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IN THIS ISSUE

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

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Jason Leyendecker, Au.D.

Let's Get Comfortable Being Uncomfortable

2024 is coming to an end and so are my responsibilities as current president of the Academy of Doctors of Audiology. When I was nominated and elected for the presidential seat, I knew there would be a lot of hard work, long hours, travel and relationship building. I knew we had a dedicated board of directors who we could count on to help make this year successful and I knew our executive director and management company were all in, making sure operations ran smoothly and we had everything needed to keep audiology moving forward. What I didn't know was what we were going to accomplish, what relationships we were going to build and what curveballs we would need to handle.

I am extremely proud of the team leading ADA and the profession of audiology forward. What we have accomplished this year is nothing short of amazing. After all the research we did to understand where the doctor of audiology started and why it started, the board came together to create a vision of the future, a vision that will solidify a place at the highest level in the medical community for audiology.

I want to remind audiologists that the profession of audiology is very young. We are less than 30 years into our doctoral degree and there have been major strides forward in our clinical standards, creating a foundation for legislative and policy changes, and continuing to modernize care with better technology, diagnostic tools and improved therapies so our patients can have a better life. We should be proud of our profession for what we have accomplished thus far but we are just getting started!

Our comfort zone has been expanded with the recent legislative changes in Maryland to modernize the scope of audiology practice there. To quote David Goggins, "Comfort zones--if you live in one too long it becomes the norm. Get comfortable being uncomfortable." We are branching out of our comfort zones every day. There is no "because we have always done it this way" in our profession. It will always be new and there will always be a level of discomfort pushing things forward. What a time to be alive!

We cannot stop now. We must keep moving forward and the best way forward is with a vision that has goals and objectives on which audiologists can align. Audiology 2050 is that vision. It creates a roadmap of what needs to happen based on the objectives of the Doctor of Audiology as it started, as well as the objectives required to modernize the profession based on technology, job force, legislation, and the professional socialization of future Doctors of Audiology. This isn't just what needs to happen with ADA but with all audiologists in all specialties.

I want to wrap this up by letting you know why I went into audiology. I wanted to make an impact on the community. My impact gets bigger with autonomy, and private practice is where I have the most autonomy. My impact gets even bigger by expanding my business, so more patients get proper hearing care through my team. The impact gets exponentially bigger by volunteering within my state and national organizations where we have opportunities to make changes that will provide better access for our patients across the country. We all need to be volunteering to make the biggest impact on the community.

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ADA
ACADEMY of DOCTORS of AUDIOLOGY

BECOME A MEMBER!

Welcome to the Academy of Doctors of Audiology (ADA), the only national membership association focused on ownership of the audiology profession through autonomous practice and practitioner excellence as its primary purposes. ADA is the premier network and resource for audiologists interested in private practice.

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Visit audiologist.org/membership to learn more!

Brian Taylor, Au.D.

Practicing in the Era of the "Good Enough" $300 Hearing Aid

In this issue of *Audiology Practices,* we feature an article from well-respected audio engineer and business executive, Alexander Goldin, titled, *Will Apple Change Hearing Health?* In it, Goldin opines about the evolution of low-cost, easy-to-buy, earbud-style hearing aids. He emphasizes that the newest version of Apple's AirPod Pro with a built-in hearing aid is ushering in a new era of hearing care. He even goes on to say something that some might call earth shattering:

"I am pretty sure Apple's competition, as in many other cases, will try to offer a similar free, self-fitted OTC hearing aid feature. Once this happens, this feature will become standard. And if it becomes the standard feature, there is a good chance that hearing aids for mild and moderate hearing loss will become obsolete."

His statement bears repeating: If a hearing aid built into the ever-present consumer earbud becomes a standard feature, hearing aids for mild and moderate hearing loss may soon become outdated and obsolete. Of course, if Goldin's prediction is correct, this could have profound consequences on clinical practice in the following ways both good and bad.

More people seen wearing hearing aids.

As more people use their earbuds as hearing aids, perhaps the ageism and stigma associated with hearing loss will decline. Although there is one caveat associated with this: Using earbuds as hearing aids could have so-called reverse stigma characteristics associated with them. Many people believe when a person is wearing earbuds he is listening to music and tuning out conversational partners around him. If more and more people are wearing earbuds as hearing aids (rather than the solitary activity of streaming music) in these situations, it could be perceived as rather off-putting by their conversation partners. Consequently, wearing earbuds in social situations might be associated with rudeness and anti-social behavior.

Lower the age of first-time hearing aid wearers.

The availability of hearing aids in earbuds means that a rising number of people in their 40s and 50s who notice they have some modest and occasional communication difficulties in noisy places are likely to dabble with the amplification these devices provide. Rather than putting off seeing an audiologist for seven to 10 years before eventually investing in a pair of hearing aids, these individuals can use something that is "good enough" in specific listening situations.

Continued on page 47

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Stephanie Czuhajewski, MPH, CAE, Executive Director

Audiology 2050 Provides A Bold Vision for the Future of Audiology: Together We Can Achieve It

With the introduction of Audiology 2050, the Academy of Doctors of Audiology (ADA) has put forward an ambitious and transformative roadmap to secure the future of audiology. At its core, this initiative prioritizes patient well-being while positioning audiologists rightfully as primary care providers for auditory and vestibular conditions. By advancing professional standards, modernizing Medicare laws and state audiology practice laws, and adopting innovative workforce and care delivery models, Audiology 2050 lays the groundwork for a stronger, more effective, and patient-centered profession.

To realize this vision, the initiative outlines seven key objectives that are essential for the profession to reach its full potential. Each objective underscores the necessity of aligning audiology with contemporary healthcare demands, and ensuring access, quality, and innovation in patient care (see page 42 for the full description and design of Audiology 2050)

State and federal laws lag behind the realities of clinical audiology practice. Audiology 2050 seeks to update these laws reflect the full competencies and capabilities of audiologists, including the evaluation, diagnosis, management, and treatment of auditory and vestibular conditions. This alignment will ensure that audiologists are recognized for their education and training, enabling them to practice at the top of their license—and enabling millions of Americans to have ready access to hearing and balance healthcare services.

As the practice of audiology is modernized, so too must be the clinical practices that support it. Consistency and quality are foundational to patient care. Audiology 2050 emphasizes the importance of adopting standardized, evidence-based clinical practices. By collaborating with interdisciplinary experts and promoting ADA's Audiology Practice Accreditation standards, Audiology 2050 aims to promote the delivery of equitable and optimal audiologic care for every patient.

To meet growing patient demand and optimize care delivery, Audiology 2050 supports the development of new workforce models that include qualified extenders. These professionals will enhance service delivery, improve efficiencies, and allow audiologists to focus on more complex clinical responsibilities. Innovative educational models will prepare future professionals for these roles while maintaining the high standards that define the profession of audiology.

Audiology 2050 can only be achieved if individual audiologists take up the cause in large numbers. Together we can achieve this vision, strengthening audiology and improving patient outcomes, while transforming the practice of audiology to achieve its full potential as a clinical doctoring profession. Please contact me at sczuhajewski@audiologist.org for more information or to volunteer to serve on a committee advancing one of the Audiology 2050 initiatives. ■

Professional Sales Techniques for Audiologists:

COMMON THREADS TO SUCCESS

Robert M. Traynor, Ed.D., MBA

Thoughts of salespeople often bring to mind used cars, vacuum cleaners, snake oil sales, or the QVC Network. While there are unprofessional and/or high-pressure salespeople for virtually all products, most professionals also sell services, procedures and products. Consider an attorney selling time and legal skills to their client, a dentist that sells procedures and dental products, and even physicians and surgeons that sell evaluations, examinations, and operative procedures to their patients. Virtually any profession, including audiology, is a sales profession. Simply stated, most audiologists receive little to no training in any sort of professional selling or persuasion, and when they embark on their career journey, they are poorly equipped in the skills needs to be successful at persuading persons with hearing loss to make buying decisions.

VIRTUALLY ANY PROFESSION, INCLUDING AUDIOLOGY, IS A SALES PROFESSION.

Selling professionally is difficult because there are often two sides to professional interaction with patients: clinical and business. While it is an ethical, fiduciary and professional responsibility to clinically provide the very best in hearing care, clinicians and practice managers also need to ensure that there is enough profit in each sale to provide ongoing support for the clinic. In fact, is the utmost ethical responsibility is to stay in business so that patients are provided the proper hearing care throughout the use of the products and procedures sold to them as part of their rehabilitative treatment program. Selling is an essential skill to all audiology practice specialties; however, it is rarely addressed in a Doctor of Audiology (Au.D.) curriculum. Typically, Au.D. programs teach to certification standards set up by academic accreditation boards, often by

those that have not seen a real patient in years. Summing up how Au.D. students are prepared, Wignall (2015) states that students need further education in performing hearing evaluations, relating to patients, explaining test results, selling hearing aids, writing a contract, asking for thousands of dollars, fitting the hearing aids, explaining the care of the aids, and conducting follow-ups. Wignall's concerns have not changed over the past 10 years as entry level professionals still do not know much about professional selling of products. While the winds of audiology educational programs are slowly changing to include many of these business skills, audiologists are generally not prepared to sell the products and services. Taylor (2024) states that so much has changed since his 2012 reminder to audiologists of their need to be salespeople. He then said:

"Like it or not, most audiologists and other hearing health care professionals engage in selling everyday… keep in mind that all medical professions engage in selling. Surgeons often must convince their patients to undergo surgery, therapists must persuade their clients to follow their treatment guidelines, and even dentists have to sell whiter teeth or braces. Whether you are a recent Au.D. graduate or a seasoned clinician, the sooner you embrace the selling process the sooner you will be successful, as the path to financial rewards and professional independence rests with your ability to sell."

Traditional Sales Techniques:
Do's and Don'ts

When reading books and listening to tapes of how to sell, there are many high-pressure tactics that have been used in all professions. No matter the profession or what is being sold, traditional concepts such as "Always be closing," "Think positive and the fear of sales can be overcome," or "Your salespeople have never read any sales training books." These are the sales images that professionals, such as audiologists, when thinking of the sales process. For professionals, these outdated sales techniques fail to address the core issue of allowing the patient to arrive at their own purchase decision. The ultimate goal in professional selling is for the patients to feel they have chosen the correct course of rehabilitative treatment without feeling they have "been sold." Patients that have been influenced by these so called "sales techniques" return products more often than those that have arrived at their own decision to proceed with treatment. At the basis of these professional sales techniques are some do's and don'ts in professional selling:

DON'T	DO
Deliver a strong sales pitch.	Cease the sales pitch and begin a conversation and listen carefully.
Think that the central objective is always to "close the sale."	Discover whether the clinician and the patient are a good fit, if not adjust the interaction to facilitate the fit.
Think that when a sale is lost it is the closing technique at the end of the sales process.	Realize that when a sale is lost, it is usually occurs at the beginning of the sales process.
Accept that rejection is a normal part of the sales process.	Understand that sales pressure on patients is a major cause of rejection. In a clinical situation, rejection should never occur.
Keep chasing every potential patient until the answer is either yes or no.	Realize that chasing patients with telephone calls and letters only leads to a perception of high sales pressure.
Challenge and/or counter objections offered by the patient.	When a patient offers objections, uncover the truth behind them and explain the details necessary to reduce the concern as a consideration in the purchase decision.
Defend and explain the value if a patient challenges the benefit of the product or service.	Realize that recommendations may need some explanation and rationale, getting defensive about them will only lead to perceived high sales pressure.

According to many researchers and practitioners, selling is an advanced form of communication and requires the utilization of all senses. There are hundreds of references for selling available in libraries and virtually every corner of the Internet. There are, however, some fundamental concepts that are threads woven into most of those references, which is covered in the next section of this article.

Listening Skills

In today's high-tech, high-speed, high-stress world, effective listening within the clinical situation is essential to the rehabilitative sales process. Of course, the art of listening has long been a part of audiology counseling, as well as good salespersonship (Clark & English 2014). Genuine listening builds relationships, solves problems, ensures understanding, resolves conflicts, and improves accuracy and efficiency, with less wasted clinic time. Listening is both a complex process and a learned skill; it requires conscious intellectual and emotional effort. Without intensively listening to patients, audiologists lack essential information as to their generation, personal style, lifestyle, communication needs, and other facts fundamental to the aural rehabilitative process. While there is a need for the audiologist to talk during the clinical session for informational counseling, talk should be kept at a minimum. Counselors and sales professionals suggest that 60% listening and 40% talking is a good place to begin, however, that mixture can change as the relationship develops between the patient and the clinician. Most audiologists are not formally taught effective listening skills; therefore, these skills must be developed to effectively facilitate the sale of the rehabilitative products. Ineffective listening can damage clinical relationships and deteriorate the delicate trust that has been established with the patient. Thus, a professional sales process is actually a counseling process dependent upon the specific attributes of the consumer/patient to determine their wants and needs.

Clinicians should make eye contact and relax, while not staring at the individual. While the clinician may look away now and then, it is important to be attentive to the discussion at hand. Attending to the conversation means the following:

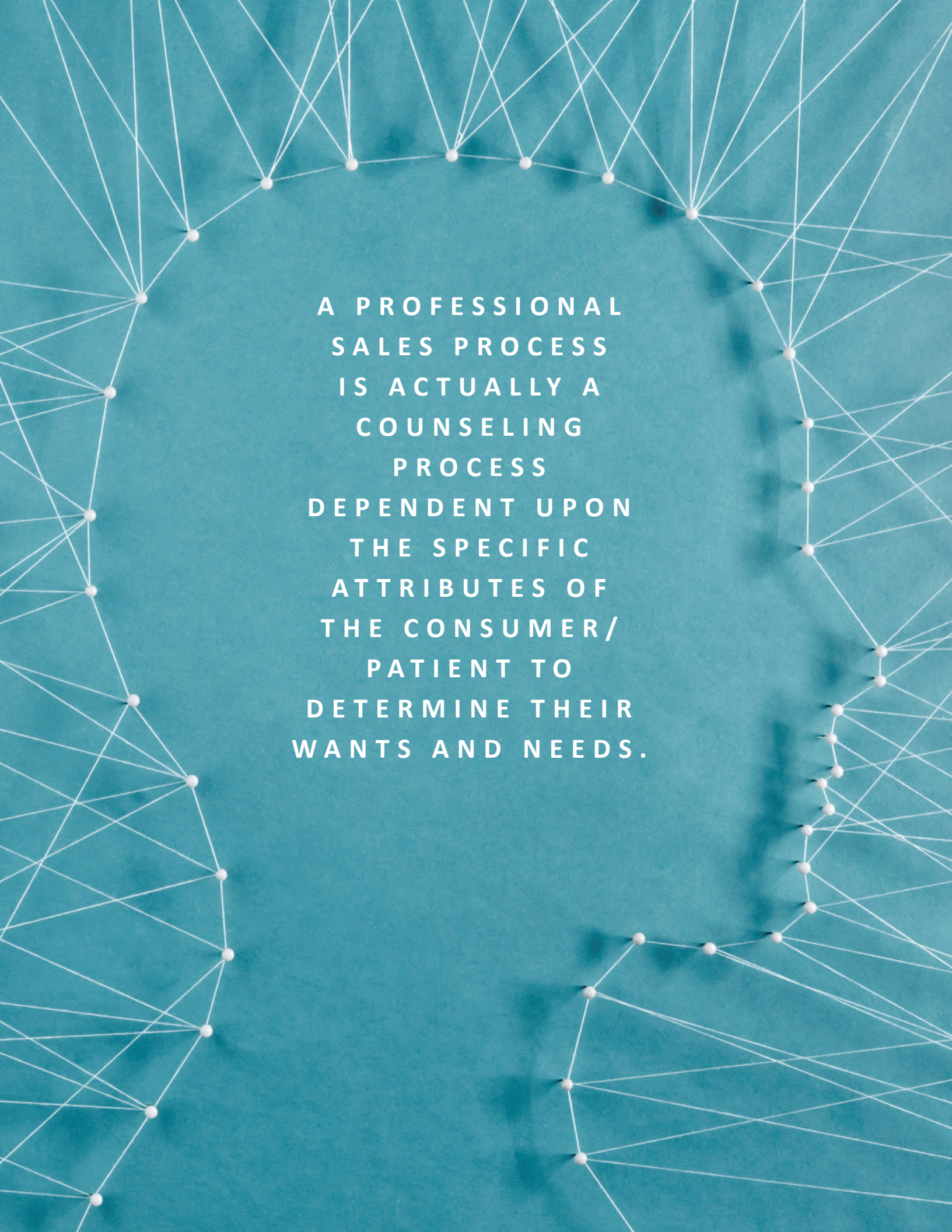
- Be present and not distracted by other conversations or tasks.
- Offer full attention and interaction in the conversation.
- Be ready to apply or directly interact to the situation presented by the consumer (patient).

It is necessary to mentally screen out distractions, such as background activity, noise, speakers accent or mannerisms.

- Keep an open mind. Clinicians should attempt to not be distracted by their own thoughts, feelings, or biases and listen without judging the consumer (patient) or mentally criticizing, if what is said is alarming. It is OK to feel alarmed, but do not demonstrate it. As soon as judgmental bemusements are indulged, the clinical effectiveness as a listener has been compromised. It is necessary to listen without jumping to conclusions and appreciate that the consumer (patient) is using their own language to represent the thoughts and feelings inside their brain. Clinically, the only way to learn their thoughts and feelings is by truly listening. It is essential that the clinician is not a sentence grabber by finishing sentences or put words in the mouth of the speaker. Aging and communication issues are part of our business, and many consumers (patients) have difficulty expressing themselves rapidly.
- Listen to the words and try to picture what the speaker is saying. The listener should allow their mind to create a mental model of the information being communicated. Whether a literal picture, or an arrangement of abstract concepts, the brain will do the necessary work if the clinician remains focused, with their senses fully alert. A listening tool for long discussions is to concentrate and remember key words and phrases, thinking only about what the other person has said, even if it is boring. If thoughts start to wander, immediately force refocusing.
- Don't interrupt the conversation. Interruptions in the conversation by the clinician says the following to the consumer (patient):
  - » "I'm more important than you are."
  - » "What I have to say is more interesting than what you have to say."
  - » "I don't have time for your story or opinion."
  - » "This isn't a conversation, it's a contest, and I'm going to win."

Interruptions are a major sign that the clinician is talking too much and in need of relaxing to let the consumer (patient) tell their story or history.

- Wait for the speaker to pause to ask clarifying questions. When critical points are not understood, it is necessary to have the speaker explain. Rather than interrupt, it is essential to wait until the speaker pauses. Then it might be said, "Let's back up a second. I didn't understand what you just said about…"
- Ask questions only to ensure understanding.


A PROFESSIONAL SALES PROCESS IS ACTUALLY A COUNSELING PROCESS DEPENDENT UPON THE SPECIFIC ATTRIBUTES OF THE CONSUMER/ PATIENT TO DETERMINE THEIR WANTS AND NEEDS.

Questions can lead people in directions that have nothing to do with the discussion. While answering a question, the consumer (patient) will sometimes work back to their original thought but may often forget an important point fundamental to their situation. It is the clinician's responsibility to bring the conversation back to where the question was inserted to keep the discussion on track.

- Try to feel what the speaker is feeling. Clinicians should attempt to feel sad as the consumer (patient) expresses sadness, joyful when joy is expressed, fearful when describing feat, conveying those feelings through facial expressions and words assures effectiveness as a listener. Empathy is the heart and soul of good listening. To experience empathy, it is necessary for clinicians to put themselves in the other person's place and allow the feeling of what it is like to be them at that moment. Empathy is not easy, as it takes energy and concentration, but it greatly facilitates communication and builds relationships.
- Give the speaker regular feedback. As a listener, clinicians need to demonstrate an understanding of where the speaker is coming from by reflecting the discussion. Acknowledgements of what has been said such as, "You must be thrilled!" "What a terrible ordeal for you." "I can see that you are confused." If the clinician feels that the speaker's feelings are hidden or unclear, then an occasional paraphrase of the content of the message may be necessary. Other interactions might simply be a nod to show understanding or through appropriate facial expressions and an occasional, well-timed "hmmm" or "uh huh."
- Pay attention to what is not said—to nonverbal cues. While a lot can be discussed, a significant amount of direct communication is nonverbal. Face to face with a consumer (patient), enthusiasm, boredom, or irritation can be easily detected by expressions around the eyes, the set of the mouth, or the slope of the shoulders. It is easy to determine if the consumer (patient) does not want to be there by their mannerisms.

Summarizing at the end of the listening session is extremely helpful. Summarizing will not only ensure accurate follow-through, it will feel perfectly natural. Listening well improves the quality of the relationships with patients and the tips presented above can keep a good discussion on track. Actively listening to patients takes concentration, challenging work, patience, the ability to interpret other people's ideas and summarize them, as well as the ability to identify nonverbal communication such as body language.

As noted earlier, ineffective listening can damage clinical relationships and deteriorate the delicate trust that has been carefully built with the consumer (patient). Rosen (2024) reiterates a summary of listening errors that have been encountered by consumers (patients) in audiology clinics:

- The clinician is doing something else when the patient is talking.
- The clinician is thinking about the next patient and not concentrating on the person that is talking about themselves and their situation.
- Waiting for pauses in the conversation so that the clinician can make specific points.
- Not allowing for pauses in the conversation. It is not necessary to fill pauses with speech.
- Clinicians need to think before they speak.
- Fake listening to the patient to enable getting comments into the situation.
- Clinicians selectively listening or only hearing what they want to hear.
- Not attending to body language, facial expressions, eye contact and vocal intonation.
- Background noise in the room while communicating with patients.
- Passing judgement on people due to age, success, how they look, etc.

These are only some of the errors made each day in the clinic. Care must be exercised to not commit these errors as they will damage your relationship with patients.

According to Caitlin Barr, an Australian research audiologist, the typical audiologist, on average, engages in the following behaviors with first time help seeking adults:

- Interrupts their response to case history questions within 15 seconds
- Talks 3 to 4 times more than the help seeking individual
- Focuses most of the content of their dialogue on test results and hearing aid technology

In this same study (Greenness, et al 2015), from the perspective of the help seeking individual, these communication tactics of the audiologist tends to yield:

- A poor emotional connection with the provider
- Low trust of provider
- A perception that the person with hearing loss is "not being heard"

General Patient Variables in Hearing Aid Sales

Powers and Carr (2022) in their discussion of MarkeTrak 10, presented that the majority (83%) of hearing aid users were satisfied with their devices, confirming that hearing aids are positively impacting their relationships, work performance, general ability to communicate, overall quality of life, and ability to participate in group activities. These are the successes in the use of hearing instruments that have conquered personal obstacles to the use of amplification. A comparison of these data to MarkeTrak 1 in 1989, which reported a 38.8% binaural hearing aid ownership, to the current binaural ownership rate of 70%, reported in MarkeTrak 10, shows remarkable progress. While this demonstrates great success in market penetration, there are still approximately 20 to 30% of wearers who should be fitted binaurally with hearing aids

Overcoming Objections to Hearing Aid Use

There is more to the use of hearing instruments than the hearing loss itself. There is also the individual, each with their own special set of variables such as that cause the average person to wait 5-7 years after they know they have a hearing problem to seek assistance. In the 1970s there was great confusion among rehabilitative audiologists as to why two patients with the same hearing loss would react differently to the use of the same hearing instrument. While some of these classic patient reactions dealt with the technology of the time, many of these personal issues still prevail almost 55 years later. The variables observed by Trychin (2003), a noted hearing impairment psychologist, are still factors in the adoption of hearing instruments. The following are the classic list of reasons that patients choose not to use amplification:

Don't Realize They Have a Hearing Loss.

Typically hearing loss among adults is a gradual impairment that occurs over years. It is not easy sometimes to realize that there is an impairment, especially if the patient lives alone or has a limited lifestyle and those around them have good projected voices for communication.

Denial 1: Do not admit they have a hearing loss.

The literature is full of examples and research that indicate the average patient that seek rehabilitative assistance with hearing aids has known there is a hearing deficit for about 5-7 years. They tend to put the burden of communication on others rather than seek treatment until it is necessary.

Denial 2: Know they have a hearing loss but don't think it is a problem for them or others.

These patients know that they do not hear very well but feel that it is not a handicap. Sometimes this is perpetuated by those that always speak up to the person, or the individual does not go out much and to interact with others.

Denial 3: Know they have hearing loss but do not think there is anything that can be done for it.

The technology of the 21st century lends this concern a bit in the past as there is amplification for just about all but those with severe word recognition issues. Today's products truly offer significant benefit for most all hearing impairment that is tolerated well.

Other Priorities

Of course, there can be hearing impairment, but the patient and their family may have set a higher priority for something else that costs about the same as amplification. Communication may not be that important to some individuals and there is a conscious choice to spend the time, energy effort and costs somewhere else other than hearing care.

Costs

While costs are a factor and may be used as an excuse in the use of amplification, it is generally not a major concern. Further, many managed care programs now offer hearing devices as a benefit and subsidize the costs of many types and styles of hearing aids. Thus, most older people can afford the initial costs of hearing devices and their maintenance. Those that cannot afford the best products will do rather well with older technology that is readily available for a substantial reduction in cost.

Lack of Transportation

Older people often have difficulty with obtaining transportation to the clinic. As eyesight fails, and driving is no longer an option, patients must depend upon others to take them to their appointments. While this is usually an accommodation offered in assisted living, and paid by some managed care programs, patients may not choose to use amplification due to the lack of the capability to get to the clinic for appointments.

Lack of Motivation to Hear

The person who lives alone may rationalize that they can hear the TV well enough by turning it up and there is no one else with which to communicate around the house. Additionally, this issue may also be part of depression in that the person does not care to communicate with anyone and then will not choose to use amplification.

Fear of Being Seen as Failing or Incompetent

While stigma is significantly less in this century, it remains an issue. Although products are smaller and more beneficial, it is the stigma of the use of amplification that keeps some patients from considering the use of devices. Although with all the various types of hearing products in use in 2024, society tends to look at those that use hearing instruments as not as capable as those that do not use these devices.

Afraid of Doctors & Professionals

There is an actual phobia called iatrophobia, or the fear of doctors that affects about 3% of the population (Esposito, 2014). Defined as the morbid and irrational fear of doctors or hospitals, this does not refer to those who simply do not like these places, but rather those who are deathly afraid of them and anything associated with them, such as audiologists. Medical Economics (2021) reports that patients' general trust in doctors is also declining. Surveys have shown that nearly 40% patients in the United States believe that today's physicians do not care about patient wellbeing.

Motor Coordination Problems

Fine motor skills of the hand are important in many daily activities, such as buttoning a shirt, unlocking doors. If these skills deteriorate, it will be difficult to manipulate hearing

devices to put them on and off, changing batteries, and other necessary skills. Additionally, there can be cerebellar issues that cause special perception difficulties as part of the aging process that cause difficulty with the use of amplification.

Bad Prior Experience with Hearing Aids or Vendors

While there are many positive stories for the use of amplification, cursory check of the Internet will glean much discussion about bad experiences with hearing devices and those that sell them. These bad experiences could be due to the purchase of the wrong device, inaccurate fitting or programming, not giving the devices the opportunities to work, or not being able to hear in noisy environments. It could be due to customer service, lack of expertise, education or experience by the dispenser. Expensive products that do not work create a lack of wanting to repeat that terrible experience.

Friends or Relative Bad Experiences with Hearing Aids or Vendors

Hearing instruments have a terrible reputation, and it is easy to find a friend or relative that has advice for the patient that is shopping for hearing devices. Most stories are similar to those above that are not firsthand and full of bad advice.

Overstimulation

While sensory overload can be a result of a disorder such as recruitment or hyperacusis, hearing devices are often fit with excessive sound or overamplification. Patients are not ready for the full recommended levels of amplification in the beginning and psycho-acoustically require a gradual introduction of sound into their lives. This is particularly true if there has been sound deprivation for an extended period of time prior to the use of hearing instruments.

Emotional Status

The loss of hearing causes many people to go through emotional stages similar to the loss of a loved one: denial, anger, depression and finally, acceptance. Adults that lose their hearing slowly without a diagnosis may undergo a slow change in personality. Isolation is common as they may be confused or fearful about their inability to communicate as clearly. The fear of losing one's income, relationships or social standing can have a huge emotional impact, causing elevated levels of stress that then affect health in other areas.

Even with diagnosis, the thought of wearing a hearing device can cause loss of self-esteem. It is not unusual for hearing loss to turn a once friendly, confident adult into an angry, isolated grump. Thus, people with hearing loss feel less comfortable and less confident in social situations, which increases psychological stress.

Ear Pain and Allergies

Of course, if the ear hurts or there are allergies to the devices, obvious difficulty arises in the use of hearing devices.

Vanity

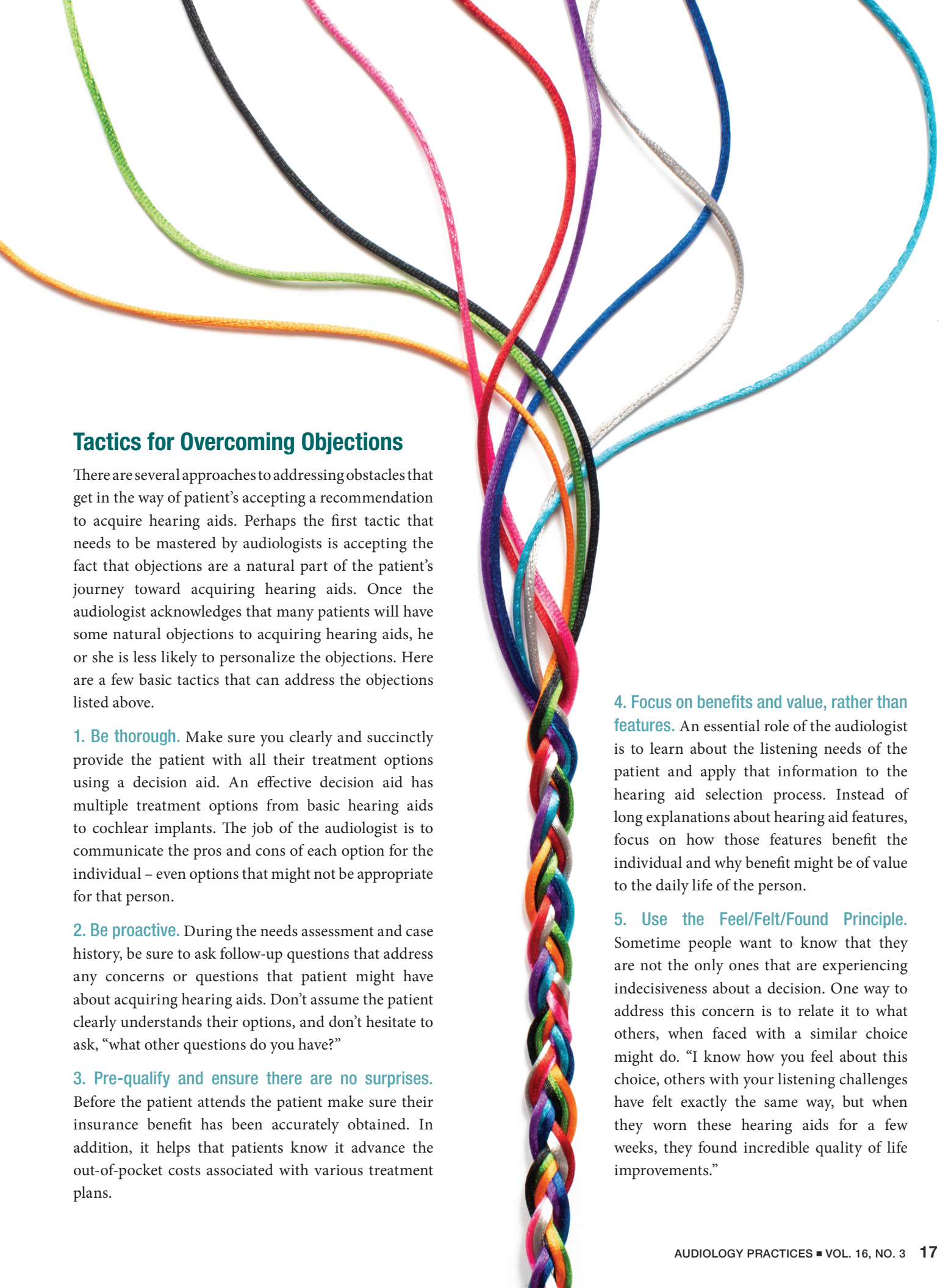
For many the image of themselves does not fit their age and/or their hearing impairment. Many patients associate hearing problems with being old, however, do not feel old. Their self-image is that of a young confident robust person with successful careers and responsibilities. No matter the differences in the product, hearing instruments do not fit the self-image of the hearing-impaired person.

Fear of Ridicule

Alcido & Lloyd (2024) report that there is still a pervasiveness of perceived stigma associated with hearing loss and use of hearing aids and their close association with ageism and perceptions of disability. They also identify the potential influence of media and advertisements on maintaining hearing loss and hearing aids as stigmatizing.

- Almost half (46%) of people diagnosed with some degree of hearing loss do not regularly wear a hearing aid.
- Nearly half (48%) of those with hearing loss believe that there is still a stigma associated with wearing a hearing aid.
- Over half (51%) of respondents said the main benefit of wearing a hearing aid is that it allows them to have better communications with friends and family.
- Cost is the most common reason people do not wear hearing aids, with 56% of respondents saying they are too expensive. [Not supported by other studies].

The most common social barrier people with hearing loss experience are difficulties hearing important announcements or information in public spaces like airports or train stations, as reported by 55% of respondents.



Tactics for Overcoming Objections

There are several approaches to addressing obstacles that get in the way of patient's accepting a recommendation to acquire hearing aids. Perhaps the first tactic that needs to be mastered by audiologists is accepting the fact that objections are a natural part of the patient's journey toward acquiring hearing aids. Once the audiologist acknowledges that many patients will have some natural objections to acquiring hearing aids, he or she is less likely to personalize the objections. Here are a few basic tactics that can address the objections listed above.

1. Be thorough. Make sure you clearly and succinctly provide the patient with all their treatment options using a decision aid. An effective decision aid has multiple treatment options from basic hearing aids to cochlear implants. The job of the audiologist is to communicate the pros and cons of each option for the individual – even options that might not be appropriate for that person.

2. Be proactive. During the needs assessment and case history, be sure to ask follow-up questions that address any concerns or questions that patient might have about acquiring hearing aids. Don't assume the patient clearly understands their options, and don't hesitate to ask, "what other questions do you have?"

3. Pre-qualify and ensure there are no surprises. Before the patient attends the patient make sure their insurance benefit has been accurately obtained. In addition, it helps that patients know it advance the out-of-pocket costs associated with various treatment plans.

4. Focus on benefits and value, rather than features. An essential role of the audiologist is to learn about the listening needs of the patient and apply that information to the hearing aid selection process. Instead of long explanations about hearing aid features, focus on how those features benefit the individual and why benefit might be of value to the daily life of the person.

5. Use the Feel/Felt/Found Principle. Sometime people want to know that they are not the only ones that are experiencing indecisiveness about a decision. One way to address this concern is to relate it to what others, when faced with a similar choice might do. "I know how you feel about this choice, others with your listening challenges have felt exactly the same way, but when they worn these hearing aids for a few weeks, they found incredible quality of life improvements."

Audiologists walk a fine line, on one side there is the fiduciary responsibility to the patient to provide the best hearing care possible (aural rehabilitation), but there are also the business pressures of running and maintaining the practice (the need to make sales). Aural rehabilitative treatment and the sales process, however, are one in the same as when the rehabilitative process is conducted correctly the sales will simply happen as a result. The process is really a journey by the patient toward a goal of better hearing and, if conducted properly, the journey naturally leads to a "sale." By realizing that patients are on a journey toward better hearing, rather than a "sales prospect," clinicians can meet both the needs of the patients and the practice. The method involves moving the patient toward a decision to pursue treatment, building a relationship with them through 1st impressions, building trust, and offering continuous care; the "sale" comes easily and is a natural part of the aural rehabilitative process.

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This article is an excerpt from the upcoming textbook, Strategic Practice Management, 4th Edition. It will be published in 2025 by Plural Publishing. The author can be contacted at bob@rtaudiology.com ■

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INTRODUCING

Sound Check

CLINICAL BULLETINS

Brian Taylor, Au.D.

Each year hundreds of research articles are published in the academic peer-reviewed journals. This work of course reflects the expertise and dedication of researchers who often devote decades of their career to advancing the profession of audiology. Currently, there are few places to find analysis and translation of academic research into clinical practice. Besides published best practice standards and the occasional Grand Rounds webinar at Audiology Online or general session at one of the large annual professional organization meetings, there is a dearth of material in this area. *Sound Check Clinical Bulletins* hopes to be one additional place where busy clinicians can find relevant, current evidence-based summaries of peer-reviewed research.

There are several reasons clinicians need to be mindful of research and strive to stay current by reading and analyzing as many articles as possible. Here are some of the most valid reasons:

Evidence-Based Practice

It provides a solid foundation for clinical guidelines and interventions, helping audiologists make informed decisions based on the latest research that ultimately drive better patient outcomes.

Advancement of Knowledge

Peer-reviewed studies contribute to the ongoing development of the field, identifying new trends, technologies, and treatment methods. A big part of gaining respect from other professionals is through the advancement of knowledge in your own profession which is then shared with other similar professions.

Professional Credibility

Similar to the previous point, research published in reputable journals elevates the credibility of the profession and fosters trust among patients and healthcare providers.

Collaboration and Innovation

It encourages collaboration among researchers, clinicians, and educators, leading to innovative solutions for hearing-related issues.

Quality Assurance

The peer review process used to create and disseminate research ensures that studies meet high scientific standards, enhancing the reliability and validity of findings, further enhancing the credibility of the profession and the clinicians who work within it.

Although there are several valid reasons for reading and digesting peer reviewed research, there are several barriers to prevent clinicians from do so. This list includes:

Time Constraints

Busy schedules and heavy workloads can make it difficult for clinicians to find time to read and analyze research articles.

Access Issues

Some clinicians may have limited access to academic journals or databases due to institutional restrictions or subscription costs.

Complexity of Research

The technical language and complex methodologies used in peer-reviewed studies can be intimidating or difficult to understand without a strong background in research methods. Most clinical audiologist have had one college-level statistics course, so their knowledge tends to be limited in this area. Thus, lack of training is also an issue. Some clinicians may not have received any formal training in how to critically evaluate research, leading to hesitation in reading studies.

Relevance

Clinicians may feel that certain studies are not directly applicable to their specific practice or patient population.

Overwhelm from Volume

The sheer volume of new research can be overwhelming, making it challenging to keep up with the latest findings.

Preference for Practical Guidance

Many clinicians prefer clear, practical guidelines or summaries over detailed research articles that require interpretation.

Perception of Research

Some may view research as too theoretical or disconnected from clinical practice, leading to a lack of interest.

Given the value of research, combined with these barriers, *Sound Check Clinical Bulletins* attempt to bridge the gap. The hope is to promote better engagement with peer-reviewed literature among clinicians by taking relevant studies and demonstrating how their findings can be translated and applied into clinical practice.

Sound Check | CLINICAL BULLETIN #1

Getting Snug with the COSI:

The Patient Expectations Worksheet (PEW)

The Client-Oriented Scale of Improvement (COSI) is probably the most popular outcome metric used in clinical audiology. For the unversed, the COSI asks the person with hearing loss, along with guidance from the clinician, to target and record up to five listening situations where hearing aids will provide benefit. Like other outcome measures, the COSI is first completed during a pre-fitting appointment before hearing aid use begins, and then re-assessed several weeks later in the aided condition. Developed by researchers at the National Acoustic Laboratories (Dillon, James & Gillis, 1997), the COSI captures two dimensions of outcome: final ability and degree of improvement, using a 5-point scale.

Much has been written about the COSI; see for example, pages 215-219 of the textbook, *Essentials of Modern Hearing Aids*. The focus of Clinical Bulletin #1 is using the COSI to gather information about patient expectations. As any experienced clinician knows, expectations can influence outcomes: Exceedingly high expectations can lead to disappointment, including returns for credit and non-use. In contrast, a patient with too low expectations, although easy to satisfy because their expectations are -ahem- low, nevertheless is not receiving the service and attention they deserve. For these reasons, the Patient Expectations Worksheet (PEW) is an easy and efficient way to align the individual's expectations with final outcomes. The PEW was originally created by Palmer & Mormer (1999).

Here is how it works: As usual during the pre-fitting appointment, designate and record up to five goals on the COSI. In the example below, to keep it simple, there are just two goals listed. Next, after these goals have been recorded on the PEW, using the 1 to 5 scale, the patient indicates how often he is successful in the situation currently (C), prior to hearing aid use, and how he expects to function after the intervention (E). The "E" stands for expectations. Then, the audiologist marks the PEW with an X-mark ("x") to indicate what she believes is a realistic expectation for that individual. The judgement of the clinician – where the "X" is placed for each goal – is based on the audiologic and non-audiologic information of that individual gathered during the pre-fitting appointment.

Assessing the individual's self-reported functional communication ability and expectations using the 1 to 5 scale is an effective counseling tactic that helps establish the clinician as the trusted advisor. Figure 1 shows an example of a completed PEW in which the patient's expectations and the audiologist's judgments of success are fairly well aligned.

Goal	Hardly Ever	Occasionally	Sometimes	Most of the Time	Almost Always
To participate in social situations with friends		C		X	E
To gossip with my neighbors on the back porch without having to strain or repeat	C			X	E

Figure 1. An example of the completed PEW where treatment goals, expectations are recorded. Expectations of the patient are compared to how the audiologist believes the patient will be achieved post intervention. C = how patient rates their current ability to communicate, E = how the patient expects to communicate post-intervention, X= audiologist's judgment of what outcome the patient will achieve. Note in this example how patient expectations and audiologist expectations are closely aligned.

When Expectations are Out of Alignment

Occasionally the "E" of the patient and "X" of the clinician will not agree. In practical terms, this occurs when the "E" and "X" are separated by two or more categories. For example, the patient may state his expectations in the "almost always" category, while the clinician believes that realistic expectations fall in the "sometime" category. When expectations don't align, the audiologist counsels the patient until he understands why his expectations might be too high or too low. Alternatively, when patient and clinician cannot align on expectations, a conversation about modifying the planned intervention must take place.

Determining Your "X"

A critical part of conducting the PEW is the clinician's ability to determine or predict the outcome of each targeted goal on the 1 to 5 scale. This determination relies on sound clinical judgement and experience. However, the clinician should use the results of objective tests like the pure tone audiogram and Quick SIN, as well as familial support and the patient's perceived attitude toward wearing hearing aids when deciding where to place the "X" on the 1 to 5 scale.

The Crux of the Matter

By allowing patients to weigh in on their post-fitting expectations and comparing those expectations to the clinician's expectations of that patient, the PEW is an excellent vehicle for having a deeper, more person-centered dialogue about expected treatment outcomes.

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Sound Check | CLINICAL BULLETIN #2

Measuring Listening Related Fatigue

with the VFS-A-10

Spend a few weeks in a busy hearing aid dispensing practice and it's just about guaranteed that you will have several patients state that various settings, such as long meetings, conferences, or environments with continuous background noise cause them to feel tired and often extremely exhausted at the end of the day. What patients are describing is a type of mental and physical exhaustion that occurs from prolonged or intense listening, called listening-related fatigue.

Recent research has shown that listening-related fatigue is linked to people being less productive at work, more prone to accidents, more socially isolated, and more likely to be depressed. Symptoms of listening-related fatigue may include difficulty concentrating, irritability, headache, or a sense of mental exhaustion. Additionally, this research indicates older people and persons with hearing loss are more likely to suffer from listening-related fatigue. No wonder so many individuals seeking the help of audiologists complain they are so worn out at the end of a long day of listening.

Although we have known about the ill-effects of listening-related fatigue on persons with hearing loss, it was not possible to readily assess it in the clinic – until now. Benjamin Hornsby and colleagues recently created the Vanderbilt Fatigue Scale for Adults (VFS-A-10). And there is additional good news: hearing aids can reduce listening-related fatigue.

The VFS-A-10 is a ten-question self-report that assesses several dimensions of listening-related fatigue. It can be administered pre and posting fitting. The VFS-A-10 is scored by summing the responses from the five-point Likert scale. It takes less than two minutes for most patients to complete it.

Given the brevity of the VFS-A-10, it can be used as a counseling tool, even when the unaided score is innocuously low.

Simply stated, the higher the tallied score, the more self-reported problems the individual has with listening-related fatigue. According to the originators of the VFS-A-10, a score of 26 or higher is an indication of "frequent problems with fatigue" (Hornsby, et al 2023). A recent clinical study showed that five of 42 (12%) individuals fitted with hearing had a score of 26 or higher, and two of 42 (5%) had a score greater than 30 (Tagvaei & Taylor, 2024). In this study, the mean unaided score was 13, while the mean aided score with 6. This finding demonstrates the benefits of hearing aids at reducing listening-related fatigue.

Symptoms of listening-related fatigue may include difficulty concentrating, irritability, headache, or a sense of mental exhaustion.

		Never/ Almost Never	Rarely	Sometimes	Often	Almost Always/ Always
1.	I feel worn out from everyday listening.	0	1	2	3	4
2.	Struggling to listen and understand makes me feel tired.	0	1	2	3	4
3.	I get so exhausted from listening that I cannot do the things I enjoy.	0	1	2	3	4
4.	I schedule my day to avoid getting tired from listening.	0	1	2	3	4
5.	I get so tired from listening that I start to miss details in a conversation.	0	1	2	3	4
6.	I get so exhausted from listening that I go to bed early.	0	1	2	3	4
7.	I withdraw when I am unable to follow conversations in noisy places.	0	1	2	3	4
8.	Feeling tired from listening causes strain on my relationships.	0	1	2	3	4
9.	I feel emotionally drained when it is hard for me to listen and understand.	0	1	2	3	4
10.	It takes a lot of energy to listen and understand.	0	1	2	3	4

Figure 1. The VFS-A-10 administered to patients pre- and post-fitting (Hornsby et al., 2023).

Given the brevity of the VFS-A-10, it can be used as a counseling tool, even when the unaided score is innocuously low. For example, let's say an individual has an unaided overall score on the VFS-A-10 of eight but the patient circled a "4" on Question 7, "I withdraw when I am unable to follow conversations in noisy places." Even though the other scores were "0's" and "1's", the high score on Question 7 would serve as an area to target for improvement with hearing aids. This high score on just one question of the VFS-A-10 could be addressed through counseling, prior to hearing aid use.

The VFS-A-10: As Easy as 1-2-3

Since the VFS-A-10 can be administered in two minutes or less, has been validated, and measures a common problem that can be alleviated with hearing aids, it is highly recommended for routine clinical use. The VFS-A-10 can be used in the following ways.

1. Have each patient complete it in the reception area prior to their initial appointment. Review the results during the initial appointment.
2. Re-administer it 2 to 4 weeks post fitting to assess aided benefit in listening-related fatigue. As a general rule, the aided score should be about half of the unaided score.
3. Even when the overall aided VFS-A-10 score is low, high scores on individual questions can be identified for improvement with hearing aids and items that can be targeted for counseling.

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Will Apple Change Hearing Health?

Alexander Goldin, PhD

On October 16 and 17, 2024, I attended the EUHA exhibition in Hanover, Europe's leading event for the hearing aid acoustics and audiology industry. I had 19 meetings in two days and in half of them I was asked for my opinion on Apple's upcoming firmware update for the #AirPods Pro 2. This firmware update will officially turn the AirPods into over-the-counter, self-fitting hearing aids.

Is this a big step towards helping tens or even hundreds of millions of hard of hearing people worldwide?

Is this a big step towards helping tens or even hundreds of millions of hard of hearing people worldwide and reducing the $750 billion burden of untreated hearing loss on society? Or is it just another feature of the AirPods that Apple introduced for a short-term marketing buzz that will soon become an obscure function that few know about?

My opinion is that both answers are YES.

Why My Opinion Matters

I am the founder and CEO of Alango Technologies, a 22-year-old Israeli provider of speech and audio enhancement DSP software for leading brands in the consumer audio, automotive and conferencing markets. I have been following the global situation in solutions for the hearing impaired since 1998. Twelve years ago, I thought we would soon have one. Alango began developing digital sound processing technologies for hearing enhancement and foresaw a near-term interest in integrating hearing aid functionality into Bluetooth headsets (there were no TWS earbuds at the time). Our vision was shared by our silicon partner Cambridge Silicon Radio (CSR , now part of Qualcomm), the leading supplier of #Bluetooth SoCs and the only one with a digital signal processor integrated into their chip at the time. We developed it and in 2014 it was included in the CSR partners' solution catalog as a solution for "hearing enhancement and assistive listening". We called our solution HearPhones™.

We were wrong, the time for HearPhones was not yet ripe. The introduction of True Wireless Stereo (#TWS) earbuds in 2014, followed by the Apple AirPods, kept the entire industry busy with the task of making as many TWS earbuds as possible with good sound but no additional features. At the time no major audio brand was interested in licensing the Alango HearPhones solution. Until recently.

Two days after Apple's announcement, we received requests from our existing or potential customers who wanted to support similar features in TWS products. Some of them want it as soon as possible, actually even sooner.

It took 10 years, but now I am hopeful again. Let us look back in history. That will help us understand whether and why things can be different this time.

SoundID

The idea of integrating a hearing amplification into a consumer audio headset is almost 20 years old. I believe it was first introduced by Rodney Perkins, a physician and entrepreneur, the founder of hearing aid manufacturer ReSound. SoundID, shown in Figure 1, was introduced in 2007 and was the first product to combine a Bluetooth headset with a hearing aid. SoundID has failed commercially.

Figure 1. SoundID Bluetooth headset & hearing amplifier.

SoundHawk

Rodney Perkins had not given up. In 2014, he founded another company that launched a new product called SoundHawk, which was more compact and elegant looking. The earphones featured beamforming technology with two microphones. SoundHawk was also equipped with a remote microphone, another innovation that could help people with hearing loss communicate in a difficult, noisy environment.

Figure 2. SoundHawk Bluetooth headset with a remote microphone and charging box

Bose Hearphones

That the time was still not yet ripe is confirmed by the story of Bose Corporation and a product they called Hearphones, introduced in December 2016. Figure 3 illustrates the Bose Hearphone. The Bose Hearphones were controlled by a smartphone app, and it worked pretty well as hearing aids. It had active noise cancellation when you didn't want to hear anything and were reasonably comfortable for situational hearing. The product was discontinued because demand was much lower than Bose expected. Bose made another attempt to develop over-the-counter hearing aids based on the same technology and self-fitting process, but eventually gave up the business and licensed its self-fitting solution to Lexie.

The Bose Hearphones product and the Alango HearPhones™ software solution had nothing in common except the general idea and the name itself. You can read more in my LinkedIn article "The Game of HearPhones"

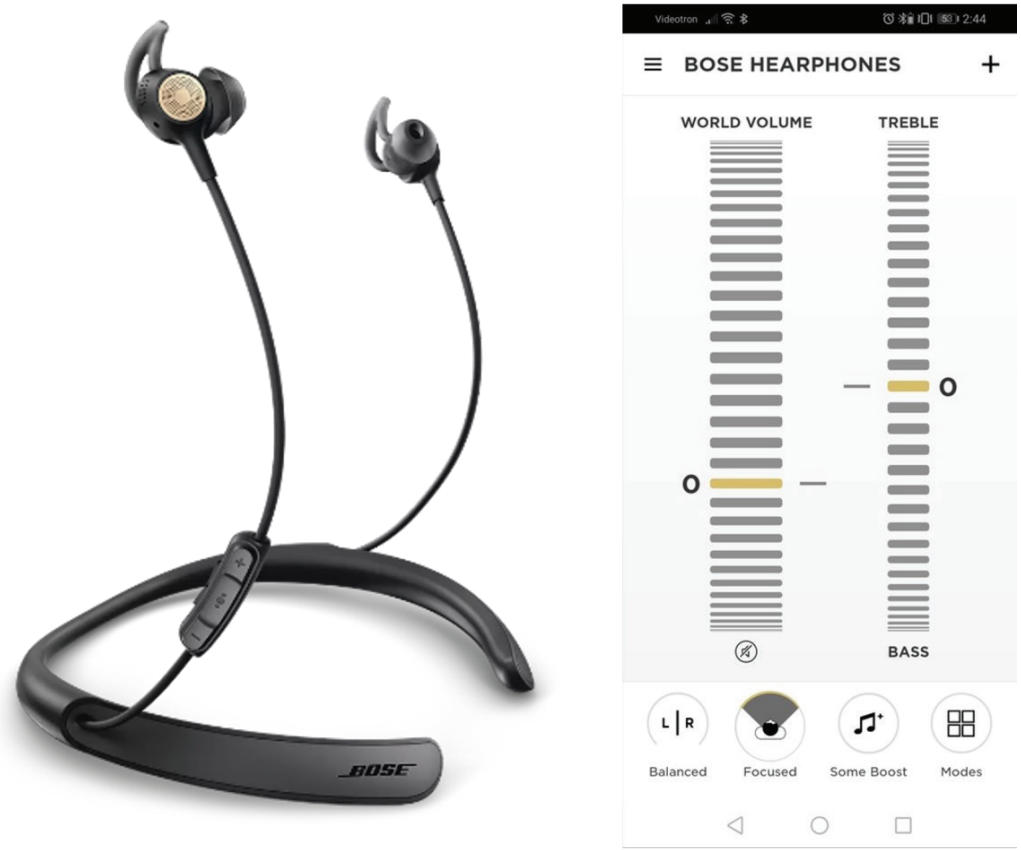

Figure 3. Bose Hearphones and their self-fitting/tuning app.

Alango BeHear

After realizing in 2014 that no major consumer audio company would license our HearPhones software solution to add hearing aid features to their products, I said to myself, "If you want something done right, you have to do it yourself". In early 2017, Alango introduced BeHear NOW, its own Bluetooth stereo headset that also functions as a powerful hearing aid. You can watch the fun introductory video for BeHear NOW here: https://www.youtube.com/watch?v=ueZFtiftevU

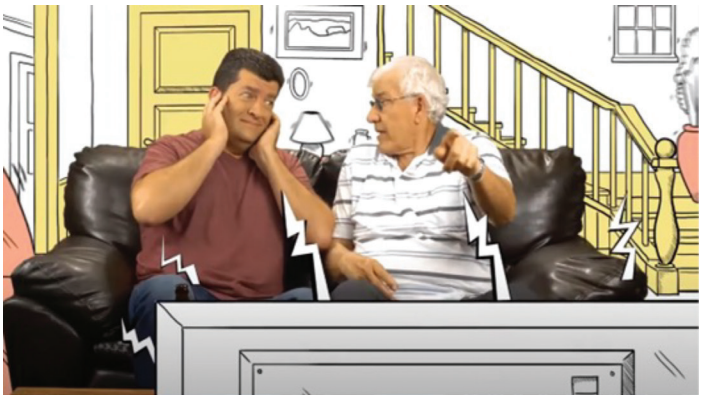

Figure 4. BeHear NOW video screenshot

Figure 5. BeHear ACCESS Bluetooth headset and personal hearing amplifier

The successor model, shown in Figure 5, BeHear ACCESS with a similar form factor but with a telecoil option and a charging cradle was introduced two years later. Some new advanced features were added to the software, such as Alango EasyListen™ technology to slow down fast talkers while on the phone and self-tuned tinnitus masking. We've even added a low-latency Bluetooth transmitter to our portfolio so that BeHear ACCESS can be easily connected to a TV or other audio source.

BeHear ACCESS soon received CES and Hearing Technology awards, good reviews from hearing care professionals and good customer testimonials. But BeHear ACCESS did not make us rich. The problem was that the product was self-funded by Alango and we didn't have enough money to promote it the way we needed to. Also, Covid-19 wiped out all our work and agreements with potential distribution partners in the US, Europe and worldwide. But we gained a lot of experience that we could not have as a pure software company.

"Apple will influence hearing health by forcing other manufacturers to follow suit."

Why This Time Might Be Different

Apple did not introduce the self-fitting feature for over-the-counter hearing aids in the AirPods to significantly increase AirPods sales. Apple has a vision, an accessibility strategy and resources to stay ahead of the competition. The hardware has been there for a long time. Now it's time to upgrade your AirPods and you can get your first hearing aids. It's the FDA concept of Software as a Medical Device (SaMD) . If you don't have AirPods yet, they will only cost you $249. Not really a lot of money for good hearing aids. However, there is a small caveat. If you are an Android user, you will have to pay "slightly" more for a new iPhone as well.

I am pretty sure Apple's competition, as in many other cases, will try to offer a similar free, self-fitted OTC hearing aid feature. Once this happens, this feature will become standard. And if it becomes the standard feature, there is a good chance that hearing aids for mild and moderate hearing loss will become obsolete. Unless hearing aid manufacturers introduce something truly innovative, which they have not done since the introduction of the first successful and fully digital hearing aids at the start of the new millennium.

Conclusion

The Apple AirPods with enabled hearing aid function will not change the situation of hearing health worldwide. Apple will influence hearing health by forcing other manufacturers to follow suit. The corresponding marketing campaigns will increase public awareness of alternatives to hearing aids. Competition will eventually lead to devices that work for 20 hours on a single charge, are comfortable to wear all day long, excel at reducing unwanted interference and may one day know what I want to hear and what I don't want to hear – all at a price point of less than $300.

***Alexander Goldin, PhD**, is the founder and CEO of Alango Technologies* ■

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Introducing Merlin

Making Hearing Care Accessible to All

Hearing health is a critical issue that affects millions of people worldwide, yet it is often overlooked—especially among vulnerable populations like the elderly, low-income communities, and those living in remote areas.

Terry Mactaggart

According to the World Health Organization (WHO), over 80% of people with disabling hearing loss live in low- and middle-income countries, where access to hearing care is severely limited. Even in high-income countries, many people face challenges in accessing hearing health services due to financial constraints, lack of awareness, and geographical barriers.

The Global Challenge of Hearing Health

Hearing loss isn't just a personal issue—it has far-reaching social and economic impacts. Untreated hearing loss can lead to social isolation, reduced quality of life, and a decline in mental and cognitive health. Globally, untreated hearing loss costs the economy an estimated $750 billion annually due to lost productivity, healthcare costs, and educational support. These figures highlight the urgent need for accessible hearing care, yet the reality is that many people simply do not have the resources or access to necessary services.

Globally, untreated hearing loss costs the economy an estimated

$750 billion

annually due to lost productivity, healthcare costs, and educational support.

In low- and middle-income countries, the situation is even more dire. The WHO reports that in these regions, there is often only one audiologist per million people. This scarcity of resources means that many people with hearing loss never receive the care they need, leading to avoidable disability and suffering. Even in wealthier nations, barriers such as high costs, limited availability of specialists, and lack of awareness prevent people from seeking timely treatment.

How Merlin Is Changing the Landscape

Merlin is designed to break down these barriers and make hearing health accessible to everyone, regardless of their circumstances. With Merlin, hearing care is no longer a luxury but a service available to all. The platform leverages cutting-edge AI technology to offer personalized, actionable insights that empower users to take control of their hearing health from anywhere in the world.

Accessible Technology for All

Merlin's user-friendly interface makes it easy for anyone to monitor their hearing health, even without prior technical knowledge or expensive equipment. The platform's hearing tests are simple and non-invasive, allowing users to assess their hearing at home with nothing more than a smartphone or computer. This ease of access is particularly valuable for elderly individuals or those in remote areas who might otherwise struggle to access traditional hearing health services.

Personalized, Actionable Guidance

Merlin doesn't just provide hearing tests; it offers personalized recommendations tailored to the user's specific needs. For instance, an elderly person living in a rural area with limited access to healthcare might not know where to turn if they experience hearing loss.

Merlin can guide them through the next steps—whether it's exploring affordable hearing aid options, seeking further medical evaluation, or making lifestyle changes to protect their hearing. This personalized approach ensures that users receive care that is appropriate for their individual circumstances, reducing the risk of untreated hearing loss and its associated complications.

Culturally Sensitive and Multilingual

Merlin's commitment to accessibility goes beyond technology. The platform is designed to be culturally sensitive and available in multiple languages, ensuring that users from diverse backgrounds can benefit from its services. Whether someone speaks English, Spanish, Mandarin, or another language, Merlin is there to guide them through their hearing health journey in a way that is respectful and understandable. This cultural inclusivity helps break down additional barriers to care, making Merlin a truly global solution.

Your Role in Expanding Merlin's Reach

Imagine a world where everyone, regardless of their location, income level, or background, has access to the hearing care they need. With Merlin, that world is within reach. Your contribution can help us develop new features, enhance our multilingual support, and ensure that even the most remote and underserved populations can benefit from Merlin's life-changing capabilities.

My recent post about **"Moving the Meter for Hearing Health"** summarized a perspective gained over the last decade as the hearing health market evolved. That, for me, started with an article published in Audiology Practices (Winter, 2013) where, as a business professional and hearing tech company founder, I noted that concentrated industry structure and bundled trade practices would inevitably lead to disruption and the introduction of new hearing care models. Several posts followed about "Navigating the Road Ahead" concluding with those during the last couple of years when "Disruptions" were described as becoming more obvious.

A complimentary insight stemmed from the substantial data set we have accumulated from testing in several different settings (family physicians, hearing aid dispensaries, pharmacies, public spaces) covering a wide demographic from young children to Super Seniors. Given our ability to interpret pure tone results and place them in standard audiological categories, we were able to determine the proportion of users in various age cohorts who classified as Normal, Conductive, Sensorineural, and Mixed.

A third stimulus continues to come from the research community – numerous studies and articles stressing the growing incidence of hearing problems, comorbidities with other disease states and relationships to cognitive concerns.

This combination of influences has led me (corroborated by others) to conclude that Hearing Loss is arguably the **largest untreated chronic health problem in our society** and that current approaches, several innovative and progressive, are not doing enough to stem the still rising tide.

The traditional market approach has long been limited in scope. While identifying hearing loss and prescribing hearing aids are essential components of hearing health, they are only pieces of a much larger puzzle. Many aspects of an individual's hearing health, except when examined carefully by a skilled professional, go unaddressed, leaving gaps in care that can impact overall well-being. This is particularly true of internet-based testing.

Hearing Loss is arguably the largest untreated chronic health problem in our society.

Critical factors that are frequently overlooked include:

- **Age and Messaging:** Position in one's life cycle is an obvious consideration. While the proportions of so-called "Normals" are higher at younger ages and "Sensorineurals" increase with older people, most virtual testing doesn't account for the age factor. And clearly the messages provided as motivators to different age cohorts with similar classifications need to be different and nuanced.
- **Lifestyle Considerations:** One's daily activities, hobbies, and work environment all play a significant role in hearing health. Standard tests rarely account for these differences, leading to one-size-fits-all solutions.
- **Overall Health:** Conditions such as diabetes, cardiovascular disease, and even stress can influence hearing health significantly. These factors are often ignored particularly in net-based hearing assessments, yet they are crucial for understanding the full picture of auditory well-being
- **Personal Preferences:** The decision to use hearing aids or other interventions is deeply personal. Factors such as comfort, aesthetics, and lifestyle compatibility should be considered, but they are often sidelined in the rush to fit a device.

This narrow approach can result in missed opportunities for early intervention, underutilization of preventive measures, and suboptimal care that fails to address the unique needs of each individual.

Bridging those gaps by offering a more holistic and personalized approach to hearing care will contribute to redefining how we think about and manage hearing health. Rather than waiting longer, we have decided at Summus to embark on an ambitious project which, when fully available, should help **"Move the Meter"** in a significant way. It is being branded "**Merlin**" and represent a major, potentially breakthrough, addition to our well-established Hearing Guidance Process.

An introductory description reads…

Introducing Merlin, a branded extension – Going From Good to Great

merlin
Your Hearing Health Guide

Our current Guidance Process is very GOOD, used by tens of thousands from ages 10 to 80, resulting in incremental gains.

But that's not enough. Delays of 7-10 years in taking action are common, far too long to be effective.
We need to move the meter!

Merlin's Mission
Merlin will become an easy-to-use app, designed to tackle the hearing health problem head-on by testing members, guiding the referral process if healthcare professionals are warranted, providing an understanding about the repercussions of delay, and nudging users to take necessary action.

Merlin will layer in influences like age and lifestyle to its inference engine, integrating attitudes and behavioral considerations in its follow-up assessments and ensuring that his motivational and action-oriented prompts are tailored to the specific user needs.

And is amplified by the hearing healthcare problems it is designed to address…

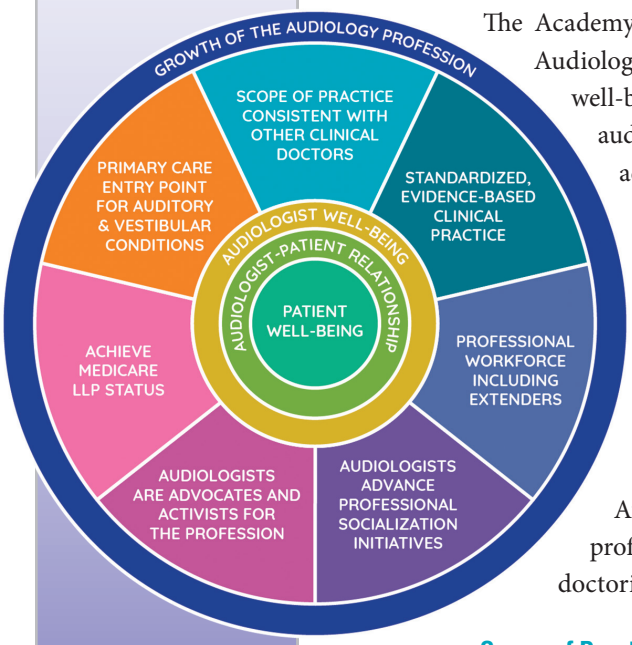
Our hope is, that with sufficient backing, an "AI Companion" like Merlin - a capability still scarce but likely to see more in healthcare - will become conventional in use.

Breaking down silos to foster greater collaboration, mandating doctors to add hearing to their protocols, new applications of AI and more robust, well funded policy initiatives would also make a positive difference. My wish, over time, is that that the hearing ecosystem will mature to approximate what has been achieved in other disease arenas. And that's a Big Wish!

Terry Mactaggart *is founder and CEO of Summus, the Hearing Guidance Company. Inquires can be forwarded to him at terry.mactaggart@bell.net* ■

HAVE YOU HEARD?

ADA Launches Audiology 2050



The Academy of Doctors of Audiology (ADA) recently announced the launch of the Audiology 2050 Initiative, laying out a bold vision for audiology's future. With patient well-being at its core, the Audiology 2050 roadmap aims to solidify the role of audiologists as primary care providers for auditory and vestibular conditions, advance professional standards, modernize audiology's scope of practice, and enhance patient care through novel and innovative education, workforce, and care delivery models.

"Over the past 25 years, audiology has transitioned from a master's-degreed profession to a clinical doctoring profession," said Jason Leyendecker, Au.D. "But the work has only begun. Over the next 25 years, we must achieve the objectives that will fully transform the practice of audiology to obtain all the rights, roles, and responsibilities worthy of clinical doctors."

Audiology 2050 focuses on seven key objectives, necessary to advance the profession of audiology and ensure that it reaches its full potential as a clinical doctoring profession:

Scope of Practice Consistent with Other Clinical Doctors:

The initiative will modernize state audiology laws to reflect the full scope of audiology practice, including evaluation, diagnosis, management, and treatment of auditory and vestibular conditions.

Standardized, Evidence-Based Clinical Practice:

ADA aims to collaborate with other organizations and interdisciplinary experts to establish, promote, and endorse up-to-date, evidence-based standards of care, with a focus on achieving universal clinical guidelines and promotion of the ADA Audiology Practice Accreditation.

Professional Workforce Including Extenders:

By developing and supporting new staffing and educational models, Audiology 2050 seeks to incorporate qualified extenders and optimize audiology service delivery, ultimately improving patient outcomes and practice efficiencies.

Audiologists Advance Professional Socialization Initiatives:

Doctors of Audiology must ensure that future Doctors of Audiology are professionally prepared and socialized as clinical doctoring professionals through practical residency, mentoring, and professional training standards that include support for private practice.

Audiologists as Advocates and Activists for the Profession:
Audiologists must lead advocacy efforts at the state and national levels to protect consumers and advance the profession.

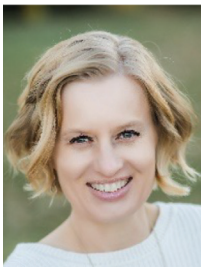
Achieve Medicare LLP Status:
Reclassifying audiologists from suppliers to practitioners within the Medicare system will improve beneficiary access and enhance Medicare system efficiencies. Audiologists must prepare for compliance responsibilities that come with this important change.

Primary Care Entry Point for Auditory & Vestibular Conditions:
Audiologists must position themselves as the first point of care for hearing and balance concerns, with increased emphasis on comprehensive, interdisciplinary approaches to patient care.

Visit www.audiologist.org to learn more about the Audiology 2050 Initiative.

Drs. Davis, Kopetzky, and Tarvin Elected to Positions on the ADA Board of Directors


Jill Davis, Au.D.


Nikki Kopetzky, Au.D.


Alexandra Tarvin, Au.D.

The Academy of Doctors of Audiology (ADA) is pleased to announce that Jill Davis, Au.D. has been elected to serve as ADA President-Elect for the 2025 program year. Dr. Davis is the owner and audiologist at Victory Hearing and Balance in Austin, Texas. Driven by her desire to help patients hear their best, she created a music-based auditory training program called Victory Brain Training, which is designed to improve memory and speech in noise processing.

Dr. Davis works with students from the University of Texas and surrounding Au.D. programs to encourage full scope audiologic care in the private practice setting and educates on small business ownership. Dr. Davis is a graduate of the University of Cincinnati, where she received both her Doctor of Audiology and Bachelor of Science degrees.

Nikki Kopetzky, Au.D. has been elected to serve as a director-at-large on the ADA Board of Directors. Dr. Kopetzky became a private practice owner in 2020, where she serves patients in Omaha, Nebraska. Prior to that time, she held positions in a hospital-based ENT clinic, and a manufacturer-owned clinic during her two-decade career. Dr. Kopetzky holds bachelor's and master's degrees from the University of Nebraska-Lincoln (UNL) and a Doctor of Audiology degree from Salus University.

Alexandra Tarvin, Au.D. has also been elected to serve as a director-at-large on the ADA Board of Directors. Dr. Tarvin is the founder of Elevate Audiology, a private practice in Easley, South Carolina, dedicated to evidence-based practice, exceptional and personalized patient care, and a supportive company culture. Dr. Tarvin holds a Doctor of Audiology degree from the University of South Florida and is certified by the American Board of Audiology (ABA).

Dr. Davis, Dr. Kopetzky, and Dr. Tarvin will begin their terms of service on January 1, 2025. Continuing in service on the ADA Board of Directors will be Dr. Jason Leyendecker (2025 Immediate Past President), Dr. Amyn Amlani (2025 President), Dr. Stacy O'Brien, and Dr. Judy Huch. ADA would like to thank and recognize Dr. Dawn Heiman, Dr. Liz Rogers, and Dr. Whitney Swander, who have made significant contributions to ADA during their terms of service, which will end in December 2024. ■

Recent Coding, Billing and Reimbursement Questions from Members Addressed

BY KIM CAVITT, Au.D.

ADA has received numerous member inquiries related to the following topics. We wanted to take this opportunity to provide guidance and insight and address member questions and concerns.

Billing Services of Technicians to Health Plans, Including Medicare and Medicaid

Medicare is very clear that 1) technicians/audiology assistants can only provide technical services (performing the procedure but not interpreting and reporting the procedure) when the procedure has a TC/PC split, 2) technicians/audiology assistants must be trained, and, most importantly, 3) can only provide covered services under the direct supervision of a physician (not an audiologist). This is clearly documented in chapter 15, section 80.3 (D) and 80.3.1 of the Medicare Benefit Policy Manual. Many state Medicaid programs and commercial insurers follow these same requirements.

Medicare Benefit Policy Manual

So, it is important that providers confirm the scope of practice requirements of audiology assistants and technicians in their state and the supervision and billing limitations of each payer before utilizing technicians and audiology assistants in their practice for managed care covered services. Lack of mention in licensure does not mean it is allowed; instead you could be supporting unlicensed practice of audiology or medicine. It is important to get clarification from your state on the ability to utilize audiology assistants and technicians when not specifically addressed in licensure.

It is also important to know that, when you bill the services of an audiology assistant or technician to an insurer or third-party under the NPI of an audiologist and it is not explicitly allowed, you could be supporting the unlawful practice of audiology or hearing aid dispensing without a license and/or filing a false claim. Please consult all payers before allowing audiology assistants or technicians to provide covered services to their beneficiaries and determine, with each payer, how these services are to be billed.

Billing for Binocular Microscopy

As its name indicates, Binocular Microscopy (CPT Code 92504), requires use of a binocular microscope to visualize the ear canal and tympanic membrane.

In the October 2011; Volume 21: Issue 10 of *CPT Assistant,* which documents appropriate code use across all health plans, the following was provided:

> **Question:** Please provide an example of when it is appropriate to report code 92504.
>
> **Answer:** An example for reporting code 92504, *Binocular microscopy (separate diagnostic procedure)*, is when a patient presents with ear fullness and decreased hearing. Routine otoscopy suggests an abnormality of the tympanic membrane. To further evaluate this finding, binocular microscopy is performed.

Binocular microscopy may be medically reasonable and necessary when 1) you have a binocular microscope (an otoscope or video otoscope is insufficient to meet the code description), 2) you were unable to visualize clinically significant portions of the ear canal or tympanic membrane with an otoscope and 3) your documentation supports the medical necessity of the procedure for the specific patient.

Use of this code implies binaural. As a result, a 50 (bilateral procedure) modifier would be inappropriate. If only one ear is viewed, the 52 (reduced services) modifier must be added.

Evaluation and Management Code Use in Audiology

There are clinical situations where the consistent use of evaluation and management codes (CPT 99-) are warranted and recommended BUT, before these codes are used in your practice, there are several considerations each provider must be aware of:

1. Per the American Medical Association, who owns the CPT code set, evaluation and management codes are accessible to "physician and qualified healthcare professional". Per the AMA, a physician or other qualified healthcare professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service".
2. It important, as a result, that "evaluation and management" is within the scope of practice of audiology in your state. This documentation will be useful in situations where the health plan assigns financial responsibility of the service to the provider and you need to be able to override that decision, in appeal to charge a patient privately.

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3. These codes should be applied to diagnostic test visits only; their descriptions and requirements are incompatible with hearing aid visits (and there are better codes for that situation anyway).
4. These codes and their usage should be consistently applied to all patients in the same clinical situation, regardless of payer. In most situations, the patient will be responsible for the costs as many payers do not cover evaluation and management services provided by an audiologist, even if it is clearly in scope in their state.
5. The provider must meet the requirements of the specific code, especially documentation requirements.
6. Code selection is NOT merely based upon time; it is also based upon new or existing patient, level of case history, type and amount of data reviewed, the complexity of the case and the risks of morbidity and mortality.
7. Your providers must be trained on the appropriate use, documentation and billing of these codes.

There is a history of audiologists being audited for use of this code set and being unsuccessful in appealing the payer decision. This is why it is important to educate yourself on the appropriate use of these codes before utilizing them in your practice.

Electronic Hearing Protection

In general, health plans do not cover items or services for recreational, occupational, or educational uses. They cover items and services that are medically reasonable and necessary to manage or treat an illness, disorder, or condition.

These considerations are important when considering the billing of electronic hearing protection to a health plan:

- Health care plans, as a general rule of thumb, do not cover hearing aids in the absence of a documented peripheral hearing loss.
- Health plans generally do not cover hearing aids for ear protection or for the treatment of tinnitus, balance, or auditory processing in the absence of at least a documented mild hearing loss (26dB).
- Some health plans, including UHC, Tricare, Aetna, and many BCBS Association plans, have medical policies that indicate requirements for minimum hearing loss, medical necessity, recommendations/clearance, and, importantly, documentation. We encourage you to locate and review these policies yourselves if you participate with or bill health plans for hearing aids.
- If the patient has a hearing loss (greater than 26dB or as specifically allowed by payer medical policy or benefit) and the devices are being prescribed as a treatment for that hearing loss, I recommend billing these aids to a health plan using the code V5298 (hearing aid not otherwise classified). For binaural devices, you will add the 50 (bilateral) modifier.
- If the patient does not have a hearing loss or if the devices are being recommend solely as a means of hearing protection, the devices should be billed as V5274 (assistive listening device not otherwise classified).

Academy of Doctors of Audiology members (individual and practice) have access to ADA resources for support on compliance, coding, billing, reimbursement, and insurance questions. This is a value-added benefit of ADA membership. Please contact ***Kim Cavitt*** *at kim.cavitt@audiologyresources.com for any questions, guidance or support.* ■

PRESIDENT'S MESSAGE

Continued from page 3

Now is the time for all audiologists to understand the impact of their hard work and dedication to audiology. Becoming an audiologist is only the first step. We must be lifelong advocates and activists for audiology, and we must work together. Now is the time to start being comfortable, being uncomfortable as we have hard conversations and push our boundaries of what could be. Now is the time to put our gloves on and fight for what we believe in! Now is the time to open our wallets to advocacy because the only way this vision doesn't succeed is if we give up! Now is the time to modernize audiology. I want to thank ADA for giving me the opportunity to represent audiology at its highest level. It is truly an honor to have a seat at the table and say I helped make an impact in the community. I'm excited about the future for audiology, and I hope you are too. ■

EDITOR'S MESSAGE

Continued from page 5

Reduce complexity for some first-time wearers.

For individuals with vision, dexterity or cognitive challenges, earbud-style hearing aids are easier to insert and remove from the ear. Just pop them in and go about your daily activities. They also have the added bonus of doubling as a pair of music streaming earbuds for those who can use a smartphone.

First-time help seekers already have hearing aid experience.

Because a rising number of people will have had some hearing aid experience prior to their encounter with an audiologist, more individuals will be well-versed on how hearing aids work. Because of smartphones, tech savviness is already on the rise. When more people dip their toe into the water and try earbud-style hearing aids on their own, they have already been self-taught on some of the essential aspects of hearing aid care, maintenance and use before they've seen an audiologist.

Puts more emphasis on the audiologist to provide a memorable and engaging in-clinic experience.

As more people buy their hearing aids on-line without the guidance of a licensed professional, when they eventually find their way into a clinic with a specific problem, individuals are likely to expect that providers will engage with them on a personal level by providing a meaningful and memorable experience. They are expecting a level of professionalism and service that is different from a purchase in the Apple store.

A premium placed on managing complex cases.

Since modest and occasional communication difficulties in noisy places are likely to be addressed through earbud-solutions, it could mean that more complex cases are left to highly trained AuD-level clinicians. For this reason, researchers inside the profession must find novel approaches to alleviating complex problems, including drug therapies, implantable devices and a wider range of auditory rehabilitation offerings.

A renewed focus on addressing how the emotional and social well-being is affected by hearing loss and how hearing aids can help.

If more devices are purchased without the involvement of an audiologist, that does not mean opportunities to improve outcomes with these purchasers don't end. Recent work from the lab of Australian researcher, Bec Bennett indicates that many hearing aid wearers want a "safe space" where they can talk about the impact their hearing loss has had on their overall health and well-being. She has even developed a program, under the acronym AIMER, that helps audiologists become more comfortable asking patients about their social and emotional well-being and how hearing aids help improve it. ■

Meet The Game Changer For Your Business

What makes the ADA Business Card a game changer for your business?

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- **$750 Signup Bonus** [2]
- **Paid ADA Dues every year** [3]
- **No effect on personal credit**
- **No Annual Fee**

ADA ACADEMY of DOCTORS of AUDIOLOGY®

Designed specifically with audiologists in mind.
It was created with input from audiologists and the ADA.

The ADA Business Card is already being utilized by your fellow ADA members and we're excited for you to be next.

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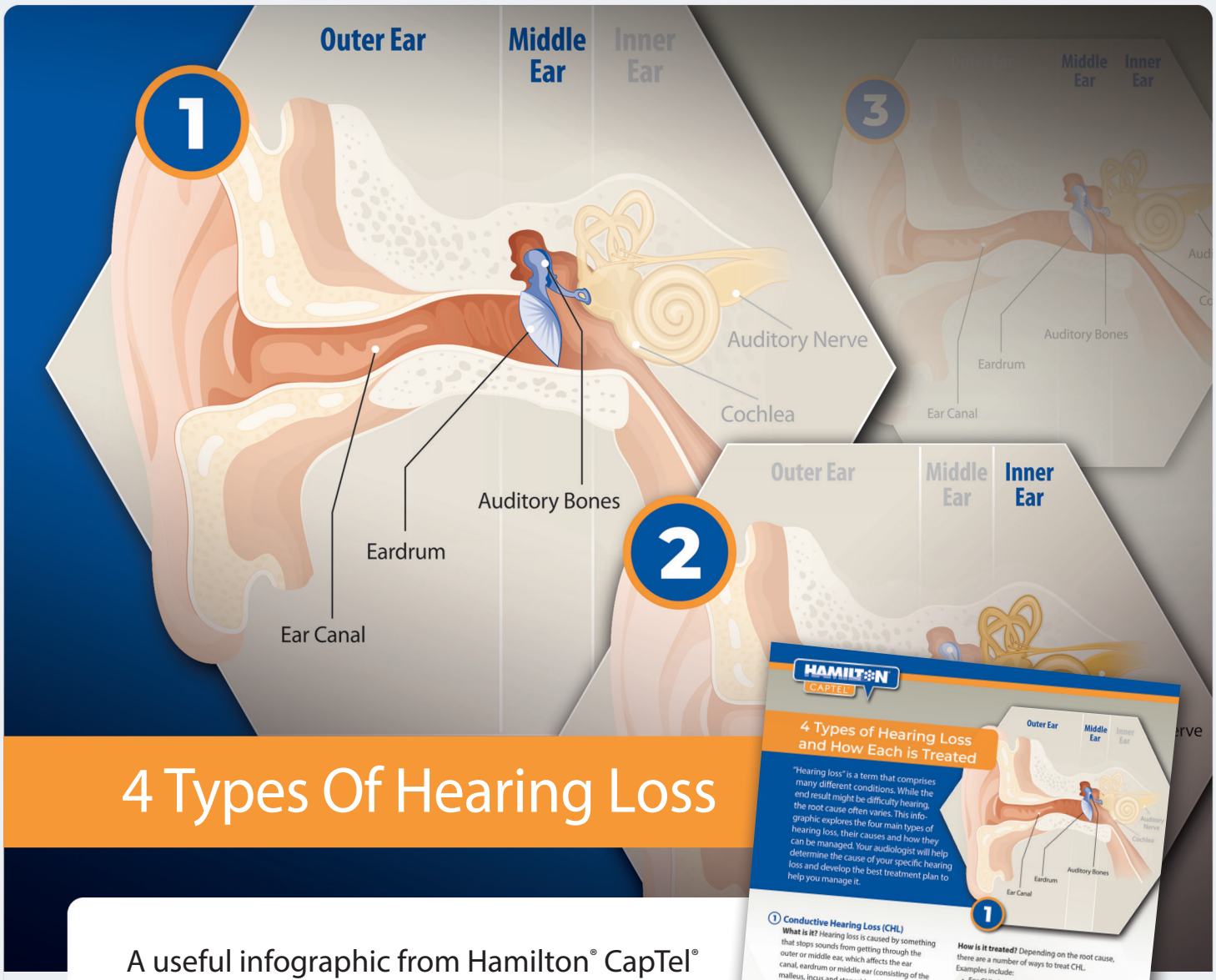
1 – 1.5% rewards on all purchases, no cap on rewards. You will not earn rewards on returned, disputed, or fraudulent transactions. We will reverse rewards associated with the return, credit, or adjustment.

2 – Get $750 Signup Bonus in statement credits when you spend $10,000 or more in the first 4 months after account creation. This includes the $115 ADA dues for the first year. Your Card account must not be canceled or in default at the time of fulfillment of any offers. After the 4 months, Rewards points will be credited to your account if you have met the threshold amount. If we in our sole discretion determine that you have engaged in abuse, misuse, or gaming in connection with the welcome offer in any way or that you intend to do so, we may not credit Rewards points, we may freeze Rewards points credited, or we may take away Rewards points from your account. We may also cancel this Card account and other Card accounts you may have with us.

3 – The ADA dues of $115 are paid every year when you spend $25,000 or more in every subsequent calendar year after the first year. Annual value of $115 per practice. You still have to pay your dues as normal. We will simply credit you back the $115 value in the form of a statement credit. Your Card account must not be canceled or in default at the time of fulfillment of any offers. If we in our sole discretion determine that you have engaged in abuse, misuse, or gaming in connection with the welcome offer in any way or that you intend to do so, we may not credit Rewards points, we may freeze Rewards points credited, or we may take away Rewards points from your account. We may also cancel this Card account and other Card accounts you may have with us.



A useful infographic from Hamilton® CapTel® designed to assist hearing healthcare professionals in educating patients on the four main types of hearing loss.

Get the Visual Aid at HamiltonCapTel.com/ADA924

Brought to you by Hamilton® CapTel®, your trusted source for Captioned Telephone.

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STUDENT ACADEMY OF DOCTORS OF AUDIOLOGY

The purpose of the **ADA Student Academy of Doctors of Audiology (SADA)** is to serve the varied needs and concerns of student and emerging graduated members of ADA. SADA members have access to exclusive student resources, ADA's mentoring program, eligibility to participate in the Student Business Plan competition at the annual AuDacity Conference, and can help set the direction of ADA student initiatives.

Get involved today! Visit audiologist.org/sada for more information.