.S. Veterans Health Administration (VHA) launched their telehealth service in 2018 and saw its use expand rapidly last year.

Closer to home, the hearing aids I purchased in late 2018 came with an app allowing remote tuning. I asked an audiologist if she thought her clients would find this useful. She responded that most of her patients were older and not comfortable with using smartphone tech. Therein lies the challenge for hearing care providers specifically.

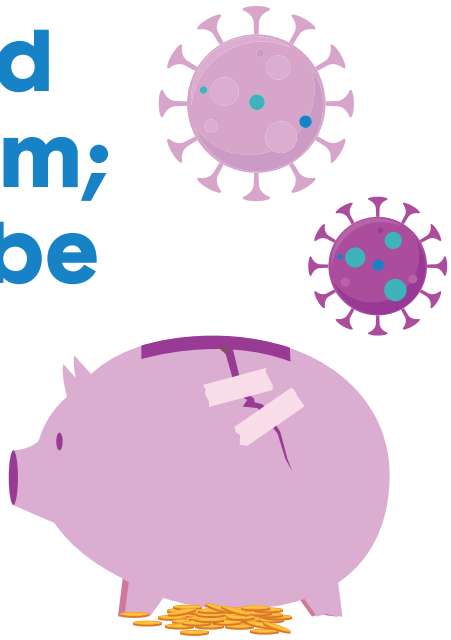
From consumer point of view, I see adoption of remote hearing care dividing up along two lines. The first is between existing and new clients. Though it would be ideal to introduce remote care services in an office visit that is not possible today. It is possible for hearing care professionals to proactively reach out to their existing clients (or someone assisting them) to introduce remote care. There will be lower friction for clients who already have an established relationship with a provider. Therefore, remote care adoption rates will likely increase amongst existing patients.

I see a different picture for potential new clients. Because hearing health is infrequently addressed as part of routine medical exams, there is a high degree of reliance on self-awareness in seeking hearing care. In the best of times, people wait years before coming to grips with their hearing loss, this contributor included. I have a difficult time envisioning potential new patients, already uncomfortable with the associations attached to hearing loss, making the leap when they must initiate the relationship on remote basis. Without having seen data, I suspect new client intake is very low today and will remain so during the pandemic.

The second dividing line is along comfort with tech and remote care in general, with the line shifting in longer term. As consumers become used to remote care in other settings, hearing care will be part of the package. At the same time, more of tomorrow's hearing aid users will have become comfortable being seen in public wearing something in their ears. Having adopted both hearable tech and smartphones, the next generation of clients will feel less stigma around hearing loss and give more weight to the convenience of remote care. While I would not hazard a guess as to the timeline, I have little doubt that remote care will one day be mainstream when in-person exams are not necessary.

Andrew Bellavia *is a hearing aid user who currently works as Dir. of Market Development for Knowles Corp. in the music earphone and hearable spaces. He has written or contributed to numerous articles and podcasts on the future of voice and hearing tech. All opinions are his own.*

Fewer Office Visits and Less Sales in Short Term; Telecare Expected to be Adopted and Utilized More Over Time



by Steve Claridge

Hearing aid purchases are going to be pushed right down to the bottom of people's priorities while they isolate and then try to get back to work. I predict very low sales, particularly of the latest models with the highest price tags. People who were putting off a purchase now have even more reason to delay it.

I hope more practices start to offer telehealth. I have tried the GN offering and it works really well. It's a working solution to the social distancing problem, for patients with models that support it, but we shouldn't see it as just a temporary fix during lock-down. Remote programming should become part of the normal service to give patients shorter wait times for updates. In my experience, a remote assistance session was every bit as good as visiting the practice in-person.

What Might Occur in the Next 2-3 Years?

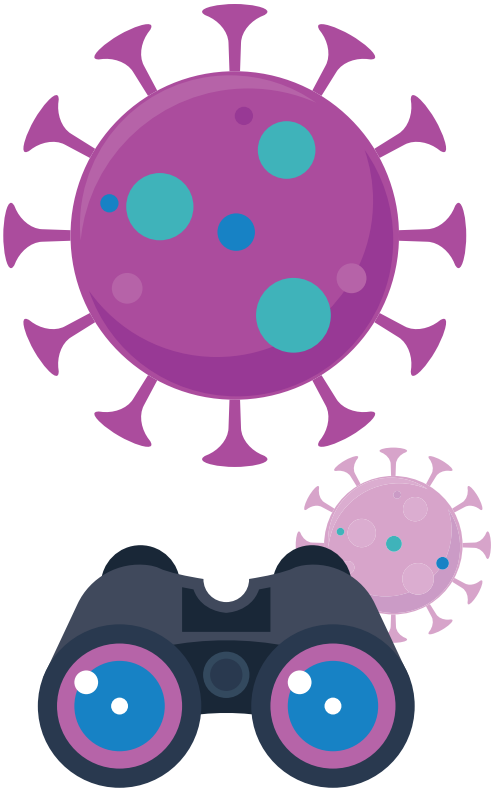
Face masks could well become commonplace and that is going to be a big problem for the hard of hearing. A lot of people are going to suddenly realize how much they rely on lipreading.

I predict that we will soon see manufacturers releasing more powerful smartphone apps. The current crop already gives patients a good deal of flexibility and controls to change the way they hear, but I think (and hope) that the next generation of apps will give even more control. I would like to see apps that are smart enough to make basic decisions and reprogram hearing aids based on guidance from the patient. For example, if the patient selects the "help" option and enters "I am struggling to hear female voices", the app should be able to reprogram automatically and allow the patient to test the new sound, reverting back if necessary.

Big-box retailers will embrace telehealth. It makes sense for them as they can offer a more personal and responsive service remotely while still maintaining in-store presence for sales and repairs, limiting any social distancing issues.

With a global recession looming, there will be far fewer people able to pay top dollar for their hearing aids. Hearing technology has improved a lot since the last recession 12 years ago, so online and store retailers are in a much better position to offer a quality hearing experience. There has always been the argument that big-box/OTC/online sales don't deliver optimal hearing experiences. While I definitely agree with that, technology is closing the gap and will continue to do so. That, coupled with downward pushes on pricing, is a major concern for local practices.

Steve Claridge *has been wearing hearing aids since he was 5 years old, when a mild hearing loss was first diagnosed - now in his 40s, that mild loss has progressed to a severe one and he relies on some pretty awesome hearing aid technology to be able to stay in the conversation. He's passionate about helping people to understand hearing loss, hear more and communicate more easily. He has been writing about his hearing loss on Hearing Aid Know for over 14 years. Also a huge software geek, programmer and keen runner.*



Consumer View: What Changes Might We Expect to See?

by Gael Hannan

It is likely that consumers will continue to use the online shopping that they have come to depend on, during their isolation in this pandemic, and this could extend to hearing aid supplies. I already order batteries from Amazon and from the Canadian company that handles Cochlear's CI supplies.

As for auditory telehealth, I believe people will be more open to it, particularly Baby Boomers and those who are younger. Just as I can let the Geek Squad access my computer remotely, it makes sense that you could access my hearing aid or cochlear implant remotely to make adjustments.

Unfortunately, people have gained a new fear of transmittable viruses, and I think that handshaking will cease to be a common custom. Hearing clinics will have to adopt a new standard of sanitization--standards that I am sure are being developed even as I write.

On the other hand, I fully intend to hug everyone I know, once it is deemed permissible, because hugging had increased dramatically in recent years, even among strangers. I have hugged my audiologists! But I predict that in the future, many people will not want to be hugged even by people they know.

Gael Hannan *is a writer, speaker and advocate on hearing loss issues. In addition to her weekly blog for Hearing Health & Technology Matters, which has an international following, Gael wrote the acclaimed book "The Way I Hear It: A Life with Hearing Loss". She is regularly invited to present her uniquely humorous and insightful work to appreciative audiences around the world. Gael has received many awards for her work, which includes advocacy for a more inclusive society for people with hearing loss..*

Blended Care Will Become Part of a New Standard

by Brian Taylor, Au.D.

Although in-person care is likely to remain the gold standard after the COVID-19 pandemic, remote care, telehealth (or eHealth) will provide a boost in operational efficiency, offer added touchpoints that enhance patient outcomes, and appeal to untapped segments of the market who until now have not sought help for their hearing difficulties.

Technological innovations in hearing aids and changes in the way they are dispensed has, historically, been incremental in nature. Every 12-to-18 months, in a predictable manner, hearing aid manufacturers release a new feature or an updated platform that results in slightly better performance or improved patient benefit compared to its earlier generation.

Public health or economic crises, like today's once-in-a-century pandemic, tend to accelerate these typically incremental changes in our industry. It should not be a surprise to anyone that the most recent economic crisis – the Great Recession of 2008-2009 sped corporate consolidation of small private practice hearing aid centers and sparked a rise in managed care involvement in hearing aid sales. These two factors have changed the way hearing aids are dispensed today in the United States.

Despite these changes stemming from the last economic disruption more than a decade age, as audiologists, our primary obligation remains the well-being and safety of persons with hearing loss. Some of the most vulnerable populations reside in nursing homes and other types of long-term assisted care situations. Many of these facilities remain locked down, yet their residents need access to continued hearing health, especially if they are wearing hearing aids. The ability to use telehealth to maintain close contact with all persons with hearing loss, during these unprecedented times, is extremely critical to their overall health and quality of life. Individuals with hearing loss, like all of us, deserve to communicate effectively with the family, caregivers, and medical staff - even when sheltering in place or practicing social distancing.

Another obligation, of course, must be the sustainability of our practices during the pandemic. After all, without a steady, predictable revenue stream, we cannot expect to serve our patients, now or in the future. Telehealth enables audiologists to offer a relatively wide range of service and support that is valued by patients and often reimbursable, thus providing a stream of revenue to our practices. Regardless of how a person with hearing loss chooses to interact with an audiologist – either face-to-face or remotely - the primary role of the provider is to improve day-to-day communication and health-related outcomes, usually through the provision of hearing aids. Given the low uptake of hearing aids and the harmful consequences of untreated hearing loss, all industry stakeholders must embrace new approaches to engage and inform persons with hearing loss. Today, all segments of the patient journey, from information gathering to testing, fitting to rehabilitation, initial consultation to aftercare benefit from evidence-based, in-person care enhanced or supplemented with eHealth remote care services. As we move into the future, it is likely persons with hearing loss will prefer a blended approach, combining the warmth and compassion of in-person with the convenience and efficiency remote care solutions - both delivered by a trusted and caring expert.

Most of us are accustomed to slow, incremental changes in the hearing healthcare industry, but now, due to recent events, they are moving at what seems to be breakneck speed. Undoubtedly, the COVID-19 pandemic has accelerated the use of eHealth remote care services. By keeping the needs of persons with hearing loss grounded at the center of our work, audiologists and their manufacturing partners can fulfill their mission of improving the lives of all people with hearing difficulties, no matter how the person with hearing loss wants to engage in the process. The audiologist's essential role remains the personalization of the physical and acoustic fit of hearing aids, customization of treatment goals, and matching technology to the individual needs of each person. Our world has changed, but humanistic person-centered patient care, regardless of how it is delivered must remain the standard. ■

Brian Taylor, Au.D. *is the editor of Audiology Practices. He is also Director of Clinical Content Development for WS Audiology.*

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Successfully Navigating the Shift in Third-party Reimbursements Post COVID-19

By Austin Singleton, Au.D., and Patty Greene, M.A.

Unlike many other countries, hearing aid wearers in the United States have had limited government or private insurance coverage for their hearing aid purchases. Beyond the Government Services channel, primarily reserved for members of the military, most Americans in need of hearing aids pay for them out-of-pocket without any third-party payor involvement. Experts have identified this lack of government or private insurance coverage as a contributing factor to the U.S. market's low hearing aid penetration rate, which by most accounts hovers around 25% to 30% of the adult hearing-impaired population and compares to other developed countries where penetration ranges from 35% to 45%.

In recent years, the hearing aid industry has seen an increase in private insurance coverage for hearing aids. This shift has created a need for providers to change or streamline some of their customary business practices in order to maintain profitability. The sudden onset of COVID-19, and its economic impact is likely to hasten this shift as more patients, looking to save money will utilize their third-party benefit when acquiring hearing aids.

The proliferation of third-party hearing aid benefits, such as Medicare Advantage programs, mean that audiologists must adjust their business practices. These practices may include operational changes, staffing responsibilities and compensation, or patient communication. Before we examine these business practices, it is important to understand why these changes have become necessary – simply put, there is a constellation of forces that are changing reimbursement for hearing aids – forces now moving at a breakneck pace due to the fallout from COVID-19.

There are several peer-reviewed studies that indicate untreated age-related hearing loss in adults, which is the most prevalent type of hearing loss of adult onset, is not a benign condition. Hearing loss has been linked to cognitive decline, depression, social isolation, and loneliness. This linkage also contributes to the skyrocketing costs of healthcare. The aging population, who are the most at-risk for developing these conditions associated with untreated hearing loss, is growing at a rapid rate. Driven by the aging Baby-boomer population, it is estimated 10,000 people per day in the U.S are turning the age of 65 and are thus more susceptible to age-related hearing loss. Healthcare in the United States is expensive, as it now comprises nearly 20% of the total gross domestic product. Additionally, the COVID-19 pandemic is likely to have long-term economic and social consequences, some of which will motivate consumers to save money on expensive purchases such as hearing aids and move toward using third-party insurance plans to save money. These factors suggest many people in need of hearing aids cannot afford a large out-of-pocket expense. Given the rising overall cost of healthcare, combined with the deleterious effects of untreated hearing loss, a growing number of third-party payors, including Medicare Advantage programs, include hearing aids as a reimbursable expense.

Today, the number of insurance plans offering some level of coverage for hearing aids has substantially increased. It is estimated that 5% to 10% of U.S. hearing aid private market purchases are at least partly funded by insurance. Experts suggest that the number of hearing aid purchases, funded at least in part by third parties, is expected to triple over the next five-to-ten years. Currently, there are more than a dozen Medicare Advantage and similar third-party insurance plans that offer their members a hearing aid benefit. Although the details of these Medicare Advantage programs vary, members of these plans can purchase a pair of hearing aids at more than a 50% savings compared to an average out-of-pocket expense of about $2,000 per hearing aid in the U.S. private market. Considering these substantial out-of-pocket savings, a growing number of consumers will gravitate toward using insurance coverage to offset the out-of-pocket costs of hearing aids – a number likely to rise because of the long-term economic impact of the COVID-19 pandemic.

Although the benefit of third-party insurance contracts is clear for consumers, managers or owners of a clinical practice will need to determine what overall benefit, including financial benefit, these referrals may add to their practice. After all, if provision of a new product or service does not generate revenue for a practice, it is difficult to justify

implementing it. Hearing aids purchased through a third-party payor are not a new concept. Many clinics around the country have been accepting third-party business for several years. Although there is no reason to believe patients receiving hearing aids through a third-party payor contract derive less benefit or satisfaction than those paying completely out of pocket for similar devices, many clinics are challenged by the business metrics associated with third-party contracts, such as smaller margins, and capitated rates for products and services. Most hearing aid dispensing practices have built their businesses around generating revenue from individuals who pay out-of-pocket for hearing aids, where hearing aid margins and capitated rates are not determined by third parties. Rather each patient in need of products and services is able to negotiate directly with the clinic, or, do as what typically happens--accept the rates that the clinic offers and purchase them out-of-pocket.

Since a growing number of persons with hearing loss have a Medicare Advantage (or similar) benefit, it behooves all clinics to implement strategies that allow acceptance of these patients in a manner that is profitable for the clinic. This article examines some of the key best practices to implementing an effective business strategy for accepting patients with Medicare Advantage plans in a way that is beneficial to the patient and advantageous for the clinic.

1. Examine *"the why"* from the consumer's perspective.

Every independent provider needs to be able to calculate the economic value a third-party referral offers their clinic. To do this accurately, it is important to account for all factors related to profitability, rather than only looking at top-line

revenue per sale. The most accurate way to do this is to calculate the *profit per patient per hour*. Details about how to perform this calculation are explored in detail later in this article, but first it is important to understand today's consumer mentality and why third parties are attracting them. The internet has played a major role in creating a hearing aid consumer who is more knowledgeable about hearing aid technology, pricing, and the many avenues available for purchasing hearing aids. Readily available information and online consumer reviews and recommendations often compete directly with the independent provider's marketing in attracting consumers to a non-traditional path for purchasing hearing aids. Some of these paths include the provider and some do not.

For example, direct-to-consumer options—like iHear Medical, BuyHear and Audicus—exclude hearing care providers altogether. On the other hand, many third-party referral companies—like TruHearing, EPIC, Hearing Care Solutions, and Hear.com, do include providers in the hearing care process. However, not all third-party companies attract the same types of consumers or operate in the same manner. Some use online direct-to-consumer marketing practices to generate leads, which are then funneled to the providers within their network. Others operate using a managed-care model, by partnering with insurers to offer their services to members in the form of a benefit or discount. In both cases, providers are paid a professional fee—which varies by company—for dispensing hearing aids to these third-party referrals.

The reasons consumers choose to go through third parties are fairly simple – they believe their insurer, or the online channel is a trusted source, they are attracted by the promise of saving money, and they believe they will receive the best overall value. Given the way the COVID-19 pandemic is affecting the economy, clinicians can expect the number of persons with hearing loss using a third-party benefit will increase.

2. Compare Profit from a Retail Patient versus a Third-party Referral

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

Most providers now work with a mix of hearing aid buyers – third-party referrals for which a professional fitting fee is paid to the provider and those patients who pay out-of-pocket. These market changes have made it necessary for providers to calculate profit in a new way – *profit per patient per hour.*

Providers who know their *profit per patient per hour*, will be able to utilize this data to make informed financial decisions to maintain a successful clinic. Calculating *profit per patient per hour* helps practices to determine if third-party referrals are a good financial fit or whether to shift their business to a medical model, where patients are charged for value-based services, rather than continuing to focus on the income from the sale of a product.

3. Gathering the Right Data to Measure Profit Accurately

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

To calculate profit from retail patients and from third-party referrals, all factors which influence profitability must be measured and tracked independently for each type of patient. This is because not all metrics apply to both types of patients. For example, there is no customer acquisition cost or cost of goods for third-party referrals but there is for retail patients.

It is important to keep in mind that these metrics will be different for each third-party referral company therefore, *profit per patient per hour* must be calculated independently for each company as well.

A closer look at what data points must be measured and whether they influence retail profitability, third-party referral profitability or both are shown in Table 1 below.

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

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

Metric	Definition	Track for retail, third-party or both patient types
Average Customer Acquisition Cost (CAC)	Annual marketing spend divided by total # of sales opportunities, which include: • All patients seen who were tested, screened, demo'd, trialed, or discussed hearing aids even if they did not purchase	• Applies to retail patients only • No cost to acquire a third-party referral
Average Selling Price (ASP)	• Average sales price of hearing aids sold in the clinic • Include all price points when averaging	• Retail sales: track ASP • Third-party referrals: track average professional fees paid
Average Cost of Goods Sold (COGS)	• Average cost to provider for all hearing aids sold in the clinic	• Applies to retail patients only • Providers don't pay for hearing aids sold to third-party referrals
Average Closing Rate	• Of the total number of patients seen in your clinic annually, what percentage buy hearing aids?	• Track independently for both retail and third-party referrals
Average Return Rate	• Of the total number of hearing aids sold annually, what percentage are returned?	• Track independently for both retail and third-party referrals
Average number of hearing aids sold per patient	• Total # of hearing aids sold divided by total # of patients who purchased • Note - industry retail average is 1.72[1]	• Track independently for both retail and third-party referrals
Average number of times the patient is seen after the fitting	• Average # of visits per patient during the first 12 months, *after* the initial fitting	• Track independently for both retail and third-party referrals
Time spent on hearing exam, fitting visit, follow-up visit	What is the average time spent performing: • Hearing exam • Fitting visit • Follow-up visit	• Track independently for both retail and third-party referrals
Amount paid for hearing exam, fitting visit, follow-up visit	What is the average fee you are paid for: • Hearing exam • Fitting visit • Follow-up visit	• Track independently for both retail and third-party referrals
Average transaction fees incurred for patient financing	• Average fee incurred by the provider for patient hearing aid financing	• Applies to retail patients only • Provider does not incur a transaction fee for third-party sales

4. Calculating Profit per Patient per Hour

Once the data outlined in Table 1 is gathered, the *profit per patient, per hour,* calculation can be completed. Providers are encouraged to contact their business or financial advisor for assistance with performing this calculation.

Alternatively, contact TruHearing's Network Management team at networkmanagement@truhearing.com to request a copy of the TruHearing Financial Calculator to use in your clinic. This can also be viewed on YouTube at https://www.youtube.com/watch?v=kWW-rYQ88ZM

Sample Financial Calculations

1. How much does it cost to bring a patient in the door?	Retail Patient	Managed Care Patient
Average Customer Acquistion Cost (CAC)	($500.00)	0.00

2. Of the *total* number of patients seen in your clinic annually, what percentage of hearing aids are returned?	Retail Patient	Managed Care Patient
Gross Closing rate	55%	75%
Return Rate	12%	6%
Net Closing Rate	48%	71%

3. What is the average selling price of a hearing aid sold in your practice? What's the average price *you* pay for a hearing aid?	Retail Patient	Managed Care Patient
Gross Revenue per Aid	$2350.00	$475.00
Average COGS (cost of goods sold)	($900.00)	0.00
Average # aids sold per patient	1.72	1.87
Transaction fee (credit card/care credit)	(3%)	0%

4. On average, how many times do you see a patient, *after* the fitting?	Retail Patient	Managed Care Patient
Hearing Test	$50.00	$75.00
Follow-ups	Bundled	$65.00

5. How many minutes do you spend on a hearing test? How many minutes do you spend on a fitting visit? How many minutes do you spend on a follow-up visit?	Retail Patient	Managed Care Patient
Average time per patient	2 hrs, 19 min	2 hrs, 50 min

PROFIT PER PATIENT HOUR	Retail Patient	Managed Care Patient
	$302.47	$263.97

Figure 1. Sample Financial Calculations

Other Third-Party Managed Care Considerations

For the 2018 benefit year, 73% of Medicare Advantage enrollees nationwide chose a Medicare Advantage plan that offered a hearing aid benefit. This is an increase from 65% in 2017 and 47% in 2015. The number of insurers partnering with a third-party company to administer their benefits increases each year. These factors make accepting these referrals an increasingly important decision for providers to make. The following are several considerations when planning to add a third-party partner to your portfolio of products and services.

Competitive Advantage

Third-party referrals are only sent to in-network providers, giving those providers a competitive advantage. Becoming an in-network provider may open your practice to a large number of patients who cannot visit other clinics in your area because they are not part of the third-party, managed care contract.

Access to Referrals

In order to maintain access to plan members, a growing number of plans require providers be in-network with the third-party company administering the hearing care benefits. For providers located in an area where a third-party managed care company has contracted with large plans in their area, this may play a significant role in the decision to accept these referrals.

High Purchase Rate

A hearing aid benefit offers consumers a compelling factor in the decision to purchase hearing aids[2]. Consumers value controlling out-of-pocket costs while utilizing the insurance they are already paying for. Largely because of the cost factor, patients who have a hearing aid benefit are more likely to purchase from you than patients without insurance coverage. Thus, conversion rates are better for patients with the hearing aid insurance benefit.

First Time Users

When insurance plans notify members of their benefit, referrals increase. Many of these are first-time users seeking to utilize their hearing aid benefit. First-time hearing aid users present many practices with an opportunity for additional revenue, both now and in the future. According to the recently published MarkeTrak 10 survey, just under 60% of hearing aids purchased in 2018 were first-time buyers, making them the largest segment of the market.

Save Time and Money

With no customer acquisition cost, no time or resources spent on insurance verification, and for many no time spent on claims submissions, third-party managed care referrals save providers and their staff time and money.

Not All Third-party Managed Care Referral Companies are the Same

As more third-party managed care companies emerge, providers must also consider that not all operate in the same manner, making some companies easier to work with than others. These differences, in addition to profit potential, should contribute to a practice's decision about the third-party companies with which to partner.

Here are a few considerations which impact provider and staff time and resources:

- Timeliness of provider payments
- Service visit requirements and charges
- Appointment scheduling process
- Patient preparedness prior to appointment
- Ordering process
- Insurance verification
- Billing/claims process

COVID-19 is bringing about rapid changes to clinical audiology. In addition to the rising use of telehealth, managed care contracts, including Medicare Advantage programs are gaining momentum. Many industry experts believe that, in post COVID-19 world, more persons with hearing loss will utilize the benefits of their Medicare Advantage plans. The prudent audiologist must carefully plan for how they fold Medicare Advantage and other similar third-party contractors into their existing business. By examining the needs of persons with hearing loss within their community and the financial sustainability of their business, audiologists are poised to adapt to the evolving nature of the payment and delivery of hearing care services. ■

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

Dr. Austin Singleton *is Vice President of the Provider Network and Audiology at TruHearing. He has a strong understanding of the provider's perspective through his experience running private practices in Chicago Illinois, working in hospital and ENT settings. He is fluent in American Sign Language and has worked at the Utah School for the deaf and Blind. He currently maintains an audiology practice servicing patients.*

Patty Greene, M.A. *is an audiologist with more than 29 years of experience in the hearing care industry. As TruHearing's Director of Provider Engagement, Patty is responsible for helping providers successfully utilize TruHearing programs and services through provider communications and education. She has presented nationally on topics of Managed Care, current trends and consumer impact on the hearing industry, and marketing. Previously, she has held positions in sales, marketing and training with leading hearing aid manufacturers as well as having managed her own private audiology practice.*

Advocacy in Audiology

Influencing Policy & Patient Care During Uncertain Times

by Angela Morris, Au.D.

Advocacy is an important aspect of any profession. It is, in many ways, what keeps the profession viable, informed, and relevant to patient and practice needs regarding economic, social, or political issues. Advocacy raises awareness, creates change, and may further an entire professional movement. This is especially critical during uncertain times when patients and providers alike are unsure about the future.

A provider's role and ethical responsibility does not stop with patient care in the clinic. For physicians, it is clear in the American Medical Association (AMA) Code of Medical Ethics that "physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care" and that "the medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services."[1]

Many other professions, such as pharmacists, believe it is the provider's professional responsibility to be a part of advocacy efforts. The position statement on advocacy as a professional obligation by the American Society of Health-System Pharmacists (ASHP) states in the first line that "ASHP believes that all pharmacists have a professional obligation to advocate on behalf of patients and the profession."[2]

When issues within the profession of audiology arise, it is imperative that audiologists as a whole advocate for their value as healthcare practitioners. Examples can be anything from payment of professional services to ensuring that patients receive proper treatment and care, to confirming that patients are being seen by the appropriately licensed providers in an ethical manner. Advocacy becomes even more critical during uncertain economic times. Policy makers at the local, state, and federal levels must be constantly reminded that our profession makes a positive difference in the lives of many of the most vulnerable members of our population. Further, it is our professional obligation to clearly communicate the scientific evidence that supports prevention and early interventions, which extend the quality of life and other health-related benefits to underserved people in their communities.

Beyond daily activities in the clinic, advocacy could be endorsing the reclassification of audiologists as limited licensed practitioners within the Medicare system. For example, policy makers must be familiar with data demonstrating that audiologists provide thorough, accurate, and cost-effective diagnostic services to persons with suspected ear pathology.[3] It is the responsibility of the audiologist advocate to share scientific evidence to support advocacy initiatives, with local, state and federal legislators and agencies.

There is one additional component of advocacy--promoting the high quality of care your own practice provides members of your community. Many view these types of activities merely as marketing initiatives. Yes, some methods of advocating can be perceived as advertising or marketing, but these business tactics also represent another type of advocacy. For example, you can go to your local social, business, professional clubs in your area and talk about hearing loss, how hearing loss can affect the hearing-impaired person and their family, and advocate for regular screening. This type of advocacy could be perceived as an advertisement for your business; however, when you focus on science that indicates preventive care, such as periodic hearing screening and use of hearing protection, slows the trajectory of hearing loss, you are engaging in community advocacy that benefits all citizens.

You could also give back to the community in many ways, by doing fundraisers, helping sports teams, doing health fairs, etc. – all activities done not for the purpose of business promotion, but for the promotion of good hearing health and access for persons with hearing loss. It is all about the message. Instead of only promoting your business name on a high school ball field billboard, as an advocate you might use messaging to inform the audience, such as "Did you know hearing loss affects…" In this way, you are educating, contributing to the health and wellness of your community, and advocating for your practice and profession all in this one activity. This is the area of advocacy where you can think outside the box and see what the needs are in your community for topics related to hearing health.

Most widespread advocacy efforts for hearing health are undertaken by, or in collaboration with, professional organizations representing healthcare providers, industry stakeholders, or consumers who are impacted by hearing loss. There are at least 12 national associations representing audiologists, including the Academy of Doctors of Audiology (ADA). Every organization has its own unique agenda and objectives to consider when prioritizing advocacy efforts. It is, therefore, extremely important to research each organization and what they believe in and stand for and make sure that it is in alignment with your core values and the direction that you want your profession to go, before supporting their efforts.

In addition to joining and supporting at least one national organization, it is also extremely important for all audiologists to join their state audiology organization, if one exists. State organizations play a critical role in scope of practice and licensure issues, while the national organizations are focused on issues such as Medicare reimbursement and other federal issues.

Advocacy is your obligation as a professional, and it goes beyond simply paying annual dues to a professional organization. It warrants direct, personal involvement and often additional nominal financial investments. If you had an issue in your practice that was potentially also affecting other practices, but you had to retain an attorney to get some resolution, wouldn't you rather share the costs with other professionals, instead of paying them all yourself? It is the same with advocacy—combining and leveraging the resources of all audiologists across the state and/or nation, makes our voice much stronger than if we all try to go it alone.

There are various ways that you can help with advocacy efforts. Of course, one of the most important ways is by contributing financially to help cover the costs of lobbyists and advocacy professionals, who specialize in legislative or regulatory issues at the state or federal level. Your annual membership dues do not typically cover these costs, at least not in totality and without these "boots on the ground" it is very difficult to advance initiatives. Unfortunately, it is estimated that 75% of audiologists do not make financial contributions to support advocacy efforts that protect their profession. As dedicated professionals, we cannot sit back and hope that others will take care of it. We all need to do our part to take responsibility for the advancement of profession we chose and the patients we serve. This is especially true during these unsettling times when COVID-19 and an economic recession threaten to upend how audiology is practiced.

Setting aside time to meet with state or federal policymakers and their staff is another way to advocate. Visiting Washington D.C. or your state government offices personally and setting up meetings with your representatives is one of the most effective ways to advocate. As a constituent, your visit means a potential vote. Your representative also recognizes that you can influence other people in their district as well. Representatives genuinely want to understand how policies affect their constituents. Their job is to make life better for their regions and if you have an issue that is a potential problem, the representative should want to try to fix it if they can.

Inviting government representatives to your practice, when they are back in their home district, is also a great way to support advocacy efforts. Representatives oftentimes like to meet with advocates as it is a good photo opportunity for them when they are getting out in the community. Most government representatives also want to provide meaningful help to the communities they serve.

Writing letters and calling legislative and regulatory offices to advocate for specific issues is another way that audiologists can help with advocacy initiatives. Most organizations have a template set up if the provider does not feel they know exactly what to say or write. Most of these activities take about two minutes to complete, but the effect this has on an issue can be substantial. The more a representative can see that an issue is affecting their constituents; the more attention and importance the issue will be given.

If you are a recent graduate or an audiologist with less than ten years of experience, you need to know that your future profession can be greatly influenced by your active involvement with an advocacy group. This involvement can take many forms of commitment including the investment of time, money, or expertise. The critical point is that to improve the standing of the audiology profession or to reach more persons with hearing loss in need of high-quality care, all audiologists must be actively engaged in advocacy efforts. We all play a role in shaping the profession in a positive way. Now is the time to make the leap. ■

Angela Morris, Au.D. *is currently a regional sales manager at Widex and former owner of Southeast Kentucky Audiology in Corbin, KY. Dr Morris is a past president of Academy of Doctors of Audiology (ADA).*

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Go Figure

Deconstructing the Stages of Change Model of Behavior

By Brian Taylor, Au.D.

The treatment planning process, one of the essential duties on a clinical audiologist, is a series of clinical decisions that usullay looks something like this: First, you convince a patient, who has often ignored their hearing difficulties for several years, to try hearing aids. Second, realistic goals and expectations are targeted, and finally the audiologist offers the patient some thoughts on the longterm success with hearing aids based on the information collected during the in-take appointment.

A big challenge for many audiolgists, however, is they rely on the pure tone audiogram to make these clinical decisions. Numerous studies have shown the audiogram to be a poor predictor of both hearing aid acceptance and long-term success with amplificaiton. If the audiogram is such a poor predictor, one best ignored after a medical disorder or ear disease has been ruled out, what other tools does the audiologist have available that helps them make better clinical decisions?

One possibility is the transtheoritical stages of change model of behavior or SOC. The SOC model describes an individual's current attitude, motivations, behaviors and intentions to change by adopting and sustaining healthy behaviors. The SOC model can be applied to any chronic condition in which a person has a choice on getting help or changing an unhealthy behavior or lifestyle. For audiologists, the healthy behaviors we want patients to adopt and sustain revolve around active use of hearing aids.

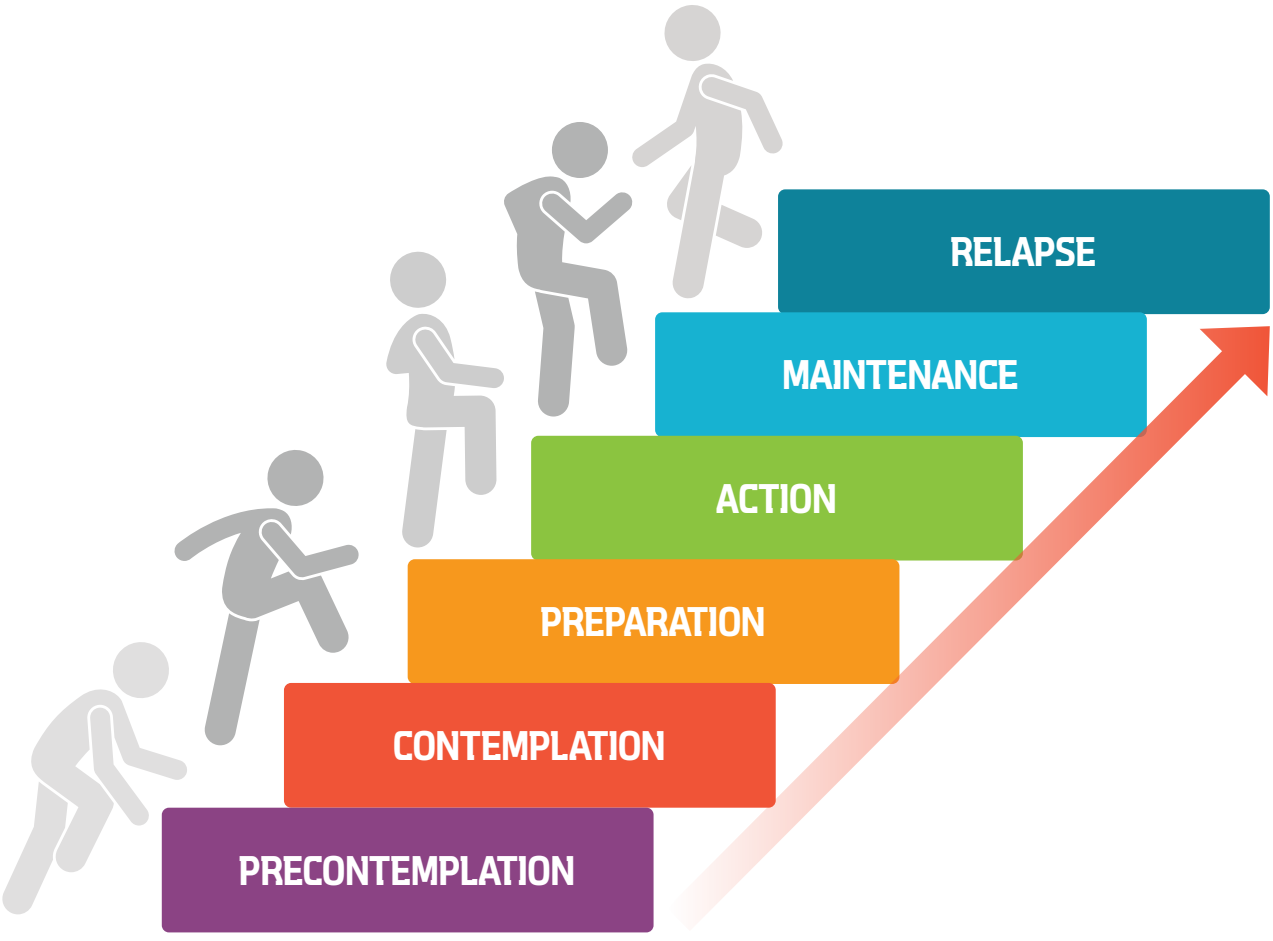

Figure. The Stages of Change Model of Behavior.

The Figure outlines the six stages of change. The arrow denotes the typical pathway in which these stages progress over time. We know, for example, that the average person with hearing loss takes about eight years to move from a point where others are noticing that person's hearing difficulties (represented by the pre-contemplation stage) to the person with hearing loss acquiring hearing aids and actively wearing them (represented by the action stage). Individuals with hearing loss usually move from stage to stage in a fairly predictable manner, however, not everyone moves through the stages at the same pace. That is, some individuals may stay stuck in one stage for years, while others move from stage to stage quickly or even revert to a previous stage.

Understanding the SOC model is important for two reasons: 1.) Audiologists who ascertain the stage of change the person with hearing loss is in during their first clinical encounter can guide that patient into the action stage more effectively and avoid feeling like they are pressuring the patient to do something, and 2.) In collaboration with the patient, the audiologist devises a plan that moves the person with hearing loss into the action stage. The use of the SOC model is predicated on the belief that a patient will not become a successful hearing aid wearer until he moves into the action stage, and the role of the audiologist is to recognize what stage of change the patient is in today and craft a plan that moves them into the action stage, and eventually into the maintenance stage.

If you want to practice patient centered care, the SOC model is an essential building block of that clinical philosophy. Let's look at how an audiologist can apply the SOC model in their daily practice. Remember, knowing the patient's stage of change helps us devise a plan to move the patient to action sooner and will improve the probability of long-term results.

Table 1. Common Behaviors or Characteristics of Each Stage of Change

PRECONTEMPLATION
• Unaware that problem exists • Reluctance to change ("I don't know if I really need to change") • Rebellion against outside pressures ("No one is going to make me change") • Resignation ("I'm too old to change") • Rationalization of the problem ("It's not that bad").
CONTEMPLATION
• Aware that a hearing problem exists but… • Indifferent or ambivalent regarding the pros and cons of accepting recommendation for help • May lack confidence or determination to accept help at this time
PREPARATION
• Actively seeking advice or information on hearing loss or hearing aids • Expresses desire in simply getting a baseline hearing test • Propensity to compare hearing aid prices (doing their homework) • Comes to the clinic with a lot of information about hearing loss or hearing aids
ACTION
• Active participation and engagement in the treatment planning process • Expresses an interest in accepting your opinions and recommendations • Willing to accept your recommendation
MAINTENANCE
• Schedules and keeps routine follow-up appointments • Actively seeks information and advice on how to be a better hearing aid user • Participates in communication training or other rehabilitative activities
RELAPSE
• Stops wearing hearing aids • Stops participating in follow-up appointments • Resists recommendations to re-activate hearing aid use

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A simple way to know what stage of change a patient is likely to be in is to simply ask them this question:

"Mr. Jones, which of the following statements best describes your attitude and motivations today?"

A. I don't think I have a hearing problem; therefore, I am not planning to do anything at this time.

B. I think I have a hearing problem; however, I am not yet ready to do anything about it

C. I think I have a hearing problem and I intend to act in the future, but not now.

D. I think I have a hearing problem and I am ready to act now.

Here is a simple guide on next steps that correspond with each of the four possible responses

Next Step for Response A

Following the hearing assessment, focus on educating the patient about the importance of hearing loss prevention and consequences of hearing loss

Next Step for Response B

After the hearing assessment, ask the patient to participate in long range exploring and planning. Send the patient home and ask that they begin the process of discovering where they are having difficulty and why it might be a good idea to seek treatment sooner.

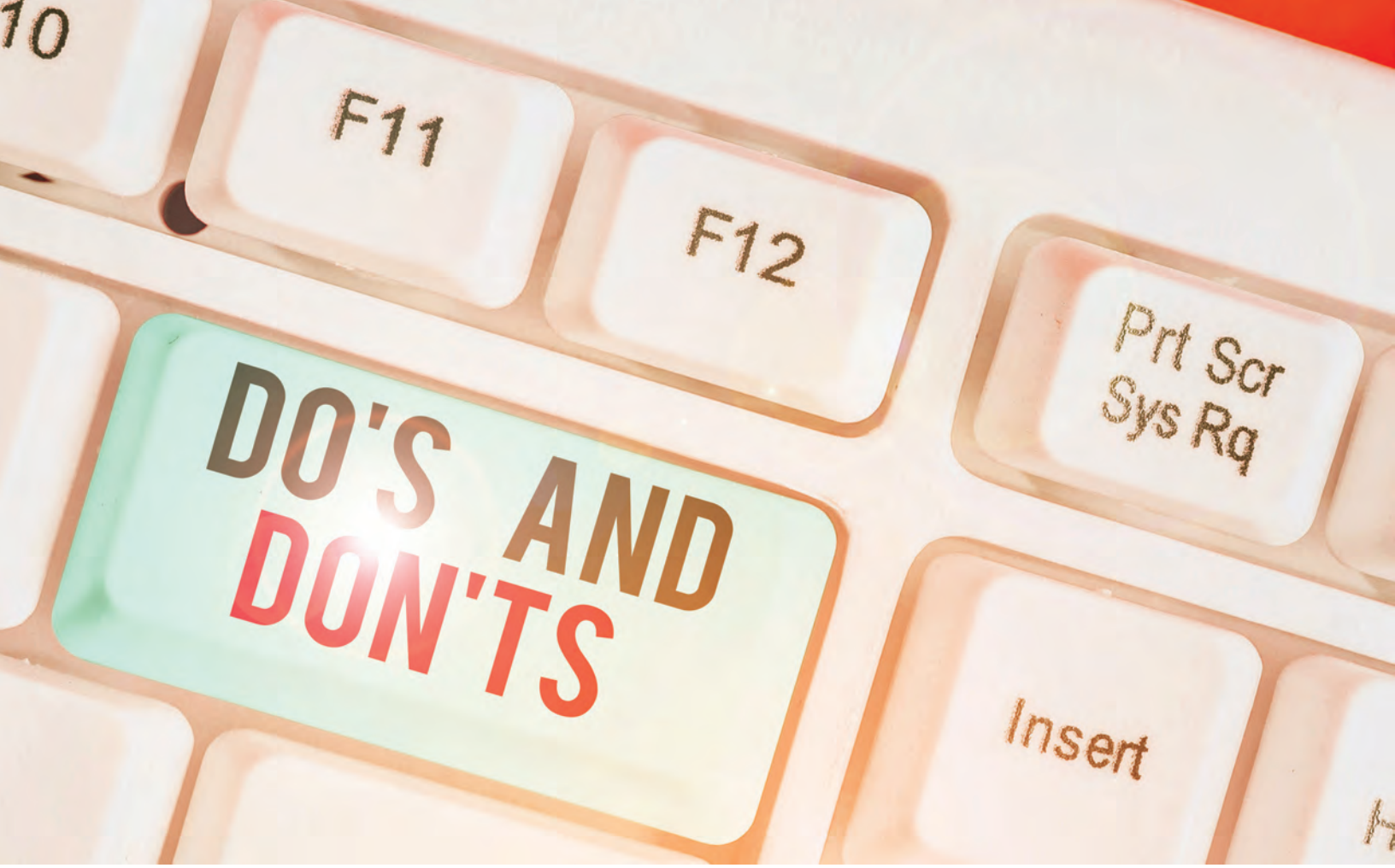
Next Step for Response C

Similar to Response B, help the patient explore and plan why it is a good idea to seek treatment sooner. To speed the process, consider sending the patient home with a hearing aid demonstration unit.

Next Step for Response D

Immediately move into goal setting and treatment planning

Audiologists who work primarily with adults, spend most of their time selecting, fitting and maintaining hearing aids. Because the hearing aid is so central to patient success, it is easy to focus too much time and attention on the components of the hearing aid selection and fitting process. By using the stages of change model in the decision making process, audiologists can take some of the focus off hearing tests and hearing aids and place it squarely on the patient and what they need to do to be successful communicators. ■



HEALTH INFORMATION TECHNOLOGY

Do's and Don'ts for Today and Tomorrow

by Jaan Sidorov, MD and Akash Randhar

While advocates of health information technology (HIT) emphasize its role in achieving the Triple Aim of lower cost, improved health, and better care (Berwick 2008, Sheikh 2015), insurers and healthcare providers are increasingly asking just how HIT translates into greater business efficiencies, better clinical outcomes, and enhanced customer loyalty.

Thanks to the rapid pace of change in HIT, the moving targets of health reform, and the particularities of local healthcare delivery, "it depends" is really the best answer. However, that does not mean there aren't some lessons from HIT implementation so far that can be applied across many settings.

In our roles as founders of a health tech company, we have observed several trends that may inform the collaboration between HIT service providers and buyers. Below, we offer some insights and practical suggestions about HIT and its relationship to evidence-based healthcare, clinical workflows, cost savings, and big data. We also look at the future, sounding a note of caution about whether artificial intelligence will be ready for widespread adoption any time soon, while expressing optimism about the potential for gamification to improve patient engagement.

Today: Evidence-based vs. Innovative

While businesses in every economic sector conduct research, healthcare's large investment in evidence-based practice is noteworthy. History, training, and culture have led generations of physicians, applied health professionals, academics, and regulators to routinely apply considerable scientific scrutiny as well as skepticism to reports of new diagnostics or treatments. It's no surprise, then, as providers, insurers, vendors, pharma, and other stakeholders compete for market share, claims of new HIT-based innovations continue to prompt old questions on whether the underlying data are tainted by bias, poor design, limited generalizability, questionable effectiveness, and unknown or unintended long-term effects.

To the frustration of investors and management teams, the pace and proprietary nature of much innovation in HIT is ill-suited to the pace of traditional peer review. Fortunately, the number of biomedical publishers has expanded, and many have expedited their review process and offer online publication. Two telling examples of the risk of failing to take advantage of this are lab provider Theranos and some direct-to-consumer skin care smartphone apps, which rushed to market with little peer-reviewed evidence to back up their claims and abysmally failed (Ioannidis 2016, Resneck 2016).

As a result, HIT service providers and their customers should routinely contemplate investing in gathering, interpreting, and reporting their impact on Triple Aim-based outcomes with every customer in a peer-reviewed forum. Innovative healthcare entities that neglect healthcare's reliance on evidence-based medicine and go to market without the benefit of any peer review, do so at their peril. While time-consuming and expensive, promotion without accompanying proof can ultimately be far more costly.

That is not to say that a fast pace of innovation is bad for the healthcare industry. However, a careful consideration of the scope of rollouts and design of supporting studies can achieve getting the latest in the market quickly while verifying that it is, indeed, the greatest based on well-designed studies. Moreover, as healthcare evolves so individuals can make treatment choices based on quality, price, and convenience, researchers can adopt some of the practices used in the retail industry, such as quick parallel studies, to develop evidence that has traditionally come from randomized trials, observational studies, and case series.

The expedient adoption of health technology can be additive, not substitutive. Absent modification of existing job descriptions or workflows, frontline employees who are asked to adopt new technology will have to grapple with additional roles, new policies, unfamiliar procedures, extra oversight, and unforeseen problems. For them, the addition of more HIT—no matter how innovative it might be—inevitably leads to more work. Absent the concurrent assignment of incumbent low-value duties to machines or the dustbin, layering more HIT on top of a group of busy employees turns them into even busier employees. The introduction of HIT often means copying and pasting across multiple applications scattered across two or more devices rather than added efficiency.

Outside the travails of the electronic health record (Mandl 2012), this additive downside to HIT has gone largely unexamined in the peer-reviewed medical literature. Other reports describing this problem have noted the importance of obtaining frontline worker input and fostering collaboration across multiple vendors (Perna 2014). In our experience, importing a HIT solution also should serve as an opportunity to review which legacy tasks can be modified or discarded. Buyers also should be wary of "middleware" and quick fixes, which tend to add complexity over the long term. Instead, they should consider implementing staged rollouts of HIT-based innovations using a plan-execute-evaluate-adjust ("PLEXEVAD") strategy.

Additive work often happens when new technology is not accompanied by adoption of the new ways of doing things by the end users of the technology. Without those changes, the promise of technology will often go unrealized. For a healthcare organization, that can mean wasted time, money, and employee goodwill.

What is Health Information Technology?

Health information technology (HIT) involves the exchange of health information in an electronic environment. Widespread use of HIT within the healthcare industry will improve the quality of healthcare, prevent medical errors, reduce healthcare costs, increase administrative efficiencies, decrease paperwork, and expand access to affordable healthcare. Smartphones and smartphone enabled are part of the HIT ecosystem.

Grappling with insurance risk-transfer

One value proposition for HIT includes the reduction of avoidable healthcare utilization or costs. However, successfully decreasing claims expense often translates to a combination of 1) a very real loss of provider revenue, and 2) an abstract calculation avoiding healthcare utilization. Both are reduced further by the direct and indirect costs of HIT's associated personnel and capital. As the art and science of shared-risk arrangements continue, it should be recognized that as the parallel role of HIT expands, gauging just how it "bends the cost curve" involves multiple care settings and has wide confidence intervals (Asch 2016).

To effectively navigate this challenge, both HIT providers and customers need to account for the health burden of the insured population being served, the impact of social determinants, baseline expenses, insurance claims trends, background cost inflation, and local provider network performance. Without this knowledge, calculations of the economic value of a particular HIT-based innovation in a particular setting for a particular population may not be a question that can be precisely answered.

Healthcare correlations derived from the analysis of huge, multisource datasets need to not only render meaningful insights, but be accompanied by actionable opportunities that can be scaled to available resources. In other words, the "big" of "big data" needs to be boiled down to a manageable number of achievable interventions for a manageable number of patients. For example, while the clinical issues and social determinants underlying an increased risk of rehospitalization have been the subject of considerable research, far less is known about prioritizing and modifying these determinants so that the few patients who are most likely to benefit are selected for the right intervention.

As population health and care management spreads to more and more consumers, the value proposition of HIT will include access to insights that give the greatest impact on cost and clinical outcomes. Once that is achieved, the experience can inform additional interventions for additional numbers of patients in a virtuous cycle of continuous improvement.

The ecosystem and gadgets

Early versions of HIT were single source, end-to-end, and complex. This has given way to a networked and decentralized array of smaller and interchangeable billing, claims, health record, laboratory, imaging, data warehousing, and analytics components (Surviving 2016). As a result, healthcare's chief technology officers increasingly preside over complex "ecosystems" of local and remote software and hardware. As with other systems, the whole becomes greater than the sum of its parts. The growth of HIT means the merits of upgrading, swapping, or supplementing any part is dependent not only on their individual functionality, but also on their interdependent compatibility and synergy.

Given this reality, the incorporation of consumer apps and monitoring devices into the HIT ecosystem is less revolutionary than evolutionary. While the consumer allure is undeniable, the ultimate value proposition of these apps and gadgets will depend more on their ability to enhance the consumer and provider experience by supporting, for example, patient-centeredness and shared decision making (Moore 2006). Their potential in these and other areas of the Triple Aim has only just begun to be documented in the peer-reviewed literature. The healthcare app and device vendors that can prove they create value in this ecosystem will have a key competitive advantage.

Tomorrow: Humans plus health tech

While artificial intelligence promises to completely outsource much complex decision-making to machines, the experience in many nonhealthcare settings with established robotics is that computers plus human insight make for greater efficiency and effectiveness than either alone (Automation 2015). In addition, the art and science and associated cost management of healthcare delivery are still a matter of limited knowledge, insufficient evidence, myriad logic exceptions, and very human irrationality (Eichner 2010). While expedited access to scientific databases and the generation of potential diagnoses and treatments are well within reach, it remains unlikely that diagnostic and treatment guidelines will be translated into accurate computer code in the near future (Semigran 2016). The superiority of having live subject matter experts enter the HIT loop for even "simple" clinical tasks, such as giving advice to patients on how to successfully use their hearing aids, suggests that for now, HIT will remain a decision support tool rather than a decision substitution tool.

The change to a more automated approach to management of hearing loss and other related disorders should not be discouraged; however, a note of caution about implementation is warranted. Adopters of cutting-edge HIT should be skeptical about claims that we are on the cusp of HIT that is independent of any human oversight. If implemented prematurely, the result could be a limited menu of one-size-fits-all care options or a high incidence of exceptions. For now,

the artificial intelligence version of "Dr. Watson" that is fully independent remains experimental. It is best to leave it in the labs of researchers or to your competitors.

Until now, mainstream efforts to improve diet, exercise, medication adherence, or provider appointments have had limited success. This is because such efforts are largely based on 1) educational appeals to improving personal health status or 2) the use of economic incentives to change behavior. The former has had a disappointing track record, while the latter have substantial cost and regulatory limitations.

Enter the alternative of healthcare "gamification," in which consumers pursue healthful behaviors by competing for noneconomic and symbolic awards. This is emerging as a surprisingly effective tool in motivating behavior change, and its science is still evolving. The phenomenon of millions of Pokémon Go users increasing their physical activity levels in the pursuit of virtual avatars is just the latest, if very public, example of the potential low-cost synergies of gamification and HIT (Althoff 2016).

Gamification has been the subject of a considerable amount of applied research (King 2013) and, in contrast to artificial intelligence, may be ready for adoption in many healthcare settings, including audiology. Once this tipping point is achieved, the disruptive technologies that support gamification for health promotion and disease management are likely to transform patient education and engagement. As a result, we predict early adopters will have a competitive advantage.

Summary

As HIT service providers rush to provide innovative solutions in the healthcare marketplace, they will need to manage multiple challenges all at once. They and their customers will need to meet the expectations of evidence-based healthcare, deliver on the substitutive promises of innovation, avoid burdening physicians with additional tasks, grapple with risk-transfer calculations, leverage big data in the service of achievable outcomes, and serve as one of many components of an informatics ecosystem that also includes patient apps and other gadgetry. While artificial intelligence holds great promise, the even greater complexity of healthcare decision making means its adoption is likely to be delayed for several years. In the meantime, the limitations of traditional education and incentives and the surprising appeal of handheld games makes "gamification" the next frontier of consumer engagement. HIT vendors and customers that succeed in these key areas will be the most likely to succeed in achieving the Triple Aim. ■

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Jaan Sidorov, MD, *a primary care physician, serves on the editorial advisory board of Managed Care and is the chief medical officer of Medsolis Inc., a HIT company.* ***Akash Randhar*** *is the CEO of Medsolis.*

A REFRESHING CHANGE OF PACE

DESIGNING INNOVATIVE PROVIDER AND PATIENT EDUCATION IN A DIGITAL SPACE

An Interview with Dawn Heiman, Au.D.

AP *Dr. Heiman, thank you for taking time to talk to Audiology Practices about the importance of targeted training for patients and caregivers. Please tell us a little about yourself.*

DH I consider myself to be a typical audiologist. I have been practicing for 21 years and have worked in most audiology settings during that time. I currently own and work in a private practice in Illinois. Most of my day involves working with patients who wear hearing aids.

AP *To provide some background for readers, can you talk a little bit about your interest in and foray into digital marketing and how you expanded that personal interest in a way to help others?*

DH Absolutely. In short, it all started because I became frustrated with the marketing options available to audiologists. I began researching alternatives and found myself diving headfirst into the digital marketing world and taking digital marketing courses to drive more patients to my office.

While taking course after course on how this new digital marketing industry works and seeing it from a perspective outside the audiology profession and hearing care industry, I gained a lot of knowledge that I felt compelled to share with my fellow audiologists. I started applying the techniques that I learned and then, people would reach out to me and want to schedule a time for me to teach them what I know. And then, because I am a sharer, I started doing free YouTube videos to teach other audiologists. I discovered that by creating a video,

that one instruction could be watched by multiple people and they all received the same level of instruction consistently--and I didn't have to schedule a time out of my day to teach each one individually.

AP *What was the impetus that led you to go from putting together YouTube videos to share your knowledge with audiologists to developing full-blown training courses for providers and patients?*

DH As I was taking courses that intrigued me, it occurred to me that I could move beyond making individual videos, to actually creating my own courses, with purposeful content and a collection of videos that could serve a higher purpose.

At the same time, I had been feeling a tug on my heart and an internal conflict for years, as it relates to patients who were struggling to put on their old and new hearing devices. They sometimes forget which ear, or what direction to put the hearing aids on, or they may forget to put their hearing aids into the charger each night. I feel ashamed to have said, "It will be fine," or "Someone will know how to help you," when patients verbalized that "[they] just don't think [they] can do it." A small part of me inside would crumble every time this happened, as I wasn't at all sure that it would be fine. I just wanted to go home with them and help them.

So, as audiology reimbursements and average sales prices of hearing aids were dropping, I was feeling like I needed to add more time to each appointment to teach patients everything they need to know in order to master their hearing aids and be successful. This is a huge conflict and dilemma in most clinics!

Finally, about a year ago, as I was washing dishes and listening to a digital marketing course, an idea popped into my head: *Why don't I create a course that will teach the staff at senior communities to help my frail senior patients?!?* I got so excited that I yelled to my family, with my hands sopping wet from the dishwater, "Mommy knows what she's going to do to change the world!"

Right then and there, with my mind racing, I dried my hands, tore off a huge sheet of paper from my 5-year-old son's painting easel, taped it to the dining room wall, and began sketching out ideas. Those ideas, conceptualized that day turned into the Hearing Aide Certification program to help train nurses and caregivers to help patients with their hearing aids, the Hearing Wellness Journey, an online aural rehabilitation program, and the EntreAudiology Academy, a resource built upon my previous work to help audiologists.

The EntreAudiology Academy was the first to fruition. I drew out what it would look like if I took what I was teaching through YouTube videos and expanded it to a resource page, designed to help audiologists who run a practice. I put together the collection of audiology practice building videos and launched the EntreAudiology Academy in August 2019.

Since that time, I have slowly but surely been writing the content, and creating the videos for the Hearing Aide Certification program and the Hearing Wellness Journey program, simultaneously during evenings and weekends. As fate would have it, I finished the last video on Saturday, March 14, 2020, just as the nation, Illinois, and my practice, were shut down due to the COVID-19 Pandemic. If there was a silver lining, it is that I suddenly found myself with the two months I needed to effectively turn the videos and content into two website courses. Talk about opportunities!

AP *Congratulations on the accomplishment! Can you talk a bit more about the Hearing Aide Certification and how you hope it will impact your community?*

DH The Hearing Aide Certification training program has two primary objectives. First and foremost, I'm hoping to educate nurses, nurse's aides, and home caregivers about why hearing is important. Secondly, I want to empower them with the skills they need to support our elderly patients who rely on them daily in the skilled and assisted living communities, as well as those they serve through a home health agency.

Now, more than ever, long-term care, assisted living, and home care senior communities need the Hearing Aide Certification because residents are not allowed to freely leave the communities and in many cases, audiologists are not being allowed to go inside to care for their patients.

AP *What are your overarching goals for these projects in the future?*

DH My three "Why" circles are:

1. I can help people improve their hearing because I'm an audiologist.
2. I am good at making videos and websites.
3. I am constantly concerned about who leaves my office and wonder if they have the knowledge and support they needs once they return home.

My big goal is to make a remarkable change in the senior living world, one person at a time. I want to help change the overall mental health and morale of those living in senior communities because they can hear better, socialize more, and engage in life at their best.

I created the Hearing Aide Certification program to help ensure that seniors who go home to their senior community have the support that they need, and I created the Hearing Wellness Journey for patients who would like reinforcement and reminders about what I taught them in the office, and also listening exercises to help retrain their brain.

While each course is geared for different audiences, both courses, are designed to demonstrate the importance of hearing, hearing aid care and use, strategies for success, and to encourage and challenge patients, so they can be as successful as possible.

AP *Is there one important takeaway that you have learned through your work on these projects?*

DH I have learned that we, as humans, do not like change--but that if we embrace change and try something new, we often also find a new way of thinking that brings us new opportunities for joy in life. This is true for the person who finally goes to the audiologist after years of denying themselves hearing help. And it is just as true for this audiologist who, after a time of complacence and frustration with the status quo, decided to do something "disruptive". Being open to learning new things can be a life changer.

AP *Thank you for your time, Dr. Heiman. AP readers can find more information about all of these programs at* ***www.entreaudiology.net****.* ■

Dr. Dawn Heiman earned her Au.D. from the Pennsylvania College of Optometry, School of Audiology. She obtained Bachelor of Arts degree from the University of Pittsburgh and her Master of Science degree in Audiology from Bloomsburg University of Pennsylvania. Dr. Heiman is the owner and founder of Advanced Audiology Consultants, a private practice in the suburbs of Chicago, Illinois.

Reimbursement Reminder

BY KIM CAVITT, Au.D.

92700: THE CODE FOR WHEN THERE IS NO CODE

This code is described as an "unlisted otorhinolaryngological service or procedure" and is used to classify services and procedures that do not have their own, unique, specific CPT codes.

Some common examples of 92700 use:

- Communication needs assessment
- Vestibular evoked myogenic potential testing
- High-frequency audiometry
- Behavioral observation audiometry
- Eustachian tube function testing
- Auditory steady state response testing
- Middle/late latency response testing
- Use of goggles
- Saccade testing
- Head thrust testing
- Speech in noise testing
- Removal of incidental cerumen
- Fistula testing
- VHit
- Vestibular autorotation test
- Fukada
- Acceptable noise level
- Auditory prosthetic device fitting and service
- Auditory prosthetic device assessment that take less than 31 minutes to complete.

These codes are individually reviewed so you will need to be able to supply, upon request from the payer, documentation of a procedure's clinical utility and medical necessity for this patient. You can use more than one use of this code on the same claim, as separate line items.

Coverage is limited for this code and the service will typically become the financial responsibility of the patient. The patient should pay your usual and customary rate on the date of service. An Advanced Beneficiary Notice (ABN) is required for traditional Medicare beneficiaries and notices of non-coverage are required for other payers.

THE UPDATED ADVANCED BENEFICIARY NOTICE

The current traditional Medicare (Part B) Advanced Beneficiary Notice (ABN) expired in March 2020. This form has been renewed and now has an expiration date of 06/30/2023. Your current form will no longer be valid if the expiration date on the form is not updated by August 31, 2020. For more information, please visit: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.

ADA members can download a free updated customized ABN form at the following link: https://www.audiologist.org/practice/forms-library. ■

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.*


There are STEPS
we can take to reduce
or prevent falls!
#thinkaudiology
See an audiologist today!
think audiology
Hear More. Fall Less.

HAVE YOU HEARD?

AuDacity 2020 Invites Participants to Think Outside the Box and the Ballroom

On **October 16-17, 2020**, the Academy of Doctors of Audiology (ADA), the Independent Audiologists Australia (IAA), and the Independent Audiologists New Zealand (IANZ) will bring together audiologists, students, and industry leaders from around the world for a shared virtual experience that will allow participants to learn and network in unexpected and delightful ways. ***AuDacity 2020: Forge Ahead and Forge Ahead Down Under*** will challenge assumptions about the framework and format for interactive conferences in this era of social distancing by eliminating geographic, time, and spatial boundaries.

The AuDacity Agenda: Design Thinking and AuDiology

AuDacity 2020 will demonstrate why and how audiologists can integrate design thinking with evidence-based practice to enhance patient outcomes. The AuDacity general session mainstage will feature a view from the forefront of design thinking in healthcare from innovators in the field, as well as crisp, practical presentations from audiologists and industry experts who are successfully using design thinking in clinical, business, and professional initiatives to optimize patient care and improve customer satisfaction.

Mainstage programming and structured networking activities will run consecutively for 21 hours, from 8:00 a.m. Eastern time USA on Friday, October 16th until 5:00 a.m. Eastern time USA on Saturday, October 17th to accommodate delegates from around the world. After a brief programming hiatus, the agenda will pick-up again on Saturday with the ADA Member Business Meeting, the Audiology Student Track and other live specialty business and clinical workshops, which will be held throughout the day. In addition to the exceptional live programming, all attendees will have access to more than 30 hours of on-demand recorded sessions.

Keynote Speakers

Bon Ku, M.D.

Assistant Dean for Health and Design and leader of the Medicine+Design initiatives at Sidney Kimmel Medical College at Thomas Jefferson University in Philadelphia, PA.

José Colucci, Ph.D.

Director of Research & Development of the Design Institute for Health (DIH), a collaboration between the Dell Medical School and the College of Fine Arts at the University of Texas at Austin.

FRIDAY, OCTOBER 16, 2020	
8:00 AM - 8:45 AM	Early Bird Session 1: **Comparing the Cost-Effectiveness of Provider-Fit versus Self-Fit Hearing Aids:** Amyn Amlani, Ph.D.
8:45 AM - 9:30 AM	Early Bird Session 2: **Diagnosing Dizzy:** Robert Allen, Au.D.
9:30 AM - 10:00 AM	**Wake up Call, Morning Coffee and Activities in Virtual Exhibit Hall and Career Fair**
10:00 AM - 10:45 AM	President's Address and Keynote Presentation 1: **Design Thinking in Health Care:** Deb Abel, Au.D. and Bon Ku, M.D.
10:45 AM - 11:30 AM	Featured Presentation 1: **Design Thinking in the Clinic:** Alicia Spoor, Au.D., Kent Collins, Au.D., and Deborah Clark, Au.D. (Moderated by Kate Baldocchi, Au.D.)
11:30 AM - 12:15 PM	**Bring Your Lunch to the Virtual Exhibit Hall for Special Activities, Career Fair, Networking Meetings, and Posters**
12:15 PM - 1:00 PM	Featured Presentation 2: **Design Thinking and Digital Storytelling:** Lana Joseph Ford, Au.D., Paul Dybala, Ph.D., and Dawn Heiman, Au.D. (Moderated by D'Anne Rudden, Au.D.)
1:00 PM - 1:45 PM	Featured Presentation 3: **Advocacy to Support a Design Thinking Approach to Care** (Moderated by Tom Tedeschi, Au.D.)
1:45 PM - 2:15 PM	**Break in Virtual Exhibit Hall, Career Fair, Posters, Special Entertainment, and Virtual Networking**
2:15 PM - 3:00 PM	Featured Presentation 4: **ADA Student Business Plan Competition**
3:00 PM - 3:30 PM	Featured Presentation 5: **Industry Leadership Panel Part 1**
3:30 PM - 4:00 PM	**Break in Exhibit Hall**
4:00 PM - 4:30 PM	Featured Presentation 6: **Industry Leadership Panel Part 2**
4:30 PM - 5:00 PM	Keynote Presentation 2: **Better Health Care through Design Thinking:** Jose Colucci, Ph.D.
5:00 PM - 5:30 PM	**Welcome & Recognition of Representatives from Independent Audiologists Australia & Independent Audiologists New Zealand**
5:30 PM - 6:00 PM	Featured Presentation 7: **Hearing Aids and Cognition**
6:00 PM - 8:00 PM	**Roving Reception & Happy Hours in the Virtual Exhibit Hall, Career Fair, and Networking Lounge**
AuDacity DOWN UNDER Begins!	
8:00 PM -9:15 PM	Down Under Presentation 1: **Advocacy—A Day in the Life**
9:15 PM - 9:45 PM	**Morning Tea and Virtual Networking in the Exhibit Hall**
9:45 PM - 11:00 PM	Down Under Presentation 2: **Using Evidence in the Clinic**
11:00 PM - 11:30 PM	**Afternoon Tea and Lunch Down Under, with Virtual Networking and Games**
11:30 PM - 1:00 AM	Down Under Presentation 3: **Paediatrics**
1:00 AM - 2:00 AM	**Break in the Virtual Networking Lounge**
2:00 AM - 2:45 AM	Rebroadcast of Keynote Presentation 1: **Design Thinking in Healthcare:** Bon Ku, M.D. with live chat discussion
2:45 AM - 3:30 AM	Rebroadcast of Featured Presentation 1: **Design Thinking in the Clinic:** Alicia Spoor, Au.D., Kent Collins, Au.D., and Deborah Clark, Au.D. (Moderated by Kate Baldocchi, Au.D.) with live chat moderated by IAA and IANZ
3:30 AM - 4:30 AM	**Break in the Virtual Networking Lounge**
4:30 AM - 5:15 AM	Rebroadcast of Featured Presentation 2: **Design Thinking and Digital Storytelling:** Lana Joseph Ford, Au.D., Paul Dybala, Ph.D., and Dawn Heiman, Au.D. (Moderated by D'Anne Rudden, Au.D.) with live chat moderated by IAA and IANZ
SATURDAY, OCTOBER 17, 2020	
9:00 AM -10:00 AM	**Design Thinking Problems and Prototypes in Audiology, Next Steps, Group Discussions**
10:00 AM - 11:00 AM	**ADA Member Business Meeting**
11:00 AM - 2:15 PM	Workshop 1: **Audiology Student Track** Workshop 2: **TPA and Market Differentiation** Kim Cavitt, Au.D. Workshop 3: **Remote Programming Hearing Aid/Telehealth Workshop** Moderated by Brian Taylor, Au.D. Workshop 4: **Ethical Considerations for Audiologists** Michael Page, Au.D. Workshop 5: **Performance Indicators and Profitability in Private Practice** Randy Baldwin
4:00 PM - 7:15 PM	Workshop 6: **Cochlear Remote Programming Workshop** Ginger Grant, Au.D. Workshop 7: **Remote Programming Hearing Aid/Telehealth Workshop Second Class**
4:00 PM - 10:30 PM	Workshop 8: **Motivational Interviewing (Part 1) and Personality Inventory (Part 2)** Robert Traynor, Ed.D., David Citron, Ph.D., Victor Bray, Ph.D.
Plus 16 Additional On-Demand Sessions!	

AuDacity 2020 Sponsorship and Exhibit Opportunities

Connect with your customers at AuDacity 2020. Reach customers around the world without leaving your office. Brand your customizable exhibit booth and upload digital information that attendees can put in their virtual briefcase. Talk to your customers live using group chat, individual chat, and individual audio and video conferencing capabilities (great for live demos). Visit www.audiologist.org/audacity/at-a-glance or contact Ilse Dehner at idehner@audiologist.org for more information or to reserve your sponsorship and space.

Exhibit Hall Live Hours

Friday, October 16, 2020

8:00 a.m. – 10:00 p.m.

Eastern time USA.

Attendees will be able to return to the exhibit hall for 30 days post event to download information and materials.

Participate in the AuDacity Career Fair

The AuDacity Career Fair will make the most of the opportunity to bring audiologists, students, company representatives, and practice owners together to exchange information in an innovative virtual space. Audiologist and student extern candidates will be able to learn about career opportunities and position openings. Employers will be able to set-up and conduct walk-in or scheduled interviews via private chat, audio and video conferencing. Contact Ilse Dehner at idehner@audiologist.org for more information.

▶ 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.

PRESIDENT'S MESSAGE

Continued from page 5

AuDacity. This is not your mother's webinar! AuDacity will be held in a virtual world that will include an exhibit hall, career fair, and networking rooms—and will deliver incredible knowledge without the time, expense, and health concerns involved to go to a meeting. Wear your comfy clothes, and enjoy AuDacity from your home or office. Most importantly, for ADA members, there will be a Happy Hour!

Finally, the work for the Medicare Audiologist Access and Services Act (MAASA) goes on. Several new co-sponsors have signed on even during this pandemic, including Senator Susan Collins (R-ME), who is Chair of the U.S. Senate Special Committee on Aging. Please help build on this momentum by contacting your legislators to ask for their support at : http://chooseaudiology.org/congressional-connect. MAASA has to become a reality in this Congressional session! If you are able, please also consider donating to the effort here: http://chooseaudiology.org/donate. There is no amount too small--we know with reopening your office, money is likely tighter—we also have seen first-hand that until MAASA is enacted, our Medicare patients do not have safe, efficient access to the care that they need during this pandemic.

Things are difficult now, but I believe they will get easier. Thank you, ADA members, for all you are doing to help those with hearing and balance issues, and to advocate for social justice and your profession. And thank you, ADA staff and AuDacity Program co-chairs Dr. Amyn Amlani and Dr. David Citron, for creating unbelievable opportunities for learning and collaboration. This is what makes ADA home and why ADA is such a great professional home.■

HEAR AND NOW

Early Career AuD Resources

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

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

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

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

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

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