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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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Amyn Amlani, Ph.D.

Closing the Gap on Professional Autonomy

Achieving autonomy is the crown jewel of every profession. Autonomy is derived from the Greek words, *autos* ("self") and *nomos* ("law"). A self-governing profession affords its members the opportunity to make informed, evidence-based decisions with respect to factors such as (i) standard of professional care, (ii) service delivery that is equitable, accessible, and economical viable to every population, (iii) modernized and harmonized organizational scope of practice that promotes efficiency and accountability, (iv) self-sufficient revenue streams and less beholden to corporate vertical integration partnerships, and (iv) promoting workforce growth efficacy through an educational channels that promote future practitioners and scholar/scientists.

The profession of audiology's journey towards achieving autonomy began during WWII in military aural rehabilitation centers. Soon afterwards, the profession transitioned to academia, where scholars and scientists studied the anatomy and physiology of the auditory system and developed methods to quantify hearing sensitivity. Between the 1960s and 1990s, graduates of academic programs entered the workforce, and many elected to operate and still operate independent private practices. During this period, our professional ancestors were successful in achieving licensure permitting the dispensing of hearing aids, as well as transitioning the terminal academic requirement from a master's degree to a professional doctorate. While our historical success is noteworthy, these victories were achieved largely independently and not as part of a long-term cohesive vision for the profession. This is not a criticism, but the reality of a young profession embarking on its journey.

Since the early 2000s, when the audiology became a doctoring health profession, our evolution continued without closing the gap towards achieving professional autonomy. Our workforce, for instance, has stagnated growth when compared to similar healthcare professions. In most states, our scope of practice is not consistent with that of a doctoring profession, permitting other healthcare professions to expand their licensing requirements that overlap with that of audiology. In addition, the current academic curriculum is based on the longstanding tenets that align neither with current state licensure scope of practice nor the current and future needs of patients.

Lastly, and most importantly, we continue to be classified by the Centers for Medicare and Medicaid Services (CMS) as only diagnostic suppliers, nomenclature that is prohibitive to Medicare beneficiaries in need of accessing rehabilitative hearing healthcare services, and to audiologists who provide these rehabilitative services as governed by their state licensure. It is imperative that the profession—from students to late career professionals—advocate and support the reintroduction of the bipartisan-supported Medicare Audiology Access and Improvement Act (MAAIA). The passing of this bill accelerates audiology forward towards its goal of professional autonomy.

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Brian Taylor, Au.D.

Make it Your Mission to Inform Rather than Persuade

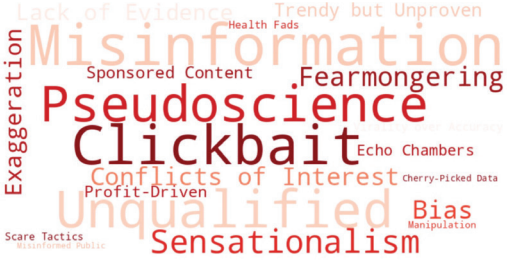
If there is a theme for this issue of *Audiology Practices* it is this: It is the ethical responsibility of audiologists to ensure they are communicating in a clear and trustworthy manner. This includes communicating with both patients and colleagues. The role of clear and trustworthy communication with patients is self-evident. Persons with hearing and balance problems are seldom experts in their condition and rely on audiologists to be both balanced in their explanations of their condition and candid about uncertainty of outcomes as it relates to scientific evidence. Perhaps most importantly, audiologists need to anticipate when patients are confused or anxious about their condition, or our interpretation of test results, and step in to provide clarity that eases these concerns.

In this issue, Clinical Bulletin #3 is devoted to how audiologists can talk about the risk of dementia and the use of hearing aids to *possibly* slow down cognitive decline — and do it in a way that accurately reflects the latest scientific evidence. Audacity 2024 keynote speaker, Jan Blustein provides us with three schematics that can be used with patients to describe the possible relationship between hearing loss and dementia and how hearing aids *might* help. A second article goes into more detail on some general communication strategies that promote honest and transparent dialogue with patients in an age when social media influencers in our profession — a group who prioritize the monetization of clicks and views over honestly and clearly educating the public — are jostling for the attention of both help seekers and professionals.

Ethical and responsible communication is not confined to the patient-audiologist relationship. When it comes to communicating financial information like cash flow and other key performance indicators, Robert Wabler, sheds some valuable light on how to do this in a manner that is frank and to-the-point. Regardless of whether they are communicating in the clinic or in their business, audiologists must maintain high standards of clear, ethical, transparent and responsible communication.

You can even use AI to generate word clouds that summarize the key differences between attention-grabbing social media influencers and ethical and responsible communication. Would you rather your communication reputation look like this...

Or this...



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Stephanie Czuhajewski, MPH, CAE, Executive Director

Modernizing Audiology's Scope of Practice Requires Modernizing Audiology's Scope of Influence

As outlined in Audiology 2050, modernizing audiology practice statutes will help secure audiology's position as a doctoring profession that is responsive to evolving patient needs and clinical advancements. ADA commends AuDvocates working to advance legislative initiatives aimed at updating their state audiology practice acts to reflect contemporary practices, and to empower audiologists to practice to their full education and training.

I am frequently asked how audiologists can most effectively advocate at the state level to modernize their audiology practice acts. *Simply put, to modernize audiology's scope of practice, we must first modernize audiology's scope of influence.* And to do that, we must develop and cultivate relationships with various publics that demonstrate that audiologists are credible and capable. And that requires community engagement that is both deep and wide. While there is no single pathway to public policy improvement, there are three essential steps that must be taken to increase audiology's influence and lay the groundwork to accomplish legislative goals:

1. Find and nurture relentless advocates. These audiologists are willing to sacrifice time, money, and energy to the cause. They are willing to reschedule patients, cancel vacations, attend legislative hearings, and stay up all night to write rebuttal briefs and bill amendments. These audiologists come back year after year until the legislative objective is accomplished. Without them, it won't be.

2. Form and foster a broad coalition of support. Identify key stakeholders such as consumers/patients, academics, and physicians/providers. Then, convert these stakeholders into supporters who can help inform the broader community. Their support can help legitimize arguments related to the qualifications of audiologists and the important role they play in the delivery of hearing and balance care.

3. Seek out shepherds. Remember, "All politics is local." Modernizing your audiology practice statute will require navigating complex legislative processes. Professional lobbyists can significantly shorten your time to success. If your organization cannot afford to pay a professional lobbyist, then seek out sympathetic allies who may be able to offer advice (contact associations in your state who represent professions who have had success in modernizing their scopes of practice and get their advice).

ADA is an extra arrow in your quiver—our team is here to champion your interests and help you grow your influence and impact. Please contact me at sczuhajewski@audiologist.org and let's discuss how ADA can help you modernize your state's scope of practice! #audiology2050 #chooseaudiology. ■

British Society of Audiology
Promoting excellence in hearing and balance

BRITISH ACADEMY
OF AUDIOLOGY

BSHAA
The British Society of
Hearing Aid Audiologists

British Society of Audiology, British Academy of Audiology and The British Society of Hearing Aid Audiologists Joint Document

Position Statement and Practice Guidance

The link between adult-onset hearing loss and dementia

Date: November 2024

General foreword

This document presents a joint position statement by the British Society of Audiology (BSA), British Academy of Audiology (BAA) and British Society of Hearing Aid Audiologists (BSHAA). To the best knowledge of BSA, BAA and BSHAA, the position statement represents the evidence-base for the association between adult-onset hearing loss and dementia.

Although care has been taken in preparing this information, the BSA, BAA and BSHAA do not and cannot guarantee the interpretation and application of it. The BSA cannot be held responsible for any errors or omissions, and the BSA accepts no liability whatsoever for any loss or damage howsoever arising. This document stands until superseded or withdrawn by the BSA.

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The authors represent professionals in in the field of hearing loss (including the UK Devolved Administrations) and old age psychiatry, service users and BSA, BAA and BSHAA.

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1. Introduction and Aims

While some areas of cognition improve with age (e.g. knowledge), everyone experiences age-related declines in other aspects of cognition throughout adulthood. Areas of decline include aspects of short-term memory, our speed of processing and our ability to process one set of information over another (i.e., inhibition). These changes will affect an individual's ability to understand speech in challenging environments, e.g. speech in noise, and this is a normal part of ageing. Just because someone experiences age-related cognitive change, and associated auditory deficits, does not mean that they will go on to develop dementia.

Dementia is a group of symptoms that can affect memory, problem-solving, language, and behaviour making it hard for the individual to do everyday activities by themselves. Alzheimer's disease is the most common type of dementia. Dementia is a major global challenge: the incidence may be decreasing in some high-income countries (Wu et al, 2017), but the number of people living with dementia is growing because of increasing life expectancy. The topic of dementia raises considerable fear and alarm because of the potential devastating consequences for individuals, with a significant impact on families and carers as well as the health and care system.

The well-documented association between adult-onset hearing loss and cognitive decline / dementia (shortened to hearing loss and dementia for ease of reading) is sometimes interpreted as evidence that hearing loss causes dementia, and that treating hearing loss will reduce the risk of dementia. However, there is currently no good evidence to support (or refute) either of these claims. Excessive attention to association and causality may detract from the need for timely clinical research on identification and treatment of people who live with both hearing loss and dementia, and ensuring audiology becomes a dementia-friendly profession.

Clear communication about the hearing loss-dementia link can support realistic expectations and informed decisions. Misleading messages can promote a sense of alarm and stigma around hearing loss and may also discourage help-seeking (Blustein et al, 2023a, 2023b; Dawes and Munro, 2024). There is a need for positive and clear messaging, and this document provides suggestions for the busy practitioner who knows that adult-onset hearing loss can be managed successfully with hearing aids and / or other support. Hearing aids have proven benefits for improving communication with spoken language (Ferguson et al, 2017) and this helps to keep the user cognitively and socially active (Holman et al, 2021, Wells et al, 2020). Therefore, managing adult-onset hearing loss facilitates an active, engaged, independent, and healthy older age (National Academies of Sciences, Engineering and medicine, 2016).

Hearing better can help you to live better; however, it is misleading to imply there is evidence that hearing loss causes dementia, and that treating hearing loss will reduce the risk of dementia.

The aim of this position statement is to present a balanced view on the nature of the association between adult-onset hearing loss and dementia. The objectives are to provide:

1. An evidence-based summary on what is known about the nature of the association between hearing loss and dementia as well as the benefit of hearing intervention, with an assessment of the quality of the evidence and its presentation to the public (Section 2).
2. Guidance for clinicians, including how to describe the relationship between dementia and hearing loss, including acceptable statements (Sections 3 and 4).
3. More detailed definitions of the relevant terminology (Section 5).

Those who prefer to receive their information via video, or are less familiar with the relevant terminology, may wish to supplement their reading by viewing a presentation tailored for hearing care professionals by Blustein (2024). This video explains how to communicate clearly and ethically about the link between hearing loss and dementia.

This document is specific to adult-onset hearing loss. As previously highlighted by Blustein (2023), the discussion does not apply to people who identify as being Deaf and are members of a vibrant community that uses sign language to communicate.

2. Summary of evidence

Hearing loss is the most prevalent sensory deficit (Mathers, 2000) and the third leading cause of disability in the world (World Health Organization, 2021). Untreated adult-onset hearing loss can result in communication difficulties for spoken language that can lead to social isolation and withdrawal, depression and reduced quality of life (Davis, 2007). Hearing aids with appropriate support are the primary intervention for adults with hearing loss. Hearing aids are effective at improving hearing-specific health-related quality of life, general health-related quality of life and listening ability in adults with acquired hearing loss who communicate by speech (Ferguson et al, 2017). The Lancet standing commission on dementia prevention, intervention, and care was published by Livingston *et al* in 2017 and updated in 2020 and again in 2024. Since prevention is better than cure, the updated report highlights 14 modifiable, and ***potentially*** modifiable, risk factors throughout the life course (up from nine in 2017 and 12 in 2020). Hearing loss in mid-life has been identified as a ***potentially*** modifiable risk factor for dementia. The updated report also highlights advances in preventative interventions and treatments. The report represents an enormous amount of work and has received widespread attention. However, in its desire to be ambitious about dementia prevention and intervention, identifying hearing loss as a possible modifiable mid-life risk factor has resulted in misunderstandings and misinterpretations on the relationship between hearing loss and dementia. In order to address this, Munro and Dawes (2024) published a commentary on the Lancet commissions specific to the topic of hearing loss. Dawes and Munro (2024) provided a general review of the evidence on the association between hearing loss and dementia, and the benefit of hearing interventions (see Dawes and Munro, 2024). These two articles form the basis of this position statement.

Association between hearing loss and dementia

There is consistent evidence of an association between hearing loss and cognitive decline in adults with acquired hearing loss, dating back almost 150 years (Galton, 1883). Around 30 years ago, Lindenberger and Bates (1994, 1997) reported that age-related declines in hearing (and vision) closely followed declines in cognition. Interest in the connection between sensory function and cognition was given a further boost when Lin *et al* (2011) reported that baseline levels of hearing loss were associated with incident dementia i.e., new cases of dementia.

Observational studies have shown that people with greater adult-onset hearing loss are likely to have greater cognitive decline. However, association is not causation. For example, the sales of ice cream and sunglasses show a positive correlation (i.e., as the sales of ice cream increase so does the sales of sunglasses) but this is likely due to a common cause (i.e., the arrival of summer weather). This is not to deny the possibility that adult-onset hearing loss may cause dementia. This could occur due to reduced auditory input or lack of social stimulation (direct or indirect causes, respectively), but this has not been proven. Even if adult-onset hearing loss precedes cognitive decline, this does not rule out a common cause. For example, hearing loss could be a marker of dementia because they both share the same underlying cause e.g., vascular disease. Also, hearing loss may be an early manifestation of dementia rather than hearing loss accelerating dementia (Abidin et al, 2021). There is currently a lack of good quality evidence to settle this question.

Association is not causation. It is a mistake to think that if two things co-occur, one must have caused the other.

Do hearing interventions reduce dementia risk?

The possibility of reducing cognitive decline and mitigating dementia risk has been examined in several observational studies, which compared cognitive outcomes for hearing aid users and non-users. Dawes and Völter (2023) reviewed the evidence for both cochlear implants (CI) and acoustic hearing aids. The CI studies report positive outcomes for cognitive improvements, although design limitations of the CI studies make it impossible to attribute these positive outcomes to CIs (rather than to practice effects with repeated cognitive testing, for example). For acoustic hearing aids, the balance of evidence is equivocal: eight studies report positive benefits of using hearing aids and eight did not. More recently, two large-scale observational studies have been published. One showed no association between hearing aid use and cognitive impairment (Grenier *et al,* 2024). The other, by Jiang *et al* (2023), was retracted when an error in the analysis was discovered (Retraction Watch, 2024): the codes for hearing aid users and nonusers was reversed suggesting risk of dementia was higher (not lower, as originally reported) in hearing aid users compared to nonusers.

A challenge for observational studies is the lack of randomisation to intervention and control groups, which means the results may be biased. For example, typical hearing aid users are better educated than non-users (Sawyer *et al*, 2019). Education is a factor which reduces the risk of cognitive decline and dementia (Livingston et al, 2024) irrespective of any potential benefit from hearing aids. This makes it difficult to rule out alternative explanations for the potential positive cognitive outcomes associated with hearing aid use. Because of such problems, randomised controlled trials (RCTs) are considered the gold standard in terms of evidence. RCTs involve randomly allocating people to treatment (i.e. hearing aid) or a control group so they avoid any problems with pre-existing differences between users and non-users. Although dementia prevention is the primary interest, having dementia as the main outcome would require an unfeasibly large and long running trial. For practical reasons, trials tend to focus on cognitive change as the primary outcome of interest.

The Aging and Cognitive Health Evaluation in Elders (ACHIEVE) RCT investigated use of hearing aids as part of a comprehensive hearing intervention programme, on cognitive decline among a group of people with adult-onset hearing loss (Lin *et al,* 2023). The main finding of ACHIEVE was negative; i.e., after three years of using hearing aids there was no slowing of cognitive decline. Rates of cognitive decline were the same

in the control group of non-hearing aid users as in the intervention group. As such, there is no convincing

> There is no convincing evidence that hearing interventions reduce the risk of dementia in the general population.

evidence that hearing interventions reduce the risk of dementia in the general population. A secondary analysis of ACHIEVE reported a benefit of hearing aids in reducing cognitive decline among a subgroup of people characterised as 'high-risk' group, but because this was a secondary finding where study-wise error rate was not controlled, this apparent benefit for a subgroup may not be reliable. Further, the benefit reported for the high-risk group was very small and may not be clinically meaningful to the individual (Dawes and Munro, 2024).

3. Guidance on statements

Examples of suggested statements, and some statements to avoid, when assessing and managing hearing loss in adults, are provided in Table 1.

Table 1. Statements suggested for communicating with adults with hearing loss.

ADULT-ONSET HEARING LOSS	HEARING AIDS
Suggested statements	
✓ Reduces your ability to communicate with ease. ✓ Means your brain may need to work harder to understand what is being said. ✓ Can limit your social interactions and lead to frustration, fatigue, isolation, feelings of loneliness, anxiety and depression.	✓ Make spoken communication easier and will improve your quality of life. ✓ Keep you socially engaged, and this will help you live better. ✓ Make listening less effortful.
Statements to avoid	
× Is known to cause dementia. × Has been shown to be the leading cause of dementia. × Means you will get dementia.	× Are known to prevent dementia. × Have been shown to reduce cognitive decline or risk of dementia.

Based on the available evidence, it is our view that:

- Clinicians should fairly represent any association between dementia and hearing loss, based on the available evidence.
- Clinicians must take care not to cause any unnecessary fear or anxiety for their service users due to concerns about hearing loss and dementia.
- Clinicians must never use any association between hearing loss and dementia to encourage or cajole patients to use or acquire hearing aids but should discuss the benefits and problems of hearing aids in a balanced manner. This should be regarded as an issue of professional ethics.
- Marketing materials for hearing devices and hearing services must not indicate any causative association between hearing loss and dementia and must not promote hearing aids as a prevention for dementia.

- Educators and trainers, in academia and in clinical practice, should highlight the evidence base and promote professional values to students and trainees.

4. Frequently asked questions

Suggested responses to Frequently Asked Questions (FAQs) are provided in Table 2.

Table 2. Frequently asked questions and suggested answers.

1. Does hearing loss cause dementia?
There is currently *no* good quality evidence that hearing loss causes dementia, only evidence to show that there is an association between them.
2. If there is no evidence of causality, why do people say hearing loss causes dementia?
This is most likely a misunderstanding of the evidence. There are several health conditions that are associated with increased risk of dementia including depression, high cholesterol, high blood pressure and diabetes. Further down the list is hearing loss. But this *does not* mean that hearing loss causes dementia.
3. But my chances of dementia are higher if I have a hearing loss?
It is not exceptionally high, but adults with hearing loss *do* have a slightly higher chance of dementia. To give you an example, if 10 people in every 1000 with no hearing loss are at risk of dementia, the equivalent number will be 14 people out of every 1000 who have a hearing loss. In this example, that's an extra four people in every 1000 at risk of dementia.
4. If hearing loss hasn't been proven to cause dementia, why do people say hearing loss is a risk for dementia?
When using risk to discuss health issues, it doesn't necessarily have the same meaning as everyday language. Here we use risk to mean that hearing loss is *associated* with dementia. It does ***not*** mean an adult with hearing loss will definitely get dementia, *nor* does it mean that hearing loss causes dementia. Sometimes one thing causes the other (we all know that a poor diet can cause health issues) but sometimes the association is due to something else: for example, we know that sales of sunglasses and ice cream increase in the summer, but the common cause is the warmer weather. Hearing loss could indicate a risk of dementia because hearing loss and dementia share common causes (e.g. genetic risks, age-related physiological changes).
5. But I have heard that hearing loss is the number one risk factor for dementia.
People have estimated the proportion of new cases that can be avoided if hearing loss can be completely eliminated. They have *assumed* that hearing loss causes dementia, and that hearing loss can be fully treated. These assumptions are *not* supported by the evidence.
6. Will wearing hearing aids reduce the chances of me getting dementia?
There are well known benefits of using hearing aids (see table above). However, there is *no* good quality evidence proving that hearing aids will reduce your chances of dementia.

7. But I heard that research has shown that hearing aids reduce the risk of dementia?
There is not much high-quality research to answer this question. The best study investigated if hearing aids could slow down cognitive decline (the sort of brain changes that occur to most of us as we get older). There was no difference between people in the general population who wore hearing aids during the study and those who were not given hearing aids. The study suggested that hearing aids *may* slow cognitive decline in people at high risk of dementia (meaning that they have other health conditions such as diabetes) but we *do not* know if this finding is reliable or if the benefit is large enough to be meaningful.
8. So, wearing hearing aids won't help my brain?
We *do not* know if hearing aids will reduce your risk of dementia because we *do not* know if hearing loss causes dementia. But *we do* know that hearing better can help you live better. Listening and trying to communicate with others when you have a hearing loss can be a challenge. If hearing aids help you to hear more easily, this means your brain probably doesn't have to work so hard. That could free up your brain to do other things, and that could be good for people with or without dementia.

5. Relevant Terminology

Risk factor: In everyday language, risk is frequently used synonymously with cause. For example, "the heavy rain is a risk factor for flooding" is interpreted as heavy rain will cause flooding if it doesn't stop. However, in epidemiological studies, risk means an association (or probability), not necessarily a cause. This is an important distinction. Some risk factors are known to modify the chances of disease. It is not appropriate to refer to hearing loss as a "modifiable risk factor" for dementia because it has not been proven that hearing loss causes dementia.

Based on current evidence, we can say that hearing loss is associated with an increased risk of developing dementia. The additional risk is small. However, there is no good evidence that hearing loss causes dementia.

Relative risk (RR): Personal risk to an individual is usually reported as a relative risk. This is the probability of someone with hearing loss developing dementia compared to someone without hearing loss. For example, a RR of 1.4 means the risk of dementia to the individual with the risk factor is 40% higher than someone without the risk factor. For example, if 10 in 1000 people are at risk of dementia, this increases to 14 in 1000 for people with the risk factor. **Hearing loss is not the leading personal risk factor for dementia.** This is an important point that has frequently been misunderstood. According to the 2024 Lancet report on dementia prevention, intervention and care, the top six personal risk factors for dementia are: depression (RR = 2.2), traumatic brain injury (RR = 1.7), diabetes (RR = 1.7), less education (RR = 1.6), social isolation (RR = 1.6) and untreated vision loss (RR = 1.5). The personal risk of dementia associated with hearing loss is similar to the risk associated with obesity, high levels of low-density lipoprotein (LDL) cholesterol (i.e., the bad cholesterol that can build up in your arteries), and smoking (RR = 1.3-1.4).

Although hearing loss is associated with increased risk of dementia at a population level, it is not a leading risk factor for dementia at an individual level.

Population attributable fraction (PAF): The maximum proportion of new cases of dementia in the population that can theoretically be avoided if the cause can be completely eliminated. PAF is highest for high LDL cholesterol and hearing loss, each 7%. The proportion is high for hearing loss because it is a common condition, despite a relatively low RR. PAF may vary over time and may be different in sub-groups within the population; minority and lower socioeconomic groups often have a higher burden of modifiable risk factors. PAF is concerned with whole populations and is not the same as the personal risk to an individual with hearing loss developing dementia.

The estimated prevalence increased from 31.7% reported in the 2017 and 2020 Lancet commission reports to 59% in the 2024 report. The report did not provide an explanation for the increase in the prevalence estimate. Irrespective of the calculation of PAF, its use remains problematic for the interpretation of dementia risk associated with hearing loss because it assumes, incorrectly, that hearing loss has been proven to cause dementia and that all cases of hearing loss can be completely avoided or entirely mitigated with hearing intervention. The latter is improbable because only a subgroup of people with hearing loss use hearing interventions, even then, hearing aids or cochlear implants do not restore hearing to normal. Finally, some risk factors may co-occur, or lead to a different outcome.

Public facing documents and websites that use the Population Attributable Fraction (PAF) as the basis for claiming that hearing loss is the single greatest risk factor for dementia can be misleading. This is because the public generally assume: (i) this is the personal risk, and (ii) risk means cause.

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Talking to Patients:

Communicating Clearly and Ethically About the Link Between Hearing Loss and Dementia

How is hearing loss related to cognitive decline and dementia? What does it mean to say that hearing loss is a "risk factor" for dementia? These are questions that patients are asking, and in Clinical Bulletin #3 we're providing you with some help in answering those questions, as well as some simple teaching aids that you may wish to use in your practice.

We draw on a plenary talk from the ADA's 2024 annual meeting in Dallas, Texas. The talk featured Dr. Jan Blustein, a Professor of Medicine and Public Health at New York University's Langone School of Medicine. Dr. Blustein draws on her knowledge of statistics and epidemiology as well as her experience as a person with hearing loss to critique some of the messages that have circulated about the hearing loss – dementia link. She argues that patients, providers and the members of the public have misunderstood much of the information that they've received, because "risk" means something different in scientific langugage than it does in everyday speech. While hearing loss is certainly a risk for dementia, evidence that hearing loss causes dementia is thin. However, evidence suggests that having a hearing loss disadvantages those who are likely to develop dementia symptoms for reasons unrelated to their hearing loss. There's much more to this story, and if you're interested, take the time to review the whole talk.

View Dr. Blustein's AuDacity 2024 Talk

But let's get back to communicating with your patients. On the following pages, we provide three downloadable teaching aids based on the Dallas talk. These three illustrations should be used together to help explain to patients the hearing loss-dementia link and how hearing aids might break this link. You can download and print them for use in meetings with patients who raise the question of the hearing loss – dementia link. To help get you ready to use them, you may want to review the relevant sections of Dr. Blustein's talk. You can view her talk by scanning the QR code (about 10 minutes; from 35:29 – 46:34 is the most relevant section).

DIAGRAM 1

The Link Between Hearing Loss & Dementia

A COMMON MISUNDERSTANDING

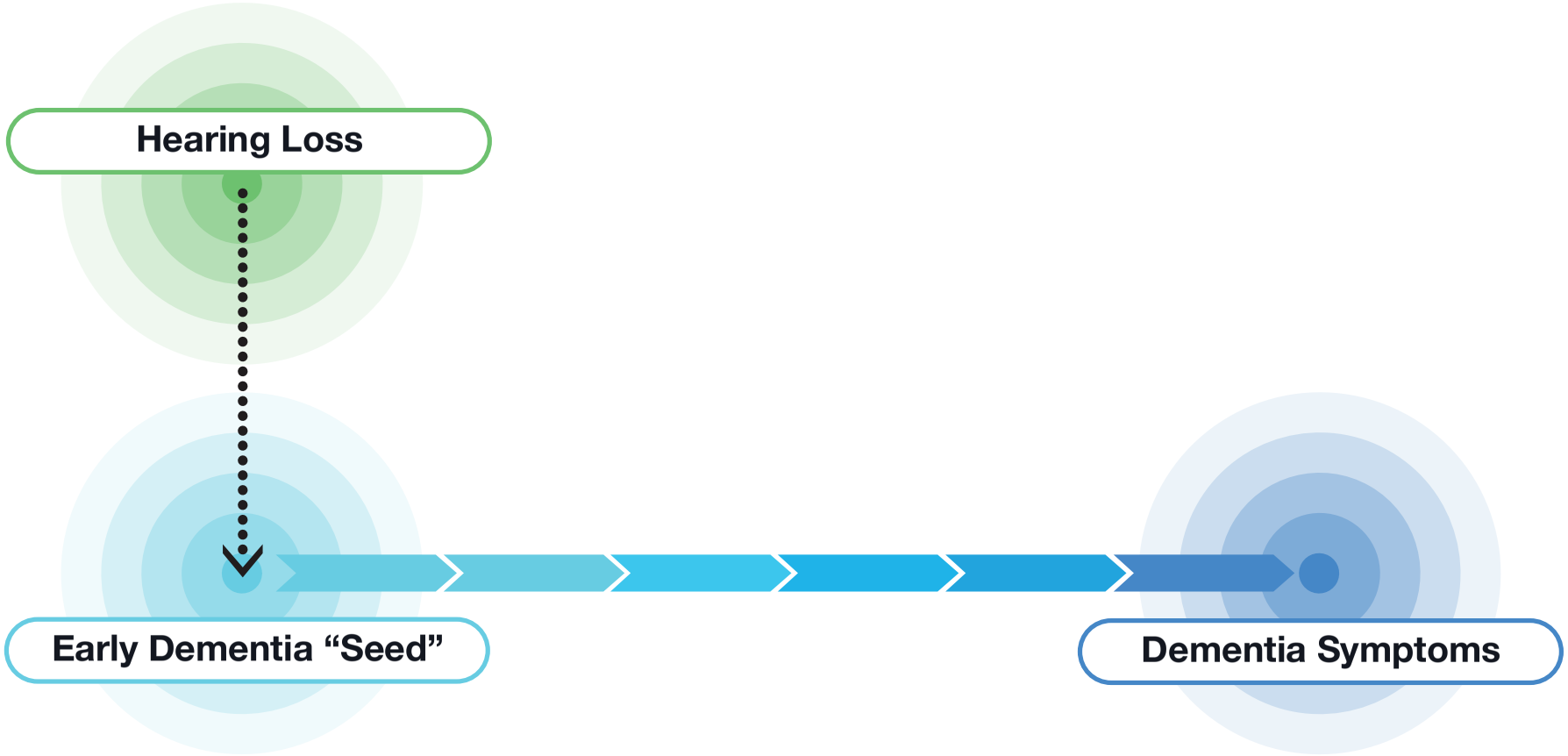


DIAGRAM 2

The Link Between Hearing Loss & Dementia

WHAT MIGHT EXPLAIN IT?

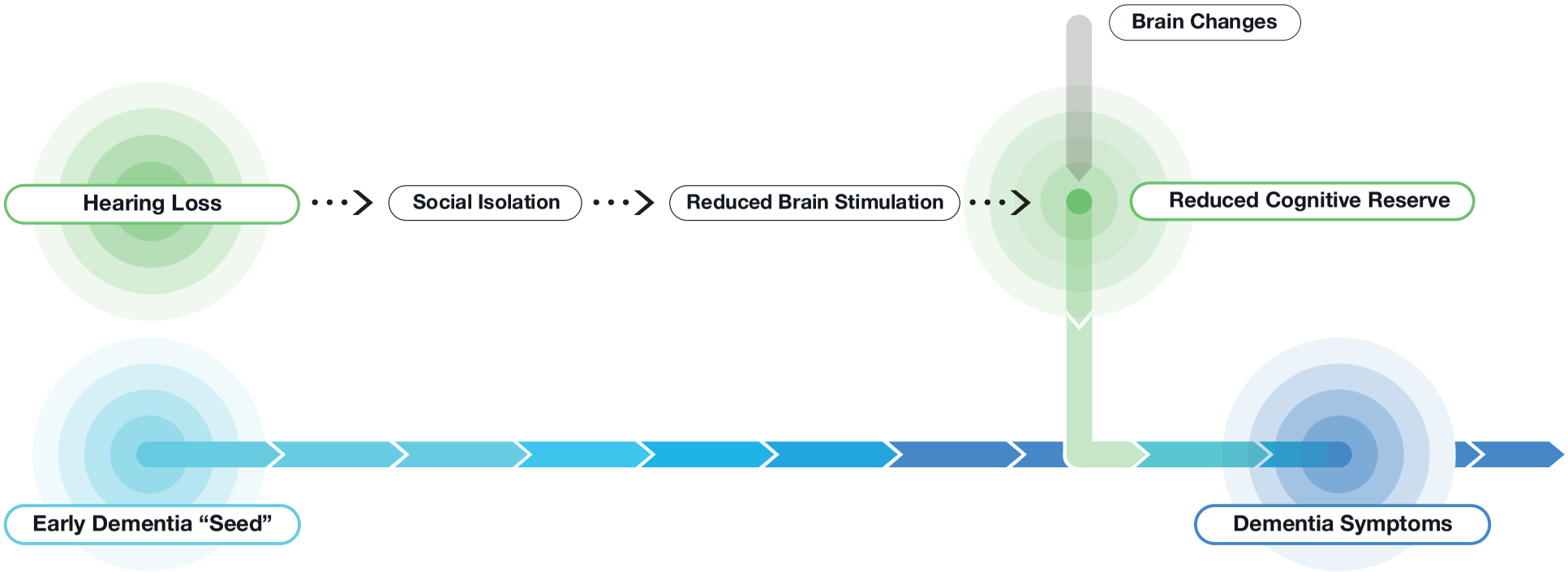
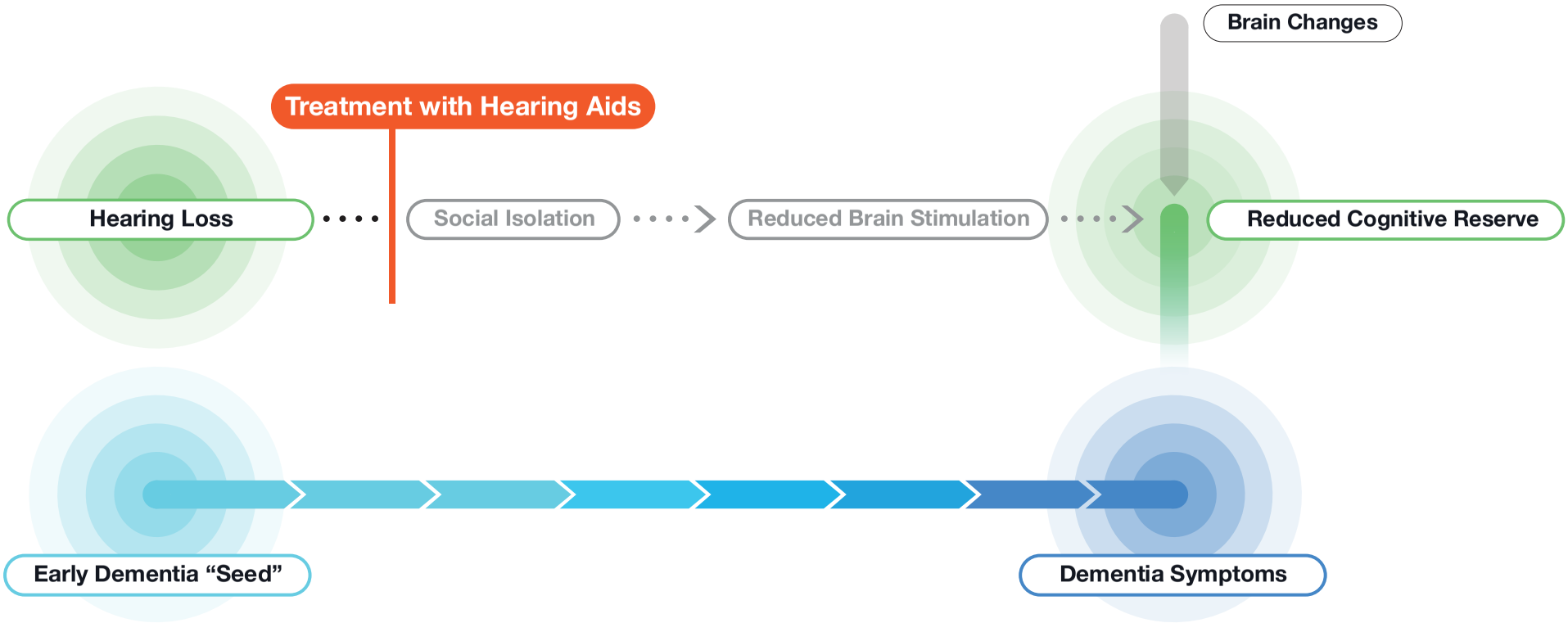


DIAGRAM 3

The Link Between Hearing Loss & Dementia

HOW HEARING AIDS MIGHT BREAK THE LINK



Key Talking Points

For each of the three diagrams, we provide some language or talking points that can be used to have more focused, research-supported conversations with patients about the topic of hearing loss and dementia. All three diagrams should be used during counseling sessions with patients and their families.

A note about the dementia "seed" in the diagrams: since we do not know what causes dementia, we've used the term "seed" as a placeholder for the underlying cause(s). Those causes could be genetic, environmental, or a combination of factors.

Diagram 1

Diagram 1 illustrates how many non-scientists misunderstand the way the term "risk" is used in research.

In everyday language, "risk" is usually understood as something that causes a bad outcome. For example, not wearing a seatbelt is a "risk" for injury in a car accident.

So, when non-scientists (i.e., almost all patients) hear that "hearing loss is a RISK for dementia," they are prone to understand in the way that is illustrated in Diagram 1: somehow, hearing loss plants the dementia "seed."

Diagram 2

Diagram 2 illustrates a more ethical and responsible way to discuss risk in relationship to hearing loss and dementia – one that details how hearing loss can lead to greater social isolation and reduced brain stimulation, which eventually may result in physical and psychological changes.

In this uncoupled model illustrated in Diagram 2, note that the path between the dementia "seed" and dementia runs in parallel with the path between hearing loss and reduced cognitive reserve.

Diagram 2 illustrates how individuals with hearing loss who also have the "seed" that predisposes to dementia may develop dementia symptoms earlier as a result of the reduced cognitive reserve brought on by their hearing loss.

Diagram 3

Diagram 3 illustrates how hearing aids have the potential to break the link between hearing loss, social isolation and reduced brain stimulation – factors that may be linked to the timing of dementia onset.

For those individuals with the dementia "seed," treatment with hearing aids may delay or slow down the onset of dementia symptoms.

It is also important to emphasize, using Diagram 3, that treatment with hearing aids reduces social isolation and improves brain stimulation — whorthwhile benefits that make life better. ■

HOW TO PROFITABLY MANAGE THE CASH FLOW OF YOUR CLINIC

By Robert Wabler

In 2025 the hearing aid industry is encountering increased competition and economic challenges. With each passing day it seems more likely that the American economy will enter a recession this year. **Given this economic uncertainty, these can be difficult times for many clinics.** In times of uncertainty, the need of business owners to aggressively work on stabilizing and increasing their cash, sales and profits is more important than ever.

As noted by Jerry Mills in his 2007 book, *Avoiding The Danger Zone*, The danger zone is defined as the situation wherein the cash needs of a company far exceed the available cash that is on-hand to cover operating expenses. This situation can cause a Chapter 11 bankruptcy filing, liquidation of assets or other stressful time-consuming planning events that are needed to salvage the company. The lesson: A company can never have too much cash on-hand. A company can, however, easily run out of cash and get into Mills' Danger Zone. It takes proactive planning to avoid that situation.[1] In this article I will address some financial "proactive planning" ideas to aid in profitably managing your clinic(s) and maintaining a positive cash flow.

CASH IN
MUST EXCEED
CASH OUT

Over my career, I have been involved with numerous successful turnaround businesses. This means working with companies to turn them around from losing money to becoming profitable. Turnaround management principles and disciplines are more critical than a company owner, even one who is profitable, might realize. A major principle is – Cash In must exceed Cash Out. This advice sounds pretty simple and basic doesn't it? However, the business world is littered with troubled companies and in this industry – clinics – which ignore this truism. I will address the importance of cash and cash forecasting later in this article.

Another basic turnaround management principle is – Drive profitable revenue and profits after disposing of unnecessary and wasteful expenses. Most companies I have worked with have expenses that can be eliminated with the money being used to drive profits higher. An example of this principle comes from an audiologist-owned hearing aid dispensing clinic. This clinic was experiencing high levels of returns for credit. After reducing this high level of returns, the owner was able to reinvest the savings into a successful new marketing campaign. This new marketing campaign substantially increased sales and profits, and rather quickly reversed a negative cash flow problem.

Over the course of many years, I developed, implemented and honed The Profit Pinnacle Strategy. "The prime objective of this strategy is to attain financial stability and profitability in any size, or any type of an organization based on their needs, talents, objectives and goals."[2] Many of the ideas in this article are embodied in The Profit Pinnacle Strategy.

Let's review about one way to successfully manage your clinic for profitability. As the former President of Amplifon USA for many years, I would visit and talk with business owners of profitable and some not so profitable clinics.

The most successful clinic owners had one person/group devoted to the marketing and sales efforts and another person/group responsible for the administrative side. Using a sports analogy, I refer to the sales/marketing drivers as the offense with an Offensive Coordinator and the administrative side as the defense with a Defensive Coordinator.

Jerry Mills refers to these two groups in his book, *The Danger Zone – Lost in the Growth Transition* as Finders (Offensive Coordinators) and Minders (Defensive Coordinators). Quoting from his book, *The Danger Zone – Lost in the Growth Transition*, "Finders start their business or businesses in countless ways. In the beginning there is one constant. The Finder spends most of his or her time in "finding activities," which typically give the Finder an adrenaline rush. They will work six or seven days a week, often over long periods of time, to be involved in these finding activities, which include:

- Building relationships with customers
- Creating relationships with vendors
- Delegating tasks to employees or associates
- Causing sales and cash to come into the company"[3]

It is important for the Offensive Coordinator to be continuously involved in revenue generation for the clinic(s). They need to have knowledge of what is happening on the administrative side of the business but do not need to do the work. They need to have reports on critical clinic information given to her on a routine basis.

This leads to the importance of the activities for the Minder (Defensive Coordinator) which Mills comments on in The Danger Zone – Lost in the Growth Transition as follows:

"Minding is good and minding activities are necessary for the success of any company. Therefore, hiring, training and retaining good Minders is critical for the future success of any company…

Most of the assignments given to Minders deal with historical matters or events that have happened in the past, such as:

- Last month's sales tax return
- Historical financial statements
- Last month's bank reconciliation
- Filing documents
- Making copies of information for bankers
- Fixing a computer that crashed
- Installing software and converting old data

All of the above items are important to be done and done correctly."[4]

It is important that the Offensive Coordinator trusts the Defensive Coordinator since the administrative activities usually include dealing with the cash of the clinic(s).

Many of the most profitable and growing clinics had the following characteristics:

- Developed and implemented their vision and goals
- Developed strategic business plans for their clinic(s) and company
- Constant and consistent attention to sales activities
- Attention to cash flow, planning and forecasting
- Reviewing profit contribution
- Develop and constantly review Key Performance Indicators
- Reviewing reports for the clinic

Developing a vision and goals for your company and clinics are paramount for success. For an owner's vision and goals to be effective, they should:

1. Be measurable – this means that the desired outcome should be quantifiable.
2. Be written clearly and specifically.
3. Have a specific accomplishment date.

One way I recommend addressing the owner's vision and goals is to have quarterly planning and goal setting meetings. Whether you have one or multiple locations, reviewing and updating your business plan and business goals on a quarterly basis is extremely beneficial to make sure that your company is staying on course. For example, quarterly planning and goal setting meetings in one company I worked with were an important factor in propelling the company from a valuation of approximately $15 million to a valuation in excess of $500 million.

Brian Young's *Ernst & Young Business Plan Guide* (2007)[5] states the following on the importance of planning:

"Entrepreneurs are most often doers rather than proposal writers. They would frequently rather be on the battlefield – the cutting edge of business – than behind the lines planning their assault. In addition, many entrepreneurs have difficulty articulating the business concepts that have become second nature to them. Consequently, one of the difficult chores they face is the preparation and actual writing of a business plan. Whatever difficulty the preparation of a business plan may present, a plan is an absolute necessity for any business."[5]

Plans can be very basic. Good business plans should include:

A. Vision for the clinics
B. Measurable goals
C. Plans for marketing/ advertising the services your clinic provides
D. Financial plans (including budgeting and forecasting) for your clinics
E. Plans for your associates performance measurements
F. Your clinics' operational plans

You may not like the sound of it, but audiologists are in the sales and marketing business. Sales are critical to your clinics' long-term survival. Sales is loosely defined as any product or service that you offer. Under this broad definition of sales, even services like balance testing and central auditory processing assessments are items that you must "sell" to the community you serve. Of course, you "sell" them by advertising to your community that these services exist and might be of value to them.

Sales can be increased by continuing to measure and improve the following:

- Sales key performance indicators (KPIs) which are pertinent to your clinic(s)
- Sales closing rates
- Marketing efforts
- Advertising efforts
- Networking activities
- Sales results/productivity by associate
- Sales opportunities and sales not closed

CASH IS KING

Cash is the life-giving resource for every organization. Each business owner needs to constantly challenge where money is being spent compared to the organization's objectives and goals. Monthly free cash flow is an important component of any clinic. A quarterly break-even analysis should also be performed.

It is imperative for the business owner to understand both cash inflows and cash outflows through the use of a rolling 13 week cash forecast. As President of Amplifon USA, we prepared and continually adjusted a rolling 13-week cash flow forecast. Each week we would compare the actual results to the forecast. We then would take actions to make sure that our cash position stayed positive. These actions helped us to turn the company from losses to profitability and then grow in sales and profitability. Constantly tracking cash flows was one of the keys.

Profit contribution planning, monthly profit and loss reviews and profit contribution analysis, along with the necessary corrective actions, are critical. It is important to make the expenses congruent with accomplishing the goals of the clinics. I cannot stress this enough. Each expense needs a mission. The Defensive Coordinator should continually identify areas with the greatest potential savings and the greatest opportunities. Once critical problem areas have been identified then solutions need to be put in place immediately.

One way this can be established is through establishing Key Performance Indicators. The clinic owner should choose 4 or 5 key indicators that drive your business and that you need people to concentrate on. As an example, as President of Amplifon USA, I would daily have the prior day's sales and cash position on my desk as the day started. I would review these two key performance indicators consistently on a daily basis. Then we would have 2 to 3 rotating Key Performance Indicators which would change as the company's business conditions warranted. The use of Key Performance Indicators would keep our organization focused on cash flow, profitability and constantly improving operationally.

Clinic business owners, at a minimum should have the Defensive Coordinator of their organization prepare or have prepared the following reports, for review on a daily, weekly or monthly basis:

1. Sales Reports

On a daily basis the business owner should review the sales from the previous day. On a weekly and monthly basis, sales by associate and by product type should be analyzed. This data, which is typically comprised of hearing aid sales and other revenue generated from testing, can be used to compare to marketing efforts for the current period and for associate productivity.

2. Cash Balances and Cash Flow

Cash flow projections should be prepared on a thirteen week rolling basis. Weekly the actual cash should be compared to the original forecast. This is critical to see where the clinic(s) are from a "cash health" standpoint. Cash is the life blood of any organization. This means that revenue from insurance reimbursement is counted only when the reimbursement check is received from the third party payer, or the patient has paid their bill with a credit card, check or cash.

Cash flow projections can easily be prepared on Excel spreadsheets. The cash information you will need, on a monthly basis, for the projections are:

A. Total Sales

B. Beginning of month Cash on hand

C. All cash receipts – from cash, Accounts Receivables, Loans or cash injections

D. Total Cash Available

E. Cash Paid Out by line item – examples are cash paid for purchases, payroll expenses, rent.

F. Total Cash Paid Out

G. End of month Cash position

CASH BALANCES SHOULD BE REVIEWED

DAILY

Actual monthly cash balances should be compared to the forecast. Any discrepancies should be evaluated for timing issues or for real differences. This may appear tedious but this will keep your business on a healthy track and out of potential danger if performed and followed up correctly.

3. Financial Statement Reports

On a monthly basis a financial statement reports should be prepared for the clinic(s). This package of reports should include:

A. Balance Sheet

B. Profit and Loss Statement

C. Cash Flow

D. Key Performance Indicators

Once completed these financial statements should be reviewed monthly with the business owner for problems, issues to be resolved and opportunities within the clinic(s). There exist several accounting software packages that prepare a Balance Sheet, Profit and Loss statement and cash flow from operations. Key Performance Indicators can be performed on an Excel spreadsheet.

Balance sheet accounts – reviews of balance sheet accounts are critical and often overlooked. These accounts – both asset and liability – result in increases and decreases in your cash balances.

Profit and loss (P/L) statements – these should be reviewed line by line to look for trends and potential opportunities for the clinic(s).

Cash flow statement – this statement is different than the cash flow projections described above. This statement describes cash activities on an annual basis or for whatever period your financial statements are covering.

Key Performance Indicators – another critical and often overlooked tool is the importance of choosing 4 – 5 key performance indicators and tracking these at least monthly. The performance indicators can be financial, process driven, or customer-based satisfaction metrics.

4. Dashboard

Dashboards have been increasingly utilized in most businesses. An article in the *Journal of Accountancy* states,

"Dashboard reports created in Microsoft Excel are powerful, flexible and easy to design. In much the same way that an automobile dashboard graphically displays numerous measures of performance from the gas level to oil pressure, a computer dashboard presents critical data in a variety of visual formats. From the organizational visual display, optimal business decisions can be made quickly and efficiently."[6]

Clinic owners can have a dashboard program developed where the Key Performance Indicators and other critical metrics can essentially be at the clinic owners' fingertips.

Following these guidelines and experiences could improve the cash flow and ultimately the profitability of your clinic.

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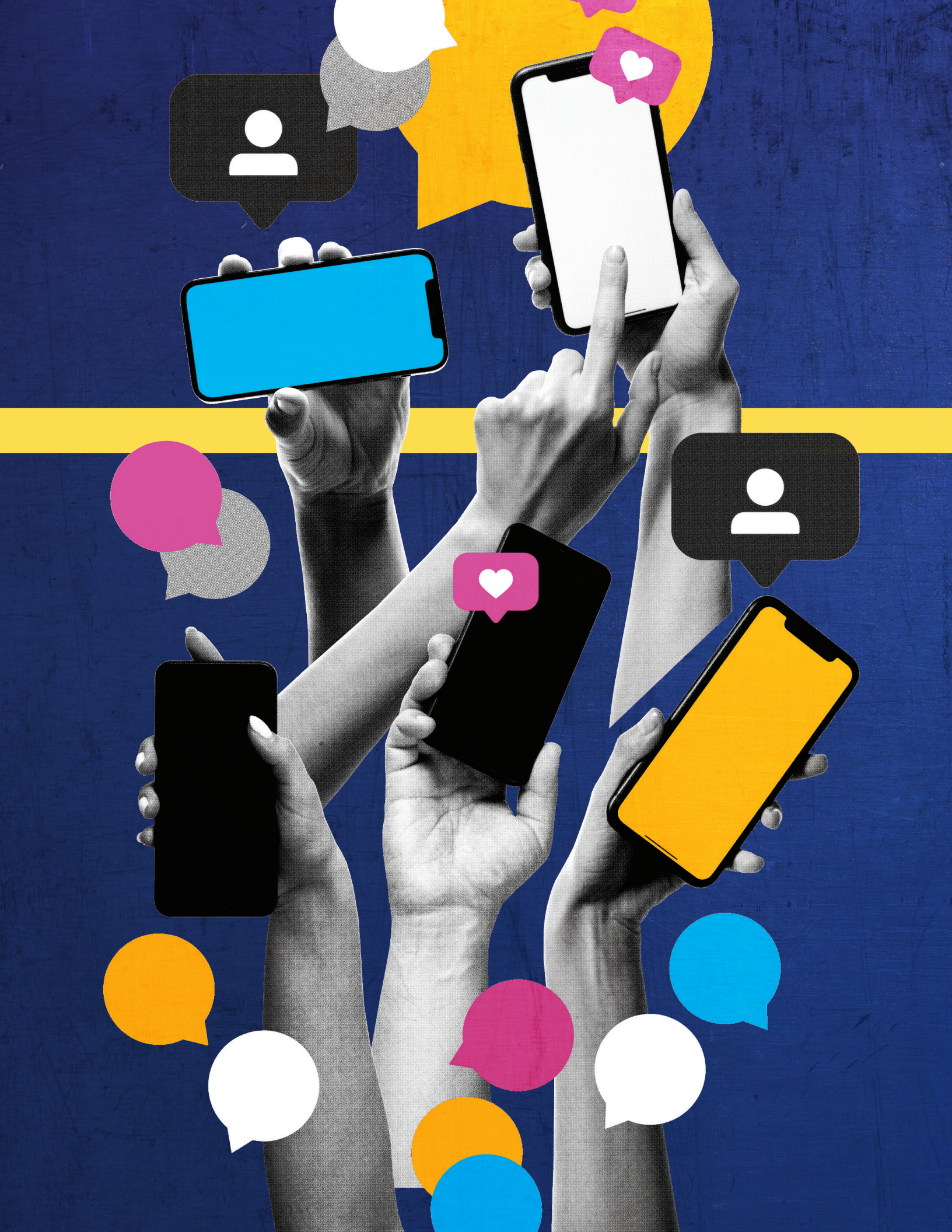
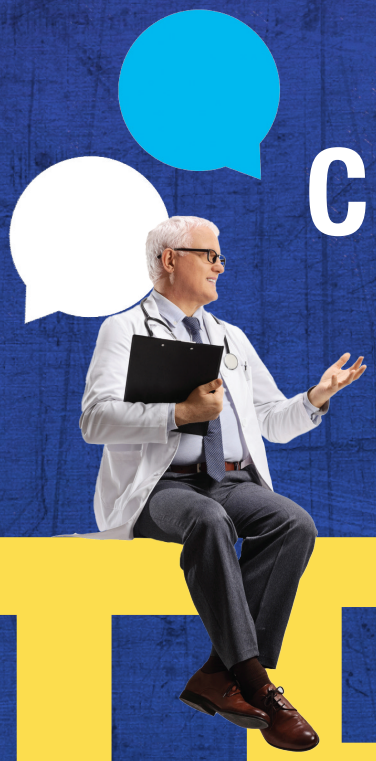
***Robert Wabler** is the former President of Amplifon USA and now retired.* ■





COMMUNICATION STRATEGIES that Promote TRUST in the Age of SOCIAL MEDIA INFLUENCERS

Robert Tysoe and Brian Taylor, Au.D.

Persons with hearing loss who trust their care to audiologists deserve unbiased and honest information; social media influencers, however, often make our jobs tougher. Here are some thoughts on how clinicians can overcome the glut of misinformation and promote a more trusting relationship with help seeking individuals.

Scroll, Share, Mislead

A rising number of people now receive their news from social media platforms. Sites like Facebook, TikTok, Instagram and YouTube are among the most popular places that people of all ages receive news and other important information. Although these sites are easy to access, convenient, and often fun, they have at least seven critical downfalls. One, the sheer abundance of these sites, combined with their ready access via any smartphone, tablet or laptop computer leads to information overload and difficulty sorting the pertinent information from the noise. Two, the rapid consumption of bite-sized content can lead to superficial understanding of complex issues. Rather than read one 5-page article, you can skim through dozens of entertaining listicles and infographics in the same amount of time. Three, clickbait headlines, a staple of just about every social media platform, often exaggerate findings, thus prioritizing engagement over factual reporting. Four, the algorithm inside each platform tends to bring content to the user that aligns with their existing beliefs and reinforces existing biases. There is even some evidence that social media platforms push opinions about controversial topics in a more radical direction (Cinelli, et al 2021).

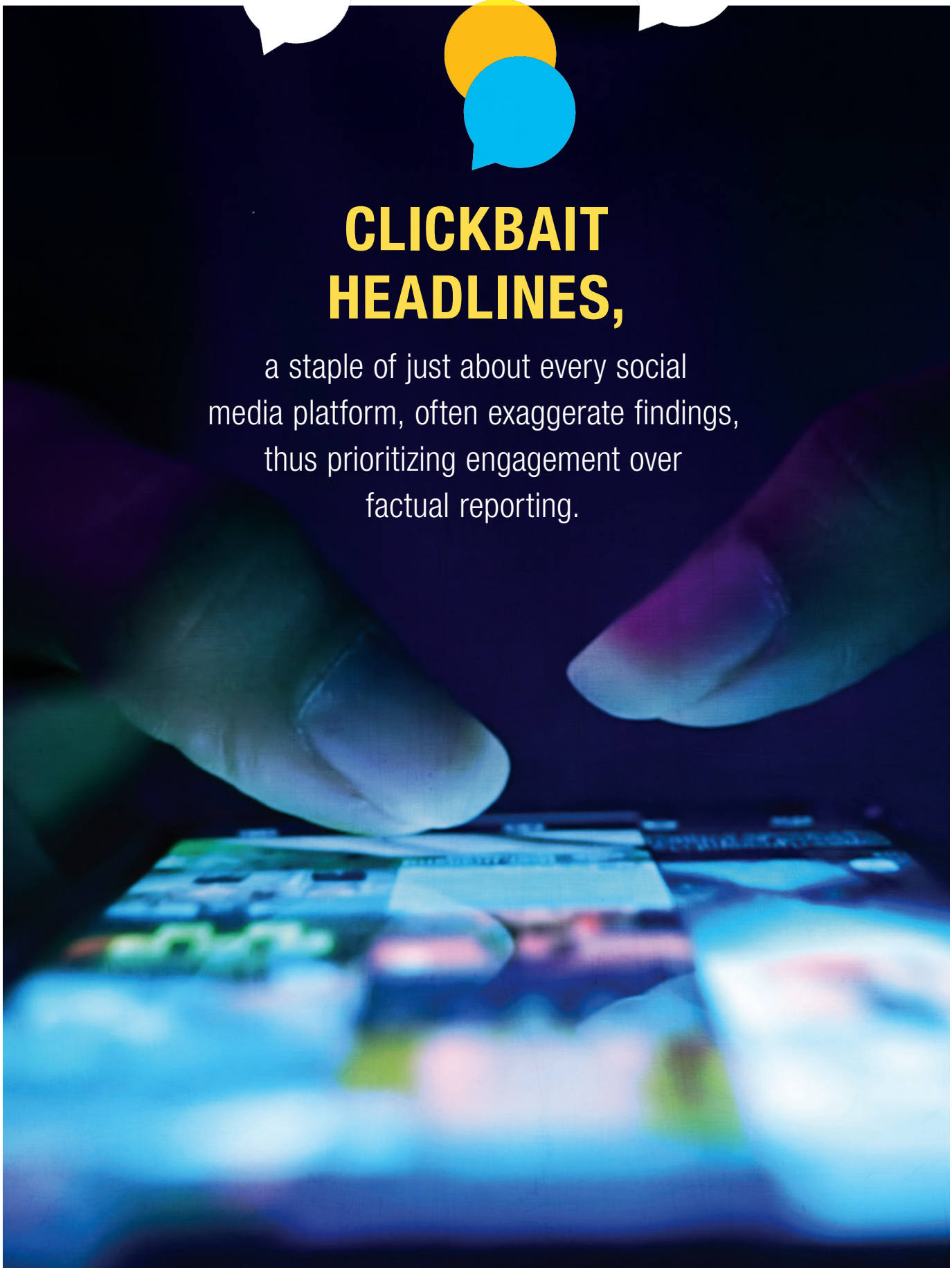
And the list goes on… Five, a lack of gatekeepers or effective oversight leads to many platforms being overrun with false information and rumors, which can spread quickly and lead to misunderstandings. Six, given the rapid-fire way content is pushed to social media consumers, when information is shared in snippets or out of context it can be misleading or distorted. Seven, many sources of information on social media lack rigorous editorial standards, making it difficult to determine what's trustworthy. See McComb. Vanman, & Tobin, (2023) for a detailed analysis of the many ill-effects associated with social media consumption.

Influenced or Misled?

This seventh pitfall associated with misinformation relates directly to social media influencers. A social media influencer is best described as a personality who has established credibility within a specific industry and creates content for a large group of followers. Influencers can be especially pernicious because influencers have the veneer of an unbiased expert, but they often fail to disclose that they are compensated for promoting a product or service. Further, social media influencers can monetize their presence in a variety of other ways that are not transparent. For example, in addition to charging brands to promote their product, influencers can sell their own products or services directly to their followers. They can also build a paid membership program on platforms such as Patreon and YouTube where paid subscribers can access exclusive content or make money from events or workshops where they appear.

Together, these seven pitfalls associated with social media are a big reason public trust in the healthcare professions is at an all-time low. From vaccine hesitancy to the rise of antibiotic resistance, from climate change denial to an increase in "lifestyle diseases" such as diabetes and certain cancers, misinformation -- much of it propagated on social media -- is driving mistrust. As stated recently in JAMA, the global spread of false and misleading information poses serious threats to public health by promoting vaccine hesitancy non-evidence-based therapies (e.g. "natural remedies"), and even the refusal of life-saving medical treatment such as monoclonal antibodies (van der Linden & Roozenbeek, 2024).

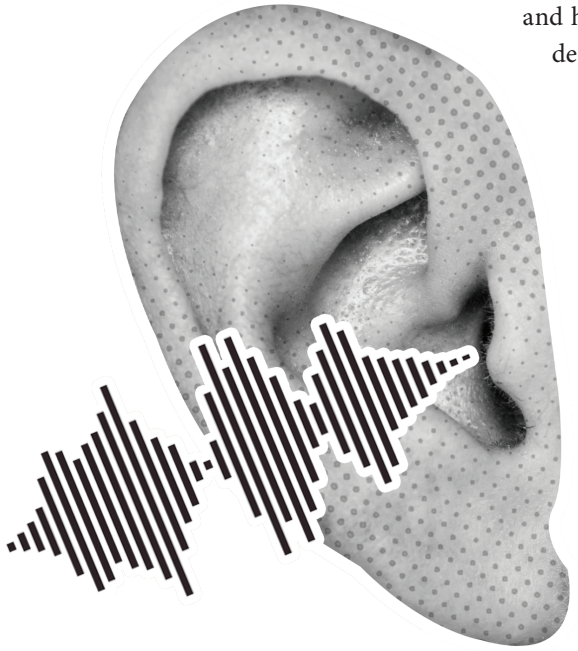
Although seldom dealing with life and death situations, audiologists still practice in a media ecosystem awash in misinformation. The central irony for audiologists in the social media age is as more and better information about the potentially harmful effects of untreated hearing loss becomes available, the greater the risks that individuals who could use our help are misled or misinformed by the information they consume on social media.


CLICKBAIT HEADLINES,
a staple of just about every social media platform, often exaggerate findings, thus prioritizing engagement over factual reporting.

This article highlights why clear and ethical communication are the underpinnings of developing trust with patients. Moreover, preventing the spread of misinformation is often more effective than trying to correct half-truths after they have already spread. But first, in order to better understand the consequences of misinformation, we review some of the recent research findings related to age-related hearing loss.

The Heightened Awareness of the Harmful Effects of Hearing Loss

Twenty years ago, the World Health Organization (WHO) determined that hearing loss is the third leading cause of years lost to disability worldwide (WHO Fact Sheet, 2024). This equates to an estimated 199 million men and 239 million women globally who have moderate or worse hearing loss. Closer to home in the U.S., age-related hearing loss is the third most common condition in older Americans after hypertension and arthritis and has been demonstrated through statistical analysis to be linked to cognitive decline, social isolation and depression (Brester at al, 2021).



Through this research, and the subsequent media buzz it has generated over the years, many have come to recognize that hearing loss in the United States is a major public health concern that warrants intervention from audiologists. We know that age-related hearing loss occurs in 20.3 % of the American population (48.1 million) and is substantially under-detected and under-treated, as a mere 20 to 25 % of the US population with hearing loss has been treated. These findings have, in turn, driven government policy initiatives, including the 2017 OTC Hearing Aid Act, which went into effect in 2022. These policy initiatives are designed to spur an uptick in hearing aid use at younger ages. (NASEM, 2016).

With the rising awareness of the harmful effects of hearing loss as well as the benefits of earlier and lower cost interventions, comes the mounting possibly that misinformation will spread, often exaggerated and twisted by social media influencers.

Here, we explore three common examples of misinformation, commonly spread by social media influencers. For each example, we try to provide some facts, more nuanced in nature that can be used to address this misinformation when communicating with persons with hearing loss.

MISINFORMATION #1:

"Hearing Aids are Expensive"

A quick search on the internet shows dozens of articles from respected publications such as Forbes and the New York Times with colorful headlines saying the price of hearing aids is extraordinarily high. So high, in fact, that a new OTC category was created to combat these high out of pocket costs.

NUANCED TRUTH:

Those headlines seen in mainstream press publications purporting the high price of hearing aids fail to mention there is a large range in prices for prescription hearing aids. They often fail to mention that in-person follow-up care and other support services are bundled into the purchase cost of the devices or can be obtained for a nominal fee. In many cases, a pair of basic-level prescription hearing aids are comparable in price to those OTC devices that have been brought to market because "traditional hearing aids cost so much." Additionally, a growing number of persons with hearing loss have an insurance benefit that might reduce their out-of-pocket costs.

HOW TO COMMUNICATE ETHICALLY AND RESPONSIBLY:

"There is tremendous range in prices and service options that are tailored to the communication needs and budget of the individual."

MISINFORMATION #2:

"XX-Brand Hearing Aids are Rating #1"

NUANCED TRUTH:

This bit of misinformation is often spread by social media influencers who often fail to disclose from whom they are receiving compensation. In other examples, social media influencers may disclose who sponsors the video but are nevertheless compensated to provide a favorable review of specific products or services. In some cases, these influencers boil their review down to a single number rating based on some scientific principles which do not fully capture all the individual variables that contribute to patient benefit from hearing aids. Although these single number ratings are grounded in science, a single number rating serves more as clickbait for consumers and should be interpreted with great caution and skepticism by clinicians.

HOW TO COMMUNICATE ETHICALLY AND RESPONSIBLY:

"Prescription hearing aids vary in how they process speech, music and background noise. Manufacturers of prescription hearing aids, however, must follow some uniform quality standards. Therefore, they all meet a basic performance criteria and it is impossible to boil all this down to a single number. The most critical variable is my (the audiologist's) ability to tailor the device to optimize benefit for you."

MISINFORMATION #3:

Hearing Aids Prevent Dementia

NUANCED TRUTH:

Although some studies show that hearing aids have a small positive effect on slowing dementia, there is no evidence that hearing aids prevent dementia.

HOW TO COMMUNICATE ETHICALLY AND RESPONSIBLY:

See Blustein's diagrams in Clinical Bulletin #3 in this issue of Audiology Practices for details.

Trust-Promoting Tactics

When it comes to examples of misinformation, we are barely scratching the surface. The problem is so rampant that we think that most patients have been misinformed to some degree. To overcome the effects of this misinformation, we propose the following approach

RESPONSIBLE AND ETHICAL COMMUNICATION

True expertise, the kind of knowledge that builds trust with patients, is combination of talent, experience, judgement and peer affirmation and is needed to be a responsible and ethical communicator. Real experts know that it takes time to explain things to patients in a way that they understand without glossing over any details. Real expertise also requires a willingness to stay current in the peer review literature as well as knowing how to properly interpret new research findings.

PRE-BUNKING

Once people are exposed to misinformation, they often rely on false details despite having been exposed to facts. A prominent response by the medical community has been to debunk false information. This can be done by leveraging "prebunking" – preemptively refuting false information – through psychological inoculation. The use of evidence-based patient decision aids and fact sheets are two tactics that can be used to pre-bunk patients.

EMPATHIC REFUTATION

An international study (Milionis, et al 2023) found that skeptical individuals were generally more receptive to reasoning from healthcare professionals who not only addressed specific concerns about vaccines but also conveyed an understanding of their initial misinformed viewpoints. Stated differently, it's not what you say it is how you say it. The study notes that although communicating facts is an important part of correcting misinformation, its effectiveness varies depending on how the information is delivered and where there is demonstrated understanding of underlying beliefs. These findings could present a path to help clinicians build trust, engage in a more productive dialogue, and potentially shift opinions around vaccination.

One example of emphatic refutation of misinformation is to use the Feel/Felt/Found principle. It looks something like this: "On the one hand I can understand your feelings about not wanting hearing healthcare, because of price, and your doubts about the benefits of care. I respect your position. On the other hand, when many of my older patients have a hearing loss similar to yours, I find that when they agree to a treatment plan they have found it uplifting to be able to hear and engage in a comfortable chat with their spouse, co-workers, and grandchildren again. Not to mention they are unburdened by from the prospect of being laid off from work because of an untreated hearing loss that decreases their productivity."

THE AGE OF LECTURING PEOPLE IS OVER

Traditional, one-way communication—where an authority figure dictates information without interaction or engagement—is no longer as effective or welcomed in today's world.

Here are some examples demonstrating why this is true.

1. THE RISE OF INTERACTIVE LEARNING

Traditional classroom lectures are being replaced with interactive, discussion-based, and experiential learning methods. This type of learning has been used for more than a decade, so a rising number of adults are immersed in it. Platforms like Khan Academy, Duolingo, and Coursera emphasize engagement through quizzes, videos, and adaptive learning rather than passive lectures.

2. THE POPULARITY OF CONVERSATIONAL CONTENT

Social media platforms like TikTok, YouTube, and Twitter thrive on short, engaging, and interactive content rather than long monologues. Content creators who engage with their audience, respond to comments, and create dialogue see far more success than those who simply lecture. These are lessons clinicians can apply to their communication with persons with hearing loss.

3. WORKPLACE SHIFT TOWARD COLLABORATION

In modern workplaces, rigid top-down communication is giving way to open discussions, brainstorming sessions, and agile team collaboration. Employees expect to contribute rather than just receive orders—hence the rise of flat hierarchies and open-door policies. It stands to reason that patients who experience in this shift toward collaborative communication expect it from their health care providers.

4. THE DEMAND FOR PERSONALIZED EXPERIENCES

Whether in education, marketing, or entertainment, people expect customized and interactive experiences rather than one-size-fits-all lectures. Netflix, Spotify, and personalized ads tailor content to individual preferences instead of pushing generalized messages and many people expected these same personalized experiences from their health care providers, too.

5. THE DECLINE OF TRADITIONAL MEDIA DOMINANCE

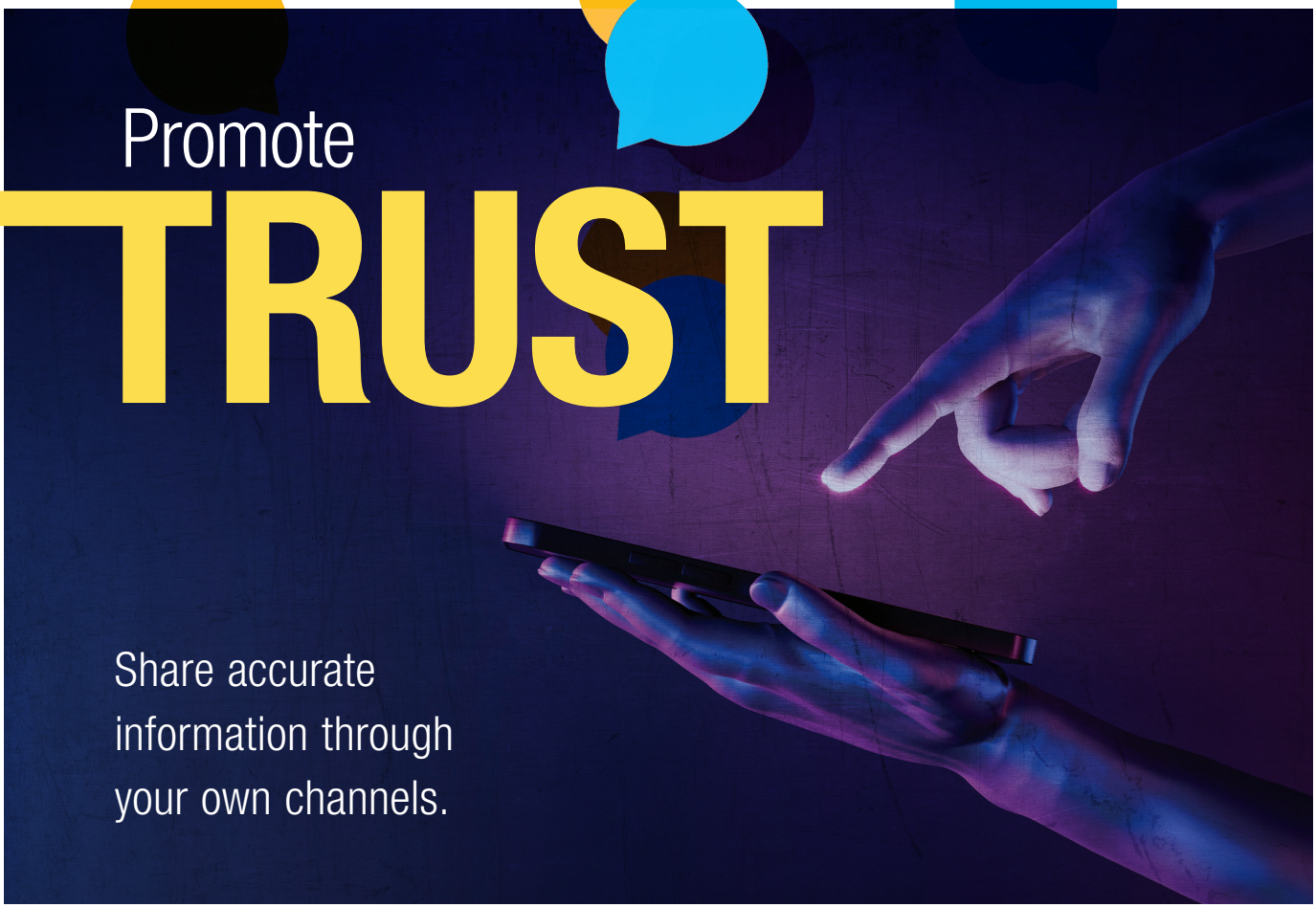
The days when people passively consumed information from newspapers or TV news are fading; now, users engage with content, comment, and challenge narratives. Podcasts, interactive news forums, and live-stream discussions allow real-time participation rather than one-sided storytelling.

6. THE POWER SHIFT FROM EXPERTS TO COMMUNITIES

While expertise is still valued, people are more likely to trust peer reviews, influencers, and crowdsourced knowledge (e.g., Reddit, Quora, and forums) over single authoritative voices. Although they should be viewed with caution and skepticism, platforms like Wikipedia thrive because information is collaborative rather than dictated by one entity.

The way people consume information has fundamentally changed. Engagement, dialogue, and participation are more powerful than static lectures. If you want to persuade or educate, today you need to listen, interact, and adapt—not just talk at people as this table shows:

Communication Variables	Outdated Approach	New Approach
Mode	One-way (didactic)	Two-way, back and forth, collaborative
Style	Formal	Informal
Format	Lecture	Conversational
Tone	Scripted, pre-planned	Perceived as spontaneous and off-the-cuff
Content	Talking points, pre-planned sound bites	Relatable storytelling
Posture	Hovering over	Seated, "living room-like"



Conclusions

We live in an age where misinformation pushes out knowledge and experts are not often trusted. Audiologists can monitor social media for false claims and share accurate information through their own channels. They can also collaborate with trusted health influencers and organizations to amplify accurate information and transition from delivering information in a didactic manner to one that is more conversational in nature.

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The Tools You Need to Run Your Practice.

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

- Adult Case History
- Business Associate Agreement
- Employee Manual
- Hearing Aid Bill of Sale/Purchase Agreement
- Hearing Aid Insurance Waiver
- Hearing Aid Loaner Agreement
- Hearing Aid Orientation Checklist
- Hearing Aid Upgrade Notice
- HIPAA Security Policy Template
- Insurance Verification Form
- Notice of Non-Coverage
- Office and Financial Policies
- Patient Registration Form
- Policies and Procedures Manual
- Price Quote Form

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

ADA
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HAVE YOU HEARD?

ADA POSITION STATEMENT

A Call to Action on Coverage of Hearing Care: Principles for Public Policies that Optimize Patient Outcomes

Background and Problem

Hearing health is essential for overall health and wellbeing. Approximately 15% of adults in the United States report difficulty hearing[1]. Disabling hearing loss affects about 5% of adults aged 45-54 years, 10% of adults aged 55-64 years, and 22% of those aged 65-74 years. Approximately 55% of those aged 75 years and older have disabling hearing loss[2]. Hearing loss is associated with diabetes, cardiovascular disease, cognitive decline and other serious health conditions[3]. Yet, coverage for audiology and hearing healthcare services is limited and deficient.

During the development of the Audiology 2050 Roadmap[4], ADA conducted a thorough analysis of the audiology and hearing healthcare coverage landscape. ADA identified coverage policies that impede beneficiary access to audiologic care and assessed state and federal laws and regulations to identify policy gaps. Some of ADA's key findings were presented to the Centers for Medicare and Medicaid Services (CMS) through the following comments:

- ADA January 5, 2024 comment on: Medicare Program: Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications (CMS-4205-P)[5], and
- ADA May 29, 2024 comment on: Request for Information on Medicare Advantage Data[6].

Upon further analysis, ADA has identified significant disparities in public policies impacting coverage of hearing services, as compared with state and federal laws and regulations governing vision and dental coverage. Audiology can only achieve its potential as a clinical doctoring profession and primary access point for hearing and balance care, when coverage parity can be established and maintained.[7,8,9] The only way to assure coverage parity for consumers, is to ensure parity in public policies that regulate insurance, benefit plans, and third-party administrators (TPAs) that currently control the delivery of hearing healthcare services.

Hearing benefit plans, supported by TPAs, aim to create national hearing aid sales and service delivery models to bolster their own products and networks, and to manage the hearing benefit plans and programs outsourced by insurers, employers, managed care organizations, and others. Most hearing benefit plans and programs are constructed to support the following assumptions:

1. That every individual who requests a hearing test is a traditional, prescription hearing aid candidate;
2. That every hearing aid candidate has the same characteristics, needs, and challenges;
3. That every hearing aid fitting, orientation, and follow-up requires the same level of effort, expertise, and time;
4. That hearing aid performance, satisfaction, and communication outcomes are solely dependent on the hearing aid product (not services such as counseling and auditory rehabilitation, for example); and
5. That every "hearing healthcare professional" has the same value and utility.

Because of their sole focus on the sale of hearing aids, hearing benefit plans and TPAs place little value on diagnostic audiologic testing, cerumen management, verification and validation, communication and functional needs assessments, and treatment services such as tinnitus management and auditory

1. https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing
2. See 1 above.
3. Jana Besser, Maren Stropahl, Emily Urry, Stefan Launer, Comorbidities of hearing loss and the implications of multimorbidity for audiological care, Hearing Research, Volume 369, 2018, Pages 3-14, ISSN 0378-5955, https://doi.org/10.1016/j.heares.2018.06.008.
4. https://audiologist.org/resources/advocacy/audiology-2050
5. https://www.regulations.gov/comment/CMS-2023-0187-3003, January 5, 2024, accessed on March 3, 2025
6. https://www.regulations.gov/comment/CMS-2024-0008-0268, May 29, 2024, accessed on March 3, 2025
7. https://glance.eyesoneyecare.com/stories/2024-01-19/aoa-town-hall-addresses-vision-plan-policy-concerns-and-future-advocacy-initiatives/
8. https://www.aoa.org/news/advocacy/state-advocacy/vsp-policy-change-may-violate-states-patient-protection-laws
9. https://www.ada.org/advocacy/legislative-action-center/dental-and-optometric-care-access-act

rehabilitation, despite the fact that these services are often crucial for optimal clinical outcomes, and most importantly, improved quality of life.[10]

Approximately 10% of adults experiencing hearing loss have a condition that can be remedied with medical or surgical intervention. Approximately 13% of adults with hearing loss are candidates for osseointegrated auditory device or a cochlear implant.[11,12] Others have auditory and communication difficulties that can be treated effectively with over-the-counter hearing aids, tinnitus maskers, assistive listening devices, and/or auditory rehabilitation.

Typically, hearing benefit plans and TPAs do not provide coverage for diagnostic and treatment services, and instead focus solely on routine hearing tests and services related to the selection and fitting of a hearing aid, incorrectly assuming those over a certain age only need hearing aids. These plans generally offer no coverage mechanism for addressing a beneficiary's complex diagnostic or rehabilitative needs, and, unfortunately, most of the plans also prohibit beneficiaries from contracting with audiologists privately for the services that are not covered. Beneficiaries are often left without the help, support, and treatment services that they need--and all too often even after having purchased hearing aids that they are unable to effectively use.[13]

Audiologists frequently receive no reimbursement at all from the hearing benefit plans or the beneficiary, unless the beneficiary purchases a hearing aid. Further, since most hearing benefit plans have no protocol for separating the diagnostic service fees, audiologists are often required to provide free hearing testing services, *even if the beneficiary does not proceed with amplification*. This practice will likely violate Medicare rules and ethical standards, depending on the audiologist's overall service fee protocols, putting them in a potentially non-compliant position ethically and legally.

Conversely, for audiologists who are contracted with the medical insurer, but not the hearing benefit plan, it is often the insurer who either denies coverage for diagnostic services or assigns responsibility for payment to the beneficiary. This is likely due to the inclusion of CPT® codes (92557, comprehensive audiometry, threshold evaluation and speech recognition, for example) into the fees paid to the TPA for administering the plan. Under current practices, simply bundling the billing code into a broader, non-transparent payment scheme seemingly absolves the insurer from covering and reimbursing for medically necessary services separately from the hearing benefit plan. This practice creates a complicated, confusing, and costly situation for both the audiologist and their patient. Even more so when the beneficiary has a Medicare Advantage plan and the testing is medically necessary (not for the purpose of fitting a hearing aid). In this case, the insurer may be legally required to cover the diagnostic service, since Medicare rules require Medicare Advantage plans to provide coverage for all services that are covered under Medicare Part B.

The Path Forward: Public Policy Solutions

The Audiology 2050 Roadmap provides a clear directive to address public policy deficiencies undercutting meaningful access to audiologic care for millions of consumers.[14] ADA has taken bold steps to develop legislative and regulatory strategies that promote parity in insurance laws for audiology and hearing healthcare services, and to advocate for affordable, accessible, audiologic care for all Americans.

10. https://pmc.ncbi.nlm.nih.gov/articles/PMC6132942/
11. MT, Pillsbury HC (2020) Cochlear Implantation in Older Adults: Effectiveness and Expanded Indications. J Geriatr Med Gerontol 6:098. doi.org/10.23937/2469-5858/1510098
12. Nassiri AM, Sorkin DL, Carlson ML. Current Estimates of Cochlear Implant Utilization in the United States. Otol Neurotol. 2022 Jun 1;43(5):e558-e562. doi: 10.1097/MAO.0000000000003513. Epub 2022 Mar 8. PMID: 35261379.
13. https://pmc.ncbi.nlm.nih.gov/articles/PMC3665209/
14. See 4

ADA has identified the following key public policies that need to be codified at the state and federal level:

1. Hearing benefit plans and third-party administrators should be classified as "health benefit plans" or a similar classification that requires them to register with the state and be subject to the purview of the State Insurance Commission or similar entity.
2. Insurers, insurance brokers, hearing benefit plan administrators, and third-party administrators should be prohibited from misrepresenting the elements of a hearing benefits plan when selling the plan or communicating the "benefits" to enrollees, or from misleading enrollees about what services are covered and funded.
3. If the hearing benefits plan is merely a hearing discount plan with a high co-payment option, the hearing benefit plan administrators and third-party administrators should be required to clearly identify and present to consumers, in plain language, what items and services are covered benefits (subject to applicable deductibles and co-insurance and reasonable co-payments), what items and services are capitated and/or discounted, and what items and services are non-covered.
4. The term co-payment should only be allowed to be used to describe a meaningful cost-sharing structure, consistent with other covered items and services within the health plan, where the insured pays a fixed fee for medical expenses and where the insurer pays the remainder.
    a. In order to use the term "co-pay," the insurer's portion should be required to be more than a nominal expense.
    b. The term "co-pay" should not be allowed to be used to describe the beneficiary's responsibility for payment under a hearing discount program.
5. Insurers, hearing benefit plan administrators, and third-party administrators should be prohibited from requiring an audiologist/provider to purchase products from any source owned by or affiliated with the same entity that issued the hearing benefit plan as a condition of participation.
6. Insurers, hearing benefit plans, and third-party administrators should be prohibited from "steering" or piloting enrollees to one provider over another, to any retail establishment affiliated with the insurer, hearing benefit plan, or third-party administrator, or to any internet or virtual provider affiliated with the insurer, hearing benefit plan, or third-party administrator.
7. Insurers, hearing benefit plans and third-party administrators, should be prohibited from "tiering" providers based on non-covered service discounts or the brands of products or hearing instruments that they carry.
8. Insurers, hearing benefit plans, third-party administrators, affiliated clinics, and providers should be required to disclose to beneficiaries when they are affiliated with or have an ownership stake in each other or with a hearing aid manufacturer.
9. Insurers and hearing benefit plans should be prohibited from offering audiologists/providers service fee differentials that would create a real or perceived conflict of interest, undermine clinical judgment, or "steer" or incentivize providers towards specific types, styles, brands, or tiers of hearing aid/amplification products.
10. Insurers, hearing benefit plans, and third-party administrators should be required to publicly publish accurate and comprehensive contact information for all providers in their network, including provider type and credentials. Provider contact information should be required to be readily accessible to the member during the open enrollment process, and should be required to be updated monthly.
11. Insurers, hearing benefit plans, and third-party administrators should be required to list the brand, type, and tier of hearing aids in their formulary, and to make this information available to the enrollee. They should be required to update that list at least annually during the open enrollment period.

12. Patients should be allowed, by law, to combine and coordinate hearing benefit plan, discount, and medical benefits to maximize their coverage.
13. An insurer should be prohibited from requiring an audiologist to contract with a hearing benefit plan as a condition for participation in the insurer's health care network or to provide covered medical services to its enrollees.
14. An audiologist, with written informed consent of the patient, should be allowed to charge a patient privately for services that are not covered under an insurance policy or health benefit plan.
15. Insurers, hearing benefit plan administrators, and third-party administrators should be prohibited from setting or determining fees for any non-covered audiology or hearing service.
16. Reimbursement rates and required co-pays (if applicable) for each covered service product, and material, should be required to be clearly communicated and itemized in the provider contract. Services that the insurer or hearing benefit plan fails to include as covered services should be treated as non-covered services, for which the beneficiary may be responsible.
17. Covered services should include services for which reimbursement is available under an enrollee's medical insurance contract or health benefit plan, or for which a reimbursement would be available but for the application of contractual limitations, such as a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or any other limitation.
18. Hearing benefit plans should be prohibited from issuing a contract that requires an audiologist, as a condition of participation, to offer services at a set fee or a discount from their reasonable and customary fee, when those services, materials, and products are not covered under the plans.
19. Hearing benefit plans should be prohibited from establishing nominal payments for otherwise non-covered services in an effort to have such services considered covered inappropriately.
    a. An item or service should be considered, with respect to a plan or coverage, to be covered under the plan or coverage only if the item or service is an item or service with respect to which the plan or coverage is obligated to pay an amount that is reasonable and is not nominal or "de minimis".
20. Insurers and hearing benefit plans should be prohibited from using "bundling" to render uncovered services nonbillable to the patient and inclusive to a professional fee.
21. Insurers and hearing benefit plan administrators should be prohibited from implementing a plan that uses "downcoding" to prevent an audiologist from collecting the fee for actual services performed either from the insurer, hearing benefit plan or the patient.
22. Insurers and third-party administrators should be prohibited from denying claims for procedures included in a prior authorization unless the patient has exceeded their annual maximum (in which case the patient should be able to be billed privately), or the prior authorization was based on information that was fraudulent or erroneous.
23. Insurance carriers, hearing benefit plans, and third-party administrators should be required to provide contact information for each entity involved in their claims process along with detailed explanations for any coverage denials when requested, including an explanation for the reasoning used to determine care was not medically necessary.
24. Any audiologist that is a party to the provider network contract must be allowed to choose not to participate in the third-party network access (network leasing). Insurers should not be allowed to change, diminish, or cancel an audiologist's rights, status, or participation in a health plan or contract because of the audiologist's decision to not participate in a network leasing arrangement. Further, the third party being granted access to hearing care insurance network must agree to comply with all terms of the provider network contract.

25. Insurers should be required to directly pay the participating/assigned audiologist/provider the amount of any claim under the same criteria and payment schedule under which the insurer would have reimbursed the insured.
26. The terms, fees, discounts, or reimbursement rates in a provider contract should not be able to be changed until the expiration of the contract, unless mutually agreed to in writing by the audiologist/provider and the insurer.
27. An insurer shall not require an audiologist to meet terms and conditions that are not required of a physician or osteopath as a condition for participation in its provider network for the provision of services that are within the scope of practice of an audiologist.
28. In accordance with Centers for Medicare and Medicaid Services (CMS) regulations, an insurer, hearing benefit plan administrator, or third-party administrator shall not require a qualified, enrolled audiologist to provide diagnostic audiologic evaluations to Medicare, Medicare Advantage, or Medicaid beneficiaries for no separate, distinct fee or for free. The charges for these medically reasonable and necessary diagnostic services cannot be bundled in or made inclusive to the hearing aid dispensing professional fee and should be the financial responsibility of the insurer, hearing benefit plan, third-party administrator, or beneficiary.
29. Enrollees should have the right, as outlined in the Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rules of 2013, to waive their insurance, hearing benefit plan, or third-party administrator discounts, coverage and/or benefits and seek treatment from a licensed audiologist even if the enrollee was referred by the plan.
30. When the enrollee or beneficiary is purchasing (submitting payment directly to) the hearing aid from the hearing benefit plan or third-party administrator, the hearing benefit plan or third-party administrator should be deemed the seller and be solely responsible for compliance with applicable state hearing aid dispensing and consumer protection laws. The audiologist who fit and oriented the enrollee or beneficiary on the hearing aid should be held harmless as the enrollee or beneficiary did not purchase the hearing aid from them or their practice. This should be clearly communicated, in plain language, to the purchaser at the outset of the relationship.

Conclusion and Call to Action

ADA seeks volunteer AuDvocates to advance these public policy initiatives at the state and federal levels. Volunteer input is critical for policy development, media and public awareness, outreach to policymakers, coalition building, and education. Your voice matters and your vote matters! Please contact Stephanie Czuhajewski at sczuhajewski@audiologist.org or at (859) 321-1595 for more information. Please use the QR code to volunteer now to advance public policy initiatives that advance optimal patient care! ■

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WE MEAN BUSINESS

Medicare Advantage Hearing and Hearing Aid Coverage and Benefits

BY KIM CAVITT, Au.D.

As Medicare Advantage is a federal program, Medicare Advantage coverage and benefits information is available online.

You or your staff can make a list (from your own patient database) or view a list by typing your zip code into https://www.medicare.gov/plan-compare/#/?year=2025&lang=en (you do not need to create an account or log in) to see the available Medicare Advantage plans in your area. Available Medicare Advantage plan offerings are tied to state and country. It is IMPORTANT that you have the EXACT plan and name.

You can see basic coverage at the Medicare.gov site. You can also search the specific plan on the plan website. There you will be able to find specific the specific summary of benefits or plan document for the specific Medicare Advantage plan. There you will see the specific hearing and hearing aid benefits for THAT specific Medicare Advantage plan.

You or your staff can create a table outlining coverage and benefits and specific hearing benefit plan (third-party) involvement. Please note that most Medicare Advantage plans (unless tied to Medicaid, a union or specific employer) offer hearing aid benefits ONLY through a hearing benefit plan (third-party).

If you build this table at the outset of the year, you will NOT need to call for coverage and benefits for individual patients (which can trigger outreach from the hearing benefit plan). Instead, you can just go to the online payer portal and confirm eligibility.

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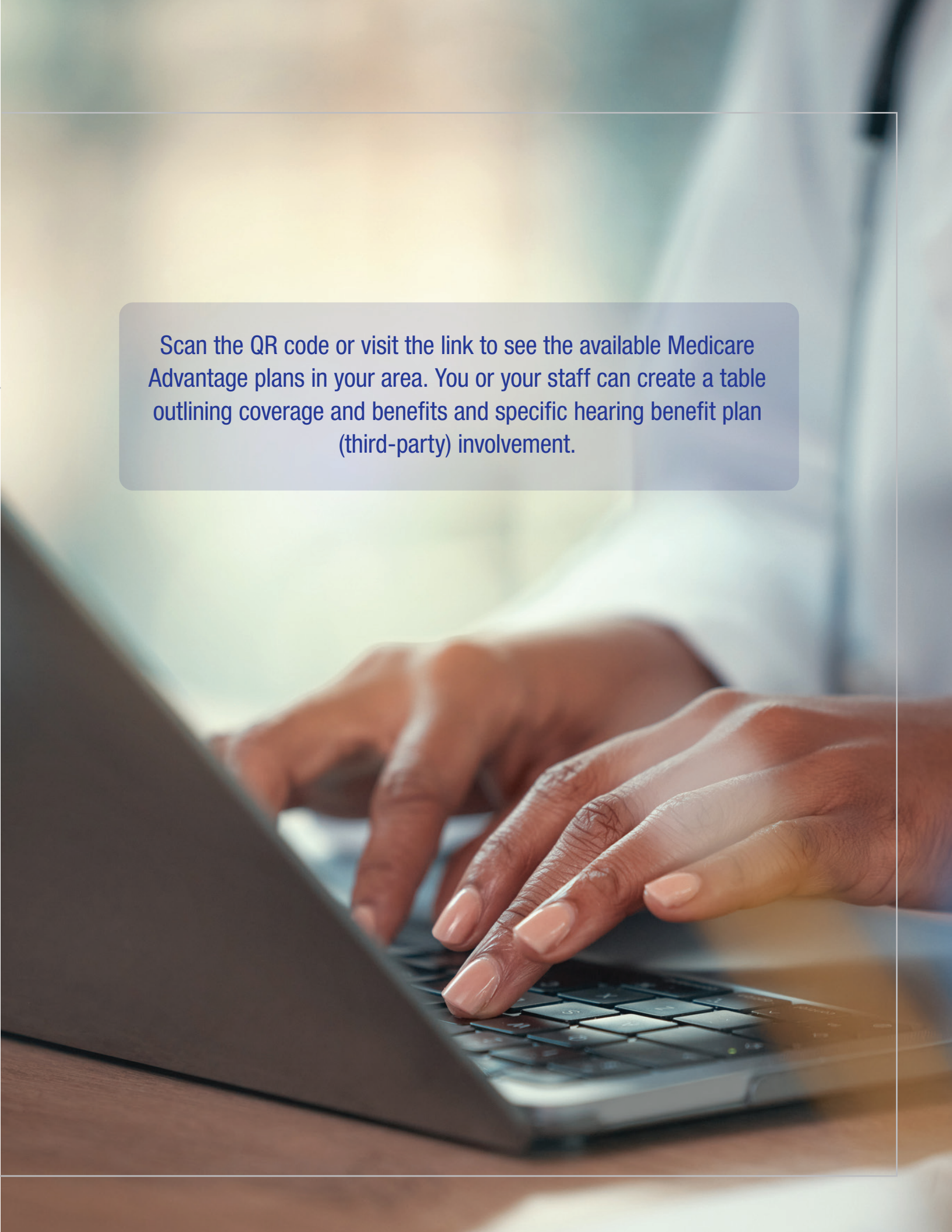
*Please contact **Kim Cavitt** at kim.cavitt@audiologyresources.com for any questions, guidance or support.* ■



Scan the QR code or visit the link to see the available Medicare Advantage plans in your area. You or your staff can create a table outlining coverage and benefits and specific hearing benefit plan (third-party) involvement.

PRESIDENT'S MESSAGE

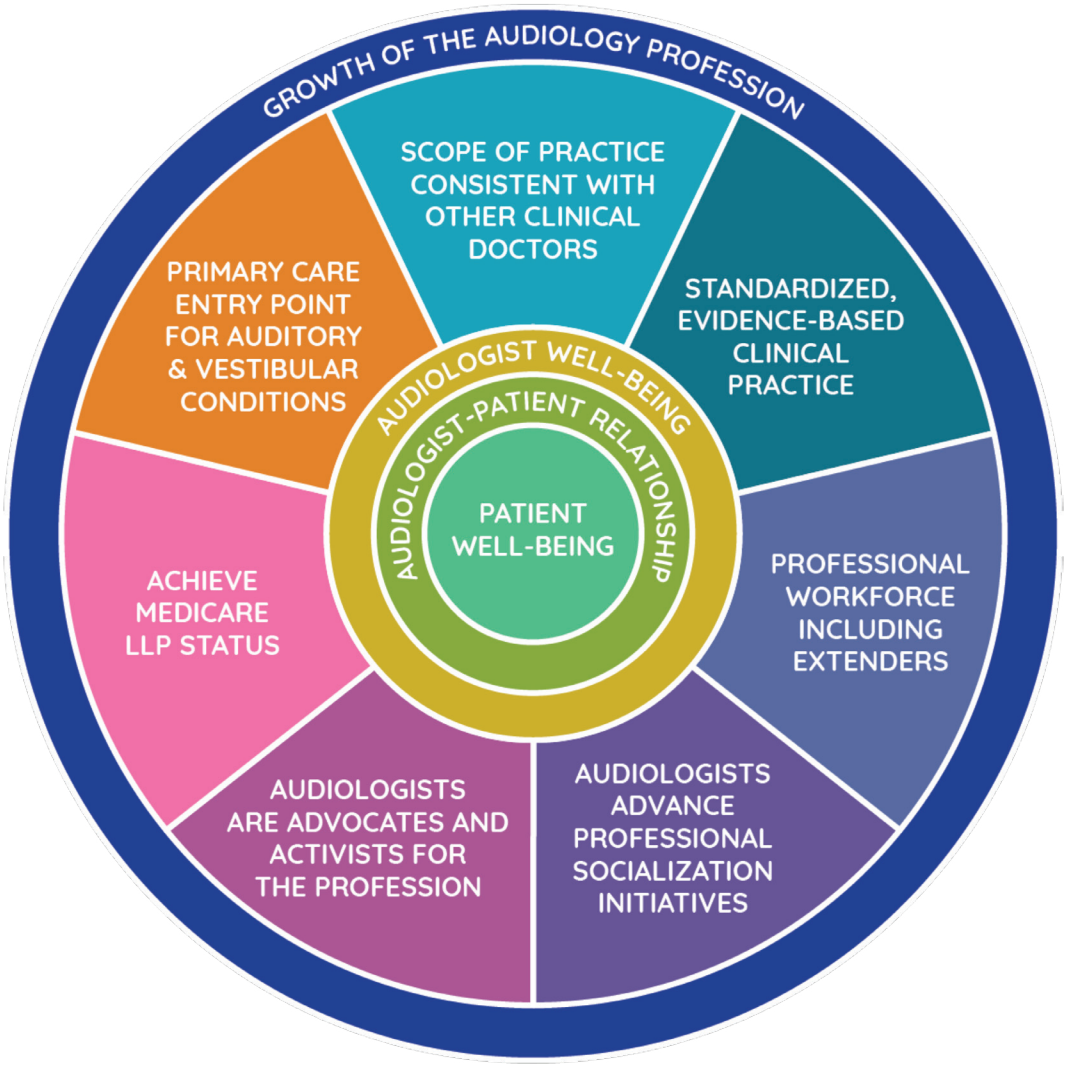
Continued from page 3

In 2024, ADA evaluated the evolution of comparable doctoral-level health professions and their continued journey towards autonomy. The outcome from this exercise revealed a strategic road map—named, *Audiology 2050*—that provides a compass in navigating audiology towards closing the gap towards its professional autonomy. The strategic roadmap—which was unveiled at the 2024 ADA AuDacity annual conference—consists of seven segments of actionable tasks. Each segment is listed and described below.

In 2025, ADA is undertaking the development of 2-3 segments through careful and evidence-based evaluation that leads to deliverables for the membership and for the profession. For example, you will find in this issue, ADA's seminal policy statement, *A Call to Action on Coverage of Hearing Care: Principles for Public Policies that Optimize Patient Outcomes,* on page 42, which was introduced on March 20, 2025.

Through my role as ADA President, it is my objective to provide members with transparent, periodic updates on the progress made for each segment of Audiology 2050. My ask of the membership and of my peers is to serve on a committee(s) towards the development of the materials that will further and hasten our journey towards becoming an autonomous, doctoring profession.

Thank you, in advance, for your service and advocacy to the profession. Wishing you all a productive, successful, prosperous, and remarkable Spring!



Audiology 2050

STANDARDIZED, EVIDENCE-BASED CLINICAL PRACTICE

- Up-to-date Standards of Care and Clinical Guidelines for Audiology
  - Tied to diagnosis
  - Developed and endorsed by professional societies
  - Implemented in practice
  - Measured (registry, outcomes)
  - Reevaluated at regular intervals
- Audiology Practice Accreditation

PRIMARY CARE ENTRY POINT FOR HEARING & BALANCE

- Audiologists increase knowledge of "whole body"
- Case history that reflects point-of-entry provider
  - Different/additional screenings
  - Knowledge of biomarkers related to metabolic syndromes and chronic conditions
- Public perception of audiology is as the pint-of-entry provider for hearing and balance
- Employ/supervise/collaborate with allied health and physicians as part of a multidisciplinary/interprofessional team
- Increase the number of independent private audiology practices
- Audiologists meet patients where they are in their hearing journey (including encouraging self-care such as OTC, when appropriate)

SCOPE OF PRACTICE CONSISTENT WITH OTHER CLINICAL DOCTORS

- Strip the term "non-medical" out of state audiology practice laws
- Ensure that state audiology practice laws include evaluate, diagnose, manage, and treat auditory and vestibular conditions, which accurately represents the scope of practice for audiology
- Expand and intensify education and training in pharmacology, imaging, and other areas of clinical focus to ensure provider readiness
- Audiologists practice at the top of scope of practice and across the continuum of care (including prevention)

PROFESSIONAL WORKFORCE INCLUDING EXTENDERS

- Develop new staffing and service delivery models that improve efficiency and patient outcomes
- Develop new educational models that develop and incorporate qualified extenders into audiology practice
- Create an undergraduate degree that qualifies dispensers in a medical audiology model
- Design and implement interdisciplinary care models in private practice settings
- Incorporate innovative channels for audiology service delivery (telehealth, mobile audiology etc.)

ACHIEVE MEDICARE LLP STATUS

- Move toward unbundled and hybrid service pricing
- Audiologists held to the same standards for ethics and compliance as other LLP providers and clinical doctoring professionals
- Eliminate reliance on profit from devices as a mechanism for profitability/sustainability
- Exceptional students compete for entrance into audiology training programs

AUDIOLOGISTS INVEST IN ADVOCACY AND PROFESSIONAL SOCIALIZATION

- Audiologists are invested members of their state and national associations
- Advocate for a CAA/ACAE standard that prioritizes encouraging organizational membership and advocacy for the profession
- University curriculum values private practice
- Preceptors require universities to meet standards of practice and professionalism as a condition of taking students ■

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2025

SEPTEMBER 25–28 | WASHINGTON, D.C.

WASHINGTON HILTON HOTEL

empowered

ADA ACADEMY of DOCTORS of AUDIOLOGY

MARYLAND ACADEMY OF AUDIOLOGY

SAVE THE DATE!

The Academy of Doctors of Audiology (ADA) and the Maryland Academy of Audiology (MAA) are excited to announce that they have partnered to co-host **AuDacity 2025: EMPOWERED!** This premier event will unite audiologists from Maryland and across the nation for advocacy, education, and professional development.

ADVOCACY + ACCELERATION

EMPOWERED will launch on Thursday, September 25th with AuDiology AuDvocacy Day on Capitol Hill, providing attendees with a powerful platform to engage directly with policymakers to advocate for improved access to audiologic care for millions of Americans and improved coverage and reimbursement for audiology services. This signature event will set the stage for an action-packed program, designed to inspire innovation, foster meaningful connections, and drive the profession forward.

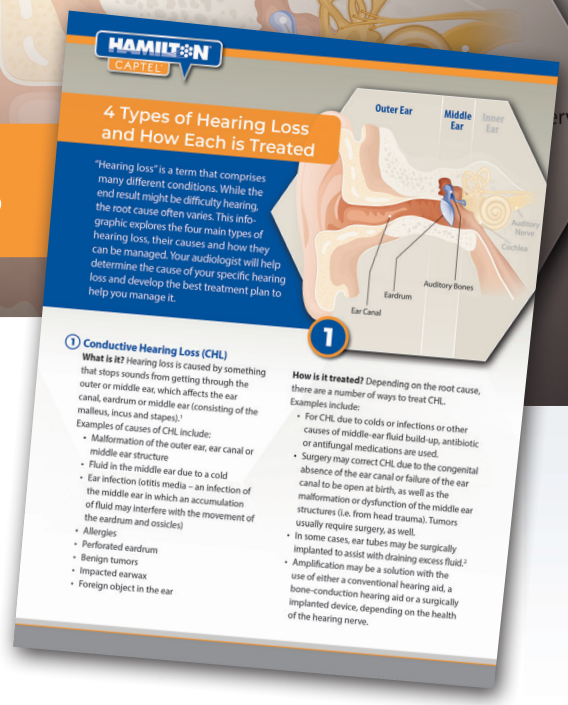
> **With a focus on advocacy and the acceleration of optimal clinical and business outcomes, AuDacity 2025: EMPOWERED, aims to move us rapidly forward.**
>
> — DR. AMYN AMLANI, PRESIDENT OF ADA

VIEW THE AGENDA

By bringing together ADA's national leadership in advancing the autonomous practice of audiology and MAA's unrivaled advocacy efforts to advance the profession and patient care in Maryland and the surrounding region, this collaboration will deliver an unparalleled experience for audiologists at every stage of their careers.

HAMILTON CAPTEL

4 Types Of Hearing Loss



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

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SADA
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.