

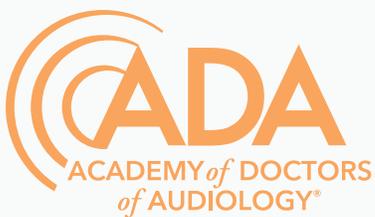
THE OFFICIAL PUBLICATION OF THE ACADEMY OF DOCTORS OF AUDIOLOGY®

Audiology PRACTICES



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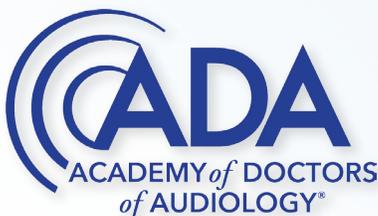
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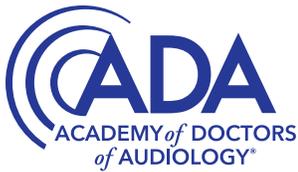


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Work Smarter, Not Harder

As we begin summer, I've been reflecting more on how to organize my life so I can not only enjoy my personal time, but also my practice time. "Work smarter, not harder" keeps popping up in my head. We hear that all the time, but what does that actually mean? It's all about a planned strategy to run your private practice more smoothly. Your life can achieve its goals more easily when you find ways to organize it. Consider seeing your patients with a planned strategy that is kinda like playing a long-term game of Jenga. As you build upon what your foundation was built from and you reach higher levels, you can do it with pre-planning and strategic moves. This edition has some great articles that you can use to ensure a great strategy for your practice.

Block Scheduling:

Have you ever arrived at work, glanced at your schedule, and thought, "How on earth did that happen?" Does your schedule feel inefficient and even profit-draining? I have found that working on block scheduling is time well-spent because it can help with efficiency and profitability while bringing the clinician a sense of joy because it is pre-planned.

Don't forget to Block Schedule your non-patient hours too. As a practice owner, we need to have time to work on community outreach, including Advocacy time to attend our local Congressperson's events – and to simply call them to let them know what matters most to us!

Community Hearing Screenings:

How will others know they need to see you? How will they know who to see when they discover they have a change in their hearing? Community screenings are a great way to give back to the community, step outside the walls of your office, meet people, and let them know they can trust you. Written advertising can only go so far. Your community needs to meet you and have at least brief interactions before coming to the office. By taking the time to carefully plan and organize your community hearing screening activities, you will be able to provide quality care for those who need it most. Efficient scheduling will also help ensure the success and reach of your event.

Plan to have a Communication Partner in Goal Settings:

When someone's hearing changes, we all know it doesn't only affect that person, it affects their entire network of family and friends. It makes so much sense to include at least one person at their initial appointment to set their goals for success. At any given time, communication partners can provide invaluable support to those whose hearing is changing. By scheduling ahead of time, they can make sure that their input has a lasting positive impact on goal setting and beyond.

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 **Hear Marty's Story**

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How Do We Ensure Persons with Hearing Loss Get the Best Quality of Care?

The Answer Might Be Found in Implementation Science

It seems that a week doesn't go by when yet another article is published demonstrating the association between hearing loss and other harmful conditions. Case in point, within a recent 10-day span, articles were published that continue to build a thorough evidence base indicating, 1.) Diabetes, obesity, hypertension, and smoking are linked with hearing loss—and higher combinations of those risk factors increase the risk of hearing loss¹, and 2.) hearing loss is a potential modifiable risk factor for cognitive decline.²

Collectively, this mounting evidence forms a nearly bulletproof case for early intervention in three ways: 1.) Improving overall wellness, particularly cardiovascular health, might prevent hearing loss, and 2.) Adults should have their hearing periodically checked beginning in middle age, and 3.) When necessary, should be fitted with hearing devices sooner, rather than later. Earlier audiological intervention is in the best interests of persons with hearing loss, their family, their employer, and their primary care physician and other medical staff that might work with them.

Despite the steady flow of peer reviewed research that one might think would prompt individuals into action, we continue to be faced with two uphill battles: 1.) The proverbial seven to 10-year wait persons with hearing loss tolerate from the moment they notice problems with their hearing until they seek a solution. A journey delayed as much or more by apathy and indifference than access to care and affordability of treatment.³

2.) The gap, actually more of a chasm, between knowledge and action – which is also, in large part, driven by apathy and indifference.⁴ Recent estimates suggest there is a 17-year gap between when new research findings are published and when those findings move the needle on decision-making in the clinic.⁵ That 17-year gap applies to general medicine, but it's not hard to see it in our own profession. There is no shortage of innovative interventions and diagnostic approaches, with research supporting their effectiveness, which have failed to be embraced by most clinicians. The 60-60 criteria for cochlear implant candidacy, use of speech in noise testing, matching a validated prescription gain target — the adherence to modern audiology protocols in clinical practice is concerningly low. And there is no reason to believe that newer tools like extended high frequency audiometry, remote fine-tuning and automated audiometry, even after sizable amounts of evidence is published supporting their use, won't follow the same path of low adherence.

What's driving this knowledge-doing gap? More than 20 years ago an academic field, known as implementation science, emerged that attempts to understand the chasm between what clinicians might know and what they actually do. Since that time, several academic centers including those at the University of Washington and Washington University in St. Louis have established departments devoted to the study of implementation science with the basic goal of narrowing the time between

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Applying UX Design Principles to the Patient Experience

User Experience (UX) design has revolutionized how we interact with technology. When done well, UX design creates experiences that are seamless, intuitive, and enjoyable. I recently had the opportunity to attend a UX design conference that demonstrated the use of UX design principles to enhance service delivery and offered examples of successful applications in health care. The courses emphasized themes that I was introduced to during the AuDacity 2020 virtual conference, which featured keynote speaker, Dr. Bon Ku and concepts from the book he co-authored, *“Health Design Thinking: Creating Products and Services for Better Health,”* and brought forward new ideas for applications.

Design thinking follows a structured, iterative process that involves empathizing with users, defining problem areas, ideating potential solutions, prototyping, and testing. It encourages diverse perspectives and broad collaboration among different stakeholders to address (typically) system-wide issues. UX design (often viewed as a subcategory of design thinking), concentrates on creating intuitive and user-friendly experiences for individuals interacting with a specific product or service. While commonly associated with websites and apps, the principles of UX design can also be applied to healthcare settings and services. As I recently learned, by leveraging UX design principles, healthcare professionals can improve patient satisfaction, streamline workflows, and ultimately enhance the quality of care.

Empathetic Design for Improved Patient Experience: At the heart of UX design lies empathy grounded in a deep understanding of the needs and expectations of users. By carefully considering the patient journey and optimizing each touchpoint, audiologists can design experiences that prioritize patient comfort, reduce anxiety, and enhance overall satisfaction. Experience features don't have to be grand or complicated to be successful. Clear signage, comfortable waiting areas, and user-friendly patient portals can have a profound impact on the patient experience.

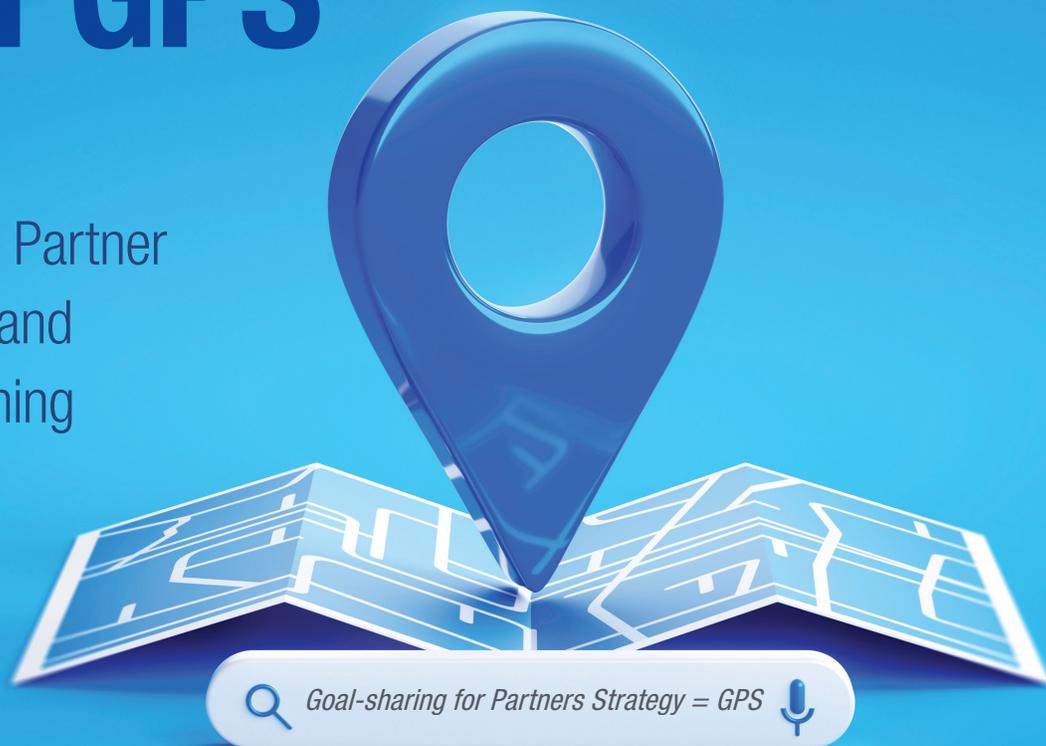
Streamlining Workflows for Increased Efficiency: UX design techniques, such as process mapping and task analysis, can identify bottlenecks in clinical workflows. By streamlining processes, eliminating unnecessary redundancy, and leveraging technology, clinicians and front office staff can save time, improve productivity, and allocate more attention to patient care.

Enhancing Communication and Collaboration: UX design principles can facilitate seamless communication and collaboration among clinical and operational teams. User-centered design methods, such as creating user personas and conducting usability testing, can help identify communication pain points and design solutions that meet the needs of various internal stakeholders.

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Finding Your Way With GPS

The Role of the Communication Partner in Goal Setting and Treatment Planning



Navid Taghvaei, Au.D.

This tutorial provides how-to guidance and insights on navigating the goal setting and treatment planning process in a way that provides a deeper level of engagement between the audiologist, person with hearing loss and communication partner.

Mr. Smith is a 76-year-old retired professor who was recently fitted with hearing aids. Based on his hearing and health history, Mr. Smith has been struggling with his hearing loss for more than 20 years. Although his wife was actively involved in the hearing aid selection and fitting process, she appears to have unrealistic expectations about Mr. Smith's initial experience with his hearing aids. This statement is based on the audiologist's observations during the follow-up appointments at one week and four weeks post hearing aid fitting. At both of those appointments, Mrs. Smith alluded to her disappointment with her husband's progress. Mrs. Smith did spread the blame around, as she expressed dismay in her husband's ability to consistently use his hearing aids. She also expressed concern that a different pair of hearing aids may

be needed since his current devices, which he's been "fool heartedly trying to use" for almost five weeks don't seem to help him all that much in the listening situations where they are needed the most. Mrs. Smith even expressed some frustration with the audiologist, questioning if the hearing aids were properly tuned for her husband's hearing loss. At the same time, Mr. Smith contrarily believes he is making steady progress, even though he's not wearing the hearing aids as much as his wife would like him to use them.

This scenario represents a relatively common occurrence in many clinics. It is a situation that cries out for mediation from the audiologist who is trying to rein in a situation that has the potential to quickly degenerate into chaos. It is a



Patient outcomes are improved when the person with hearing loss, their CPs, and the audiologists are all directly involved in the entire goal setting, treatment, and follow-up process.

situation in which the individual with hearing loss and their primary communication partner (CP) are not on the same page with respect to expectations and benefits of amplification. By the same token, it represents an opportunity for the audiologist to sort through the motivations, attitudes, and behaviors of both the person with hearing loss and their CP; in a sense to hit the re-start button and work with both parties to improve daily communication for both of them.

The objective of this tutorial is to provide some practical guidance to audiologists on the process of goal setting for the CP – an often-overlooked player in the goal setting and treatment planning process. Just how critical is the CP in the successful treatment and management of hearing loss in adults? That is a question that research helps us better understand.

More than a decade ago, the MarkeTrak VIII survey (Kochkin, 2012) found that the ‘spouse or relative’ provided substantial psycho-social influence among hearing aid non-adopters with short-term (six months to one year) hearing aid purchase intent. More than half (53%) of the individuals who had not acquired hearing aids would be motivated to adopt hearing aids if their ‘spouse or relative’ recommend them to do so. In a more recent meta-analysis, Merner et al (2023) showed that patient outcomes are improved when the person with hearing loss, their CPs, and the audiologists are all directly involved in the entire goal setting, treatment, and follow-up process. This finding is consistent with a similar evidence-based review by Kamil & Lin (2015), which highlighted the broad effects of hearing impairment on friends and family members and the importance of involving CPs in hearing loss treatment decision. In addition, goal sharing between the person with hearing loss and their CP, a process facilitated by an audiologist, has been shown to lead to better patient outcomes (Ekberg et al 2020). Finally, a retrospective explorative study by Ellis, Singh, and Launer (2023) investigated the unexplored question of whether an association exists between the type of significant other (SO) in attendance at appointments and hearing aid adoption.

The study sample consisted of adult patients from a chain of private clinics in the United Kingdom who either attended their audiology appointment with a SO or alone. Six SO

types were identified and classified: partner (n=6,608), parent (n=76), child (n=2,577), sibling (n=208), friend (n=518), and carer (n=28). In addition to replicating previous findings which showed that significant-other attendance at audiology appointments was positively associated with hearing aid adoption, results from the current paper also revealed that the odds of hearing aid adoption were greater if the SO was of a stronger relationship tie (i.e., partners, parents, children, and siblings) and not a weaker relationship tie (i.e., friends, carers). These findings suggest that the CP in attendance for the appointment should be one who spends a significant amount of time with the person with hearing loss and should be someone with whom they have a strong, emotional bond. While these studies suggest the presence of a primary CP is critical, none provide concrete guidance on how communication partners can contribute directly to the goal setting and treatment planning phases of the so-called patient journey. Consequently, this article intends to provide some how-to guidance.

Goal-sharing for Partners Strategy (GPS) is a tool developed by the Ida Institute for audiologists to use with persons with hearing loss and CPs. The GPS is designed to help the person with hearing loss and their CP accomplish four goals:

- 1 Acknowledge the hearing loss.
- 2 Acknowledge the activity limitations and participation restrictions that result from the hearing loss and how the person with hearing loss and CP are both affected by them.
- 3 Acknowledge that both parties are partners in communication with an important stake in improving outcomes of the treatment.
- 4 Realize they have a shared responsibility in managing the hearing loss and treatment approach.

The GPS is a five-step process that audiologists can use to get both the person with hearing loss and their CP directly involved in the rehabilitation process. Step 1 entails asking both the person with hearing loss and their CP to identify key listening situations where both parties want to achieve improved communication. In order to execute step one

effectively, the audiologist's line of questioning needs to focus on what successful communication looks like to both parties. Rather than focusing on communication problems, the task of the audiologist is to help both parties "paint the picture" of effective communication in everyday listening places. A substantial part of this conversation, which is facilitated by the audiologist, needs to emphasize his capabilities, rather than his disabilities. For example, if the person with hearing loss has a physical or cognitive limitation, the audiologist needs to focus on the skills a person with hearing loss can successfully master.

Step 2 can be broken down into four questions that are asked of both parties.

- Question 1 is asked to the person with hearing loss: What problems or challenges do you experience because of your hearing loss?
- Question 2 is asked to the CP: What problems or challenges do you experience because of your partner's hearing loss?
- Question 3 is asked to the person with loss: What problems or challenges does your CP experience because of your hearing loss?
- Question 4 is asked to the CP: What problems or challenges does your partner experience because of his hearing loss?

These four open-ended questions are designed to allow each party to reflect on their own experiences with respect to the individual's hearing loss and to consider each other's point of view. The intent is that each person will realize and maybe even appreciate that hearing loss is a shared condition that each person has a stake in managing.

It should be noted that the four questions posed above, under Step 2, are likely to prompt conversations about a variety of emotional topics. Because there is an emotional component to the inability to communicate, it is quite common for marital problems to be brought up during Step 2. If the scope of the conversation is moving outside the comfort zone of the audiologist, it is appropriate for the audiologist to ask the help-seeking individual and their CP to focus specifically on hearing problems.

Step 3 asks the participants to consider the hearing and communication problems they experience together. In other words, after each party has been asked to explore the problems they experience as a result of the hearing loss, the audiologist asks the couple to discuss the problems they

experience *together* because of their hearing loss. When asking this question, it is likely the response will be related to a social situation, like a restaurant, or watching television at home. The point is to identify a communication problem or challenge that affects both parties so they can address it together.

Following Steps 2 and 3 in which a list of communication problems are noted, the next step (Step 4) involves devising a set of achievable goals for each respective problem. Like any goals, the ones set for the person with loss and the CP (with guidance from the audiologist), need to be time bound and realistic. As a general rule, one goal per problem is sufficient.

Finally, Step 5 involves the person with hearing loss, CP, and audiologist brainstorming ideas and tactics that can be used to achieve each goal. Both parties (person with hearing loss and CP) need to be actively involved in this process. It is the responsibility of the audiologist to ensure the tactics and ideas tied to each goal are understood clearly. Further, the audiologist can track progress toward the goal at each subsequent follow-up appointment.

Using this five-step process, let's take a look at an example of how a list of goals is developed during an assessment. After a one-hour appointment, these four goals were created. In this example the husband is the person with hearing loss with the hearing loss and the wife is the CP.

- Problem #1: My husband never talks on the phone because he cannot hear.
- Problem #2: The television is very loud and that really annoys my wife.
- Problem #3: We avoid going to restaurants with other couples because my husband cannot hear them, and I get frustrated when that happens.
- Problem #4: Both of us get frustrated and agitated when I cannot hear during conversations during meals at home between the two of us.

Notice, for each statement of the problem, there is an emotional component such as frustration, annoyance, or a feeling of missing out. From this list of problems, also notice that the list is from both the person with hearing loss and the CP's perspective, or in the case of Problems #3 and #4, it is their combined perspective.

Now, for each of the four stated problems, let's take a look at a corresponding goals and tactics needed to achieve each goal.

Problem #1: My husband never talks on the phone because he cannot hear.

Goal: Have one conversation per week with a family member or close friend.

Tactics to Achieve Goal:

- Use Facetime or other video-based system to complete the call.
- Purchase a new smartphone with an amplifier and let the audiologist teach you how to use it.
- Make sure hearing aids have a means that allow for hearing aid use (e.g., telecoil or streaming).
- Use a speaker phone.

Problem #2: The television is very loud and that really annoys my wife.

Goal: Watch at least one television program together per night with the volume turned down and the person with hearing loss able to understand the conversation.

Tactics to Achieve Goal:

- Use an assistive listening device for the TV.
- Rely on closed captioning.
- Use the streaming capability of hearing aids.

Problem #3: We avoid going to restaurants with other couples because my husband cannot hear them, and I get frustrated when that happens.

Goal: Go with another couple or friend to a restaurant that everyone mutually agrees upon during a popular time of day.

Tactics to Achieve Goal:

- Identify the quietest part of the restaurant to have a conversation.
- Use a remote captioning app (e.g., Ava or HiThere!) on the smartphone to supplement verbal communication.
- Share with your friends that you have trouble hearing and you need to sit in the quietest part of the restaurant.
- Use remote microphone technology of hearing aids with help of audiologist.
- Be aware that it won't be perfectly clear and I will need to listen carefully. I may miss a few words and it's okay to ask others to repeat or restate sometimes.
- Use SoundPrint, a smartphone app, to identify restaurants with acceptable noise levels.

Problem #4: Both of us get frustrated and agitated when I cannot hear during conversations during meals at home between the two of us.

Goal: Carry on a conversation with each other during dinner in which both people can participate in a relaxed manner.

Tactics to Achieve Goal:

- Make sure you're wearing hearing aids and they are properly adjusted.
- Minimize all distractions such as background noise and smartphones.
- Ensure the room is well light and the acoustics are reasonable.
- Don't be in a rush.
- Be aware of the noise levels in busy social situations. Consider the use of a smartphone-based sound level meter to monitor noise levels.
- Acknowledge that you won't hear every word and it's ok to have some things repeated.
- When your wife has to repeat something, it helps to rephrase it.



Open-ended questions are designed to allow each party to reflect on their own experiences with respect to the individual's hearing loss.

Let's now turn our attention to some specific tactics that can be used with persons with hearing loss and their CP to establish clear and actionable goals. The objective of this section is to provide audiologists with practical skills and insights to help them better manage the appointment process in which communication goals are set. The next section reviews several critical areas in which an audiologist interacts with a person with hearing loss and their CP. For each of the components below, specific tactics that the audiologist can use to create deeper level of engagement between the person with hearing loss and CP.

The Appointment as an Information Gathering Process

Before going any further, it's important to appreciate the interaction between the audiologist, the person with hearing loss, and the CP as an opportunity to gather information. Too often, audiologists get ahead of themselves and focus on ends, rather than the means. That is, by virtue of their strong desire to help persons with hearing loss achieve improved hearing, it is natural for audiologists to focus all of their energy on specific recommendations to be generated at the end of the appointment. When audiologists focus on the end results, it is easy to rush through or gloss over critical points during the appointment when the person with hearing loss can "tell their story." One way to overcome a rush to the finish, is to view the hour-long appointment as an opportunity to gather as much information as possible about the help seeker's predicament with as much input as possible from the person with hearing loss and the CP.

Even though an audiologist may have seen thousands of help seekers over their career, it always helps to get into the correct frame of mind prior seeing the next help seeker for a consultation. Putting yourself in the shoes of the person with

hearing loss enables the audiologist to capture opportunities where a stronger relationship, built on trust and mutual respect, can be fostered. Imagining from the person with hearing loss and CP's vantage point what they may have been coping with over the past several years, being curious about their predicament and viewing the appointment as a fact-finding mission is a helpful approach to patient engagement.

The First Interview

The first interview with a help seeking individual and a CP is a little like meeting strangers at a social gathering for the first time. All parties – the audiologist, the person with hearing loss and the family member– know a little something about the other, but not enough to feel comfortable with one another. A primary task of the audiologist during this uncertain opening moment of an appointment is to help everyone in the room feel comfortable enough with each other to continue the relationship. It helps to include the family member/CP in this first interview, as they bring a unique perspective.

According to Perry (2008) the key to creating a trusting relationship between the audiologist and the help seeker (and their CP) rests with the audiologist's ability to communicate with genuine warmth and hospitality. The ability to communicate in this manner is determined largely by cultural norms. For example, there are differences in how you greet a help seeker in the deep South compared to the upper Midwest. In the South, cultural norms warrant a stranger is greeted like a long-lost friend, while that same avuncular greeting in the upper Midwest is likely to be perceived by the help seeker as cloying and insincere. Observing these unspoken cultural norms of your community helps put help seeking individuals and their CP at ease by introducing the familiar into what is usually an uncomfortable and anxiety-ridden situation for the help seeker and the CP.



A Word about Terms

In the patient centered model of care, the terms "persons with hearing loss" and "help seeking individual" or simply "help seeker" replace the term "patient." This tutorial uses those terms interchangeably to describe what many still refer to as patients, a term that implies the individual is passive and dependent on others in making decisions about their own care.

At the same time, it is imperative for the audiologist to maintain an aura of professionalism. After all, the help seeker and their CP will be relying on the audiologist to guide them through the process of understanding the help seeker's condition and treatment options. It is the audiologist, not the help seeker, nor his CP, who is an expert on diagnosis and treatment. On the other hand, it is the person with hearing loss and CP who has been coping with the consequences of a "problem" for a period of time. To be effective, the audiologist must keep a certain amount of emotional distance. This duality – being warm and hospitable, while maintaining an appropriate professional distance may be one of the most difficult challenges faced by audiologists.

Acknowledging Emotions

Many audiologists find their comfort zone to be confined to conducting a hearing assessment and describing the results to the person with hearing loss. A helpful approach, however, that helps audiologists get beyond their comfort zone, is to talk about the underlying emotions associated with adult-onset hearing loss. Research shows that untreated hearing loss is linked to social isolation, loneliness, and reduced quality of life. See Shukla, et al (2020) for an evidence-based review of these conditions. Some of the emotions associated with social isolation and loneliness include anxiety, fear, agitation, and withdrawal. Because CPs have a strong attachment to their loved one coping with hearing loss, they in turn manifest some of the same strong emotions. It is helpful to think about this relationship between emotions and conditions associated with hearing loss from the person with hearing loss and their CP's point of view. Most persons with hearing loss and CPs are struggling day-to-day with the consequences of hearing loss. Oftentimes they are not well versed in the underlying conditions causing the emotional strife. For this reason alone, it is vital for the audiologist to focus on the emotional struggles associated with the hearing loss, and to be willing to acknowledge and talk about the underlying emotions associated with hearing loss for both parties.

It can be easy to focus on conducting the test and explaining the results, while overlooking the tension that may be building up in the room. When the underlying emotions associated with hearing loss (and perhaps learning for the first time there is a quantifiable problem) are not acknowledged, the audiologist has lost an opportunity to engage the person with hearing loss and their CP. By earnestly acknowledging and addressing these underlying emotions, audiologists can provide a deeper level of engagement. It is this deeper level of

engagement that enables persons with hearing loss and the CP to better adhere to the recommendations that come at the end of the consultation.

The process of acknowledging the emotions in the room starts with the audiologist's ability to have the language (commonly referred to as a 'talk track') to address situations in which tensions are perceived to be rising in the room during an appointment. As a general rule, when acknowledging emotions, audiologists need to use "I" statements. Here are some "I" statements audiologists can use with persons with hearing loss and their CPs to acknowledge the emotions in the room.

- "I sense you feel anxious about that situation you just described. It's ok to feel that way. Let's talk about it some more."
- "I noticed that you nodded your head in disagreement to what he just said. What do you think is happening?"
- "I feel like there is a lot of disagreement between the two of you on his ability to communicate at home with the family. Let's have both of you explain what you are noticing."

Asking Open Ended Questions

When a person with hearing loss and their CP are interacting with the audiologist during the initial consultation, it is an opportune time to discuss the reasons why they decided to go through the hearing evaluation process. After all, many adults with hearing loss wait several years before seeking help. Thus, it is helpful to explore the salient events that prompt their appearance in the clinic for a consultation. Discovering the salient event – an occurrence of significant importance – is a chief reason for asking open ended questions of both the person with hearing loss and their CP, as it allows both parties to tell their story of what brought them into the clinic today, rather than two or three years ago.

Simply asking the person with hearing loss and their CP to tell you why they are now in the clinic seeking help is an effective approach to uncovering the salient events that prompted action. Because salient events are emotional by nature, it is likely asking about them will prompt some of the emotion discussed previously. Here is a sequence of open-ended questions pertaining to discussion of salient events. Note how some of the questions are directed at both the person with hearing loss and their CP.

- What brings you into the office today?
- What brings you into the office today along with Mr. Smith (the person with hearing loss)?
- What is it about that situation that prompted you to schedule an appointment?
- How many years would you say that your ability to hear has been an issue with your wife?
- What kind of activities do you do together?
- How much of a struggle are those activities for each of you?

How Goal Setting is Done in My Practice

In our practice, goal setting is a critical factor in the fact finding and evaluation of communication challenges experienced by both the person with hearing loss and their CP. It all starts with understanding the real-world perspective of both parties. There are at least a few ways in which we go about assessing communication needs and it all starts with the initial interview.

Interviewing the person with hearing loss, and if possible, their CP, is the most effective way for them to talk about what restricts communication and why breakdowns occur. This directs and encourages exploration of possible reasons for challenges in communication and allows them to make statements about their own subjective impression of possible challenges in a variety of settings. We pay close attention to asking open-ended solicitations like, “Tell me about the challenges you face in hearing.” The answers from the persons with hearing loss and their CP will highlight their respective concerns and their own views on problems and situations at hand. This will also give the audiologist a better sense of the degree to which informal conversations are successful for all respective parties. This is a great way to illicit person-specific information. For example, we may find that the person with hearing loss is engaged in lots of meetings at work and that this is something of utmost importance to them.

It is important to be mindful that answers from an interview do not always render themselves well to measurement, and thus may pose a problem when there is a shift in communication behavior because of treatment and rehabilitation, which needs to be documented. Generally, the audiologist should do more listening and less talking during an interview. Keeping close eye contact and listening with genuine interest is key. Asking a person to elaborate on their answer rather than moving on to the next question is a great way

to understand communication difficulties with which the interviewee is struggling. Acknowledging the person’s bravery to come to the clinic to positively change the quality of their own life, and listening to the person with hearing loss without judgement lets them know that we support them.

Another quick and easy way we use to assess communication needs and fluency in conversation is validated questionnaires. They are an excellent tool, designed to collect general information about how often breakdowns of communication occur, and how both the person with hearing loss and their CP attempt to restore those breakdowns. There are a few well-known, short, questionnaires, popular among clinical audiologists, that aim to understand subjective communication challenges faced by both parties. Currently, we use the Hearing Handicap Inventory for the Elderly Screening Version (HHIE-S) as well as a companion questionnaire to find out more about communication barriers and their subjective effect on the person with hearing loss and their CP. The HHIE-S evaluates an older individual’s perceptions of emotional and social effects of hearing loss. It is a short 10-item questionnaire with two subscales for emotional consequences, as well as social and situational effects (Ventry, 1983). The higher the HHIE-S score, the greater the handicapping effect of a hearing impairment. Scores may range from 0 (no handicap) to 40 (maximum handicap). Specifically, the purpose of the HHIE is to pinpoint communication problems, as perceived by the person with hearing loss. Each question is to be answered with YES, SOMETIMES, or NO and it is to be answered according to the way they are hearing without any hearing instruments. The HHIE-S provides a great starting point to the dialogue with the person with hearing loss, without having to have them complete a lengthy or confusing questionnaire. The HHIE-S is also available in many languages. It is an effective tool in assessing the effects of hearing loss on everyday communication, and an effective tool for identifying individuals who are most likely to accept our treatment recommendation. We have found the higher the score on the HHIE-S, the more likely it is for that person to accept our recommendation for hearing aids. Importantly, the HHIE-S is a self-reported inventory and thus appropriate for individuals without cognitive deficits who can verbally or in a written form respond to the questions.

For the CP, we counsel and give tutorials on communication strategies that help them more effectively communicate with the person with hearing loss. Behaviors such as keeping their face visible to the person with hearing loss will allow them to see and use all the visual cues available to them. Additionally, strategies like keeping a slight pause between the content

In a situation in which one party begins to blame the other for their shortcomings, intervene by asking the person with hearing loss and their CP to explore solutions to the problem, rather than find blame.



sections of sentences will allow the person with hearing loss to process the speech in chunks. Oftentimes, simulating the hearing loss for CPs (using loudspeakers in the exam room) helps them appreciate the challenges of hearing loss.

Finally, we ask the CPs to try to get the listeners' attention before starting a conversation and to control their listening environment (for all parties involved) by moving closer to the person with hearing loss. We also remind them to avoid poorly lit environments and places with higher levels of background noise. Finally, having a plan and anticipating adverse listening environments such as having CPs communicate with the staff in a loud restaurant instead of the person with hearing loss will afford more ease in communicating and less frustration trying to understand speech in such acoustically demanding spaces. Effective communication strategies such as the abovementioned tools, techniques, and goals can enhance and accelerate the hearing aid acclimatization process for both parties.

Reframing

A by-product of facilitating a conversation, using open-ended questions, is that some individuals may feel the need to blame the other party for their own personal failure. For example, a CP, when asked to discuss her frustrations with her husband's (person with hearing loss) inability to turn down the TV or willfully ignore people, may express real feelings of resentment and frustration toward their partner. The person feeling frustrated or resentful might even take an accusatory stance toward the other person and begin to blame them for a deteriorating relationship. When the tension in the room begins to become too great and one party begins to blame the other, it is essential for the audiologist to reframe the conversation.

Reframing is the audiologist's ability to intervene and guide the dialogue toward more positive ground. In a situation in which one party begins to blame the other for their

shortcomings, the audiologist can intervene by asking the person with hearing loss and their CP to explore solutions to the problem, rather than find blame. In other words, the audiologist asks both parties to look for solutions to improving communication-related quality of life issues rather than dissecting the problems as a personal failure on the part of either the person with hearing loss or their CP. Here are some reframing statements that help move the dialogue toward a solution.

- “I understand how frustrated you are. Let’s look at the future and how we can improve the situation.”
- “Now that each of you has had a chance to tell your side of the story, let’s find some ways we can work together to make it better.”
- “Let’s brainstorm some possible solutions to this problem so you feel better prepared to handle it when it happens again.”
- “No one is perfect. I am sure we can all agree on that, but now I want us to explore how each of you are impacted by his hearing loss and how we can improve family life at home. “
- Let’s work together to find ways to solve this problem so it is less likely to happen in the future.”

Opportunities to Involve Both Parties

In addition to getting the person with hearing loss and their CP involved during the initial consultation there are other times that provide opportunity for engagement. Here are some opportunities to deepen the level of engagement between the person with hearing loss and their CP after the first appointment.

It seems to be a common practice for audiologists to call a person with hearing loss 24-to-48 hours after a hearing aid fitting appointment. The purpose of the call is to check in with them and monitor for any problems that may preclude the person with hearing loss from using their hearing aids until the next scheduled appointment with the audiologist. This scheduled phone call is also an opportunity to ask the person with hearing loss if they have any questions about expectations or initial hearing aid use.

A wrinkle that can be added to this approach is to include the CP on the follow-up call. By including both parties, the audiologist gets instantaneous feedback from the person who typically spends the most time with the person with hearing loss. Involving the CP can be easily accomplished by using

video conferencing technology, such as Apple Facetime or Skype. Unlike an audio-only phone call, video conferencing allows for both parties to participate more actively in the dialogue with the audiologist in a way that better simulates the face-to-face appointment. The audiologist can set the stage for the follow-up call by scheduling this video conference at the end of the fitting appointment. During the video conferencing appointment, the audiologist aims questions at both parties, and much like the face-to-face appointments, encourages both to “tell their side of the story.”

Coaching on Technical Matters

Initial hearing aid use can be overwhelming for many persons with hearing loss. Not only is the process of acclimating to new sounds challenging but there is a considerable amount of technical information to absorb. Everything from Bluetooth streaming to remote fine-tuning and smartphone-based apps add additional complexity to the learning process. Given the abundance of information to learn, it is easy for some persons with hearing loss to become overwhelmed and give up on using their devices. Including the CP in the further acquisition of technical knowledge about hearing aid use, affords the person with hearing loss another individual they can rely on if they have a question. In addition to teaching the CP about the technical details of how to clean hearing aids, change the batteries, etc., the CP can be taught how to answer periodic technical questions that might arise by first seeking information on-line.

Four Key Areas of Dialogue

There are four areas of importance which present challenges for the CP: 1.) The broad-ranging effects of hearing loss on the CP’s everyday life, 2.) The CP’s need to constantly adapt to their partner’s hearing loss, 3.) The effect of acceptance of the hearing loss on the CP, and 4.) The impact of the hearing loss on aging and retirement. Given that these areas have an impact on the CP as well as the person with hearing loss, many of the tactics outlined in this tutorial will help improve overall engagement in the process of remediating the consequences of hearing loss. Let’s take a look at each of these four areas in greater detail.

The most successful audiologists intuitively know that their ability to ask open-ended questions in an authentic manner is a cornerstone of their effectiveness. By involving both the person with hearing loss and their CP in the process of discussing these four areas, the audiologist will likely foster a deeper level of engagement with both parties.



The most successful audiologists intuitively know that their ability to ask open-ended questions in an authentic manner is a cornerstone of their effectiveness.

1. The Broad-Ranging Effects of Hearing Loss on the CP's Everyday Life

Pose questions to the help seeking individual that allows him to elaborate on the impact of his hearing loss on the CP's day-to-day existence. For example, the audiologist may ask, "Take me through a typical day. Tell me about how you think your hearing loss might affect your spouse?"

2. The CP's Need to Constantly Adapt to Their Partner's Hearing Loss

A second line of questions can be directed to the CP. By asking the CP to discuss how they have adapted or modified their daily routine to accommodate the help seeker's hearing loss, the audiologist may help the person with hearing loss better understand the impact of hearing loss on the CP.

3. The Effect of Acceptance of the Hearing Loss on the CP

The audiologist can begin to paint the picture of what successful remediation of hearing loss looks like by asking the CP what day-to-day living would be like if the person with hearing loss were to have improved hearing. When the audiologist asks the CP to discuss what the future might look like if the help seeker had better hearing and communication ability, the process of acceptance is more likely to begin.

An example of a line of questioning around this issue might be for the audiologist to ask the CP, "What would it be like if [Name] was able to carry on a conversation at your favorite restaurants with much less difficulty, or if you could watch TV together and hear almost every word when the volume is at a comfortable level for you....how would you feel if we could help [Name] hear better in this important situation?"

4. The Impact of the Hearing Loss on Aging and Retirement

A final line of questioning is also related to the audiologist's ability to help the person with hearing loss and their CP paint the picture of a future in which hearing loss does not cause emotional strain. By querying both parties about a future that does not involve having to cope with untreated hearing loss, a deeper level of engagement can be obtained. By

asking both parties to talk about a life in which the struggles associated with hearing loss are overcome, the audiologist is able to help them focus on taking active measures to improve communication in places they deem important.

The initial consultation with the person with hearing loss and their CP is a golden opportunity to begin the goal sharing process. The ability of the audiologist to include both parties in the process of goal setting is predicated on the audiologist's ability to ask thoughtful open-ended questions to the patient and their CP. Through curiosity and authenticity, the audiologist can create a dialogue with both parties that builds trust and culminates in more successful outcomes. Applying the four principles of Goal-sharing for Partners Strategy (GPS) along with several of the other patient centered strategies, outlined in this article, goes a long way toward activating persons with hearing loss and their CP on their shared journey towards acceptance of their condition. ■

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IMPLEMENTING

BLOCK Scheduling

Work Smarter, Not Harder:

A CASE STUDY

Zach Malone and Ron Patton

Block scheduling is a method of creating a work schedule in which the workday is divided into blocks of time and each block is assigned a specific type or sub-type of activity. This framework not only ensures that critical, revenue-generating tasks are given the necessary resources to be completed, but it also provides an infrastructure to quickly alert management if a clinician or practice is falling short of projected to financial targets.

THE GOAL OF THIS CASE STUDY IS TO DEMONSTRATE THE UTILITY OF BLOCK SCHEDULING AND HOW IT HELPS A PRACTICE BETTER MANAGE TIME SPENT GENERATING REVENUE.

What is block scheduling?

Block scheduling is a method of creating a work schedule in which the workday is divided into blocks of time and each block is assigned a specific type or sub-type of activity (i.e. hearing aid evaluation, private pay hearing aid evaluations, third-party hearing aid fitting fee, check & clean, outbound calling, etc.). The level of detail for each block category can be tailored to an individual practice, but the overarching goal of block scheduling remains constant: To ensure there is necessary time to complete a given business activity and to safeguard that each clinical task is completed in a way that meets business objectives. Completing revenue-generating activities in a timely way, while setting aside sufficient time to complete other necessary work that keeps the practice operating smoothly, is referred to as efficiency. At its core, block scheduling is a proven way to efficiently manage time, a practice's most precious resource.

To clarify the point that time is a practice's most precious resource, let's review an example. Say that a practice has significantly increased the number of patients it has seen this year, compared to the previous year, but the amount of revenue has decreased. A likely cause of this revenue shortfall is the increased use of third-party insurance contracts, which tend to have smaller gross margins. As this case study attempts to demonstrate, the use of block scheduling is an effective strategy that manages this common challenge.

The block scheduling process enables a practice to attain business goals by being more efficient with how time is spent. Appointment time is set aside for appointments that tend to generate ample revenue. Additionally, this process of establishing block schedules breaks down the important annual financial goals into the daily necessary steps or subgoals. Because the annual revenue goals are broken down into daily subgoals, managers will quickly be alerted to any deviations to the plan. With the alerts being executed in real-time, management can quickly take corrective actions to get the business back on track to meet goals.

Another helpful practice that uses similar mechanics to block scheduling is called reverse block scheduling. This process helps limit specific activities that, when in overabundance, can hinder or prevent a practice from meeting its financial goals. One example of reverse block scheduling is capping the number of hearing aid evaluations involving third-party contracts or hearing aid check-ups, which generate less revenue, to a certain number per week. Of course, all patients are important, but a practice must balance financial solvency with other commitments that serve the needs of the entire community. The use of reverse block scheduling (capping the number of low-revenue appointments each week) ensures there is sufficient time on the schedule for more lucrative private pay opportunities.

Let's examine how different types of revenue-generating appointments affect net revenue. Figure 1 shows a breakdown of Clinic X's revenue for the past four years. Comparing 2021 to 2018, the managers were surprised to find that despite an 88% increase in the number of hearing aids fit, the total revenue has dropped by almost 3%. The practice manager can observe from the financials shown in Figure 1 that the disappointing revenue number comes from a combination of a higher percentage of fitting fee patients and a declining average selling price per hearing aid. Note that fitting fee revenue is generated from third-party contract sales.

Figure 1: Clinic X Annual Hearing Aid Net Revenue Breakdown

	Total Hearing Aids Fit	Fitting Fee Hearing Aids	Private Pay Hearing Aids	Total Revenue	Fitting Fee Revenue	Private Pay Revenue
2018	147	10	137	\$373,550	\$3,523	\$370,027
	100.00%	6.80%	93.20%	100%	0.94%	99.06%
2019	229	137	92	\$308,917	\$71,352	\$237,565
	100.00%	59.83%	40.17%	100.00%	23.10%	76.90%
2020	203	99	104	\$251,786	\$43,400	\$208,386
	100.00%	48.77%	51.23%	100.00%	17.24%	82.76%
2021	277	117	160	\$362,994	\$52,038	\$310,956
	100.00%	42.24%	57.76%	100.00%	14.34%	85.66%

The managers in this practice are aware of tactics to improve the average selling price but wanted to implement block scheduling to mitigate the increasing number of patients using third-party payment options to ensure they would meet revenue targets. Moreover, the managers wanted to develop a plan for identifying when the practice falls short of revenue targets throughout the year. The goal being to allow for enough time to make any adjustments to operational tactics (e.g., monthly promotions, new marketing programs) with sufficient time to execute these changes in plans.

Next, we demonstrate in a step-by-step manner how a block scheduling approach with the goal of optimizing revenue from the sale of hearing aids was implemented in this practice.

Step 1: Block Scheduling Pre-Work

Prior to implementing a block schedule, the practice manager must gather the necessary datapoints outlined in Figure 2.

Figure 2: Block Schedule Planning Pre-Work

Scheduling Blocks	Case Metric
Recurring Meetings	.5 hours/week for FOS 1 on 1
Priority Tasks	1.5 hours/week for Physician Outreach 1.5 hours/week for Outbound Calling
Administrative Time	.5 hours/day
Appointment Lengths	1.5 hour/Hearing Aid Evaluation 1.0 hour/Fitting 1.0 hour/Follow Up (.5 hour x 2)
Provider Hours	8am to 5pm w/ 1 hour for lunch break
Key Performance Indicators	Case Metric
Effectiveness Ratio (ER) or Provider Conversion	1.3
Average Selling Price (ASP)	Private Pay: \$2,800 Fitting Fee: \$500
Attrition Rate	30%
Annual Revenue Targets	Case Metric
Net Hearing Aid (<i>Private Pay Only</i>)	\$500,000

Recurring Meetings are those necessary scheduled staff interactions that occur on a regular cadence. Because these meetings are necessary to the business function, a block of time should be reserved on the schedule to ensure they will occur as needed. In the instance of this case study, the manager has dedicated 30 minutes a week for a 1-on-1 meeting with the front office Patient Care Coordinator.

Priority Tasks are those necessary tasks that occur on a regular cadence. Because these tasks are necessary to the business function, a block of time should be reserved on the schedule to ensure they will occur as needed. In the instance of this case study, the manager has dedicated 1.5 hours a week for Physician Outreach and 1.5 hours a week for Outbound Calling.

Administrative Time gives a provider the opportunity to catch up on patient notes. Since each patient's needs and appointment circumstances are unique, allotting time to making sure a patient's record and subsequent databases are up to date will ensure smooth business operations and minimize negative impacts to the business operations. In the instance of this case study, the manager has dedicated 30 minutes each day for Administrative Time.

Appointment Lengths are the length of time it takes to treat a patient for a specific need. In the instance of this case study, the manager has allotted 1.5 hours/hearing aid evaluation, 1.0 hours for hearing aid fitting and two 30-minute follow up appointments per patient.

Provider Hours are the hours in which patients are seen by providers. In this case study, the manager has determined patients can be seen between the hours of 8am and 5pm with a one-hour lunch break from 12:00 p.m. to 1:00 p.m.

Effectiveness Ratio (ER) or Provider Conversion is the rate at which a patient with a treatable hearing loss or condition agrees to move forward with amplification as part of their treatment plan. This metric can be calculated by dividing the number of hearing aids fit by the number of opportunities seen. The highest ER a provider could receive is a 2, because a provider can fit a typical treatable patient with 2 hearing aids (1 for each ear). In the instance of this case study, the Effectiveness Ratio is 1.2, meaning the provider fits, on average, each treatable patient with 1.2 hearing aids.

Average Selling Price is the mean price paid per hearing aid, inclusive of any bundled service (i.e. hearing aid evaluations, fittings, follow ups, clean & checks). In the instance of this case study, the manager’s ASP for a patient utilizing private pay at \$2800. The manager has opted to not take third party or fitting fees, because the ASP has historically been a small fraction of private pay.

Attrition Rate is defined as the rate at which a scheduled appointment does not result in a treatable patient. Attrition can happen for several reasons, but predominantly include: 1) The patient cancels the appointment without rescheduling and the previously reserved time slot cannot be filled, 2) The patient unexpectedly does not show up to the appointment, or 3) The hearing aid examination concludes the patient does not require treatment. In the instance of this case study, the attrition rate is set at 30%.

Net Hearing Aid Revenue Target is the revenue target minus any refunds, returns or discounts. A best practice for calculating this number is to work with a financial planner or CPA to protect against setting a revenue goal that will exceed business expenses and account for the desirable level of profitability.

Step 2: Calculating the Targets

Once the datapoints are collected in Step 1, they are used to complete the calculations for the following targets in Figure 3: Weekly Scheduled Appointments, Weekly Fitting Appointments, and Follow Up Appointments. Figure 4 shows the results of these calculations with the datapoints completed.

Figure 3: Target Formulas

Target: \$500,000 Annual Net Revenue (100% Private Pay)

Calculation for Weekly Scheduled Appointments Target	
Net Revenue Target / Number of Provider Weeks per Year = Weekly Net Revenue Target	\$500,000 / 52 = \$9,615.39
Weekly Net Revenue Target / Average Selling Price = Weekly Hearing Aids Sold Target	\$9,615.39 / \$2,800 = 4 (Rounded Up from 3.43)
Weekly Hearing Aids Sold Target / Effectiveness Ratio = Weekly Opportunities Target	4 / 1.3 = 3 (Rounded Down from 3.08)
Weekly Opportunities Target * (1+ Attrition Rate) = Weekly Scheduled Appointments Target	3 * (1+.3) = 4 (Rounded Up from 3.9)
Calculation for Weekly Fitting Appointments Target	
Weekly Hearing Aids Sold Target / 2 Ears = Weekly Fitting Appointments Target	4 / 2 Ears = 2
Calculation for Follow Up Appointments Target	
Weekly Fitting Appointments * # of Follow Up Appointments Offered per Patient = Weekly Follow Up Appointments Target	2 * 2 = 4

Figure 4: Clinic X Data

Step 3: Creating the Block Schedule

Now that all the components for the block schedule have been created, the block schedule can now be filled in with the blocks. The order in which blocks are placed should be dependent on the practice’s needs and schedule of staff. A common practice is to distribute patient filling blocks at a variety of times and days during the week to give patients as many options as possible.

Although the block schedule should ultimately reside in the practice's Office Management System (OMS), Figure 5 represents an example of a working draft to create a variety of block schedule options for consideration. To summarize, the below bullet points are blocks that need to be added to the schedule and Figure 6 represents a completed block schedule.

Figure 5: Blank Block Schedule Template

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00am					
8:30am					
9:00am					
9:30am					
10:00am					
10:30am					
11:00am					
11:30am					
12:00pm					
12:30pm					
1:00pm					
1:30pm					
2:00pm					
2:30pm					
3:00pm					
3:30pm					
4:00pm					
4:30pm					

Figure 6: Clinic X Block Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00am					
8:30am	Staff 1-on-1			Hearing Aid Evaluation	
9:00am					
9:30am					
10:00am		Outbound Calling			
10:30am					
11:00am			Hearing Aid Evaluation		
11:30am		Fitting			
12:00pm	Lunch Break	Lunch Break	Lunch Break	Lunch Break	Lunch Break
12:30pm					
1:00pm				Fitting	
1:30pm	Hearing Aid Evaluation				
2:00pm					
2:30pm				Physician Outreach	
3:00pm		Hearing Aid Evaluation			
3:30pm					
4:00pm					
4:30pm	Admin Time	Admin Time	Admin Time	Admin Time	Admin Time

Recurring Meetings

- Weekly 5. Hour 1-on-1 meeting with Front Office Staff
- Daily Lunch Break from 12pm to 1pm

Priority Tasks

- Weekly 1.5 Hours for Physician Outreach
- Weekly 1.5 Hours for Outbound Calling

Administrative Time

- Daily .5 Hour Administrative Time for Provider

Appointment Blocks

- 4 – 1.5 Hour Hearing Aid Evaluations
- 2 – 1 Hour Fitting Appointments
- 4 - .5 Hour Follow Up Appointments

Step 4: Implementing the Block Schedule

In most instances, a practice will already have an established way of managing the schedule and many demonstrate reluctance or even resistance to the new approach. Therefore, staff must be reminded that scheduling is a three-phase process that allows the practice to use their time more efficiently.

In Phase 1, the manager should create a sense of urgency around block scheduling, emphasizing the importance of executing this new program as seamlessly as possible. The manager can emphasize this point by assembling a strong guiding team and providing a clear vision of how block scheduling optimizes productivity by working through some financial projections when block scheduling is fully realized.

In Phase 2, the manager should work to reinforce the new process. If staff sees the new process as a success, they will more quickly adopt the process and be advocates of the process themselves. If the manager has successfully laid out a clear vision of how block scheduling works, it should help block scheduling gain traction and support among staff. Lastly, the manager should try to over-communicate. New processes can create uncertainty for staff, so frequent feedback from the manager on what staff are doing well and what they need to correct will be extremely beneficial during this phase.

Finally, Phase 3 is when the block scheduling process becomes established. Staff know their responsibilities and executing necessary action items goes off without a hitch. The most common challenge during this phase is complacency. It is crucial to keep the momentum of fully integrating block scheduling into the practice and correct any behaviors that embody the old practices. A best practice is regular reporting or checking in with staff, especially those who have questions about the implementation of block scheduling.

Block Schedule Implementation Strategy

PHASE 1: UNFREEZE
PHASE 2: TRANSITION
PHASE 3: REFREEZE

Step 5: Managing and Maintaining the Block Schedule

The most common management challenge in block scheduling is what actions to take when marketing and business development efforts fail to fill a block. A common practice for addressing this challenge is utilizing the 24- or 48-hour rule. The rule functions as an alert to the team member, in charge of the schedule that requires action, to fill an empty block that is open 24 or 48 hours *prior* to the actual appointment time. An example of some actions that could be taken include inquiring with patients who have a later scheduled appointment to see if they could come in earlier. Another option is to move the block to another date. This new date should be in addition to any other existing blocks. The decision as to whether the block should be 24 or 48 hours, is up to the practice and should be aligned with whichever timeframe is most effective for the practice.

Another common challenge is that blocks do not line up exactly with patients' desired appointment times. This is a perfect example to highlight that blocks are flexible. Although blocks should not be deleted, they can be moved to accommodate a patient's schedule so long as the time slot is not otherwise filled with other appointments.

Finally, any block-scheduled activities that have an impact on finances should be re-evaluated when budgets and targets are being set for the following year or financial timeframe. As financially based blocked schedules are established to meet financial targets, it makes sense to adjust your block schedule accordingly. For example, in a practice that does a mix of private pay and third-party contract business, it is prudent to have separate blocks for each. When open time slots are available, the more lucrative business would get first priority when filling the appointment time.

As the practice progresses through the year, monitoring progress is critical for success. There are often solutions to the challenges of block scheduling, but time is often the limiting factor that leads to failure to meet financial targets. In addition to using the 24- or 48-hour rule, progress should be reviewed on a weekly and then monthly basis. The key is identifying any deviation from financial targets as soon as possible. A reporting template should include weekly progress, year-to-date progress, as well as deviations from goals and projections, based on actual progress within the given time period.

Although a well-configured block schedule can help a practice meet its financial targets, the review of progress and accompanying key performance indicators (KPIs) will help a manager identify the types of corrective actions necessary for any deviations from targets. Any deviations from target will usually fall under one of the below scenarios.

Effective Management of the Block Schedule

There are several potential problems that can occur with a block schedule. Each of problems listed below are an opportunity for managers to provide feedback and coaching that will address the problem in a forthright and professional manner.

1. Cannot Fill Time Blocks

- Weekly Review
 - » If a practice is struggling to fill a block in the 24- or 48-hours prior to the appointment, a best practice is to reach out to patients scheduled out in the future to see if they would like to come in earlier. This will create more time for the practice to fill a later block.
- Monthly Review
 - » If the practice is struggling to fill blocks on a consistent basis, the practice will want to evaluate marketing and outbound calling efforts to see if there are opportunities for generating more flow of patients into the office. It is not uncommon for a practice to have a month below target, but marketing and outbound calling efforts should be escalated until targets are being met.

2. Effectiveness Ratio Drops

- Weekly Review
 - » If provider conversion drops below the value used for calculating the block schedule, no immediate action is required as deviations are expected.

- Monthly Review
 - » If the practice is struggling to convert patients on a consistent basis, the practice will want to evaluate training or professional development efforts to see if there are opportunities for the provider to help the patient overcome objections to treatment. It is not uncommon for a provider to have a month below target, but training or professional development efforts should be escalated until targets are being met.
 - » There is no one right answer to the decision on the ratio between private pay and third party/fitting fee patients, however this ratio should be reviewed each month.
 - » When working with a CPA or a financial advisor to calculate the net revenue targets, a best practice is to review one's personal, professional, and financial goals every few months. Although it may be tempting to set an aggressive revenue goal, a packed schedule may cause personal and other professional goals to become diminished or fall by the wayside completely.

3. Average Selling Price Drops

- Weekly Review
 - » If the Average Selling Price of Hearing Aids drop below the value used for calculating the block schedule, no immediate action is required as deviations are expected.
- Monthly Review
 - » If the practice is struggling to stay at or above Average Selling Price on a consistent basis, the practice will want to implement provider training or professional development efforts to see if there are opportunities for the provider to see the value in the services they provide to the patient. It is not uncommon for a provider to have a month below target, but training or professional development efforts should be escalated until targets are being met.

Leverage block scheduling to complete those tasks that are most frequently put off or never completed. By setting aside specific time slots to get those less than desirable tasks done, a practice will be less likely to set aside these tasks in lieu of more desirable or easier ones that are not a practice priority.

4. Too Many Appointments

A scenario where there is an overabundance of the desired appointment doesn't require any corrective action but should serve as a warning to managers to be on the lookout for complacency among staff that block scheduling is ineffective or no longer needed. A block schedule may seem irrelevant, or even unnecessary, when the schedule is full, but it is imperative to remember that a block schedule will alert a practice to any adverse changes – even ones that are so gradual that a practice staff may not notice the decline in performance until it has become severe. The bottom line is that effective management of several financial objectives begins with careful and deliberate implementation of block scheduling. This is because time can never be replaced and remains our most precious resource.

Caveats to Block Scheduling

Block Scheduling is a powerful tool to help manage time, but it is not recommended for every type of appointment or activity. As block scheduling requires ongoing monitoring and maintenance, it is a best practice to save block scheduling for critical business tasks. Minimizing tasks for block scheduling also reinforces the level of importance the block schedule and associated monitoring and maintenance tasks are to the business. A few of the tasks not recommended for block scheduling include:

- Repairs
- Clean & Checks
- Annual Hearing Tests
- Warranty Checks
- Diagnostic Test

Time should be set aside each week for walk-in patients or the provision of virtual care.

The primary benefit of block scheduling is to help a practice reach financial goals and more effectively manage time. Any task that is critical to a business' success is a candidate for block scheduling. The following tasks should be considered for block scheduling:

- Recurring Meetings (Team Member 1-on-1's, Staff Meetings)
- Priority Tasks (Outbound Calling, Patient Follow Up Calls)
- Administrative Hours (report writing, billing)
- Hearing Aid Evaluations
- Fittings
- Follow-up appointments
- Annual hearing checks

Any task, when done in excess, can detract from the success of the business. In an audiology practice, an appointment type that has a low margin or causes the practice to lose money, could be considered for reverse block scheduling. In our experience, adoption is the most common challenge associated with block scheduling. A best practice for addressing this challenge is through a robust implementation that includes a strong guiding team, a clearly articulated vision, and a sense of urgency. These elements are reinforced through consistent and clear communication about expectations and results. A team should also be empowered to act when the plan needs to be calibrated to meet targets — a process that starts with clear-eyed effective management leading a productive staff. ■

Zach Malone and Ron Patton are operations managers for Audigy.

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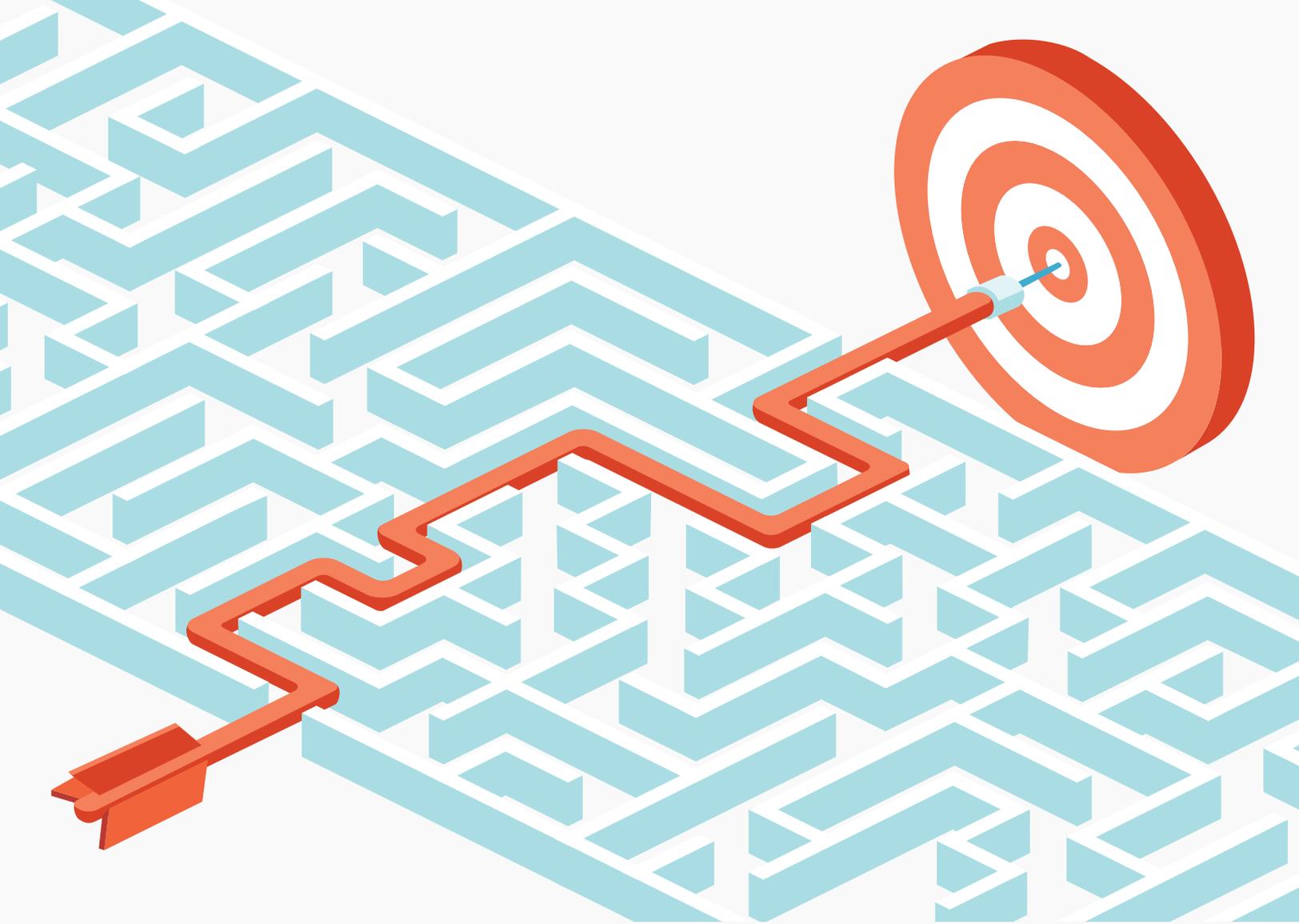
Strategic Plan:

Implementing Hearing Screenings during Health and
Wellness Appointments for Individuals 55 years and Older

Lexi Rozycki

It is often said that hope is not a strategy.

Even though most audiologists do not have any formal business training, it is a mistake for them to simply hope their business operation will improve. That is where careful, deliberate, and systematic strategic planning comes in. Strategic planning, when completed periodically, requires us to look into the future and use data, often collected from numerous sources, to create a plan that will narrow a financial gap, start a new program, or improve the performance of some existing element of the business.



This case study is one such example of how strategic planning can be used to create a new revenue stream – one that taps into an unmet need of the market that could be better served by an audiology practice. It is meant to serve as an example of how entrepreneurial audiologists can do more than hope; they can create a plan and then work the plan they have created. Let this case study serve as a template for others who may be looking to expand their practice or close a service gap in their community.

The Executive Summary

Miami Multispecialty Clinic has been a staple of the community since 1987. Over the years, the relationship between patients and providers has only grown and has allowed for the quality patient care to improve. However, based upon customer reviews and feedback, there is room for the company to grow and excel even further. Current patients report there is a deficit in the interprofessional relationship regarding the care they receive from several of the departments with our clinic. This statement is supported by Net Promoter Score data, collected over the past three years. The number of net promoters of our practice (those circling an 8-10 on a satisfaction survey) has dropped from 82% in 2020 to 74% in 2023.

As the largest multispecialty clinic in southern Florida, doctors and clinical professionals should have stronger relationships and a better internal referral system between departments. We believe improving this referral network will improve the Net Promoter Score. Within the Audiology department of the Miami Multispecialty Clinic, we believe we can improve transitions of patient care from the primary care provider (PCP) to the Audiology department. By training PCPs on the importance of hearing health and providing a specified room for hearing screening for patients coming from PCP appointments for a screening, we believe we can not only increase clientele for the Audiology department but improve the quality of life of the aging population.

Mission Statement of the Miami Multispecialty Clinic Audiology Department

To provide high quality hearing/balance testing and treatment as part of a holistic healthcare plan derived by an interdisciplinary team in a singular and convenient location for individuals regardless of any and all cultural backgrounds.

Target Customers and Industry Analysis

Age-related hearing loss (presbycusis) is a common factor associated with aging. There have been studies linking hearing loss with diabetes, vascular disease, depression, stress, and social isolation (Souza 2014).

With healthy aging, there is often cognitive decline that results in a decrease of long-term memory, working memory (processing and storage during listening), processing speed (time necessary to evaluate and assign meaning to changing acoustic signals), and executive function (ability to direct attention and ignore extraneous information). All these cognitive processes are vital to communication. In addition to aging, these factors can decline more rapidly when there is a hearing loss. Additionally, there has been epidemiology data that has shown hearing loss is associated with an increased risk of cognitive decline and/or dementia. The association persists even after controlling for hearing related conditions (Souza 2014).

Despite the known risks associated with age related hearing loss, the average time it takes for an individual to seek an appointment after noticing a decline in their hearing is about seven years. Additionally, the average age of first-time hearing aid users is 70 years old (Adirondack Audiology 2020). However, there is a significant portion of the population who will experience a hearing loss before they seek out a hearing examination or hearing aids. Table 1 below lists prevalence data of the percentage of hearing loss with different age demographics:

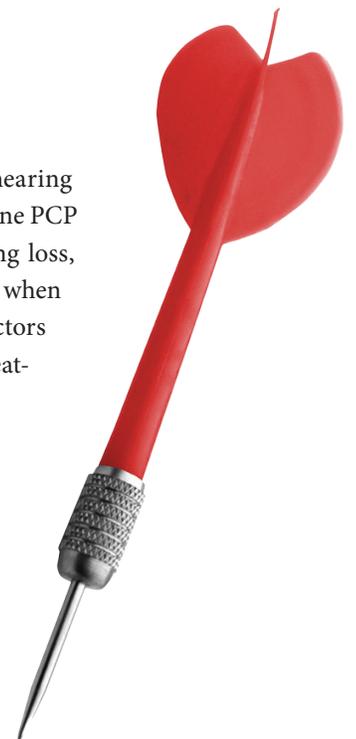
Age	Prevalence of Hearing Loss within the Age Group
55–64 years old	8.5%
65–74 years old	25%
75–84 years old	50%
85+ years old	80%

Table 1. Prevalence of hearing loss as a function of age.

Data source: <https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing>

Due to time constraints and a general lack of knowledge, PCPs often play a minimal role in hearing loss identification and treatment (Souza, 2014). By implementing hearing screening during routine PCP appointments once a year for individuals 55 years of age and older, with no identified hearing loss, Miami Multispecialty Clinic Audiology Department will be able to assist the aging population when hearing loss initially begins to occur. We believe this will help minimize health-related risk factors associated with hearing loss and increase the quality of life for patients who decide to forego treatment for hearing loss.

During a recent monthly staff meeting, the Miami Multispecialty Clinic Audiology Department conducted a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis in which all team members participated in creating. Note that this SWOT analysis was essentially a brainstorming session in which staff, lead by the department's director, agreed on the various outcomes summarized in Figure 1. The results of the SWOT analysis are shown in Figure 1.



<p>Strengths</p> <p>Experienced audiologist and supporting staff completing screenings and further testing and fittings.</p> <p>Business relation between the PCP and audiology department exist as we are within the same multispecialty clinic</p>	<p>Weaknesses</p> <p>Currently, the professional relationship with PCPs is weak, as there is little formal communication between the departments.</p> <p>Apathy and indifference of middle aged adults on the consequences of hearing loss</p>
<p>Opportunities</p> <p>Grow the current clientele in the clinic by reaching individuals who would not have sought out a hearing test and hearing aids themselves</p> <p>Provide hearing aids to those who are more at risk for cognitive decline</p>	<p>Threats</p> <p>PCP may be hesitant to refer patients without an existing concern for hearing.</p> <p>PCP ignore the consequences of untreated hearing loss or begin referring outside the clinic.</p>

Figure 1. SWOT Analysis

Implementation Strategy

To create a referral service from the PCP department to the Audiology department. Audiology staff listed a series of steps that need to be completed:

1. Purchase Equipment and Set up Screening Area
 - a. Area for Screenings
 - i. Unused exam room on the first floor of the Audiology department.
 1. The exam room already contains an audiometer for screenings.
 - b. Equipment needed for screenings:
 - i. Audiometer and supra-aural headphones
 - ii. Otoscope and Speculums
3. Conduct Training Session for PCPs
 - a. Lunch & Learn with PCPs
 - i. Creation of Material to inform PCP on the importance of hearing screenings, and how referrals will benefit their patients.
 - ii. Have one audiologist lead an hour-long lunch and learn to train PCP and begin implementation of PCPs.
3. Hire and Train a Lab Technician to Complete the Hearing Screenings
 - a. A lab technician can be trained to implement hearing screening effectively. This would be their primary role, as well as documenting those who need to be contacted by supporting to set up a hearing evaluation.
4. Hire an Audiologist to support the influx of patients from the hearing screenings
 - a. Due to a steady increase of new referrals from the screening program, a new audiologist will need to be hired to meet demand.
5. Implement Coding and Billing Revenue Model
 - a. PCP will need to refer and bill for a hearing screening during their appointments.
 - i. CPT 92551: "Screening test, pure tone, air only"
 1. Medicare does not reimburse for screenings.
 - b. If a hearing screening is failed, there will need to be a hearing evaluation.
 - i. CPT 92557: Comprehensive audiometry threshold evaluation and speech recognition
 - c. If there is a hearing loss, the patient will likely need to purchase hearing aids.



The timeline to complete each step is as follows:

1. Equipment purchased and screening area set-up: 1 week.
2. Training for PCPs, conducted by audiologists: 30 days, on-going
 - a. Creation of Materials: 1 Hour
 - a. Lunch and Learn: 1 Hour
3. Hire/Train technician: 30 days
4. Program is up and running, collected revenue: 60 days
5. Breakeven by end of first year of program's inception

Estimated Revenues

To begin calculating potential financial projections, we need to determine the demographic of the aging population. Table 2 below breaks down Miami's population into four main age demographics (55-64 years, 65-74 years, 75-84 years, 85+ years). Next, we isolated the percentage of individuals with a hearing loss based on the Miami population data categorized by age. The following percentages were used to determine how many patients would have not been identified with and treated for a hearing loss if not for the PCP hearing screening referral program.

Age (years)	% of Miami Population (Miami Matters, 2022)	% With a Hearing Loss (NICDC, 2021)
55-64	13.11%	8.50%
65-74	9.5%	25.00%
75-84	5.5%	50.00%
85+	2.43%	80.00%

Table 2. Estimated prevalence of hearing loss by age in Miami area.

The following calculations are based upon the number of PCP patients seen within the multispecialty clinic. An average multispecialty clinic ranges from 12-20 PCPs. In the Miami area, the average clinic has ~15 PCPs, which will be the number used for this analysis. Per PCP, the number of patients they see per year is 1500-2000 people. This allows for a range of 22,500-30,000 seen by a single multispecialty clinic.

Additionally, 15-20% of adults who could benefit from hearing healthcare services are currently not receiving them. (Dubno et al., 2022). This number will be important when determining the number of patients being seen who have a hearing loss and are being treated versus those who are unidentified and not being treated for a hearing loss. For this scenario, we will be using the low end of the estimate, 15% when making our estimates.

Next, we estimated the total number of patients seen in the clinic who are 55 years of age and older, and the total number of the individuals likely to have hearing loss. We started with taking the percentage of each age group of the Miami population and multiplying it by our population size, 22,500, to estimate the number of patients in each age group that we see in the clinic. From here, each age group is multiplied by the demographic of the percentage of individuals in each age group who are anticipated to have a hearing loss.

These estimates are shown in Table 3.

Age (years)	Number of Patients in seen in clinic (% of Miami Population x 22,500)	Number of Patients with hearing loss (# of pt. in clinic x % with a HL)	Number of Patients that would NOT have been helped (# of pt. with HL x 15%)
55-64	2950	153	23
65-74	2138	447	67
75-84	1238	534	80
85+	574	380	57
	Number of patients >55 seen in clinic: 6872	Number of Patients with a hearing loss: 1514	Number of Patients whose hearing loss has not been identified: 227

Table 3. Projected number of total patients seen in the clinic for screening (left column), total number of patents projected to have hearing loss identified by screening (middle column) and projected number of patients identified with hearing loss that would not have been helped without hearing screening program (right column). The three columns are broken down by age.

We now have the number of patients aged 55 years and older seen in the clinic by a PCP, those with a hearing loss in that group, and the number of those who do not know they have a hearing loss, but were identified because of the hearing screening program. From this, we can start calculating the number of patients who need to be screened. When looking at who needs to be screened, we only want to screen those who do not have a known hearing loss. We can get this number by calculating the following:

$$\begin{aligned}
 &(\# \text{ of pt. } 55 > \text{ seen in clinic}) - (\# \text{ of pt. with a HL} - \# \text{ of pt. whose HL has not been identified}) = \# \text{ of pt. with known HL} \\
 &(6,872) - (1841 - 227) = 5308 \text{ patients who need to be screened per year}
 \end{aligned}$$

The number of patients who need to be screened each year is estimated to be 5308. For each screening, we are anticipating it takes approximately 15 minutes (10 minutes to screen and 5 minutes between patients). The following calculations are based upon this number.

$$\begin{aligned}
 &(8 \text{ hours in a working day}) \times (60 \text{ min. in 1 hour}) = 480 \text{ working min. in a day} \\
 &(480 \text{ working min.}) \times (260 \text{ working days in a year}) = 124,800 \text{ working min. per year} \\
 &(124,800 \text{ working min. per year}) / (15 \text{ min. per screening}) = 8320 \text{ possible screenings per year} \\
 &\text{(approximately 32 screening per day)}
 \end{aligned}$$

With one employee acting as the sole hearing screener, it would be feasible to screen 5308 patients, as in theory, there are enough clinical hours available per day to screen 8320 patients.

Now let's look at the clinic's projected compensation for conducting these hearing screenings. Private insurance and Medicare does not cover the cost of hearing screening for patients. This means, for each screening, we would be charging out of pocket and collecting the money after the screening. Based upon research completed by Dubno et.al. in 2022, the average cost of an in-clinic PCP referral hearing screening was \$31.64.

$$(5308 \text{ patients screened}) \times (\$31.64 \text{ per screening}) = \$167,945 \text{ per year}$$

Based upon hearing screenings alone, the projected *billed* revenue would be \$167,945 per year. Further, we are projecting that just 50% of this revenue from hearing screening will be collected. This yields a projected collected revenue figure of \$83,500.

We believe that additional revenue will result from the sale of hearing aids that come from patients who fail the hearing screening and then opt to be evaluated by the Audiology department. Consequently, we calculate potential revenue from the hearing evaluations and hearing aids sold to the population that has failed the screening (estimated to be 227 patients). In the clinic, an annual hearing evaluation is covered by most private insurances and Medicare. The revenue per patient is estimated to be \$100 per patient. Based upon this projection, we can calculate the gross revenue from hearing evaluations from the 227 unidentified patients:

$$(227 \text{ unidentified patients with hearing loss}) \times (\$100.00 \text{ per hearing eval.}) = \$22,700 \text{ per year}$$

From here, we can assume a portion of these patients will purchase hearing aids. In Table 4, we have three projections of the number of patients who fail the hearing screening, and then agree to purchase hearing aids from the Audiology department. When estimating potential hearing aid revenue, the following benchmarks were applied:

- Average Wholesale Hearing Aid Cost (2 hearing aids/bilateral fit): \$1,548.00
- Average Retail Hearing Aid Cost (2 hearing aids/bilateral fit): \$4659.00
- Note the projections in Table 4 are based on a bilateral fit rate of 100%.

Number of patients accepting recommendation of 2 hearing aids	Estimated Wholesale Hearing Aid Costs (# of pts. x 1,548)	Estimated Gross Margins from Hearing Aids Sales (# of pt. x 4,659)	Estimated Net Margin from Hearing Aid Sales
15	\$23,220	\$69,885	\$46,665
34	\$52,632	\$158,406	\$105,774
56	\$86,688	\$260,904	\$174,216

Table 4. Estimated costs, gross margins and net margins from hearing aids sales to patients identified as hearing aid candidates that agree to purchase. Three different estimates are shown.

Now, we estimate the total revenue from the PCP hearing screening referral program for one year. It shows revenue streams from three sources: the screening, the hearing evaluation, and the sale of hearing aids. Note that we are estimating the amount of collected revenue and expect about one-half of the revenue, coming from the screening portion of the program, to be written off and uncollected.

Revenue from Screening:	\$83,500 (collected)
Revenue from Hearing Eval:	\$22,700 (collected)
Revenue from Hearing Aids:	\$105,775 (median estimate from Table 4)
	<hr/>
	\$211,475 (total estimated annual revenue)

Estimated Costs to Start Program

We plan to hire a hospital technician for the hourly rate of \$18 per hour to complete the screenings. Included in the cost of labor, shown in Table 5, is total compensation, including wages and cost of healthcare insurance for the newly hired technician. The total projected cost for labor for the first year is \$42,000. All the projected start-up costs are shown in Table 5.

Labor	\$52,000
Screening Audiometer with Headphones and Disposable Ear Tips	\$9,000
Marketing (Lunch and Learns, Brochures, Posters)	\$3,000
Estimated Start Up Costs	\$64,000

Table 5. Estimated Costs

Marketing Plan

Because the entire program is contained within the same multispecialty clinic, marketing costs are nominal. The \$3,000 marketing budget is mainly used for the creation of posters, brochures, and other printed material needed to educate staff and patients. There will be an initial training session with the PCPs devoted to the importance of routine hearing screenings for those 55 years of age and older. The cost for the lunch and learn sessions that educate PCPs and staff is also factored into the marketing budget.

As for raising awareness for patients coming into the clinic, we believe through the lunch and learn trainings, PCPs will be able to adequately explain the reason behind the screening program (and why it is beneficial to the patient’s health) to PCPs and their staff members. From there, we believe that after the screening, the audiologist can reinforce the importance of treating hearing loss at early stages of onset.

Although no marketing cost is accrued for it, a significant part of our overall marketing strategy is sending concise, timely reports to the referring PCP after each patient encounter with Audiology. We believe this process will build high levels of trust between the PCP and the Audiology department that will result in fewer marketing dollars being spent in later years.

Expected Obstacles Anticipated and Plans to Overcome Them

There are few anticipated obstacles related to achieving these projected financial goals. Even if there are fewer hearing evaluations and hearing sales than projected, the clinic would not lose money by continuing the hearing screening program.

PCPs may be hesitant to refer every patient 55 years of age and older for a hearing screening, especially if there are no current concerns for their hearing. To overcome this, we believe that training is a critically important aspect of the start-up process. Emphasizing the difference between the degrees of hearing loss, and how treatment at any level can help improve overall health and quality of life would help ease resistance that may come from the PCPs.

We plan to closely monitor the number of patients, aged 55 years and older seen by the PCPs, compared to the number of those patients who have their hearing screened. Our goal is to screen 90% of all patients aged 55 years and older. At the end of the year, if we fall below that number, we may add a measure of auditory wellness, the Hearing Handicap Inventory – Screening (HHI-S) version to the protocol. Adding the HHI-S would allow us to pivot away from conducting hearing screenings on all patients and simply administer a questionnaire to them. If we pivot away from traditional pure tone hearing screenings and conduct fewer of them, the technician would be cross-trained as an audiology assistant.

Perhaps a more significant obstacle are patients who fail the initial hearing screening and choose to not participate in any follow up care with Audiology. To reduce the chances of no-show appointments with Audiology, the technician will automatically schedule follow up appointments on the day of the hearing screening for those who fail it. Additionally, no-show appointments will be flagged, and a report will be sent to the PCP's staff encouraging them to follow-up with each patient who fails.

To maximize the number of patients served, education on hearing loss and how it affects their physical and mental health is very important. We want patients to make informed decisions about their health, and we want to educate patients. This is a process that begins in the PCPs office, at the hearing screening. An additional strategy that could be implemented is handing out printed information for those who fail the hearing screenings on the risk factors associated with hearing loss, and how hearing aids will be able to help mitigate these factors.

Conclusions

The PCP Hearing Screening Referral Program fulfills the mission of interdisciplinary teamwork between departments by serving the aging population of Miami, Florida. The program will not only positively impact patients, but also provides additional new revenue through the sale of hearing aids to patients who ordinarily might not seek care. ■

Resources

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To maximize the number of patients served, education on hearing loss and how it affects their physical and mental health is very important.

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HAVE YOU HEARD?

UsAgainstAlzheimer's Brain Health Academy Enrollment is Now Open, Hearing Loss Session, Featuring Dr. Frank Lin Launches July 19th

UsAgainstAlzheimer's Brain Health Academy webinar series features an ADA-sponsored course, to be delivered by Dr. Frank Lin, which will be held on July 19, 2023, at 1:00 p.m. Eastern. Several studies have demonstrated that individuals with hearing loss are at a higher risk of developing dementia and other cognitive impairments.

Hosted virtually, the Brain Health Academy is designed to help health care providers and wellness professionals understand the connection between lifestyle interventions and brain health, and to provide them with the knowledge and resources to help people reduce their risk of Alzheimer's and related dementias.



"The courses were developed in collaboration with leading experts in the field and are based on the latest research on potential risk factors for dementia and Alzheimer's disease."

— George Vradenburg,
UsAgainstAlzheimer's chair and co-founder

"People need to know that Alzheimer's is not a normal part of aging and that there are things every single one of us can do to reduce our risk of developing the disease. Health and wellness professionals play a vital role in spreading the word and encouraging people to take action – the Brain Health Academy is there to help them do that," said George Vradenburg, UsAgainstAlzheimer's chair and co-founder. "The courses were developed in collaboration with leading experts in the field and are based on the latest research on potential risk factors for dementia and Alzheimer's disease. We are incredibly grateful to the partners who are working with us on this lifechanging project."

UsAgainstAlzheimer's Brain Health Academy partners include the Academy of Doctors of Audiology, American Academy of Audiology, Academy of Nutrition and Dietetics, American Society on Aging, AARP, American Academy of Sleep Medicine, American Heart Association, American College of Lifestyle Medicine, Centers for Disease Control and Prevention, Eisai, Humana, Physical Activity Alliance, Tivity Health, and USAging.

Those interested in learning more or registering should visit <https://www.usagainstalzheimer.org/hearing-and-dementia>

Criminal and Civil Liability Risks for Audiologists Who Accept Monetary Incentives (Such as Paid Conference Registration) in Exchange for the Purchase of Hearing Aids

Disclaimer: The following information is for general informational purposes only. It does not, and is not intended to, constitute legal advice or create an attorney-client relationship between the reader and the contributor. Readers should contact their attorney to obtain advice with respect to any particular legal matter.

ADA has received several member queries regarding the potential for legal liability for audiologists who participate in promotional incentive programs whereby they purchase hearing aids from a hearing aid manufacturer or distributor in exchange for monetary compensation in the form of paid conference registration fees.

Given both the significance and time-sensitive nature of this issue for ADA members, ADA sought a legal review on this issue. ADA's attorney has reviewed sales promotions offering audiologists paid conference registrations in exchange for hearing aid purchases that have been publicized recently in public forums and offers the following general guidance:

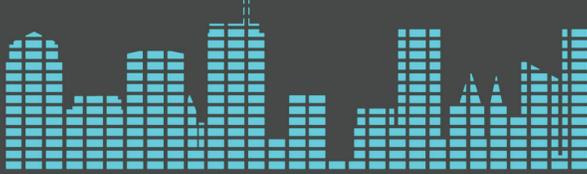
1. Federal law defines "remuneration" as anything of value given in return for referrals. Accepting the value of a conference registration from a hearing aid manufacturer or distributor would qualify as remuneration in the form of a monetary incentive.
2. Therefore, hearing aids purchased in exchange for a conference registration are essentially tainted under the Federal Anti-Kickback Statute (AKS).
 - a. An audiologist would be at risk for prosecution under the False Claims Act for violating the AKS if they purchase the hearing aids required for the incentive, participate in the incentive (accept the free conference registration, underwritten by the manufacturer or distributor in exchange for the hearing aid purchase), and then dispense one of those hearing aids to a patient who was reimbursed, in whole or in part, by Medicare or Medicaid.
 - b. Additionally, some State laws extend AKS concepts to private payors.
 - c. Finally, private payor contracts may also incorporate AKS concepts and prohibit such arrangements.

Thus, submitting a claim for the fitting of the hearing aids purchased under this promotional scheme to *any* health care benefit could trigger liability. Audiologists who participate in such a promotion would need to be certain not to dispense the tainted hearing aids to Medicare/Medicaid patients, or to any other patient whose benefit plan contractually prohibits activity mirroring AKS prohibitions. While tracking which hearing aids are dispensed to which patients is certainly possible, it could be incredibly difficult to track, and even one mistake could be costly.

3. Even in self-pay scenarios, there are additional ethical implications of participating in such promotions. The audiologist would need to ensure that their clinical judgment is not influenced by their business need to accept the promotion or fit the hearing aids purchased through the promotion.
4. Some states have Sunshine Laws or other similar disclosure laws that require healthcare professionals to report any benefits they receive from manufacturers. Audiologists accepting the promotion should check their state law to determine whether it has such requirements, and if so, must make arrangements to report properly.



The Bottom Line: Promotions that offer monetary incentives, such as paid conference fees, in exchange for hearing aid purchases pose significant risks for civil and criminal liability for audiologists. Audiologists should contact their attorney for advice related to their specific situation before proceeding.



AuDACITY

November 2-5, 2023
CONFERENCE AGENDA

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THURSDAY, NOVEMBER 2, 2023

8:00 AM - 2:45 PM	PRE-CONFERENCE WORKSHOP: Legal Issues in Audiology: Brandon Pauley, Esq.
8:00 AM - 2:45 PM	PRE-CONFERENCE WORKSHOP: Utilizing HIS Extenders: Optimizing Efficiencies and Outcomes in the Audiology Practice: Kristin Davis, Au.D., Tonya Muncy, BC-HIS, Liz Rogers, Au.D.
8:00 AM - 2:45 PM	PRE-CONFERENCE WORKSHOP: Clinical Workshop on Auditory Processing Disorders: John Coverstone, Au.D., Gail Whitelaw, Ph.D.
8:00 AM - 12:00 PM	AuDacity Student Track
12:45 PM - 1:15 PM	Student Humanitarian Initiative Panel
1:15 PM - 2:45 PM	Humanitarian Audiology: What's WHO Got to Say about It?
1:15 PM - 2:45 PM	Things to Know Before You Buy or Sell an Audiology Practice
3:00 PM - 4:30 PM	Featured Keynote Session — Industry CEO Panel: Audiology Unstoppable
4:35 PM - 6:00 PM	Industry CEO Panel: It's Your Tomorrow, Right Now
6:00 PM - 7:30 PM	AuDacity Opening Reception in the Exhibit Hall

FRIDAY, NOVEMBER 3, 2023

7:00 AM - 8:00 AM	Breakfast in the Exhibit Hall				
8:00 AM - 8:30 AM	President's Address: Go Beyond: Dawn Heiman, Au.D.				
8:30 AM - 9:30 AM	Featured Keynote Session — ACHIEVE Study: An Overview of Outcomes: Frank Lin, M.D.				
9:30 AM - 10:00 AM	Break in the Exhibit Hall				
10:00 AM - 11:30 AM	Featured Keynote Session — ACHIEVE Study: Practical Implications for Audiologists: Nicholas Reed, Au.D., Vicky Sanchez, Au.D.				
11:30 AM - 12:30 PM	Lunch in the Exhibit Hall				
12:30 PM - 2:00 PM	Speech in Noise Inventories: In One Ear and... Elizabeth Thompson, Au.D., Christine Ulinski, Au.D.	Cognitive Screening: Somebody Check My Brain Jill Davis, Au.D., Lisa Gumina, Au.D., Laura Sherry, Au.D.	F&CNA Panel: We'll Have an Effin Ball Natalie McKee, Au.D., Erica Person, Au.D., Alicia Spoor, Au.D.	Falls Risk: Bedside Vestibular Assessments: Getting the Right Balance and Getting the Balance Right Jana Brown, Au.D., Danielle Dorner, Au.D., Sara Jagger, Au.D.	Promoting Auditory Wellness: Sounds About Right
2:00 PM - 2:30 PM	Break in the Exhibit Hall				
3:00 PM - 4:30 PM	Outcome Measures in Audiology: Keep'n It 'Real' Laura Pratesi, Au.D., John Pumford, Au.D., Laura Sherry, Au.D.	Auditory Rehabilitation: Hello, Hello Again Ariel B. Fruendt, Au.D., FAAA, Dusty Jessen, Au.D., Joe Montano, Ed.D.	Tinnitus Evaluation and Care Planning: For Whom the Bell Tolls Torryn Brazell, CFRE, CAE Moderator: Jason Leyendecker, Au.D.	Cochlear Implant Evaluation: I've Got the Power Arun Joshi, Au.D., D'Anne Rudden, Au.D., Kayla Wilkins, Au.D.	Auracast: Can I Get a Connection? Andrew Bellavia
4:15 PM - 5:45 PM	ADA Member Business Meeting				
6:30 PM - 9:00 PM	AuDacity Reception and Dinner				

SATURDAY, NOVEMBER 4, 2023					
7:30 AM - 8:00 AM	Breakfast in the Exhibit Hall				
8:00 AM - 9:30 AM	Using KPIs to Find Your Rhythm: We Got the Beat: Mary Mungovan, M.A., Eric Stevens, MBA, Kristen Weinbaum, Au.D.				
9:30 AM - 10:00 AM	Break in the Exhibit Hall				
10:00 AM - 11:30 AM	Business Financing Workshop Part I: I Need a Dollar Josh Gutstein, Brandon Pauley, Esq.	Audiology Managed Care Part 1: Why'd You Have to Go and Make Things So Complicated? Patty Greene, MA, Carrie Meyer, Au.D., Laura Richardson, Au.D. Moderator: Kim Cavitt, Au.D.	Public Speaking Training: Here I Go It's My Shot, Feet Fail Me Not Annetta Wilson	Attracting and Hiring the Right Clinical and Administrative Talent: Here's My Number, So Call Me Maybe Carly Girard, Au.D., Karri Kiefat, Therese Montecalvo	ENT/PT/SLP Audiology Practice Models: Ex's and Oh's! Liz Rogers, Au.D., Meghanne Wetta, Au.D.
11:30 AM - 12:30 PM	Lunch in the Exhibit Hall				
12:30 PM - 2:00 PM	Business Financing Workshop Part II: Money, Money, Money Stacy O'Brien, Au.D., Brandon Pauley, Esq., Alicia Spoor, Au.D.	Audiology Managed Care Part II: Know When to Hold 'Em, Know When to Fold 'Em Peter Kleckner, Au.D., Nikki Kopetzky, Au.D., Natalie McKee, Au.D. Moderator: Kim Cavitt, Au.D.	Media Training for Audiologists: Say What You Wanna Say Annetta Wilson	Training and Retaining Clinical and Administrative Talent: We've Got to Hold on to What We've Got Megan Lynch	Serving the Underserved: We Could Be Heroes Sarah Curtis, Au.D., Judy Huch, Au.D.
2:00 PM - 2:30 PM	Break in the Exhibit Hall				
2:30 PM - 3:55 PM	Challengers and Champions: Trials, Triumphs, and Lessons Learned Panel: Jane Baxter, Au.D., Victor Bray, Ph.D., Bryan Greenaway, Au.D., Alexandra Tarvin, Au.D.				
4:00 PM - 5:00 PM	Believe and Beyond: Building Your Personal Practice Roadmap				
5:00 PM - 6:00 PM	AuDacity Closing Reception				
SUNDAY, NOVEMBER 5, 2023					
8:00 AM - 11:30 AM	POST-CONFERENCE WORKSHOPS (Information Coming Soon)				



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Updated CMS ABN Goes into Effect on June 20, 2023

BY KIM CAVITT, Au.D.

The Centers for Medicare and Medicaid Services (CMS) have updated the Advanced Beneficiary Notice, whose most recent update to the Advanced Beneficiary Notice (ABN) goes into effect on June 30, 2023.

All audiology practices, who bill items and services to traditional Medicare, need to replace their ABNs, dated with an expiration date of 06/30/23, with a new, updated (with updated language) ABN, dated with an expiration date of 01/31/2026. The form is not valid if it is not in its most updated version.

You can learn more about the ABN, its intent, and how it is to be used, as well as find sample templates, at <https://www.cms.gov/medicare/medicare-general-information/bni/abn>.

The Academy of Doctors of Audiology offers partially pre-filled (with common reason for denial options) ABN forms, for no charge to members, at <https://www.audiologist.org/audiologists/practice/forms-library>.

Please contact Kim Cavitt at kim.cavitt@audiologyresources.com with any questions about the ABN and its use. ■

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.

PRESIDENT'S MESSAGE

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So, as you wrap up the 1st half of the year and look ahead to the second half, make sure you reassess where you're going, strategize for efficiency, best patient outcomes, and profitability. I don't know about you, but I will definitely schedule my personal time within my daily, monthly, and quarterly schedules. Enjoy the strategic fun in the game of private practice! ■



The Tools You Need to Run Your Practice.

ADA's Practice Resource Library offers a comprehensive collection of off-the-shelf forms, documents, and guidance materials. These resources will assist audiologists and their staff with practice operations, compliance, and patient management.

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- Hearing Aid Insurance Waiver
- Hearing Aid Loaner Agreement
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- Hearing Aid Upgrade Notice
- HIPAA Security Policy Template
- Insurance Verification Form
- Notice of Non-Coverage
- Office and Financial Policies
- Patient Registration Form
- Policies and Procedures Manual
- Price Quote Form

ADA members receive a discounted rate when purchasing any of the above forms. Visit audiologist.org/forms for details!



EDITOR'S MESSAGE

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the creation of new scientific knowledge and when it is applied in the clinic. The overarching goal of implementation science is to bring about the best possible care for everyone. Implementation scientists have developed several interesting models, including what's called the RE-AIM framework, summarized in Table 1⁶. It is a systematic, five-step approach designed to speed the process of changing behaviors – both of the clinician, and in-turn, the patient. One ideal place to put implementation science to work is getting more primary care physicians and nurse practitioners, the front-line professionals who routinely interact with middle aged and older adults (those most prone to the consequences of untreated hearing loss) more actively involved in promoting the benefits of routine hearing screening and early intervention strategies.

Table 1 below outlines a hypothetical example of how the RE-AIM framework could be applied when an audiology practice partners with a local medical practice, comprised of several nurse practitioners and primary care physicians. In this example, the audiology practice is providing messaging collateral to the medical practice that promotes the importance of routine hearing screening for all adults aged 50 years and older. The vehicle for delivering this message could be posters that hang in exam rooms, brochures handed to patients and videos that play on the TV in the reception area. The core message would be along the lines of “The sooner we treat hearing loss, the better the outcome – it all starts with a quick, routine hearing check. We can do the hearing check here, right now and you will know your hearing number.”* Additionally, “Hearing better can make you think/socialize/connect with others better” would be a key part of the communication strategy — a constructive message that minimizes harm while motivating people to act.⁷

* see <https://hearingnumber.org/what-is-the-hearing-number/>

Dimension	Goals and Outcome Metric
Reach: Number of individuals exposed to message	Goal: to monitor and evaluate the exposure rate Outcome Metric: Number of people exposed to message
Effectiveness: Impact of message/intervention on attitude or behavior	Goal: Confirm effectiveness of intervention/message Outcome Metric: Qualitative interviews of staff, 2-4 weeks post kick-off of program
Adoption: Impact on staff's ability to deliver the intervention/message	Goal: To evaluate adoption rate of staff who have begun using messaging/intervention Outcome Metric: Percentage of staff self-reporting their use of message/intervention
Implementation: Degree to which intervention/message was delivered as intended	Goal: To determine number of staff that are routinely adding message/intervention to this “talk track” with patients Outcome Metric: Number of staff self-reporting they routinely use message/intervention
Maintenance: Long-term change in way intervention/message is delivered over time. “Staying power” of intervention/message.	Goal: To determine if message/intervention is still being implemented 6 months/1 year later Outcome Metric: Tracking number of staff still actively involved in using new message/intervention

Table 1. An example of the RE-AIM framework⁶ and how this framework could be applied to a program that promote hearing screening in a primary care medical practice.

One can easily imagine how these types of frameworks can be applied to audiology so that persons with hearing loss receive appropriate interventions, earlier. Although there are dozens of papers in our profession devoted to translational research, there appear to be just a handful of papers on the broader topic of implementation science.^{8,9} Now is the time for that to change. The RE-AIM framework, if applied to speeding the journey of hearing care, tells us that reducing apathy and indifference toward hearing loss and treatment is a methodical process that requires careful planning, creative thinking, imaginative messaging and systematic monitoring of outcomes for each of the five stages shown in Table 1.

Decades of research demonstrating the co-morbid nature of hearing loss tells us that the sooner we treat, the better the outcome. Speeding the journey toward hearing loss awareness, acceptance and treatment just might start with closing the gap between what clinicians know and what they do. Shortening the knowledge-doing gap will likely narrow the journey from apathy to action for persons with hearing loss. ■

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HEADQUARTER'S REPORT

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Prototyping, Testing, and Continuous Improvement through User Feedback: User feedback is a fundamental component of UX design, allowing for iterative improvements based on user experiences and needs. Patient and employee satisfaction surveys, usability testing sessions, polls, and other feedback mechanisms can provide valuable data to identify areas to improve, and where care delivery is already optimized.

One case study presented at the UX conference featured a health clinic that invited patients to provide input on the design of patient education materials. Patients were asked to evaluate different designs and provide input using a short survey on a tablet, while they were waiting for their appointment. The feedback helped ensure that the final design was visually engaging, and easy to understand, promoting improved adherence to treatment plans.

After attending the UX conference, I am more convinced than ever that the principles of design thinking and UX design have a place in the delivery of audiology services. UX design, when effectively implemented, can empower patients to actively participate in their audiovestibular health care journey and improve the quality of care they receive.

I am seeking out UX designers willing to share their knowledge to develop educational resources that will be most useful for ADA members. In the spirit of UX design—you may be asked to provide your input on who, where, what, when, and how those resources are developed. Stay tuned!. ■



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November 2-5, 2023

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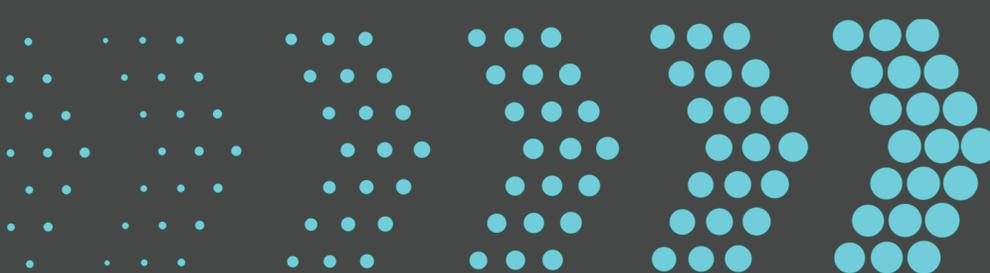
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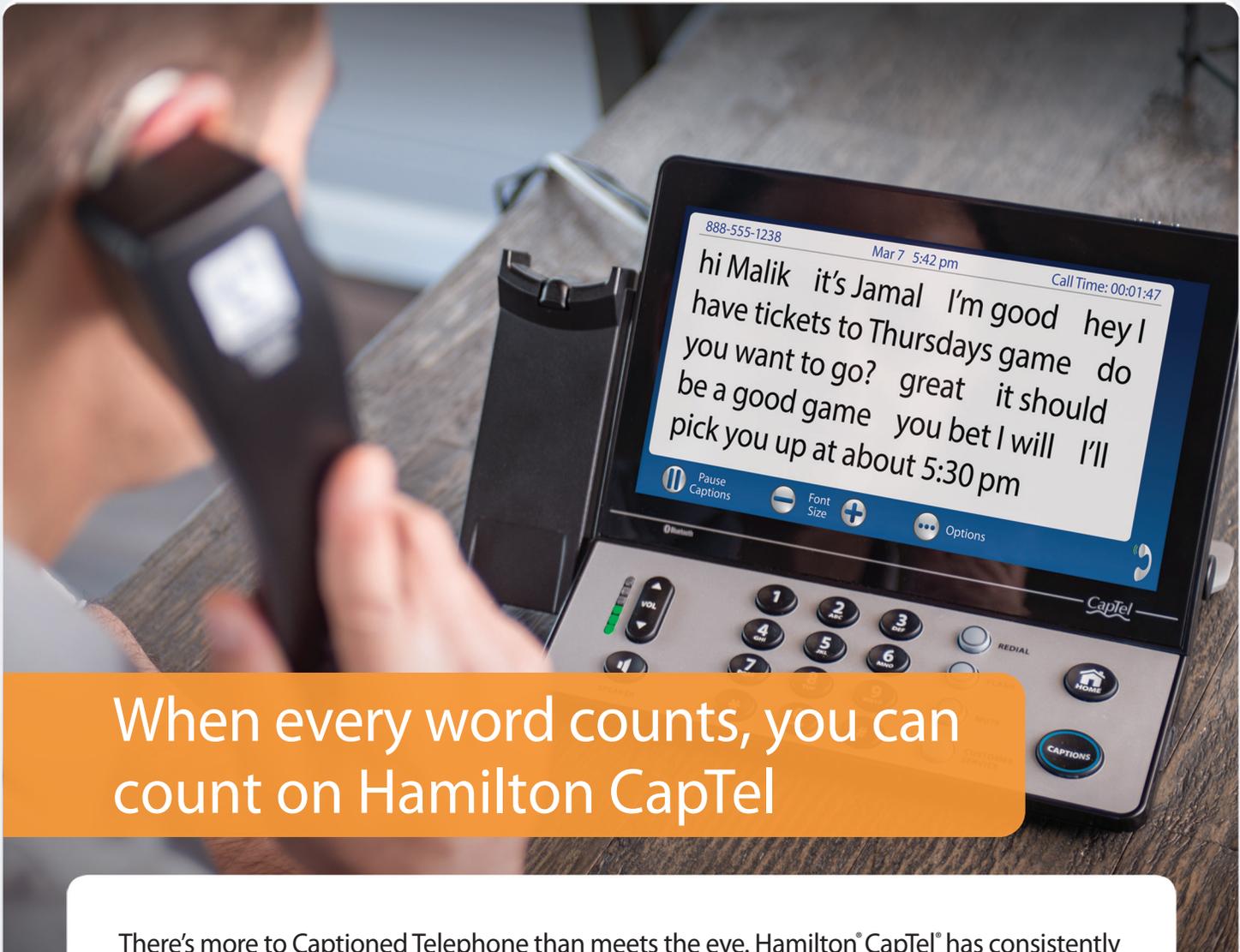


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