THE OFFICIAL PUBLICATION OF THE ACADEMY OF DOCTORS OF AUDIOLOGY®

# Audiology PRACTICES

ACADEMY of DOCTORS of AUDIOLOGY®

*The Power to Practice*

IN THIS ISSUE



VOLUME 18, NUMBER 1 ■ JUNE 2026 | WWW.AUDIOLOGIST.ORG


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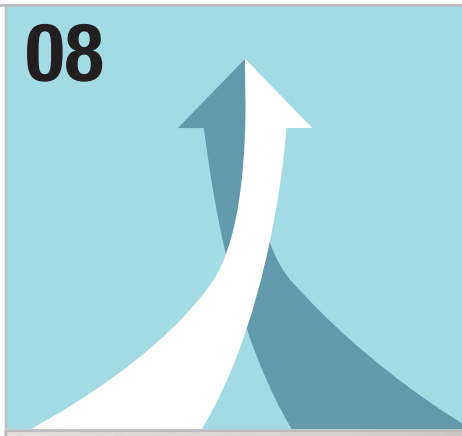


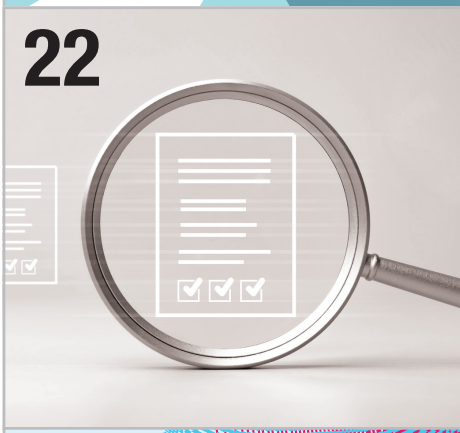


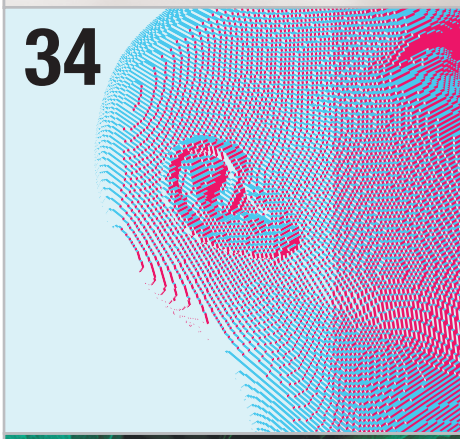


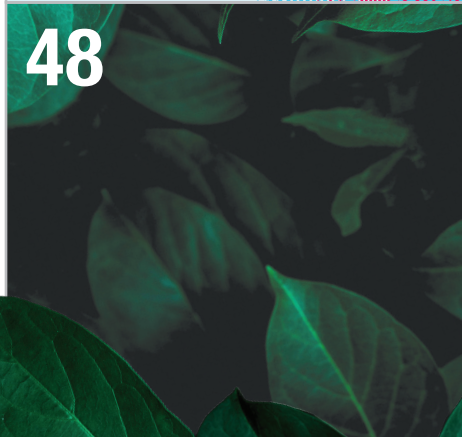

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The Academy of Doctors of Audiology is dedicated to leadership in advancing practitioner excellence, high ethical standards, professional autonomy, and sound business practices in the provision of quality audiological care.

*Audiology Practices* (USPS 025-476) ISSN (21645248) is published quarterly by the Academy of Doctors of Audiology, 1024 Capital Center Drive, Suite 205, Frankfort, KY 40601. Periodicals Postage Paid at Lexington KY and at additional mailing offices. Subscriptions are $25 as part of membership dues. POSTMASTER: Send address changes to *Audiology Practices*, 1024 Capital Center Drive, Suite 205, Frankfort, KY 40601.

Jill Davis, Au.D.

# The Future We Choose

As audiologists, we are often asked to help patients navigate moments of uncertainty. Whether someone is experiencing hearing loss, tinnitus, dizziness, or communication challenges, our role is to guide them toward better outcomes through knowledge, expertise, and action.

Today, our profession finds itself at a similar crossroads.

Across the country, audiologists are providing highly specialized care that extends far beyond hearing testing and hearing aids. We evaluate complex auditory and vestibular disorders, program implantable devices, provide rehabilitation services, perform health screenings, manage tinnitus, and help patients navigate conditions that affect their health, safety, communication, and quality of life.

Yet in many states, the laws governing our profession have not kept pace with our education, training, or clinical responsibilities.

The question before us is not whether audiology has evolved. It has.

The question is whether our profession will continue to advocate for the recognition, authority, and access necessary to fully serve our patients.

At ADA, we believe that audiologists should be empowered to practice to the full extent of their education and training. We believe patients deserve timely access to hearing and balance care without unnecessary barriers. We believe state and federal policies should reflect the realities of modern audiology practice.

Every unnecessary referral, every delay in diagnosis, every statutory limitation that prevents an audiologist from providing a needed service ultimately affects the patient sitting in front of us. Our advocacy efforts are grounded in the belief that better access, better efficiency, and better outcomes are achievable when audiologists are empowered to function as the clinical doctors they are trained to be.

That is why ADA continues to advance the Audiology 2050 initiative. Its vision is comprehensive: a profession that enjoys professional parity with other clinical doctoring professions, serves as a primary entry point for auditory and vestibular care, achieves Medicare LLP status, embraces evidence-based practice, and develops the workforce necessary to meet growing patient demand.

The future of audiology will not be determined by any single legislative victory, reimbursement change, or organizational initiative. It will be shaped by thousands of audiologists who choose to advocate for their patients, their practices, and their profession.

*Continued on page 71*

ADA
ACADEMY of DOCTORS of AUDIOLOGY®

# BECOME A MEMBER!

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

**Is ADA right for you? The answer is yes if:**

- You want to belong to a professional organization that provides valuable practice management resources you can use in your business, right now, today.
- You want to have access to expert reimbursement consulting advice.
- You want to help advance advocacy efforts that will ensure patient access to audiologic healthcare and professional parity for audiologists with other doctoring professionals.

**Visit audiologist.org/membership to learn more!**

Brian Taylor, Au.D.

# Now is the Time to Embrace Digital Therapeutics

You may not be familiar with the term, digital therapeutics, but if you use smartphone apps to track anything in your daily life, then you are already half way there. For independent audiology practices, digital therapeutics present a growing opportunity to diversify revenue while improving patient outcomes. As our society increasingly embraces technology-enabled care, audiologists can expand beyond traditional hearing aid dispensing by integrating digital tools that support hearing health, tinnitus management, cognitive wellness, and long-term patient engagement.

One of the most promising areas is tinnitus treatment. Many patients struggle with chronic tinnitus but may not yet require amplification. Digital therapeutic platforms that provide guided sound therapy, relaxation exercises, and cognitive behavioral therapy modules can create a new revenue stream. For example, an audiology practice might offer a subscription-based tinnitus management program that combines in-office counseling with app-based daily therapy and remote progress monitoring. This approach creates recurring monthly revenue while improving continuity of care.

Auditory training programs also offer meaningful opportunities. Patients fitted with hearing aids often need additional support adjusting to amplified sound, improving speech understanding in noise, and gaining confidence in their ability to actively participate in social situations.. A practice can provide personalized digital auditory rehabilitation programs that patients complete at home between appointments. These programs enhance patient satisfaction and may increase hearing aid retention rates while generating additional service revenue.

Remote patient monitoring also creates operational and financial advantages. Teleaudiology platforms allow audiologists to deliver virtual follow-ups, hearing aid adjustments, and coaching sessions without requiring in-office visits. Practices may bundle these services into annual membership plans that provide patients with ongoing digital support and convenient access to care.

By incorporating digital therapeutics, independent audiology practices can create scalable recurring revenue, strengthen patient relationships, and differentiate themselves in an increasingly competitive healthcare marketplace. Although their effectiveness has yet to be studied, digital care solutions are becoming an important part of sustainable growth and modern audiologic practice management. It is another example of how ADA members can lead the way in the profession by putting them to good use in their practices: improving patient engagement and outcomes, plus generating additional revenue. ■


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# A Personal Invitation to the Audiology 2050 Hackathon at AuDacity 2026

**When:** Saturday, October 3, 2026, from 5:00 p.m. – 9:00 p.m.

**Where:** Hyatt Regency Hotel Minneapolis

**Who:** YOU

*Audiology 2050 is a framework to achieve audiology's full potential as a clinical doctoring profession, with patient well-being at its core.*

Achieving Audiology 2050 requires us to take purposeful, proactive steps toward a future in which audiologists are fully recognized as essential healthcare providers, where patients have timely access to high-quality hearing and balance care, where educational pathways are aligned with workforce needs, and where the practice of audiology continues to evolve to meet the changing demands of healthcare and society.

*What must we do now and next to make Audiology 2050 a reality?* That question will take center stage at AuDacity 2026.

On Saturday, October 3rd, ADA will host the *Audiology 2050 Hackathon: Moving from Vision to Action*, an interactive, collaborative evening designed to transform big ideas into actionable strategies and tasks. From 5:00 p.m. to 9:00 p.m., audiologists, students, educators, researchers, practice owners, industry leaders, and other stakeholders will gather to tackle some of the profession's most pressing challenges and opportunities. Of course, there will also be dinner, networking, collaboration, and a fun, friendly competition! Participation is free, but registration is required so we can plan appropriately for dinner and seating.

*Audiology 2050 Hackathon* participants will engage in facilitated brainstorming, rapid ideation, team-based problem solving, and creative strategic thinking. Together, we will challenge assumptions, identify priorities, and develop practical recommendations that can help guide both ADA and the profession over the coming decades.

Your voice matters! I invite and encourage you to participate in this important event—the future we create will be stronger if we build it together! The ideas generated during the *Audiology 2050 Hackathon* will be shared with all participants and the broader audiology community to inform profession-wide initiatives. Your contributions will influence conversations and decisions long after AuDacity 2026 concludes.

*Continued on page 71*

PART 2

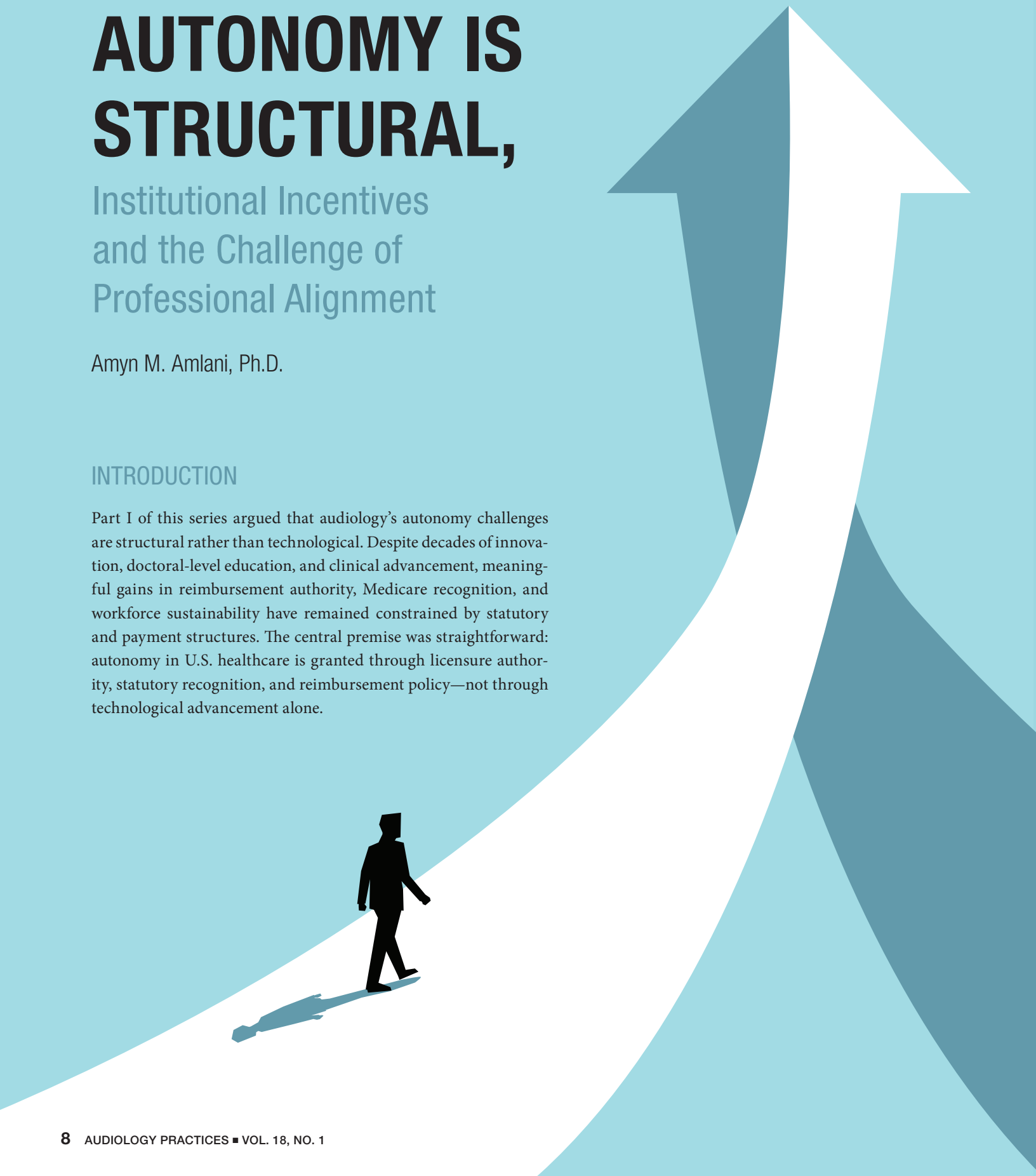
# AUTONOMY IS STRUCTURAL,

## Institutional Incentives and the Challenge of Professional Alignment

Amyn M. Amlani, Ph.D.

### INTRODUCTION

Part I of this series argued that audiology's autonomy challenges are structural rather than technological. Despite decades of innovation, doctoral-level education, and clinical advancement, meaningful gains in reimbursement authority, Medicare recognition, and workforce sustainability have remained constrained by statutory and payment structures. The central premise was straightforward: autonomy in U.S. healthcare is granted through licensure authority, statutory recognition, and reimbursement policy—not through technological advancement alone.



## IF AUTONOMY IS STRUCTURAL, THEN REFORM MUST ALSO BE STRUCTURAL.

Legislative modernization, scope-of-practice alignment, and reimbursement reform require organized, sustained advocacy. That reality shifts the focus from the healthcare system to the institutions that represent the profession within it — and to the question of why those institutions have found it difficult to move in concert.

Professional organizations, like healthcare systems, operate within structures of their own. Governance design, membership composition, revenue models, and interprofessional relationships shape what organizations can prioritize, how quickly they can move, and how much institutional risk they can assume. Institutional behavior follows institutional design.

Audiology's professional landscape compounds this challenge. Multiple organizations represent overlapping constituencies with differing mandates — some structured around broad professional coalitions, others around certification, education, or research, still others focused on clinical practice and healthcare policy. These structural differences do not imply conflict. But they do create differing capacities for pursuing reforms that are disruptive, politically sensitive, or economically consequential — precisely the category into which Medicare modernization, scope-of-practice expansion, and reimbursement realignment fall. What may appear as disagreement or reluctance is often the predictable outcome of misaligned institutional incentives. Progress requires more than shared aspiration. It requires organizational alignment.

Part II examines the governance structures, institutional incentives, and coordination failures that shape how professional organizations engage autonomy reform — and identifies the structural conditions under which meaningful alignment becomes attainable.

## GOVERNANCE DESIGN SHAPES POLICY CAPACITY

Professional organizations are structured entities with defined constituencies, representative obligations, and governance models that shape how priorities are set and pursued. Just as healthcare policy is influenced by statutory design, institutional advocacy capacity is influenced by organizational architecture.

Within audiology, organizations such as the American Academy of Audiology (AAA), the American Speech-Language-Hearing Association (ASHA), and the Academy of Doctors of Audiology (ADA) operate under distinct governance architectures and representative mandates. Understanding the limits and possibilities of autonomy reform requires examining how governance design shapes policy capacity.

### Membership Composition and Representative Mandate

Professional organizations differ fundamentally in whom they are designed to represent.

Some organizations encompass clinicians, researchers, educators, students, administrators, and industry stakeholders within a single structure. Others represent multiple professions under one umbrella. Still others are organized around a more narrowly defined membership, such as doctoral-level clinicians or practice-focused professionals. Each model carries strengths and constraints.

Organizations with broad and diverse memberships must balance competing priorities. Research advancement, academic standards, continuing education, clinical guidance, and public outreach may sit alongside healthcare policy advocacy. When membership spans multiple disciplines, policy positions must also account for interprofessional relationships and shared regulatory environments.

In such contexts, reforms that alter professional boundaries, reimbursement structures, or statutory authority introduce internal complexity. Leadership must weigh the interests of varied constituencies and maintain cohesion across members whose priorities may not be identical. This reflects representative governance functioning as designed.

By contrast, organizations with more narrowly defined memberships may have greater latitude to prioritize specific policy objectives, particularly those directly tied to clinical practice and reimbursement authority. Focused membership structures reduce internal policy divergence and can allow more concentrated attention on autonomy-related initiatives. Neither model is inherently superior. Each reflects trade-offs between breadth of representation and policy agility.

### Consensus Governance and Institutional Risk Tolerance

Governance design also influences institutional risk tolerance.

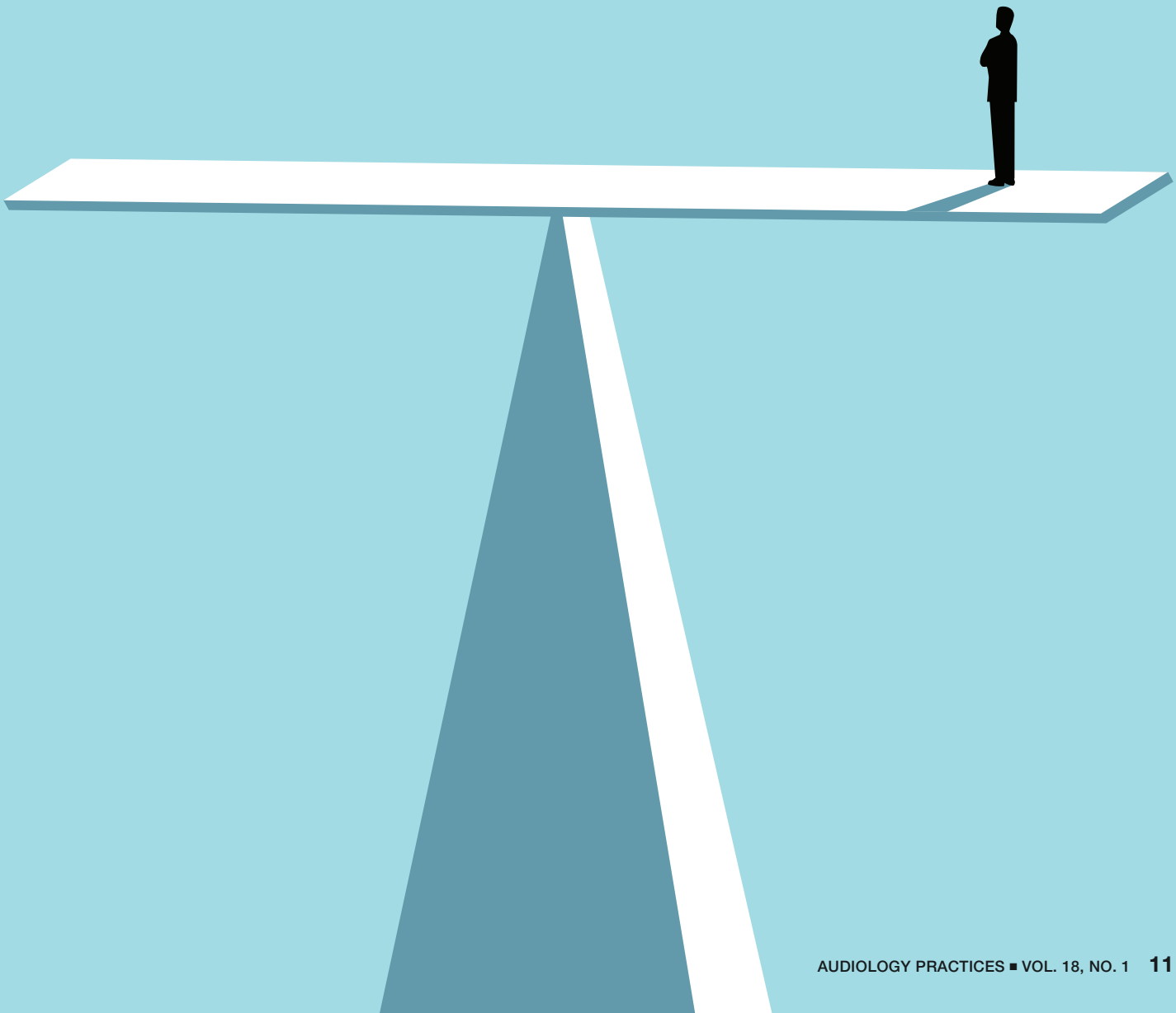
Organizations structured around consensus-building typically emphasize unity and internal alignment. Policy positions are developed through committee processes, board deliberation, and member input designed to ensure broad agreement. This approach promotes stability and inclusivity, but it can slow action on issues that are politically sensitive or structurally disruptive.

Autonomy reform—particularly modernization of Medicare recognition and scope-of-practice expansion—carries inherent risk. Such reforms may challenge established interprofessional relationships, invite regulatory scrutiny, or alter traditional referral dynamics. For institutions whose governance model prioritizes cohesion across diverse stakeholders, cautious progression is often a rational response. Consensus governance does not preclude advocacy; it shapes its pace and framing.

Organizations with more focused mandates may be positioned to assume greater policy risk. Where governance structures align tightly with a single professional objective, leadership may have clearer authority to pursue targeted reforms even in the face of external friction. The trade-off is narrower representational scope.

Institutional behavior, in each case, follows institutional design.

Organizations with broad and diverse memberships must balance competing priorities.



## Revenue Structure and Interprofessional Sensitivity

Policy capacity is further shaped by financial architecture.

Professional organizations depend on revenue streams that commonly include membership dues, continuing education programming, conferences, publications, certification structures, and industry partnerships. These revenue sources sustain operations, staff, and long-term strategic initiatives. Revenue stability incentivizes strategic stability.

Reforms that materially alter reimbursement models, credentialing pathways, or industry relationships can introduce uncertainty—not only for members, but for organizational sustainability. Institutions must weigh the long-term benefits of structural reform against short-term operational risk.

This dynamic does not imply conflict of interest or misalignment of values. It reflects the practical reality that institutions must remain financially viable to continue serving their members.

Organizations whose missions are tightly centered on healthcare policy and autonomy may structure their financial models accordingly, allocating disproportionate attention and resources toward legislative and regulatory engagement. Others may distribute resources across research, education, certification, and member services. These choices shape advocacy capacity.

Beyond internal governance and financial architecture, external professional relationships further shape policy posture. Autonomy reform does not unfold within a vacuum. It occurs within a healthcare ecosystem composed of multiple professions, each with defined scopes of practice, reimbursement channels, referral pathways, and regulatory relationships. Changes in one profession's statutory authority can have ripple effects across that ecosystem.

Scope-of-practice modernization and Medicare recognition influence referral patterns, supervisory expectations, and interprofessional boundaries. Institutions embedded within longstanding coalitions must account for these relational dynamics when calibrating policy initiatives.

Organizations embedded within longstanding interprofessional coalitions must calibrate reform initiatives to preserve regulatory and relational stability. Advocacy that is perceived as redefining professional boundaries may introduce tension within coalitions or interprofessional partnerships that have been cultivated over decades.

In healthcare policy, advancement for one profession is often interpreted as encroachment by another. Even when proposed reforms are grounded in education, competency, and patient access, the perception of boundary shift can generate resistance or require careful negotiation.

Institutions operating within such environments often adopt deliberate and measured approaches to scope expansion and statutory modernization. This measured posture reflects coalition management and relationship stewardship rather than indifference to professional advancement. Maintaining credibility within interprofessional forums, federal advisory groups, and regulatory coalitions requires strategic calibration of policy initiatives.

Furthermore, in organizations that represent multiple professions, internal governance may require consideration of how proposed reforms affect each represented discipline. Policy advancement for one group cannot be evaluated independently of its implications for another. This structural reality adds layers of complexity to autonomy discussions that extend beyond the merits of any single proposal.

Recognizing interprofessional boundary sensitivity does not diminish the legitimacy of autonomy reform. It clarifies why progress may be incremental and why alignment across organizations can prove challenging even when broad agreement exists about long-term objectives. Structural reform in healthcare requires not only internal consensus but also navigation of external professional ecosystems.

Understanding these dynamics shifts the conversation from presumed resistance to structural complexity. It underscores that fragmentation within the profession often reflects layered structural considerations rather than disagreement about the value of autonomy itself.

## Revenue and Industry Engagement

Professional organizations within hearing healthcare operate in close proximity to industry. Conferences, continuing education programming, student initiatives, and large-scale member services are frequently supported, in part, through manufacturer sponsorship and exhibit revenue.

This financial architecture is common across health professions and reflects the practical realities of sustaining national organizations.

Over time, organizations periodically reassess vendor engagement policies, sponsorship structures, and conflict-of-interest frameworks to balance financial sustainability, member expectations, and ethical standards. Such policy evolution may alter how external relationships are perceived, even when formal codes of ethics continue to emphasize transparency and professional independence.

Industry engagement does not inherently undermine advocacy capacity. However, reliance on conference revenue and sponsorship can influence risk tolerance, public messaging posture, and the pacing of reforms that intersect with market structure. In professions where product distribution, reimbursement policy, and scope-of-practice modernization intersect, financial architecture becomes part of the broader organizational landscape shaping policy behavior. This dynamic requires structural awareness; representational incentives are multi-layered, and advocacy posture exists within an ecosystem where education, commerce, and policy intersect.

Governance architecture, financial structure, and interprofessional context shape organizational posture. Those structural realities become most visible in how organizations engage reform efforts.

## Variations in Advocacy Posture

Even when organizations share broad agreement about the value of professional autonomy, their advocacy posture may differ in timing, intensity, and strategic framing. These differences are often interpreted as disagreement; more precisely, they reflect institutional structure interacting with political context.

In decentralized professional ecosystems, advocacy engagement does not always occur simultaneously. One organization may assume early leadership in drafting legislation, meeting with sponsors, and mobilizing grassroots support. Another may enter later through coalition endorsement, public communication, or member education. Differences in visibility across these stages can create perceptions of uneven commitment or asymmetrical ownership of reform efforts, even when formal support exists.

In professions where product distribution, reimbursement policy, and scope-of-practice modernization intersect, financial architecture becomes part of the broader organizational landscape shaping policy behavior.

Similarly, organizations operating within multi-profession frameworks may adopt neutral or measured public positions on initiatives that disproportionately affect one represented discipline. Such neutrality often reflects the obligation to balance cross-disciplinary relationships rather than an absence of interest in reform. Governance structures that require consideration of multiple professional constituencies may naturally moderate advocacy intensity on discipline-specific statutory initiatives.

Advocacy posture may also diverge at the state level. Scope modernization efforts—particularly those that alter supervisory structures, expand independent authority, or redefine interprofessional boundaries—can require recalibration of longstanding regulatory and referral frameworks. Institutions may vary in their assessment of political readiness, coalition stability, and strategic sequencing. Some may prioritize immediate statutory change; others may favor incremental evolution to preserve interprofessional alignment.

These variations are frequently interpreted through personal or organizational narratives. A structural lens offers a different explanation. Institutions differ in mandate, risk tolerance, and incentive alignment. Advocacy posture reflects these differences.

The result is a landscape in which reform efforts may appear fragmented, inconsistently amplified, or unevenly prioritized. While much of this divergence reflects differences in mandate and risk tolerance, it is also shaped by competitive membership dynamics within a finite professional community.

Clarity about these differences is diagnostic, not accusatory. When the profession understands the structural and incentive-based forces shaping advocacy posture, it becomes better positioned to coordinate strategy and reduce interpretive friction.

### Summary

Taken together, governance design, representative mandate, revenue architecture, interprofessional positioning, and variations in advocacy posture shape distinct institutional incentives. When those incentives differ across organizations, divergence in emphasis, timing, and strategy is not surprising—it is structurally predictable.

What may be perceived as neutrality, uneven engagement, or inconsistent prioritization often reflects differentiated mandate and risk tolerance rather than disagreement about long-term objectives. Institutions advance reform in ways consistent with their design and structural capacity.

Recognizing these structural dynamics allows the profession to move beyond attributing misalignment to personality, rivalry, or indifference. Instead, it reframes fragmentation as a coordination challenge: how can institutions with differing architectures align around shared autonomy objectives while operating within their respective mandates?

## THE COORDINATION PROBLEM

When governance structures, representative mandates, revenue models, and interprofessional relationships differ across organizations, fragmentation becomes structurally predictable. Alignment is not absent because autonomy lacks importance. It is complicated because institutions are designed with different priorities and risk tolerances.

This dynamic can be understood as a coordination problem rather than a conflict problem.

Coordination problems arise when multiple actors share a broad objective but differ in how costs, risks, and responsibilities are distributed. Each institution may support the general goal—such as advancing autonomy or modernizing Medicare recognition—yet, vary in how aggressively it is positioned to pursue that objective, how much risk it can assume, and how central that objective is to its mission. These are not contradictions. They are structural differences with predictable behavioral consequences.

In audiology's professional ecosystem, this plays out across three recurring patterns.

The first is sequencing asymmetry. One organization may assume early legislative leadership — drafting statutory language, meeting with congressional sponsors, mobilizing grassroots networks — while another enters later through coalition endorsement or member education. Both contributions are real. But differences in visibility across these stages generate perceptions of uneven commitment, even when formal support exists across organizations. The problem is not absence of alignment; it is the absence of an explicit sequencing agreement that would make each organization's contribution legible to the profession.

The second is threshold divergence. Organizations differ in what level of political readiness, coalition stability, and evidentiary grounding they require before publicly committing to a reform initiative. A practice-focused advocacy organization may assess a legislative window as actionable; a consensus-driven organization may assess the same window as premature. Neither assessment is necessarily wrong. But without a shared framework for evaluating readiness, threshold divergence produces the appearance of resistance when it more accurately reflects differentiated institutional judgment.

The third is priority displacement. When autonomy reform is one objective among many — competing with continuing education, accreditation standards, research dissemination, and interprofessional relationship maintenance — it will be resourced accordingly. For organizations whose missions are distributed across multiple professional functions, Medicare modernization may be genuinely important but not institutionally primary. The result is a misalignment in emphasis and resource allocation that coordination mechanisms can partially correct but cannot fully resolve without sustained member pressure.

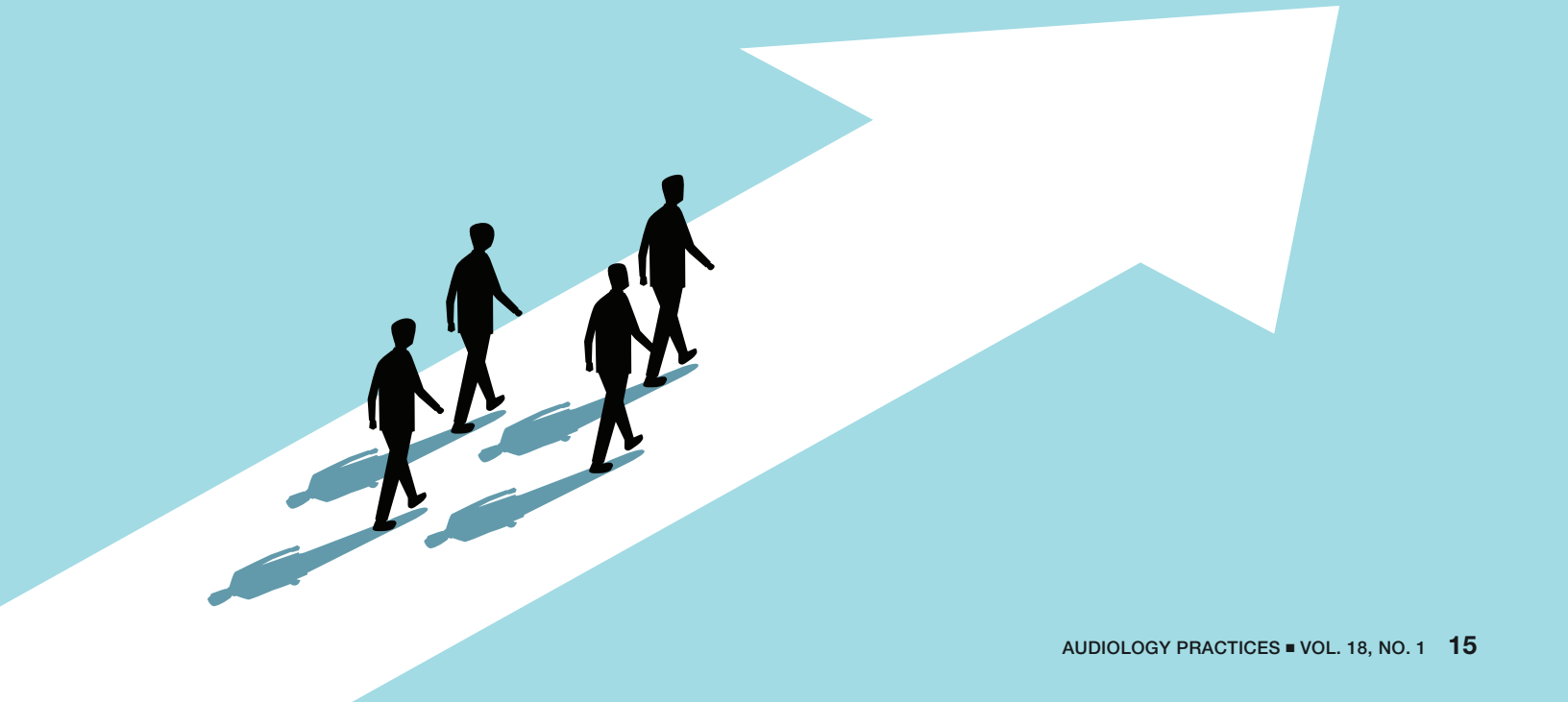
Coordination problems are further complicated when no single organization possesses both the authority and the incentive to compel unified action. In decentralized professional ecosystems, collaboration depends on voluntary alignment rather than hierarchical direction. This is not a failure of the system — it is a feature of representative governance. But it does mean that coordination must be deliberately constructed rather than assumed to emerge from shared values alone.

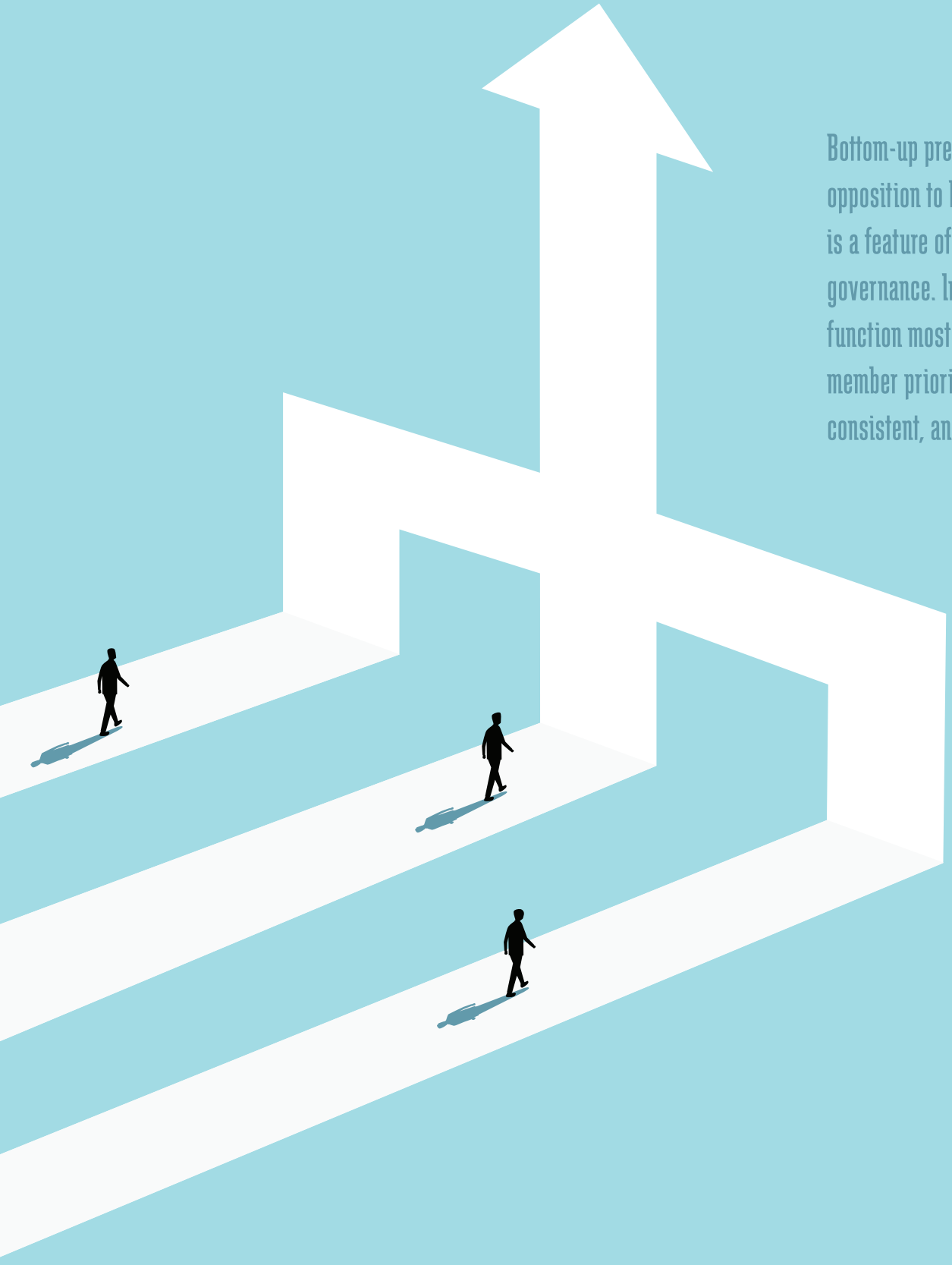
Understanding fragmentation through this lens reframes the conversation. It shifts focus away from perceived reluctance or rivalry and toward structural misalignment of incentives. If autonomy is to advance meaningfully, the profession must address not only statutory barriers in healthcare policy but also the mechanisms by which its own institutions synchronize priorities.

Coordination does not require uniformity. It requires clarity of role, transparency of objectives, and recognition of differentiated strengths — along with at least one explicit structure through which those strengths can be directed toward shared milestones. Institutions with broad representative mandates, research-focused missions, certification responsibilities, and policy-centered advocacy each contribute differently to professional advancement. The challenge is not to collapse these differences but to align them.

In this context, fragmentation becomes a design problem rather than a character problem — and design problems, unlike character problems, are solvable.

Coordination does not require uniformity; it requires clarity of role, transparency of objectives, and recognition of differentiated strengths.





Bottom-up pressure is not opposition to leadership; it is a feature of representative governance. Institutions function most effectively when member priorities are visible, consistent, and aligned.

## THE ROLE OF BOTTOM-UP PRESSURE

Structural reform in healthcare professions rarely begins at the apex. It emerges from sustained engagement at the membership level.

Across health disciplines, expansions in scope-of-practice authority, modernization of reimbursement frameworks, and shifts in statutory recognition have followed coordinated advocacy in which clinicians, educators, and early-career professionals signaled that existing structures no longer aligned with contemporary training and patient need. Institutional posture evolves in response to that signal.

Professional organizations are responsive entities. Strategic priorities are shaped not only by board deliberation, but by member engagement, advocacy participation, financial support, and consistent communication of shared objectives. When autonomy reform is one priority among many, organizational attention is distributed accordingly. When it becomes a clearly articulated and sustained priority, capacity to act expands.

Governance structures influence pace and posture, but they do not eliminate responsiveness.

In decentralized professional ecosystems, bottom-up engagement connects structural aspiration to institutional action. Legislative outreach, committee service, financial contributions to policy initiatives, and participation in regulatory processes shape the strategic environment in which organizations operate. Absent sustained engagement, institutions may default to stability across competing priorities. With it, they gain a clearer mandate to allocate resources and assume measured policy risk.

Bottom-up pressure is not opposition to leadership; it is a feature of representative governance. Institutions function most effectively when member priorities are visible, consistent, and aligned. In this sense, advocacy is not merely an organizational function—it is a professional responsibility.

For audiology, modernization of Medicare recognition, expansion of scope authority, and reimbursement alignment with doctoral preparation require long-term commitment. These reforms cannot be delegated entirely to staff or boards. They depend on durable engagement from clinicians, educators, and students who understand that structural autonomy shapes workforce sustainability, compensation trajectories, and patient access.

When bottom-up engagement aligns with institutional mission, coordination challenges diminish. Fragmentation becomes less a function of divergent incentives and more a matter of sequencing. Structural reform is accelerated not by criticism, but by clarity and participation.

In contemporary professional environments, bottom-up influence is increasingly mediated through digital platforms and informal networks. Social media enables rapid dissemination of opinion and interpretation regarding legislative initiatives and organizational posture. While this broadens participation, it can also accelerate narrative formation before full policy context or institutional constraints are widely understood.

In such environments, peer discourse may amplify partial information or emphasize organizational affiliation as a proxy for policy evaluation. This dynamic can unintentionally intensify perceived misalignment when complex legislative strategy is reduced to binary framing.

These patterns are characteristic of modern professional ecosystems. Effective grassroots engagement, therefore, depends not only on passion, but on shared access to accurate policy context and structural literacy.

Bottom-up pressure remains essential to autonomy reform. Its impact is strengthened when engagement is informed, disciplined, and aligned with strategic clarity.

## CLARIFYING COMPLEMENTARY ROLES

If fragmentation within the profession is best understood as a coordination problem shaped by governance design and structural incentives, then the path forward is not consolidation of identity, but clarification of role.

Professional organizations need not be identical to be aligned. In fact, their differences represent functional diversity within the professional ecosystem.

Organizations with broad representative mandates provide stability, research dissemination, academic integration, continuing education infrastructure, and interprofessional credibility. These functions strengthen the profession's scientific foundation and maintain its standing within larger healthcare coalitions.

Organizations operating within multi-profession frameworks contribute federal visibility, certification standards, and long-established regulatory relationships. Their scale and interprofessional reach allow for sustained engagement in national policy arenas and regulatory dialogue that extends beyond a single discipline.

Organizations with a focused practice-policy mandate may prioritize statutory modernization, Medicare recognition, scope-of-practice expansion, and reimbursement reform. Their targeted, representational scope can allow concentrated attention on structural autonomy initiatives that directly affect clinical authority and economic sustainability.

These roles are neither mutually exclusive nor inherently competitive. They represent differentiated capacities shaped by institutional architecture.

Clarity around complementary roles reduces unnecessary friction. When institutions recognize their respective structural strengths, collaboration becomes more feasible. Rather than expecting uniform advocacy intensity across all organizations, the profession can benefit from strategic specialization—where each institution advances reform consistent with its design while coordinating around shared structural milestones.

Alignment does not require identical messaging or pacing; it requires clarity of objective.

For autonomy reform specifically, alignment might involve shared acknowledgment of the importance of Medicare modernization, coordinated legislative education efforts, mutually reinforcing public communication, and recognition that statutory recognition and reimbursement authority are foundational to workforce sustainability.

Complementary roles allow institutions to operate within their structural realities while contributing to a shared objective. In this framework, differences in posture are not interpreted as opposition, but as reflections of mandate.

The profession's challenge, therefore, is not to erase institutional diversity, but to integrate it around a clearly articulated structural vision. When differentiation is understood as design rather than division, coordination becomes more attainable.

## PATH TOWARDS ALIGNMENT

If fragmentation within the profession is best understood as a coordination problem shaped by governance design, incentive structures, and interprofessional complexity, then alignment must also be structural.

Alignment cannot depend solely on goodwill. It requires mechanisms.

The first step is explicit, shared recognition that Medicare modernization, scope-of-practice authority, and reimbursement alignment are foundational to workforce sustainability — not peripheral policy concerns. When these objectives are named as structural priorities rather than aspirational goals, institutions can evaluate how their respective mandates intersect with them. For organizations structured around research and education, this means acknowledging that scientific credibility and training standards derive long-term value only when the profession retains the statutory authority to deploy them. For organizations operating within multi-profession frameworks, it means recognizing that interprofessional stability is ultimately better served by a financially sustainable audiology workforce than by deferred reform. For practice-focused advocacy organizations, it means maintaining the clarity of structural objectives even as political conditions require tactical flexibility.

The second step is explicit articulation of role differentiation. The structural analysis above suggests a functional division that, if acknowledged transparently, reduces friction and allows more purposeful collaboration. Organizations with broad representative mandates contribute scientific credibility, continuing education infrastructure, and interprofessional standing — assets that lend legitimacy to reform efforts pursued by more narrowly focused entities. Organizations operating within multiprofession frameworks provide federal visibility and regulatory reach that extend beyond what any singlediscipline organization can sustain alone. Practice-focused advocacy organizations, by contrast, are positioned to concentrate attention on statutory modernization and reimbursement reform — the structural core of autonomy. When these roles are named rather than assumed, expectations become more realistic and turf conflicts less likely.

Third, coordination requires shared structural milestones — measurable objectives around which institutions can align even where advocacy intensity and sequencing differ. These include:

- modernization of Medicare recognition
- expansion of covered services consistent with doctoral preparation
- alignment of reimbursement authority with scope-of-practice
- workforce sustainability metrics tied to compensation

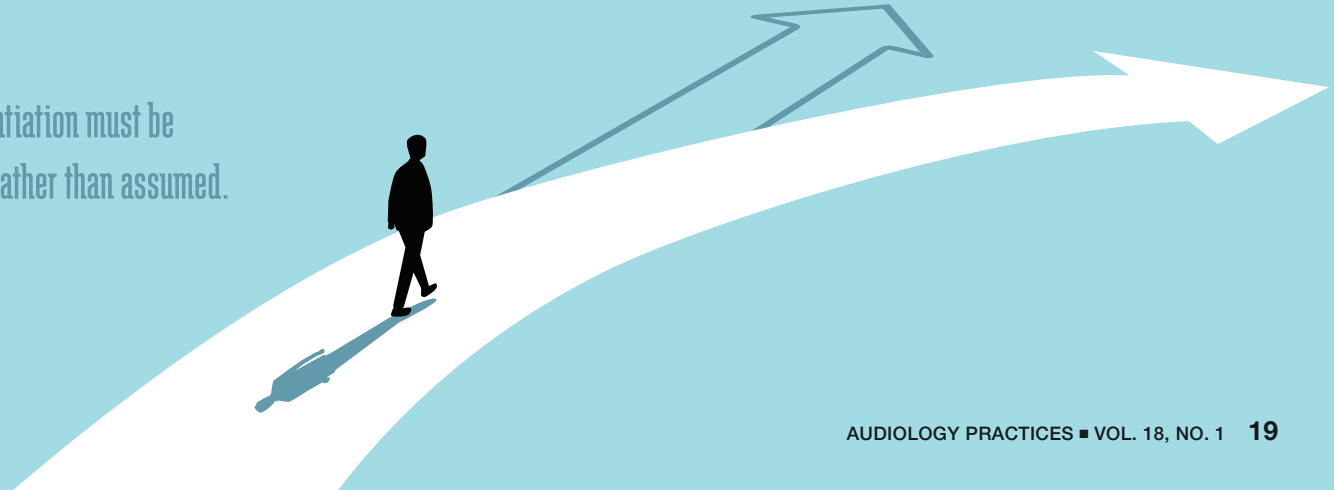
Shared milestones provide directional clarity without requiring uniform strategy. An organization focused on research and education can advance the evidentiary case for Medicare modernization; a practice-focused advocacy organization can drive the legislative engagement; a multi-profession body can provide regulatory context. Different lanes, same destination.

Fourth, communication across organizations must reflect structural literacy. When autonomy is discussed primarily in terms of innovation — new technology, expanded diagnostics, artificial intelligence — the profession perpetuates the belief that statutory constraints will resolve themselves through clinical advancement. They will not. When all major organizations consistently reinforce that licensure authority, reimbursement policy, and legislative recognition are the operative levers of professional autonomy, the narrative stabilizes across institutional boundaries and member confusion diminishes.

Fifth, sustained member engagement remains the connective tissue. Institutional alignment is more durable when member priorities are visible, consistent, and reinforced through advocacy investment, legislative outreach, and committee participation. Bottom-up pressure does not replace organizational leadership — it legitimizes and accelerates it.

Alignment does not require merger, hierarchy, or uniform messaging. It requires clarity of objective, transparency of role, and at least one shared accountability structure — whether a joint legislative working group, a coordinated milestone calendar, or a shared public communication framework — that makes coordination visible rather than assumed. In complex professional ecosystems, perfect synchronization is unrealistic. Constructive alignment, grounded in structural awareness, is not. Autonomy reform requires statutory change. Institutional alignment requires structural awareness. Both depend on disciplined coordination rather than rhetorical escalation.

Role differentiation must be articulated rather than assumed.



## CONCLUSION: STRUCTURAL REALISM AND PROFESSIONAL MATURITY

Part I of this series argued that audiology's autonomy challenges are structural. Technological advancement, clinical sophistication, and doctoral preparation alone cannot confer authority within a healthcare system governed by statute, reimbursement policy, and licensure design. Meaningful progress requires modernization of Medicare recognition, alignment of reimbursement authority with scope-of-practice, and sustained legislative engagement.

Part II has extended the structural lens inward — and found the same logic operating at the organizational level.

Professional organizations, like healthcare systems, operate within governance architectures that shape capacity, pace, and posture. Membership breadth, representative mandate, revenue structure, and interprofessional relationships influence how institutions prioritize reform and assume policy risk. What appears as fragmentation is often the structurally predictable result of differentiated design. And what appears as resistance is often sequencing asymmetry, threshold divergence, or priority displacement — coordination failures with identifiable causes and addressable mechanisms.

Recognizing this does not diminish the value of any organization. It clarifies the conditions under which alignment becomes possible.

The three coordination failures identified in this analysis point toward three corresponding requirements. Sequencing asymmetry requires explicit agreement about which organizations lead at which stages of a legislative or regulatory initiative. Threshold divergence requires a shared framework for evaluating political readiness — one that allows organizations to commit at different intensities without producing public confusion about the profession's collective direction. Priority displacement requires sustained bottom-up member pressure that elevates autonomy reform from important-but-peripheral to institutionally primary across the ecosystem.

None of these requirements demands merger, hierarchy, or uniform messaging. They demand clarity of objective, transparency of role, and at least one explicit accountability structure that makes coordination visible rather than assumed.

The profession now stands at a point where structural clarity is increasingly necessary. Workforce pressures, compensation compression, educational debt burdens, and evolving healthcare delivery models are not temporary fluctuations. They are indicators that professional authority and economic sustainability remain tightly linked to statutory positioning. Fragmentation under these conditions is not evidence of indifference. It is evidence of complexity — complexity that structural awareness can begin to resolve.

The path forward is disciplined coordination grounded in the recognition that autonomy is structural, that institutions are structured, and that progress depends on aligning both. Structural reform in healthcare is rarely rapid. It is cumulative. It advances when objectives are clear, incentives are understood, roles are acknowledged, and engagement is sustained.

Autonomy is not granted by aspiration. It is achieved through structure — and sustained through alignment.

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PART 2

# CLOSING The Regret Gap

## The Minimum Clinical Need Framework

Bill Miller, Au.D., Hearing Insights, San Jose, California

## INTRODUCTION

Consider the standard of care in physical therapy. A therapist does not offer three tiers of ACL rehabilitation based on price: Basic (some mobility), Advanced (light jogging), or Premium (full return to sport). Instead, they assess function, identify the specific intervention required to achieve the patient's goal, and measure progress. If the patient isn't improving, they adjust the protocol—not because the patient complained, but because the outcome data dictated the change.


**This sequence—Assess → Prescribe → Verify—is unremarkable in rehabilitation medicine. It is the definition of clinical reasoning.**

Yet in hearing care, the sequence often gets reversed. Technology is selected based on lifestyle questionnaires and price tiers. Fittings are verified via real ear measurements, which confirm the device is delivering appropriate gain. Follow-ups address comfort and subjective reports.

The tools for outcome verification exist. Speech-in-noise testing, validated questionnaires such as APHAB and COSI, and functional outcome measures are all available. Professional organizations, including the American Speech-Language-Hearing Association (ASHA), American Academy of Audiology (AAA), and the Audiology Practice Standards Organization (APSO), endorsed by the Academy of Doctors of Audiology (ADA), support their use. The barrier is not the lack of tools; it is the lack of a clinical workflow that makes using them routine.

This article proposes a framework that restores the clinical sequence: assess first, prescribe based on findings, verify outcomes. The framework is called **Minimum Clinical Need (MCN)**.

MCN asks:

**"What is the specific technological intervention necessary to achieve this patient's goals, and how do we verify it worked?"**

# A NEW TESTABLE FRAMEWORK

## (MCN + NASEM INTEGRATION)

### WHAT IS MCN

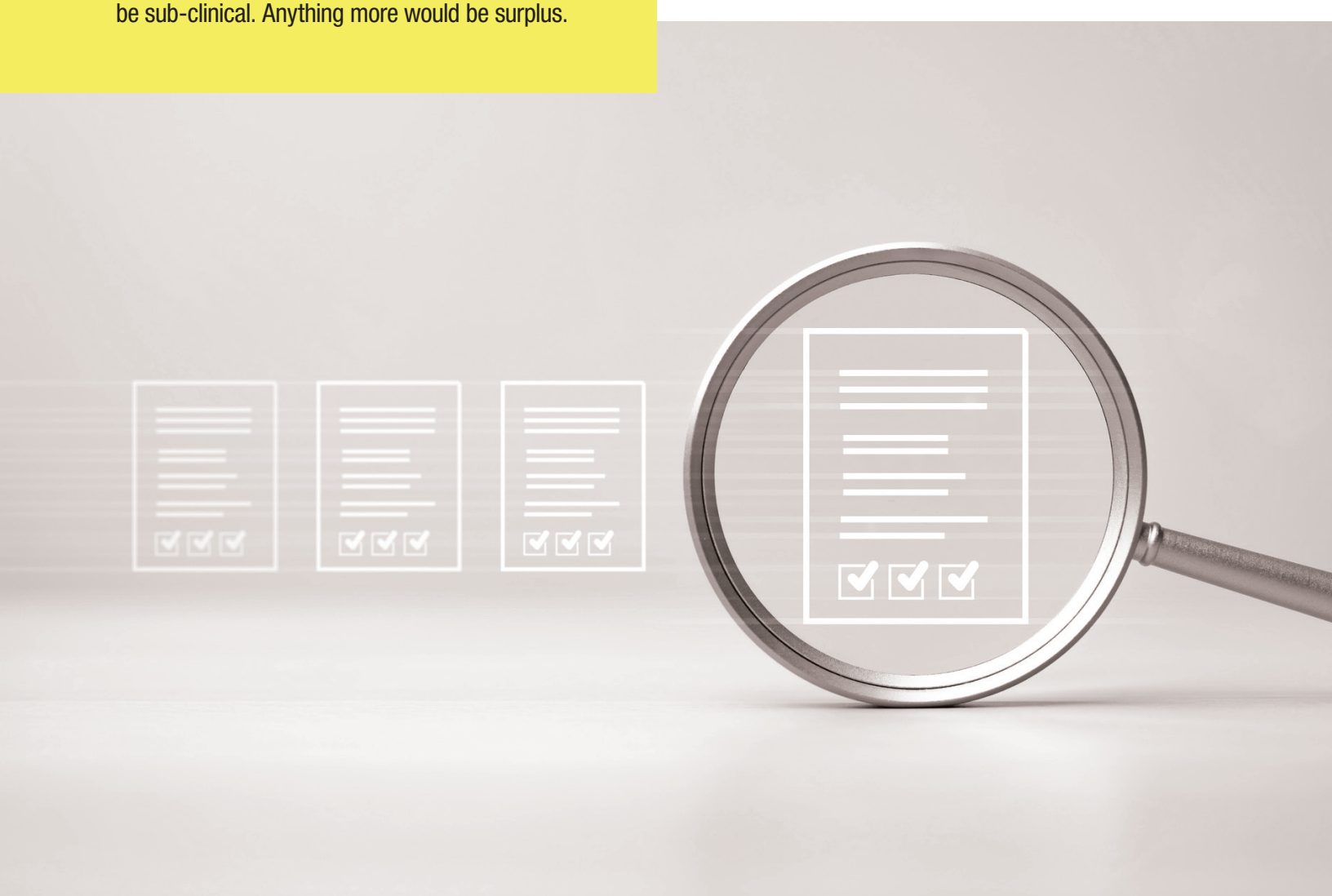
In pharmacology, clinicians prescribe the "Minimum Effective Dose" to achieve a therapeutic effect. MCN applies this logic to audiology. It asks: *"What is the specific technological intervention required to address this patient's diagnostic deficit?"*

**It does not imply "the cheapest option." It implies the necessary option.**

If a patient has a severe signal-to-noise deficit, the "Minimum Clinical Need" might be Premium-level binaural beamforming. Anything less would be sub-clinical. Anything more would be surplus.

The Minimum Clinical Need (MCN) framework is a clinical structure linking diagnostic indicators, such as Words-in-Noise (WIN) thresholds and the Abbreviated Profile of Hearing Aid Benefit (APHAB), directly to intervention requirements. It is a hypothesis-generating framework for testing how diagnostics can guide individualized intervention.

MCN is not a rulebook or sales guide. It is a clinical protocol for ensuring that diagnostics guide the prescription and outcomes validate it. It integrates into existing audiology workflows, complementing rather than replacing best practices. MCN closes the loop: it ensures that we verify the intervention actually delivered the expected outcome.



# DEFINING MEANINGFUL CHANGE:

## THE MINIMALLY IMPORTANT DIFFERENCE (MID)

Every prescription requires a defined metric for success. In medicine, that metric is the Minimally Important Difference (MID): the smallest change in a treatment outcome that represents clinically significant improvement.

In audiology, MIDs bridge diagnostic prescription and meaningful patient outcomes. For example, a 3.5 dB improvement on the Words-in-Noise (WIN) test, a 22-point improvement on a single APHAB subscale, or a five-point improvement on the APHAB global score. These are not arbitrary numbers. They represent the threshold at which we can confidently say a clinical change has occurred.

However, statistical significance alone is insufficient. A patient may report meaningful improvement in their daily life without reaching an MID threshold on testing. Conversely, testing may show clinical significance while the patient perceives little benefit. Neither measure tells the complete story.

This is why MCN requires dual verification: objective clinical significance and subjective patient confirmation. MCN determines what to prescribe. MID, combined with a patient report, determines whether the prescription succeeded.

To operationalize this, MCN anchors outcome verification to two criteria:

1. Did testing show a clinically significant change (met the MID)?
2. Does the patient report meaningful improvement in their priority listening situations?

When both align, the intervention is validated. When they diverge, it is a clinical signal to investigate further. At follow-up, we move beyond the generic question *"Are you satisfied?"* to the clinical question: *"Did the intervention produce a measurable, meaningful change?"* Without this anchor, success remains subjective. With it, clinical judgment transforms from impression to evidence.

## CLARIFYING KEY TERMS: MCN, MID

We define the two core components of this framework as follows:

- **MCN (Minimum Clinical Need):** The specific intervention profile required to address a diagnostic deficit, determined *before* the fitting.

  *Example:* "Based on a WIN threshold of +8 dB SNR, this patient requires binaural beamforming and transient noise reduction to achieve intelligibility."

- **MID (Minimally Important Difference):** The specific threshold of change that represents a clinically meaningful improvement, measured *after* the fitting.

  *Example:* "A 3.5 dB SNR reduction on the WIN test represents a confirmed clinical benefit beyond measurement error."

The Relationship: MCN defines the input (the prescription). MID validates the output (the outcome). Together, they transform clinical judgment from subjective impression to measurable evidence.

# MCN + NASEM ALIGNMENT

In 2025, the National Academies of Sciences, Engineering, and Medicine (NASEM) established a landmark Core Outcome set defining what to measure in adult hearing care. They identified:

- Speech Understanding: measured via Words-in-Noise (WIN) and APHAB-global.
- Psychosocial Health: measured via the Revised Hearing Handicap Inventory (RHHI).
- Supplemental measures: such as the SSQ12.

NASEM answered the critical question: *What outcomes matter?* However, their report focused on outcome measurement for research validation; it did not address the clinical logic of how diagnostics should guide treatment selection.

MCN addresses this complementary question: *How do we translate NASEM's recommended measures into specific intervention requirements?*

NASEM provides the measurement framework. MCN provides the prescription framework. Together, they create a closed-loop structure for evidence-based care:

**Diagnose using NASEM measures → Prescribe via MCN → Validate using NASEM outcomes**

This approach operationalizes NASEM's recommendation to link diagnostic indicators to outcome measures. It builds the practice-based evidence that currently does not exist.

NASEM tells us *what* to measure; MCN provides the logic and helps us explore *how to* prescribe interventions that meet those measured needs.

Table 1 summarizes the provisional MID thresholds for these NASEM-endorsed measures, drawn directly from the established literature. These thresholds serve as the objective benchmarks for determining whether meaningful improvement has occurred.

**TABLE 1: Provisional MID Thresholds**

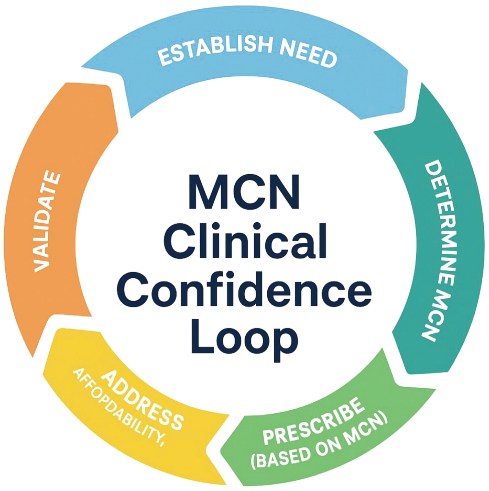
| Measure | Minimally Important Difference (MID) | Rationale | Caveats |
|---|---|---|---|
| **WIN (dB SNR)** | ≥ 3.5 dB improvement (reduction) in SNR threshold | exceeds ~3.5 dB (Wilson & McArdle, 2007) NASEM core recommendation | Standard WIN protocol; lower threshold = better |
| **APHAB** | ≥ 22 points benefit score single sub category EC, RV, BN ≥ 5 for global score | Cox, Robyn M., Administration and Application of The APHAB | Calculated as unaided minus aided |
| **RHHI** | ≥ 10 points improvement (reduction) in handicap | Extrapolated from HHIE data; convergence of published estimates | No published RHHI-specific MID. While no RHHI-specific minimal clinically important difference (MID) has been published, evidence from HHIE outcome studies suggests that clinically meaningful improvements range from approximately **7–20 points** in unaided to aided comparisons, with ≥ 9 points frequently cited as significant and many RCTs observing changes exceeding 18.7 points. We therefore adobe a ≥ **10-point reduction** in RHHI as a provisional MID. |
| **SSQ12** (Speech, Spatial, and Qualities of Hearing Scale, 12-item version) | | | Supplemental measure; not in the NASEM core set. |
| **QuickSIN** Speech-in-noise test (SNR-Loss) | ≥ 3.0 dB (Detectable Change) ≥ 6.0 dB (Meaningful Change) | Detectable change ≈ 2.7 dB; 3dB detectable, 6 dB meaningful (Killion et al. 2004 & McShefferty, 2016) | NASEM recommends WIN; QuickSIN not in the core set. Included given widespread clinical use. Clinics using QuickSIN should apply these thresholds. |

## How MCN Works: The Clinical Flow

MCN operationalizes through a five-step continuous improvement cycle: diagnose, determine the minimum technology, prescribe, address affordability, and validate. Each step links diagnostics to meaningful patient outcomes.

1. **Diagnose using NASEM measures.** Establish clinical need using speech-in-noise testing (WIN) and baseline functional outcome measure (APHAB unaided). Identify the patient's priority listening situation via COSI, such as: "I want to hear my grandchildren."
2. **Determine Required Capabilities.** Based on diagnostic findings, identify the specific processing capabilities required to resolve the deficit, such as binaural beamforming microphones, advanced noise reduction, binaural processing to preserve interaural level difference (ILD) cues, or other features matched to the specific deficit.
3. **Prescribe appropriate technology.** Make a clear clinical recommendation grounded in data. Example script: "Based on your 13 dB SNR deficit and your goal to hear in book club, you need directional microphones and advanced noise reduction. Here is what success looks like: a 3.5 dB improvement on WIN testing and a 'better' rating for your book club."
4. **Address affordability transparently.** Do not obscure the clinical reality or conflate it with the budget. The clinical recommendation must stand alone. Example script: "Based on your diagnostic results, this specific technology is the required standard of care to meet your goals. The cost is $6,000. The prescription does not change based on price. However, if that is genuinely not accessible, we can discuss lower-cost options. We simply need to be transparent about the trade-offs: choosing a lower level means you may not achieve your goal of hearing at book club, and we will document that this fitting falls below your minimum clinical need."
5. **Validate using MID and patient confirmation.** Validate using MID and patient confirmation. At four to six weeks, measure objective MID thresholds (WIN improvement, aided APHAB) and confirm with patient report (COSI: "better," "much better," etc.).

**Unlike the tier system, which relies on subjective marketing categories, MCN provides a structured logic that can be empirically evaluated, iterated, and improved based on outcome data.**




**The MCN success rule:** Clinically meaningful improvement requires both the objective threshold being met and patient confirmation.

This loop closes with data, not assumptions. If targets are not met, the protocol dictates adjustments, reprogramming, changing technology, or introducing aural rehabilitation until the MID is achieved.

## A TESTABLE HYPOTHESIS FOR CLINICAL EVOLUTION

MCN is not a static rulebook; it is a hypothesis-generating framework intended to evolve. It operates on the premise that diagnostic indicators can meaningfully predict processing needs and that published MID thresholds can generalize across populations. These are clinical assumptions that require ongoing verification.

However, MCN offers a critical advantage over the current model: it is falsifiable.

Unlike the tier system, which relies on subjective marketing categories, MCN provides a structured logic that can be empirically evaluated, iterated, and improved based on outcome data.

The goal is not to defend MCN as a finished solution, but to establish a mechanism where clinical prescriptions are anchored in measurable need. If more effective models emerge for linking diagnostics to intervention intensity, the profession should adopt them. MCN is simply the necessary first step toward that evidence-based future.

## ADDRESSING AFFORDABILITY HONESTLY

The strongest defense of tiered counseling is affordability: without tiers, would we exclude millions of patients who cannot afford premium technology?

This concern is legitimate. However, the tier system does not solve affordability; it obscures it. When patients select technology based on price tiers, they believe they are making a clinical choice. In reality, cost may be driving the decision, and clinical needs may not be fully addressed.

**MCN does not solve affordability. It is not designed to. MCN is a framework for clinical integrity, not a financing mechanism.**

What MCN does is separate two conversations that the tier system conflates: What does this patient need? And what can this patient access?

The first question is clinical. The answer should not change based on price. The second question is practical. The answer may involve insurance coverage, payment plans, manufacturer programs, or honest discussion of trade-offs.

MCN asks: "What is the minimum processing required to meet this patient's specific goals?" Sometimes the answer requires advanced features. Sometimes basic processing is sufficient. The distinction is no longer about price tier but about diagnostic match. If a patient requires advanced features to meet their MCN, those features are clinically justified. If basic processing meets the clinical need, prescribing more is unnecessary. The technology is matched to the patient, not the budget or the marketing category.

## HONEST PRACTICE VS. RATIONED CARE DISGUISED AS CHOICE

**CURRENT APPROACH:**

> "Here are three options. Which fits your lifestyle? What is the right technology?"

This framing may inadvertently conflate clinical choice and cost considerations. It makes price-driven compromise sound like clinical preference. The patient leaves thinking they got what they need, just with fewer bells and whistles. When it does not work, they lose faith in hearing aids entirely.

**MCN APPROACH:**

> "Based on your hearing loss, you need X. That costs $Y. If that is not accessible right now, here are your options: financing, insurance assistance, and payment plans. However, if we must choose a lower level, we need to be transparent about the trade-offs: choosing a lower level means you may not achieve all of your communication goals, and we will document that this fitting falls below your minimum clinical need."

MCN acknowledges the constraint honestly. It preserves clinical integrity while setting realistic expectations. If the patient chooses to compromise, they do so understanding the trade-off, not believing they made a good clinical match.

Over time, MCN could empirically expose which lower-cost technology options are truly suboptimal and which perform adequately for specific diagnostic profiles. This builds the evidence base for policy change, insurance advocacy, and informed patient decision-making.

The critical difference is clear: technology is no longer chosen by tier. It is prescribed based on diagnostic findings, validated by outcomes, and adjusted based on transparent clinical trade-offs.

## THE REAL SOLUTIONS

Prescriptions should never change based on price. Only the conversation after it should.

When the hearing care provider clearly communicates the clinical reality, patients are engaged as partners in problem-solving. If affordability is genuinely the concern, there are solutions that do not require pretending suboptimal technology is a "lifestyle fit":

- Insurance mandates and advocacy
- Manufacturer and other assistance programs
- Payment plans and healthcare financing
- Transparent, unbundled pricing that separates device cost from professional services

## MAKING IT OPERATIONAL

### How does this look in a busy clinic?

The protocol is straightforward:

1. Baseline (Initial Visit): Conduct diagnostic testing, including WIN and APHAB (unaided). Then, identify the patient's priority listening situation using the Client Oriented Scale of Improvement (COSI).
2. Follow-up (four to six weeks): Conduct aided WIN testing and readminister APHAB (aided).

Defining Clinical Success: Meaningful improvement is assessed using a dual requirement:

- Criterion A: The objective MID threshold is met (for example, 3.5 dB or greater improvement on WIN, or a 22-point or greater improvement on a single APHAB subscale, or a five-point or greater improvement on the global APHAB score).
- Criterion B: The patient confirms improvement ("slightly better" or above on COSI).

This dual requirement balances measurement precision with patient-perceived benefit. If targets are not met, the protocol dictates action: clinicians must consider adjusting technology, reprogramming, or introducing aural rehabilitation until the criteria are satisfied.

## EXAMPLE APPLICATIONS

### **CASE 1:** JOHN

- **Diagnostic delta:** WIN improvement of **5 dB** (exceeds the 3.5 dB MID).
- **Functional Benefit:** APHAB shows **25-point** improvement in subscale Background Noise (BN) (Exceeds the 22-point MID).
- **Patient confirmation:** COSI rating is **"Much Better."**
- **Clinical outcome: Clinically meaningful improvement.** The technology prescription is validated. The clinician continues with the current care plan.

### **CASE 2:** SUSAN

- **Diagnostic delta:** WIN improvement of **2 dB** (fails to meet the 3.5 dB MID).
- **Functional Benefit:** APHAB shows **four point** improvement (Fails to meet the 22-point MID or five-point global threshold.)
- **Patient confirmation:** COSI rating is **"no difference."**
- **Clinical Outcome: Not Clinically Meaningful.** The objective threshold was not met, and the patient reports no change. The protocol dictates immediate review: rerun real-ear measures, adjust programming, upgrade technology or introduce auditory training.

**What these examples show is that** MID thresholds transform clinical judgment from subjective impressions to objective, measurable outcomes. John's case validates the prescription: diagnostics led to appropriate intervention, and outcomes proved it worked. Susan's case reveals a mismatch: the data signals that the intervention, whether due to technology level or programming, was insufficient for her needs.

In both cases, the data guides the next step. We are no longer asking *"Are you satisfied?"* We are asking, *"Did the intervention achieve the measurable outcome we predicted?"*

## IMAGINE MARGARET'S JOURNEY

Remember Margaret from Part 1? She faced a 13 dB SNR deficit, and her primary communication goal was to hear her grandchildren and participate in her book club. Under the tiered model, she chose "Premium" out of fear, yet still withdrew from social settings.

With MCN, her journey looks different.

During the consultation, her audiologist reviews her WIN score (13 dB deficit), APHAB questionnaire, and COSI goals. Instead of offering a menu, they offer a prescription:

> "Margaret, based on your diagnostic results, you have a significant deficit in background noise. To achieve your goal of hearing at book club, you need directional microphones and advanced noise reduction. Here is what success looks like: a 3.5 dB improvement on testing and a rating of 'better' or 'much better' for your book club experience. This technology costs $6,000."

Margaret is not choosing a tier. She is receiving a prescription grounded in evidence, addressing the COM-B factors of Capability (she understands the need), Opportunity (she is guided by a protocol), and Motivation (she wants to hear).

The four-week follow-up: Instead of asking, "How are things going?" the audiologist validates the outcome against the MCN benchmarks:

> "Margaret, we have achieved meaningful improvement. Your WIN test shows a 5 dB SNR improvement, which exceeds our target. Your APHAB shows a 25 point improvement in aided benefit for background noise. And critically, you rated your book club experience as 'much better.' Clinically, this represents a meaningful difference. The intervention worked."

Beyond Individual Success. This data-driven framework provides objective evidence to validate, or refute, technology claims. If "Advanced" processing consistently fails to yield greater MID achievement than "Basic" solutions for specific diagnostic profiles, we gain insight into what actually works. This framework elevates our profession toward evidence-based audiology and toward hearing care that delivers on its promises.

## Reclaiming Clinical Authority

The current system allows product tiers to drive choice. MCN demands clinical need drive prescription, making price a secondary conversation.

Product tiers are marketing constructs, not clinical categories. Evidence, not marketing, should define care.

MCN emphasizes the importance of integrating evidence-based diagnostics into clinical decision-making. It proposes a structured approach to define intervention levels that can be tested and refined through clinical evaluation. This is the foundation for a profession grounded in diagnostics.

**Our professional duty is clear**:

1. Acknowledge the Evidence Gap: Encourage industry partners to demonstrate how their premium features address measurable MCNs for specific diagnostic profiles.
2. Act on Clinical Duty: Until that evidence exists, use best-practice diagnostics to identify the MCN and prescribe the solution with the highest probability of meeting the patient's goals, regardless of tier classification.
3. Make the Prescription Explicit: The conversation should begin with a clinical recommendation, not price options. Patients deserve to know what you clinically recommend and why, before affordability enters the discussion.

**The deeper issue is not pricing; it is purpose.**

This situation reflects a tension between operational convenience and clinical integrity. Every profession eventually faces a choice between the comfort of the status quo and the demands of evidence-based care.

## THE CHOICE WE FACE

I am asking you to consider a framework that offers questions rather than answers, and a hypothesis rather than a predetermined solution.

MCN is not a finished product. It is a testable structure for improving clinical reasoning. It asks:

- *What does this patient's diagnostic profile actually indicate?*
- *What is the specific intervention required to meet their stated goals?*
- *Did it work, and does the evidence demonstrate that it worked?*

This framework is meant to evolve. If there is a better way to link diagnostics to intervention intensity and validate meaningful outcomes, the profession should advance it. The goal is not to defend MCN. The goal is to build the evidence base that audiology and our patients deserve. MCN is simply one structured starting point.

In 1928, Alexander Fleming returned to a cluttered laboratory and found a contaminated Petri dish where *Penicillium notatum* had inhibited bacterial growth. He did not create penicillin at that moment. He reported an initial observation and relied on others to help refine, test, and translate. His "moldy Petri dish" was an inflection point, not a solution.

The MCN framework functions in the same spirit. It represents an early, empirical observation: a mechanism for aligning diagnostic findings with intervention intensity and for validating whether the chosen prescription actually works. It offers a path to move beyond debates over technology tiers and toward accountable, evidence-driven care.

MCN is not the final word. It is the first step. The profession's next task is to test it, challenge it, refine it, and, if warranted, improve upon it. Our patients deserve a field grounded in evidence rather than assumptions. This framework is an invitation to build that future together.

## CALL TO ACTION

What can we do now? Make the prescription explicit. Measure what matters. Confirm with patients. Document patterns.

These steps are adoptable today. They require no new technology, only a shift from tier presenter to clinical prescriber.

1. **Make your prescription explicit.** State your clinical recommendation *before* discussing affordability.
    - *Script:* "Based on your diagnostic findings, you need [specific features]."
2. **Measure what matters.** Adopt WIN and APHAB as routine outcome measures. Establish a baseline at the initial visit, measure at four to six weeks and compare results to published MID thresholds.
3. **Confirm with patients.** Use the COSI at baseline and follow-up.
    - *Ask: "Is your priority goal better, worse, or unchanged?"* Let objective data and patient perception align or diverge; both are informative.
4. **Document the pattern.** When patients report satisfaction but avoid challenging environments, note it. These patterns reveal system issues, not clinical failures.

**Research agenda:** The MCN framework requires empirical validation to move from hypothesis to evidence-based practice. Future studies should test whether MCN-guided prescriptions improve functional outcomes and reduce decision regret compared with standard tiered counseling. Ideally, this would involve multi-site, randomized controlled trials with adult hearing aid users.

**Industry call:** Manufacturers have an opportunity to lead. Prove that technology tiers correspond to measurable outcomes for specific diagnostic profiles. Earn clinical loyalty through evidence, not marketing claims.

**Until our profession stops equating satisfaction with success, we risk perpetuating a system where patients remain under-informed and functionally restricted. Evidence, not marketing, must define the next era of hearing care.**

## Acknowledgments

The author owes a profound debt of gratitude to Amyn Amlani, Ph.D., Otolithic LLC. What began as editorial collaboration evolved into mentorship, and Dr. Amlani's influence on this work extends far beyond the refinements visible on the page. At a critical juncture, Dr. Amlani chose to stand beside this research rather than in front of it, prioritizing the success of the work over personal recognition. This decision reflects the integrity and generosity that define true leadership in our profession. The author is honored to have him as a mentor and collaborator, and looks forward to continuing this partnership as the research progresses.

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## About the Author

***Bill Miller, Au.D.**, is a UX researcher and clinical audiologist for 13 years, based in San Jose, California. Specializing in healthcare user experience, patient outcomes research and evidence-based practice reform. He advises healthcare organizations and technology companies on user experience design, research program management, and patient-centered product development.*

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# TRANSFORMING AUDIOLOGY & CREATING A NEW FUTURE

Donald Nielsen, PhD

In **1977**, Bill Yost and I co-wrote an introductory book on hearing, "Fundamentals of Hearing: An Introduction." We attempted to update the field of audiology about its scientific core, which had grown significantly over the previous 30 years. Now, nearly 50 years later, there is again a need to update faculty, students, and professionals in audiology. Astonishingly, the importance of physics, psychoacoustics, anatomy, and physiology that we focused on 50 years ago has been eclipsed by computers, computer intelligence (also known as AI), synthetic biology, and precision medicine. The pace of change over the past five years easily matches the 30-year expansion in technology and science that challenged us 50 years ago.

Today's grand audiology transformation strategy can be sequenced into three steps to help ensure that we are not overburdened at the start, which could hinder its ability to deliver the rapid impact critical to building internal momentum, confidence, and support. Each transformation context is unique; the journey begins with the clinic's office transformation, which stabilizes and enhances the patient's journey and the clinic's business fundamentals.

The pace of change over the past five years easily matches the 30-year expansion in technology and science that challenged us 50 years ago.

## Three Steps to Audiology Transformation

The necessary first step is the clinic's **Office Transformation**, which will benefit early on by using computer intelligence to automate routine administrative tasks, optimize workflows, and improve patient engagement and clinical testing. However, modern computer intelligence won't just predict outcomes or automate processes—it will actively work with humans to create better clinical and business decision environments, reveal hidden opportunities and unforeseen trade-offs, challenge deeply held assumptions, and generate innovative alternatives that push the boundaries of audiology's possibilities (Schrage & Kiron, 2025). **In this first transformation, strategic value will no longer come only from human decisions. Instead, it will come from powerful, newly created decision-making environments that integrate human and computer intelligence. Looking for something to do today? This is it!** This first transformation should begin immediately in preparation for the subsequent two transformations.

In the Office Transformation, we strengthened and modernized our office practices, boosting efficiency by incorporating business Intelligent (BI) systems. In the remaining two transformations, we will modify how we practice audiology and what audiologists do. **These transformations require a fundamental redesign of our health care systems,** embracing innovation and technological advances in computer science, synthetic biology, and precision medicine.

The **Emerging Audiology Transformation**, enhanced by the Office Transformation, will continue to serve traditional patients, delivering the same fundamental value we do now, but in an innovative way that **emphasizes accessibility and affordability** made possible by advancements in computer intelligence, such as computer intelligence-based assistance for remote care and self-help and OTC virtual providers. **With this change, we will redefine how we execute and deliver audiology services. Triaging medical cases to audiology and otology, and non-medical patients to computer intelligence-based care.**

In the third transformation, **Future Audiology**, we will introduce new patients earlier in the disease process to better capture enhanced value for them. We will revolutionize audiology by expanding audiologists' roles and embracing advances in synthetic biology, big data analysis, and precision medicine, empowering us to serve our patients more effectively by preventing and addressing audiological health issues like never before. Medical care, including audiology, will shift from treating symptoms to early identification of causation and prevention or cure. Treatment will be a last resort. Because audiologists treat symptoms with devices and device revenue sustains the clinic, this transformation will significantly **change both what audiologists do and how they earn revenue.**

STEP 1

### Office Transformation

- Integrate human and computer intelligence
- Automate administrative tasks
- Optimize workflow

STEP 2

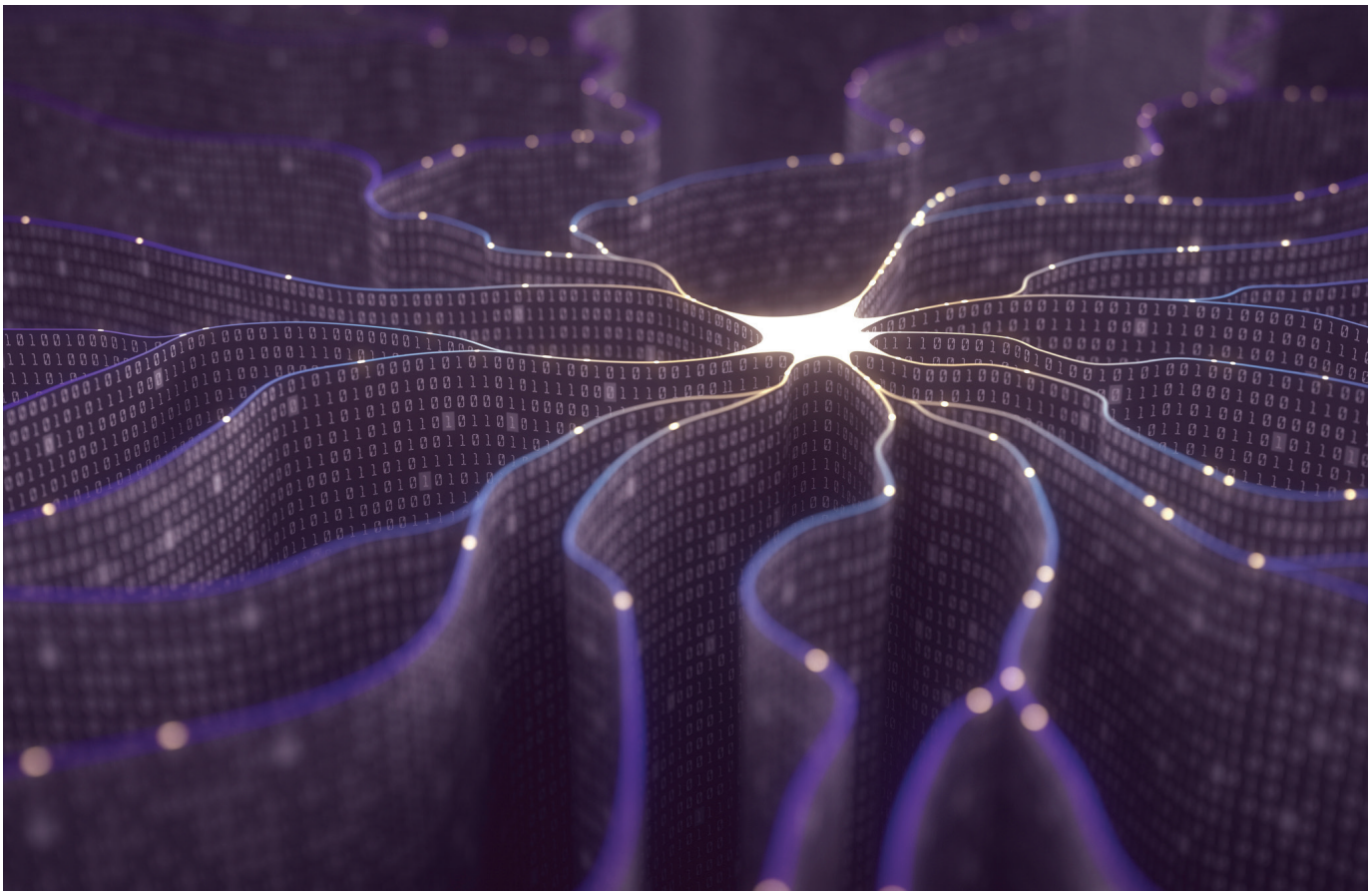
### Emerging Audiology Transformation

- Deliver value in an innovative way
- Emphasize accessibility and affordability

STEP 3

### Future Audiology

- Revolutionize audiology with advances in synthetic biology, big data analysis, and precision medicine
- Shift care from treating symptoms to prevention or cure



## A Role For Devices

In the field of synthetic biology, cell transplant therapy is in the business of replacing parts. It replaces missing, damaged, or dysfunctional cells with laboratory-manufactured cells. Lineage Cell Therapeutics has successfully used it to replace auditory nerve fibers at the base of the inner ear hair cells in an animal model (https://hearinghealthmatters. org/hearing-news-watch/2025/lineage-demant-resonance-cell-therapy/). Demant is investing $12 million in this effort with the goal of improving the function of hearing aids and cochlear implants. This approach serves as a harbinger of HHC's transformation from a predominantly device-focused treatment era to the New Era of Medicine, encompassing synthetic biology, artificial intelligence, and precision medicine. In this case, synthetic biology enhances devices. In the future, we will see devices assume the role of supplementing synthetic biology cures that are not 100% successful.

Computers are the driving force behind the ongoing transformation in medical care. Still, it is computer intelligence that enables us to harness the power of computers to solve many of audiology's problems, thereby improving patient care, increasing access and the number of patients served, encouraging and perfecting patient agency (patient self-help), and generating revenue to sustain care. For a comprehensive understanding of how computer intelligence is shaping the future of innovation, refer to Essa (2025).

**In Transformation 1,** computer intelligence enables audiology clinics to provide more precise, efficient, and personalized care, while also increasing access and streamlining operations. Here, technology complements, rather than replaces, the expertise of clinic staff, allowing them to focus on delivering high-quality, individualized patient care. Hearing devices, wearable monitors, and patient self-help and education will also benefit from computer intelligence in this transformation.

**In Transformation 2,** computer intelligence will be used to triage patients into those who require in-person medical treatment and those who don't. Furthermore, we can treat the latter group using various forms of computer intelligence to provide personalized service while freeing up audiologists to practice at the top of their license and address more complex problems, thereby increasing service availability and patient volume.

**In Transformation 3,** we will leverage computer intelligence to harness and apply the accelerating power of biology and personalized medicine, shifting from our current reactive focus on symptoms and treatment by devices to a proactive focus on prevention and cures. This computer-intelligence-driven shift will revolutionize audiology and all of medicine.

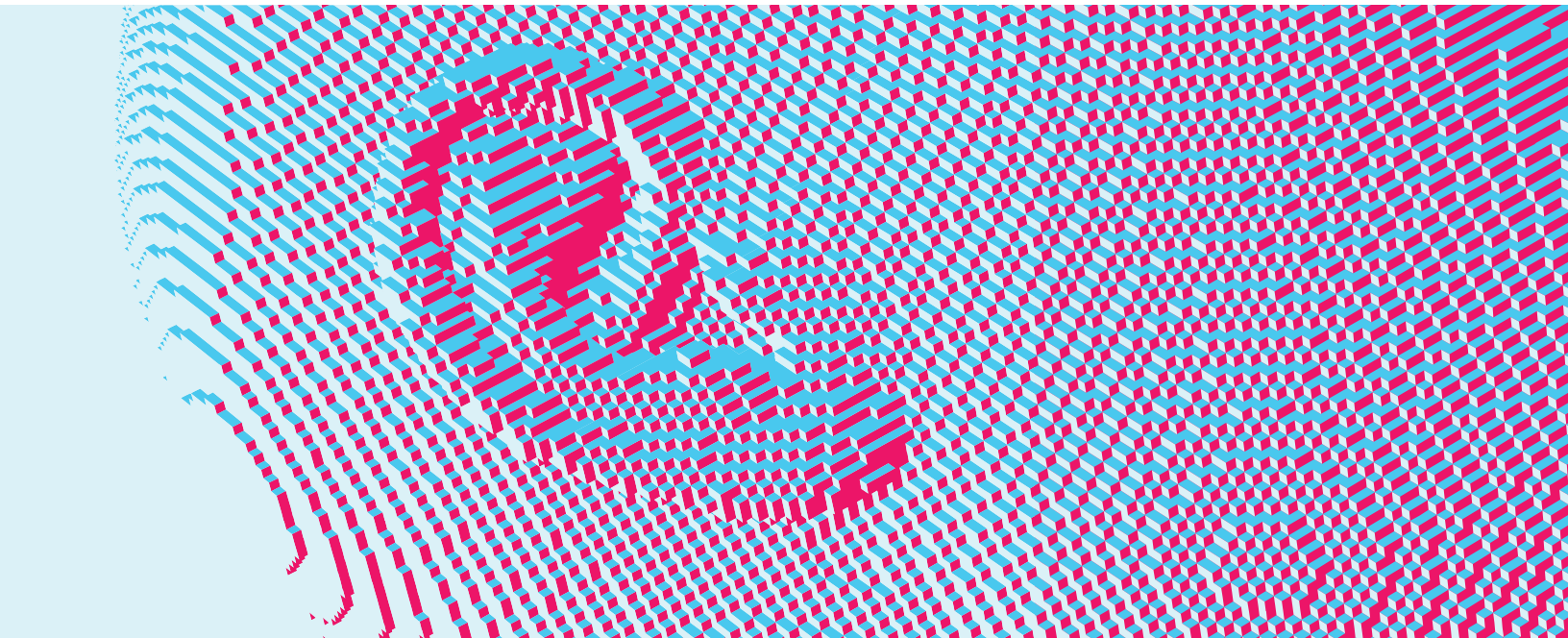
While traditional computers are rapidly enhancing their capabilities, newer quantum computers are surpassing them, reaching unprecedented computational heights once considered science fiction. Within the next five to 10 years, quantum computers are expected to reach a high level of stability, incorporate a million qubits (quantum bits, like digital bits but more powerful and useful), and become an integral part of the health care system. But this transformation is driven by more than computers.

**Synthetic biology** is the ability to design and engineer new organisms or redesign existing biological systems (Suleyman, M., Bhaskar, M., 2023). Genomics is at the heart of synthetic biology. Genomics enables us to move beyond merely treating symptoms to addressing the underlying causes instead—a historically significant turning point in medical care (Isaacson, 2021) (Davies, 2020).

Gene therapy, a medical approach that utilizes genetic material to treat, prevent or cure diseases by correcting the underlying genetic causes, involves modifying a person's genetic makeup, usually by introducing new genes and repairing or replacing faulty genes within the body's cells. Now, a newer technique, CRISPR, enables us to achieve greater precision and edit DNA within a cell in vivo. For an excellent, comprehensive and up-to-date review of gene therapy and hearing loss, see Elbagoury (2025) https://doi.org/10.1007/s00431-025-06426-9.

**Precision medicine** considers individual variability in genes, environment, and lifestyle for each person. It targets the right treatments for the right patients at the right time. It utilizes large datasets, including personal, environmental, and global medical information, to make health care more personalized and effective. Amazingly, by including genomics and proteomics, it is possible to personalize diagnosis, prevention, cures, and treatments to an exact, more individual, and cellular level. Precision medicine enables doctors and researchers to predict, in real time, which treatment and prevention strategies for a particular disease will be effective for individual patients.

Audiology will undergo significant changes as it enters the New Era of Medicine, marked by computer intelligence, synthetic biology, and precision medicine. This will transform diagnostics, rehabilitation, and personalized care for hearing and balance issues. Future audiology will leverage the large data power of computer intelligence, the bioengineering progress of synthetic biology, and personalized genetic and phenotypic information to improve patient outcomes.



## Interdisciplinary and Interprofessional Approaches Are Required

Audiologists will need to adapt by acquiring new skills to work with computer intelligence, synthetic biology, and precision medicine, as well as to manage large, diverse data streams. Existing siloed specialties will no longer suffice, and new interdisciplinary fields must emerge to meet the demands of this evolving health care system in the New Era of Medicine. Integrating isolated health and research systems into a unified, patient-centered model will require continuous progress in policy, technology, and culture.

## Readjustment to New Demographics:

The New Era in Medicine is about prevention. Unsurprisingly, the majority of preventive measures are most effective when initiated as early as possible. Synthetic biology-based therapies are no exception. They are most effective when introduced early and provide a longer-lasting prevention or cure.

Inter-uterine therapies (IUTs) are the earliest possible therapies or preventive measures, followed by newborn treatments. This means that as synthetic biology treatments gain popularity, the primary recipients of audiological services will shift from the elderly to fetuses, newborns, and infants. Many people who are genetically predisposed to hearing issues as they age can prevent them by undergoing preventive measures, cures, or treatments at an early age.

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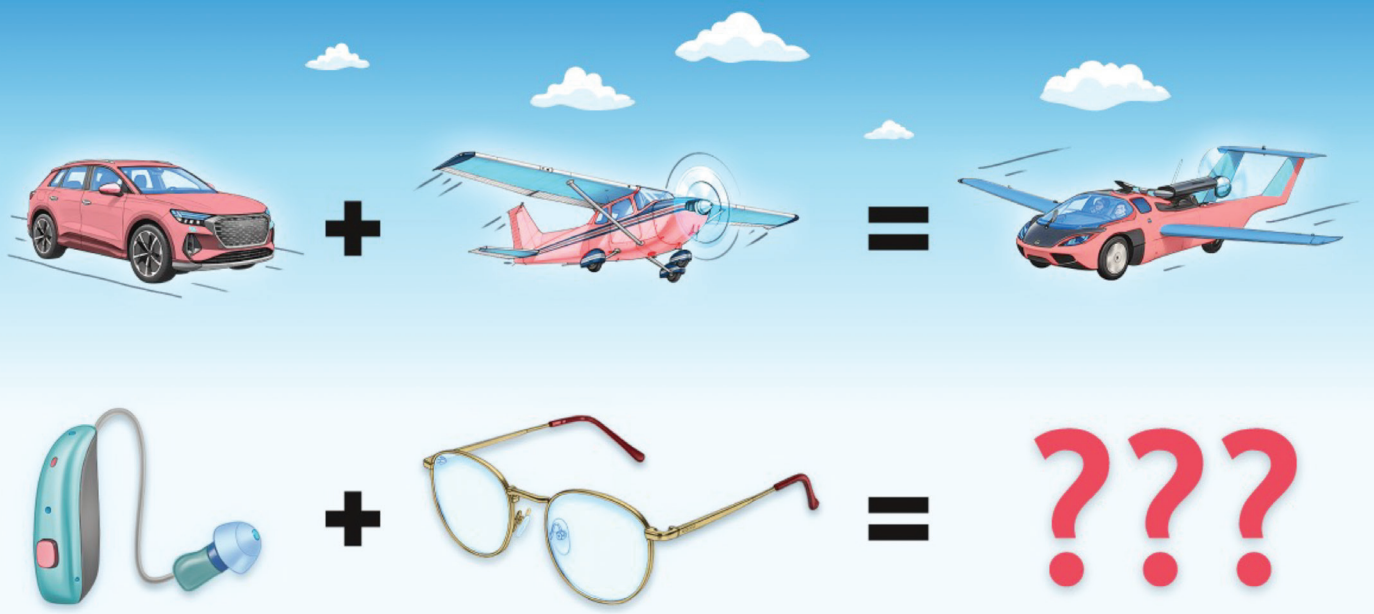
# THE TIMES, THEY ARE A-CHANGING.

We are in for an amazing journey full of surprises, rewards, and opportunities to grow and thrive. We must start the journey now.



# Smart Hearing Glasses

## Mainstream or "Flying Cars" for the Hearing-Impaired?

By Dr. Alexander Goldin, Alango Technologies, Founder & CEO

## Introduction

**The number of people with hearing loss is about 1.5 billion today and is projected to reach nearly 1.9 billion by 2030.** Approximately two-thirds of these individuals have mild to mild-moderate hearing loss, and most do not use any hearing-enhancement devices.

As a result, they struggle mainly in specific, challenging situations – most often in noisy or reverberant environments – but either do not want to use, or cannot afford, traditional hearing rehabilitation devices such as hearing aids.

Could smart audio glasses with hearing enhancement be a solution? Glasses that look almost normal, yet improve hearing without signaling hearing impairment?

## Hearing Glasses as the Mainstream Solution

While hearing glasses have existed for decades, they have never become mainstream for improving hearing. Earlier devices were often bulky and underpowered, offering minimal amplification and limited personalization that addressed only a narrow range of hearing needs. They also lacked sufficient battery life for all-day use and did not provide modern features such as audio streaming or voice calls. Technology has since advanced, with smaller, lighter acoustic components, more powerful silicon, advanced AI algorithms, and full Bluetooth voice and audio connectivity.

The question is – will this finally change the outcome? Will hearing glasses gain a major, mainstream role in hearing rehabilitation, or will they remain a niche where small players who cannot compete with the BIG 5 on the main turf struggle?

To deduce an answer, it helps to look at parallels from history and other markets.

## The Flying Car Analogy

Adding hearing enhancement to optical glasses is a bit like creating a flying car. Both ideas seem very natural.

For decades, drivers dreamed of cars that could fly over traffic jams. We have seen flying-and-driving prototypes and even commercial flying cars. But have they become mainstream? Has traffic congestion disappeared?

When two fundamentally different functions are combined, there are unavoidable trade-offs. A flying car is fascinating, innovative, and useful for a niche – but it does not replace a real car, nor does it replace a real airplane.

**A flying car is fascinating, innovative, and useful for a niche – but it does not replace a real car, nor does it replace a real airplane.**

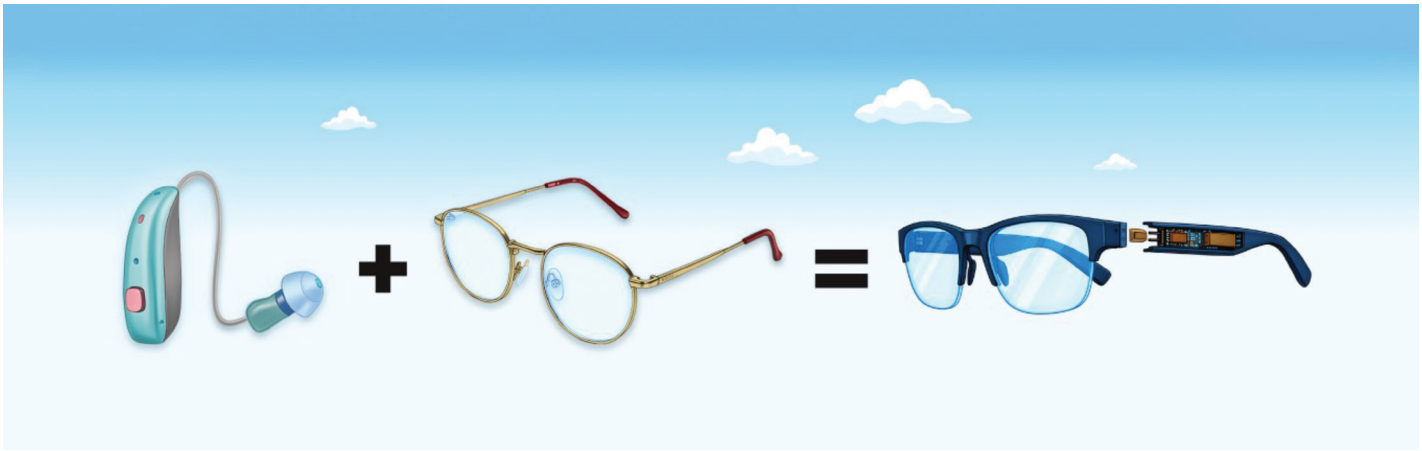
Smart hearing glasses face the same reality.

## Physical and Acoustic Tradeoffs

Beyond performance, there are fundamental physical and acoustic trade-offs. Integrating speakers, microphones, batteries, processors, and antennas inevitably adds weight and volume. That mass must be concealed somewhere, which drives frame designs toward thicker, heavier, and more constrained form factors.

In contrast, ear-worn devices such as earbuds and hearing aids are engineered from the ground up to be ultra-lightweight, acoustically optimized, ergonomically balanced, and suitable for all-day wear.

Open speakers in glasses also cause significant sound leakage, which increases acoustic feedback (whistling) and limits maximum usable amplification. Additionally, the acoustic output power of such tiny open speakers is often insufficient in noisy environments. Their sound quality is typically inferior even to the cheapest true wireless earbuds.



As a result, combining optical glasses with hearing amplification creates a hybrid similar to a flying car: neither excellent glasses, nor an effective hearing aid, nor a reliable voice and audio streaming device.

## The Good News

Glasses provide an excellent platform for placing multiple microphones around the head, enabling superior front-facing directionality (beamforming). When combined with advanced AI noise-reduction technologies, this can offer a powerful form of situational hearing assistance – sometimes even allowing users to understand speech better than people with normal hearing in specific scenarios.

**Combining optical glasses with hearing amplification = neither excellent glasses, nor an effective hearing aid.**

This capability should not be overlooked. However, it must be advertised honestly and intelligently: no overpromising, just clear benefits for users willing to accept certain compromises in exchange for improved conversational ability in noisy environments.

## Conclusion

Convergence is exciting. Specialization is essential.

Many people drive cars. Even more people are hearing-impaired. Flying cars and hearing-enhancement glasses may each attract many users.

Smart glasses with hearing features can complement the ecosystem, but they cannot replace purpose-built hearing solutions at scale.

## What Is Alango Doing

For the past 10 years, Alango Technologies has developed software solutions for hearing enhancement devices. Hearing glasses are one possible device category among many.

Advanced front-facing acoustic beamforming, combined with Alango's proprietary, patent-pending zero-latency AI noise reduction, followed by multi-channel personalized Wide Dynamic Range Compression (WDRC), is the key to better hearing in environments where other solutions fail. ■

# Make a referral. Make a difference.

Cochlear®

## Referring your patient for a cochlear implant evaluation

### Connect

- A Concierge team member will reach out by phone to the patient within 72 hours to discuss an evaluation
- If phone communication is difficult, the patient will receive a follow-up email

### Evaluate

- The specialist will ask questions regarding overall hearing health history
- Testing will be performed with and without hearing aids
- Treatment options based on results will be discussed in depth
- Most insurance companies will cover the evaluation costs†

### Educate

- Your concierge will offer additional educational resources if needed

## Where to refer patients for a cochlear implant evaluation

Scan the QR code or visit **www.cochlear.us/referralADASEPT25QR** to connect your patient with a concierge who will guide them through the evaluation process.

**If you are seeking additional training on the latest in candidacy or have specific questions on a patient you'd like to discuss, contact our Market Expansion team at amem@cochlear.com.**

I acknowledge that I have received my patient's authorization to share his/her contact information with Cochlear Limited and/or its subsidiaries and affiliates for purposes of contacting my patient about cochlear implant technology.

# Sound Check

CLINICAL BULLETIN #8


Auraloop by Opus, a combined counter Auracast™ and hearing loop system (www.aurabyopus.com/en/auraloop)

# Everyone Hear in Your Community:

## A How-to Guide to Leveraging Auracast™ in Your Practice

Juliëtte Sterkens, Au.D.

AURACAST™
A BLUETOOTH® TECHNOLOGY

Auracast™ and loops help clients hear better than they ever have and will change the way you practice, while creating priceless goodwill for the profession. Here is a list of things you can do to ensure your clients are fully experiencing all the potential benefits of Auracast™ with their hearing aids.

- Install an Auracast™ and counter loop with a quality directional mic in the waiting room. Routinely offer hands-on demonstrations to clients and family members on connecting to both technologies and always provide information in writing.
- It's *not* enough to just tell your patients about Auracast™ and telecoils. Demo again at follow-up appointments.
- Maintain a list of Auracast™, FM, and hearing loops in your community and keep a list of which patients belong to which places of worship. You'll need a signed release to share your clients' names with other congregants and clergy.
- Google Maps now lists Assistive Hearing Loops and Auracast™ under accessibility. Be sure to list *your* office. Scan the code to learn more.
- Give workshops on "Get the Most from Your Hearing Aids using Auracast™ and Telecoils" in your community.
- Routinely inform patients about their rights under the Americans with Disabilities Act and ADA-Access-Ready hearing aids. Find many free to use educational handouts on centerforhearingaccess.org/audiologists.
- Write a letter to the local newspaper or senior centers about the new "Hearing Assistance for Hearing Aids" in the community, listing your name and email as a professional willing to help consumers.
- Support an Auracast™ system in your personal place of Worship. I am happy to help with PR and a bulletin insert.
- Use the assistive listening system offered when visiting theaters or other venues. Listen carefully. Does it sound good? Are neckloops available no matter which system is offered? As a professional you want to know what is offered for your clients in your area. Get involved to improve or replace poorly functioning systems.

## Beyond Properly Fitted Hearing Aids

If a client is a successful user of a smartphone, wireless TV device and/or remote mic, it's an opportunity explain how assistive technology works in public venues — something mandated by ADA law. An Auracast™ or loop demonstration in the office is fun and takes 2-3 minutes. Offer an Auracast™ (or loop) listener to the accompanying family member – so they can hear it too. Afterward, encourage clients to try a system somewhere in the community using your list of Auracast, FM, or looped venues. If there are none, explain why you want to change this. In 2008, there were no loops in my area; today, there are over a hundred loops in the Fox Valley and some 1000 in Wisconsin alone. Many of my patients took this information to places where they wanted to hear better.

After a positive experience—be it in a waiting room or place of worship, I ask clients if they'd be willing to do one thing to move this technology forward. Requests were usually answered with "It depends" or "Sure." I would then hand over a letter (see an example of this letter on the next page) and the list of venues in the area (gradually expanded to include Auracast™). Explain that you hope to advance these systems in the community *to help all hearing aid wearers hear great.* Compare Auracast™ and loops to curb cuts for wheelchairs. Describe how *one person* took information to a minister or library with a request to make the facility more hearing-friendly/accessible. "If you hand this letter to a person in charge, *you* may be that person who makes more Auracast™ systems happen in our community." Many clients even helped with funding. Cost is often not an issue. Lack of knowledge *is.*

## Sample Letter

[Hearing Center name] [Website] [Telephone Number]

An open letter to those considering the installation of Assistive Listening:

As an Audiologist in [Local City] for over [X] years, I have helped thousands of people with hearing loss understand and cope with the challenges they face on a daily basis. My patients complain that hearing in large areas such as meeting halls and auditoriums is hard.

Hearing loss affects two out of every ten people. It is a common misunderstanding that hearing loss is only about loss of loudness. It is more about clarity and getting a good signal to the impaired ear. For people with hearing loss, it is about separating the sounds they want to hear from those they don't want to hear. People with hearing loss will tell you that they can hear your voice but cannot understand. So, the loudness is at the proper level, but the clarity of the speech signal is lacking. Distance from the sound source, reverberation, and ambient noise in a room can make it more difficult to distinguish the speech signal. This is where assistive listening systems such as Auracast™ can be of great help.

The new Auracast™ systems, and the older, and still very helpful, hearing loops are becoming more popular and are found wherever people go to listen. These systems send the audio signal from the facility's microphone and sound system direct to hearing aids or cochlear implants. An added benefit is that the Auracast™ system will benefit not only users of newer instruments, but also those with devices that still use telecoils, and also help people without hearing aids, who simply would like a boost in hearing in public settings. This improved audio signal to the ear provides speech clarity that amplification alone simply cannot provide.

I recommend assistive listening systems, not only because they are affordable and the law mandates them, but once installed, they are economical to maintain. My patients love the fact that they can go into a theater, church, or auditorium push a button on their hearing aid or smartphone and hear the sound directly. Just as hearing someone's voice on the phone brings distant speech right to your ear, these systems provide that same close-range connection to distant speech in large areas. Learn more about the different assistive listening systems on www.CenterForHearingAccess.org.

These systems give people with hearing loss access to clear, noise-free sound, and the freedom to be like everyone else who takes a seat and then relaxes to hear and listen to the program or worship service.

ABC Hearing Center does not install assistive listening systems or solicit business but acts as an educator and advocate for their hard-of-hearing patients. Email us if you have any questions.

Thank you for your interest and enthusiasm for ensuring everyone hears great in our community.

Jane Jones, Au.D.

ABC Hearing Center

DrJaneJones@ABCHearing.com

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*For any assistive listening related questions, Juliëtte Sterkens, Au.D. can be contacted at juliette.sterkens@outlook.com* ■

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SCAN TO BOOK A FREE STRATEGY CALL

# WHEN THE Leader Grows, Everything Grows

*The case that leadership development is the highest return investment an audiology practice can make*

By Amy Badstubner, Au.D., CPC and Kari Morgenstein Dermer, Au.D., CPC

A practice owner we work with was a few months into her coaching engagement when her office manager pulled her aside after a team meeting and said: "You seem different. Calmer. More present. You do not seem as frazzled lately. What is going on?"

The owner had not made an announcement or started a new initiative. She had just been growing and changing quietly, but consistently. Those around her had already felt it before she even said a word.

The changes that show up after doing leadership development impact how you walk into a room, how you react when things go sideways or how you handle a hard conversation on a Tuesday morning you may prefer not to have. From there, it moves outward into every corner of the practice, into team engagement, patient experience, retention and revenue, in ways that are more measurable than most owners could expect.

The research on this is clear. The coaching observations behind it are clearer. What follows is both.

## You Didn't Necessarily Sign Up to Be a Leader

There are two common paths into audiology practice ownership, and while they look different on the surface, they tend to arrive at the same gap.

The first path is typically the clinician route. A professional was great at the clinical side of audiology, loved the work, had excellent patient relationships, and over time a logical next step for them was ownership. Leadership came with the territory as an inevitable result of building something. Their whole professional identity had revolved around clinical competence: they see the problem, they diagnose it, they solve it. The idea that being the leader would ask them to stop being the solver, that they would have to step back from the role that made them successful, was never part of the plan.

The second path is usually someone who has an entrepreneurial mindset. They opened a practice because they wanted autonomy, or had a specific idea of how patient care should feel, or simply wanted to build their own rather than follow someone else's approach. They were not sitting down one day and deciding to become someone's leader. They were deciding to become an owner. The team management happened the day they hired their first employee, largely uninvited and entirely untrained for.

Both paths tend to produce the same result: a practice owner running a team they were never prepared to lead.

## The accidental leader

We coached a practice owner in California, we will call her Linda, who opened her practice because she was committed to "doing things the right way" with best practices, great patient care, and a strong focus on clinical excellence. The part that she wasn't expecting was what came after hiring. Linda had become, without quite realizing it, the team mascot. Everyone liked her, but she was not leading them. She was doing things alongside them, in front of them, and instead of them. The end result was a team that was fully dependent on her for every problem and every decision, a business that could not grow beyond her own capacity, and an owner who was burned out despite doing everything right clinically.

Everything changed the moment she started to close that gap and step outside the team in order to lead it. She created a team that started to own their role and the outcome rather than waiting for Linda to solve all the problems.

That transition is not easy, and it deserves to be named honestly. When a clinician steps into real leadership, they are being asked to give up the thing that made them successful. Their entire clinical identity was built around the satisfying arc of problem to solution. Leadership asks you to resist that reflex, to give the problem back, and to ask other people what they think instead of offering what you know. For the entrepreneur who opened a practice to own something rather than to lead someone, the challenge is somewhat different but arrives at the same place. They may have never built a leadership identity in the first place, and accepting that the act of leading requires a real skillset, not just authority, is usually the first real step.

The most common thing we hear from owners who never saw themselves as leaders is not arrogance or indifference. It is usually the opposite. They underestimate themselves. They are fighting imposter syndrome and questioning whether they are good enough or equipped enough for the role they are already in. A lot of them are playing small as a result, scared to take up space, scared to be direct, and unsure how to step into a leadership identity that never felt like theirs to claim.

## The Number That Should Reframe Your Business Strategy

Gallup has been studying workplace engagement for over two decades across millions of business units around the world, and one of the most replicated findings in all of the research is this: managers account for at least 70% of the variance in team engagement scores. This figure has remained remarkably stable across industries, company sizes, and geographies, consistently landing between 67% and 72% regardless of where the study is conducted (Gallup, 2015; reaffirmed in Gallup, 2024).

Seventy percent. Not compensation, not perks, not the mission statement on the breakroom wall. The single variable that explains most of the difference between your most engaged team and your least engaged team is the manager. In a hospital system, that effect gets diffused across layers of management, HR infrastructure, and institutional culture. In a five-person audiology practice, there is no diffusion. The owner is the manager, and the owner's daily behavior, how they communicate, how they hold people accountable, how they respond when something goes wrong, is the culture. There is no meaningful separation between the two.

Most of the practice owners already involved in coaching nod when we share this finding. They are self-aware enough to accept the premise. What tends to shift as the coaching work deepens is not acceptance of the statistic, it is a felt understanding of just how significant that influence actually is in the day to day of their practice, in the conversations happening without them, in the decisions their team either makes confidently or escalates unnecessarily. For owners who have not done this inner work, many of them have quietly concluded that their engagement problems are a staffing market issue, a generational issue, or a compensation issue. The research says otherwise, and there is considerably more within their control than most of them know.

The 2025 Gallup State of the Global Workplace report notes that global employee engagement fell to 21% in 2024, tied with the lowest levels recorded since the pandemic, at a loss costing $438 billion in lost productivity worldwide. More striking was where the decline was steepest. Manager engagement fell three percentage points in a single year, from 30% to 27%, the steepest decline of any other workforce segment. Once managers disengage, their team will follow, and they tend to follow quickly (Gallup, 2025).

## *By the Numbers:*

**70%**

**of team engagement variance is attributed to the direct manager**

(Gallup, 2015; reaffirmed 2024)

**21%**

**global employee engagement rate** in 2024, tied with the lowest level since the COVID-19 pandemic

(Gallup, 2025)

**$438B**

**estimated annual global productivity loss** from employee disengagement

(Gallup, 2025)

**up to 200%**

of annual salary to **replace an employee**

(SHRM, 2024)

*The single variable that explains most of the difference between your most engaged team and your least engaged team is the manager.*

For audiology leaders and practice owners, the patient implications are direct and well-documented. Data published in *Medical Care* shows that hospitals with higher employee satisfaction also consistently show higher patient satisfaction scores (Meterko et al., 2004). A VA health system study found that a one-point increase in employee engagement corresponded to a half-point increase in overall patient satisfaction (Partnership for Public Service & Boston Consulting Group, 2019). Staff engagement in a private audiology practice is a strong predictor of the patient experience, one that patients will share with their friends, their family members, and the physicians who refer to you.

The turnover math is worth doing because most practice owners have absorbed the cost without ever calculating it. Replacing a specialized healthcare professional costs between 70% and 200% of their annual salary when you account for recruiting, onboarding, lost productivity during the vacancy, and the ramp-up time before a new hire reaches full performance (SHRM, 2024). In a small to mid-size practice, one clinician departure is financially significant and a meaningful operational disruption.

When employees leave the practice, the most important question to consider is why they are actually leaving because research consistently shows that people leave managers far more often than they leave organizations (Gallup, 2015). Sometimes turnover has nothing to do with the leader, and a good practice owner can do everything right and still lose someone. The work is to hold up the mirror first, examine the gaps honestly, and then distinguish between what is within your influence and what is not.

## The Cascade: How One Leader's Growth Moves Through a Practice

Leadership development is often positioned as something a practice owner does for themselves, or a personal investment in their own growth. What the evidence actually shows is something more operationally significant: when the leader at the center of a small audiology practice grows, the effects move outward through team behavior, through patient experience, and into the outcomes and referrals that determine whether a practice grows or plateaus (Li et al., 2017).

To understand what that cascade looks like, it helps to start with the before picture. Practices without intentional leadership have a particular feel that most owners can recognize once it is named. Things feel raw. There is a low-grade chaos to daily operations, and a sense that people are working hard but not in the same direction. There may be fuzzy roles or problems that land on the owner's desk constantly.

Six months into leadership development work, that picture changes in ways our clients consistently describe the same way: "I feel like I am finally in the driver's seat!" "My team is no longer controlling my day, and my day is no longer controlling me." They tell us that communication is clearer, and the ripple effect goes further than they expected. One client told us recently that the work she did on leadership made her a better parent, and that she finds herself using the same tools at home with her kids that she uses in her practice. Leadership growth and personal growth, it turns out, are not as separate as most people assume.

The cascade itself starts with conversations. Before strategy changes, before systems change, before anything on an org chart moves, the quality of daily interaction shifts: questions replace directives, problems get handed back instead of absorbed, the morning huddle shifts from a status report delivered by one person to a team actually talking to each other and problem-solving together. These are observable, daily behaviors with direct operational impact.

One of the smallest changes we have watched produce the most significant downstream effects is deceptively simple: when a problem arrives at the owner's desk, instead of solving it, the owner asks two questions. What have you already tried? And what are your ideas for what to try next? Two questions instead of one answer. What those two questions communicate to the team is significant: I trust your judgment, I expect you to think, and I am here to develop you rather than to do your job for you. Teams that experience that shift consistently start solving problems themselves, stop escalating everything, and begin owning outcomes rather than just executing tasks.

Eventually, the cascade reaches the patient. Team members are more present, more proactive, more likely to go beyond the transactional and connect with the person sitting across from them. Patients feel that difference, and patients who feel that difference refer.

## The part nobody warns you about

Here is what leadership content aimed at practice owners almost never addresses: when a leader changes, the team's first response is frequently not gratitude or immediate improvement. It is testing.

We worked with an owner who had a conversation with an employee about chronic lateness, and the employee's response was a boundary negotiation in real time. "What do you consider late? What happens if I am five minutes late? If I am late three times, what happens on the fourth?" This employee felt that few things were ever enforced before so of course they tested the conversation about being on time. They were doing exactly what any reasonable person does when a rule has never had a consequence: they checked whether this time was different.

There is also a particular pull-back pattern we see regularly, where a growing owner goes into a team meeting with a clear agenda and real intention and then something happens mid-meeting, and they revert back toward what we call nice-guy or nice-girl leadership. They fall back into old habits and may even smooth the edges off the accountability they came in to hold. It feels comfortable in the moment, but it costs them ground.

Development of any kind is not linear, and the leaders who remember that tend to fare better than those who expect a clean arc of improvement. Real behavior change looks like two steps forward, one step back, five steps forward, two steps back. The goal is not a perfect progression but the capacity to recognize when you have slipped, learn from it, and go again without abandoning the whole effort. The owners and leaders who conclude they "tried this once and it did not work" are usually making that judgment at exactly the wrong moment, when the team is recalibrating and the friction is really evidence that the change is working (Geerts, 2024).

## The Loneliness Variable

This is the section that does not usually appear in business articles about leadership development, and we are including it because it is one of the most consistent factors we have observed in coaching practice owners. Private practice ownership can be isolating in a specific way that is worth naming directly. You cannot be fully transparent with your team, because the power differential is real even when you wish it were not. And your personal relationships, however loving and supportive, often have a finite capacity for the specific texture of practice ownership stress before the eyes begin to glaze.

The research on this goes back further than most people realize. An early academic study on entrepreneurial loneliness was published in 1984 and found that more than 50% of small business owner-managers reported feelings of loneliness (Gumpert & Boyd, 1984), and Harvard Business Review has reported that half of CEOs describe experiencing loneliness in their role (Saporito, 2012). A 2024 study in Personnel Psychology identified the factors inherent in entrepreneurship like social isolation, lack of peer support, and high-stakes decision-making without a solid sounding board, as characteristics of the role itself rather than personal failures of the individual in it (Cardon et al., 2024). The consequences of that isolation are not primarily emotional. Entrepreneurial loneliness has been linked to burnout, reduced decision quality, and a deterioration in the capacity to think clearly under pressure (Cardon et al., 2024).

The first coaching session with a practice owner who has been operating in that kind of isolation for years has a recognizable quality. There is a lot of everything is fine, or alternatively, everything is on fire, but it is what it is. There is justification, rationalizing, and a lot of outward-facing diagnosis: it is my employees, they do not follow through, they do not take initiative. The armor is on, and they are not quick to let anyone in. A lot of owners also feel like they are part of multiple groups, peer networks, associations, study groups, but are not getting truly customized support for where they actually are. There is a real difference between being surrounded by people and having an ally.

Sometimes it is simply the first honest thinking relationship the owner has had in years. The first space where they can think out loud, be uncertain, name the things they do not know, and get honest feedback from someone who is not financially or emotionally entangled in the outcome. Once they have that, the struggles feel normal, the temperature in the practice comes down, and decisions that were previously coming from fear start coming from confidence and clarity instead.

*Once they have a space where they can think out loud without consequence, the decisions that were coming from fear start coming from confidence instead.*

## The Invisible Cost of Staying the Same

Audiology practice owners are generally good at measuring what grows. They track revenue, unit volume, patient satisfaction scores, and hearing aid return rates with reasonable diligence. What they rarely measure, and what tends to go unnamed until it becomes a crisis, is what the absence of leadership development is quietly costing them.

Consider what a practice that is slowly calcifying looks like from the inside. The status quo feels fine, maybe even stable, but everything feels like it takes a lot of effort. People are not talking to each other in any real way. The blame game is audible in the hallways: that is not my job, that is yours. No genuine one-on-ones or real development conversations are happening, and if you ask people how things are going, the answer is fine, which is a word that covers a lot of ground. The practice is functioning, growing in some cases, but with an internal friction that never quite goes away.

Here is a concrete example of what that looks like. You've got a practice with a standing policy that every patient who has been wearing their current hearing aids for five or more years should receive an updated technology demonstration at their next appointment. Good clinical practice and a revenue driver. When only 10% of those patients are getting a demo, the question is not why the staff are not following through. The question is whether the expectation was ever made clear, whether the barriers were ever uncovered, whether anyone in a leadership role ever sat down with the team and asked what is getting in the way. A gap like that is a leadership problem dressed up as a conversion problem.

The most expensive thing we regularly watch practice owners do is spend their time on work that should not be on their plate at all. Perry Marshall, in his book 80/20 Sales and Marketing, describes a hierarchy of tasks by their strategic value, from $10 tasks anyone could do to $10,000 tasks only the right person can do, and his observation is that most business owners spend the vast majority of their day in the $10 column (Marshall, 2013). In audiology practices, we see this constantly. The pattern is what happens when delegation is not trusted, when systems have not been built to support it, and when the owner is still functioning as the team mascot rather than the team leader.

## What Real Development Looks Like, and Why Most Owners Feel Like They Have Already Done This

Most practice owners reading this have attended something: a conference session on leadership, a workshop on communication, a mastermind with other owners. They have read some of the books, they have a certificate somewhere, and at some point in the last year they have probably thought, with reasonable confidence, that they have already addressed this.

The distinction that matters is between exposure and development, and it is not a subtle one. Exposure is one-directional and episodic: you receive information and find it valuable, then return to your practice, and that information then competes with every operational demand on your attention until, within 30 days, most of it is behavioral vapor. You know it intellectually, but it has not changed what you do. The scale of that gap is worth naming. LinkedIn's 2023 Workplace Learning Report found that only 35% of employees were encouraged by their manager to spend time learning in the past six months (LinkedIn, 2023). This number reflects how rarely managers are actively developing their own people, let alone themselves. When organizations do invest in structured development, a 2023 cross-industry study of 752 leadership development professionals found average returns of $7 for every dollar spent, with a range of $3 to $11 depending on program design (New Level Work, 2023). Development is relational, iterative, and requires feedback from someone who can see what you cannot see about yourself, consistently and over time. A 2024 peer-reviewed framework published in Behavioral Sciences found that the primary reason leadership development programs fail is not poor content but low transfer of learning, meaning the insights never cross from the learning environment into daily behavior (Geerts, 2024). The conditions that produce transfer are specific: practice, feedback loops, accountability structures, and sufficient time, none of which a one-day workshop or conference session provides.

The lightbulb moments in real development are rarely dramatic, and that is part of what makes them easy to underestimate. Sometimes it is a slight shift in how an owner introduces a new process to their team, or a different word choice in a hard conversation, or a pause where there used to be an immediate reaction. The owner who is doing the work is still doing it, months later, implementing strategies, getting feedback on how those strategies are landing, and course correcting when something does not work rather than abandoning the effort entirely. They have better work-life balance. They feel more grounded. And it shows, not just in their bottom line, but in how they carry themselves in the practice.

## *Signs Your Leadership Could Use a Refresher:*

- Your team brings every problem to you instead of solving it first.
- The best ideas for the practice almost always originate with you.
- You have had the same performance conversation with the same person more than twice without resolution.
- Your team asks permission for decisions they should own.
- When you take time off, the practice feels it.
- Turnover keeps happening and the reason always feels external.
- The practice grows when you push hard, and stalls when you ease up.
- Nobody eats lunch together. Nobody talks to each other unless they have to.

## Before You Decide You've Already Done This

To the practice owner reading this and thinking they have already done this, and nothing changed: the first question is whether the work produced behavior change or insight that never transferred into action. If you are continuing to experience chronic turnover or team disengagement despite sustained effort, the second question is whether the issue is your leadership approach or your hiring patterns, because those are different problems with different solutions, and an outside perspective from someone not entangled in your practice is often what it takes to see clearly which one you are actually dealing with.

Real development does not produce a better presentation style or a more polished answer under pressure. It produces a different quality of presence that the people around you can feel before you have said a word about it. The practices that will be positioned to grow over the next decade are not necessarily the ones with the newest technology or the best location. They are the ones where the leader is growing, because when the leader grows, the team grows, and when the team grows, the patient experience changes, and when the patient experience changes, the practice grows.

Sometimes, when a leader really commits to this work, the team changes too, and not just in behavior. Some people, it turns out, were comfortable with the status quo and were not interested in accountability or growth, and as the leader raises the standard, those people tend to leave. That can feel like failure, but it is almost always the opposite: it is the practice finding its right people, and it almost always precedes the best growth the practice has ever seen.

Let's go back to that office manager who pulled the owner aside after a meeting and said: "you seem different. Calmer. More present. What is going on?"

The owner did not have a rehearsed answer. She just took it in. However, what that moment represented was not a personality shift or a couple of good weeks. It was the downstream effect of one person deciding to grow with intention, and a team that had already felt it before anyone said a word.

*"If your actions inspire others to dream more, learn more, do more, and become more, you are a leader."*

*— attributed to John Quincy Adams*

## *What Is Your Leadership Producing Right Now?*

**Take 10 minutes with these questions. Answer honestly, not aspirationally.**

- When something goes wrong in your practice, what does your team do first? Do they solve it, or bring it to you?
- When was the last time a staff member told you something you did not want to hear? How did you respond?
- If your team described your leadership style to a colleague, what would they say?
- How many issues from last month were yours to solve versus problems your team should have owned?
- What is the thing you keep not saying to someone on your team? What is that silence costing you?
- If you left for two weeks tomorrow with no contact, what would break?

**Discomfort with these answers is useful. Sit with it and start there.**

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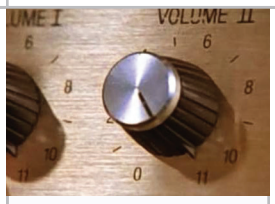


# HAVE YOU HEARD?

## ADA, WSA, and KAA Pilot a Targeted State-level PSA Campaign to Elevate Hearing Health as a Public Health Priority

The Academy of Doctors of Audiology (ADA), WS Audiology (WSA), and the Kentucky Academy of Audiology (KAA) are pleased to launch *Listen Up Kentucky*, a new state-focused public awareness initiative focused on prevention, early intervention, and the lifelong importance of hearing health.

Through this collaboration, WSA and ADA are piloting grassroots, local-market, public service announcements (PSA) across the Commonwealth of Kentucky, bringing critical hearing health messages and awareness about the risks of untreated hearing loss directly into communities where people live, work, and play. These efforts are designed to encourage individuals to protect their hearing from noise exposure and to see an audiologist for regular hearing checks.

The goal of the *Listen Up* PSA pilot program is to create a scalable model that can be tailored for every U.S. state and territory. This campaign dovetails with the WSA- and ADA-developed lifestyle medicine physician marketing resources, which can be downloaded and customized with your practice logo and contact information.

"ADA is proud to collaborate with WSA on this bold initiative to elevate hearing health as a public health priority," said Jill Davis, Au.D., ADA president. "We are grateful to WSA leaders for their commitment to meet consumers literally where they are in cities and towns across America. Together, I am confident that we will succeed in connecting more individuals to the audiologic care that they need, so that they can stay connected to the people and experiences they love."

"Our commitment to the audiology profession has never been stronger and we are excited to partner with the ADA to help educate consumers about the importance of their hearing health and the benefits of early treatment," said Mike O'Neil, WSA wholesale president. "Our vision is to make visiting your local audiologist for a hearing screening part of an individual's annual preventative care routine, and it's through partnerships like these that we can start to make meaningful steps towards this goal."

ADA and WSA plan to expand the initiative to other states in the near future. Stay tuned to see where we land next! For more information, please contact Stephanie Czuhajewski.

As part of the initiative, Kentucky-specific PSA spots are now available for local TV and radio media placement and for use by audiologists throughout the Commonwealth.

Scan the QR code to view them and learn more.

# Department of Education's Final RISE Rule Excludes Audiology from Professional Degree Programs: ADA Continues to Advocate for Policy Change

The U.S. Department of Education (DOE) released its final rule under the Reimagining and Improving Student Education (RISE) initiative on May 1, 2026, marking a significant and deeply disappointing outcome for the audiology profession. Despite extensive advocacy from the Academy of Doctors of Audiology (ADA), its members, and a broad coalition of healthcare organizations, the final rule does not recognize audiology as a "professional degree" program for federal student loan purposes.

This designation is critically important. Under the new federal framework established by the One Big Beautiful Bill Act, students enrolled in programs classified as "professional degrees" are eligible for substantially higher federal loan limits (up to $200,000) compared to $100,000 for other graduate programs. (CGS) By excluding audiology, the DOE has effectively placed future audiologists at a financial disadvantage despite the rigorous doctoral-level education, extensive clinical training, and licensure requirements required to enter the profession.

Throughout the rulemaking process, ADA worked tirelessly to ensure audiology was included. The Academy submitted formal comments, engaged policymakers, collaborated with coalition partners, and mobilized grassroots advocacy to demonstrate that audiology clearly meets the criteria of a professional degree. These efforts emphasized the real-world consequences of exclusion, including reduced access to education, increased student debt burden, and potential workforce shortages that could limit patient access to hearing and balance care.

> *"The Department acknowledges that SLPs and audiologists meet the operative test, as do many graduate programs. However, like physical therapists (91 FR 4266), advanced degree, licensure, and certification requirements for SLPs and audiologists are a recent development and therefore were not included in the original list of professional degrees. This degree progression pre-dates the changes made to the professional degree definition in 34 CFR 668.2, yet the Department did not update definition to include SLP or audiology."*

The Department's rationale is both shortsighted and flawed, particularly as audiology was notably highlighted as a profession that should be included, by members of the rulemaking committee.

ADA remains steadfast in its commitment to advancing policies that support audiologists and their patients. We will continue to advocate for legislative and regulatory solutions to correct this inequity and ensure that the next generation of audiologists has access to the resources they need to obtain the Au.D. degree and meaningfully serve their communities.

May 27, 2026

David Zapala Ph.D., President
Erin Schafer, Ph.D., Editor, *Audiology Today*
American Academy of Audiology
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**RE:** "Valuing What We Do," President's Message, *Audiology Today*, March/April 2026, Vol. 38, No. 2[i]

Dear Dr. Zapala, Dr. Schafer, and Members of the AAA Board of Directors,

The March/April 2026 President's Message in *Audiology Today*, titled "Valuing What We Do," makes substantive claims about audiology's path to professional valuation and the Academy of Doctors of Audiology (ADA) that the public record, government and commercial insurance reimbursement policies, and state statutes do not support. ADA writes to correct them.

**"Valuing What We Do" incorrectly characterizes the current state of the state statutes dictating the scope of practice for audiology throughout the United States, and by extension, the landscape for advocacy efforts to modernize state audiology practice acts.**

The article portrays state audiology scope of practice modernization efforts as narrowly constructed to exclusively add the ordering of diagnostic tests such as imaging, bloodwork, and cultures for auditory and vestibular conditions, and the administering and prescribing of topical medications for conditions in the ear to the services that audiologists are authorized to perform under their state licensure acts.

In fact, the vast majority of state audiology scope of practice modernization efforts are grounded in the urgent need to update state statutes to explicitly authorize audiologists to perform services such as vestibular testing and rehabilitation, cerumen removal, conducting health screenings, programming surgically implanted devices, and prescribing hearing aids.

A September 2025 ADA state-by-state review[ii] of audiology practice statutes revealed the following:

- Only 13 states authorize audiologists to perform intraoperative monitoring services by statute.
- Only 22 states authorize audiologists to perform cerumen management services by statute.
- Only 43 states statutorily authorize audiologists to deliver vestibular services. However, two of those explicitly require a physician referral to do so.
- Only 23 states authorize audiologists to evaluate auditory or vestibular conditions by statute.
- Only 22 states authorize audiologists to diagnose auditory and vestibular conditions by statute. Of those, 10 states restrict the diagnosis to a "non-medical" diagnosis, and two (2)

additional state statutes omit "vestibular conditions" from those which audiologists are authorized to diagnose by statute.
- Only 9 states authorize audiologists to manage auditory or vestibular conditions by statute.
- Only 8 states authorize audiologists to perform health screenings by statute.
- Only 21 states authorize audiologists to program cochlear implants and other surgically implantable devices by statute.
- Only 13 states have statutorily authorized audiologists and dispensers to order/prescribe prescription hearing aids.

**Modernizing state licensing laws to ensure that they reflect contemporary training for audiologists does not pose a risk to audiologists. Quite the opposite—Modernizing state practice acts mitigates substantial financial and legal risks to audiologists that exist today.**

When an audiologist performs a service their state statute does not authorize, even one well within their training, their professional liability carrier is not obligated to defend or indemnify a resulting malpractice claim. Despite their extensive education and training, audiologists in most states are currently exposed to uncovered malpractice claims arising from evaluating, diagnosing, managing, and treating the very auditory and vestibular conditions that they are the most qualified to address.

Additionally, government and commercial insurers are increasingly scrutinizing licensing laws as part of their coverage determinations. Payers are not obligated to cover services delivered by providers who are not explicitly authorized to perform them under their state licensing acts[iii].

It is also worth noting that the Medicare Audiology Access Improvement Act (MAAIA), a legislative initiative supported by ADA, AAA, and the American Speech-Language-Hearing Association (ASHA), among others, cannot be practically implemented until audiologists in every state are statutorily authorized to perform cerumen management and vestibular rehabilitation services.

**"Valuing What We Do" inappropriately characterizes state scope-of-practice modernization initiatives to add diagnostic test ordering or the prescribing of topical medications for conditions of the ear as being 'all risk and no reward,' financially, because in AAA's view, 'the effort, appears to increase the breadth of non-reimbursed services audiologists are expected to provide.'**

Reducing the time to diagnosis and treatment for patients with hearing and balance problems should be an imperative for every audiologist, and a reward in its own right. The vast majority of other clinical doctors and advanced practice providers (APPs) are already authorized to order medically necessary diagnostic tests and prescribe medically necessary medications for their patients, and they embrace the responsibility to do so, without being paid for those activities.

In fact, federal and state anti-kickback statutes, the False Claims Act, and other laws and codes of ethics governing healthcare service delivery rightly prevent providers from receiving remuneration or reimbursement in exchange for the acts of making referrals, ordering tests, and/or prescribing

medications. None of those activities constitutes a payable/billable service for *any* provider under government or commercial insurance plans *or* private pay models.

Obtaining diagnostic test results timely and making subsequent differential diagnoses will allow audiologists to more effectively and efficiently deliver the services for which they are reimbursed. The Accreditation Commission for Audiology Education (ACAE), the AAA-controlled audiology training program accrediting body, includes several accreditation standards that implore universities to train audiology students on the interpretation of diagnostic tests and the pharmacological management of conditions related to the ear.[iv] ACAE Standard 22: Required Knowledge & Competencies, 1-4, states that audiology students must be trained to:

1. Diagnose, triage, treat and manage auditory and vestibular/balance conditions and diseases for patients over the lifespan, including newborns, infants, children, adolescents, adults, elderly, and special needs individuals.
2. Apply audiologic diagnosis, treatment and management principles in diverse settings including, for example, private practice-based, educational, and occupational/industrial environments.
3. Apply critical thinking skills to assess the patient's auditory and vestibular status.
4. Prescribe, perform, and interpret clinical, laboratory and other diagnostic procedures and tests in consultation with other health professionals as may be required for proper management of the patient.

ACAE also requires that Doctor of Audiology graduates be prepared to, *"Discuss pharmacological treatment options with the patient, parent or guardian, family or other health care or service providers as it relates to the prevention of hearing and balance disorders and, specifically, as it relates to appropriate vestibular system functions."*

AAA's position on state audiology practice act modernization conflicts with ACAE's standards for academic audiology training programs. It is also inconsistent with the U.S. Department of Education (DOE) Classification of Instructional Programs (CIP), which defines Audiology (Au.D.) programs as:

> *"A program that prepares individuals to diagnose and treat hearing loss and other disorders involving the ear, advise patients on means to use their remaining hearing, and select and fit hearing aids and other devices. Includes instruction in acoustics, anatomy and physiology of hearing, hearing measurement, auditory pathology, middle and inner ear analysis, rehabilitation therapies and assistive technologies, and pediatric and other special applications."*[v]

"Valuing What We Do" underestimates the risk of doing nothing and miscalculates the risk of modernizing state scope-of-practice acts to ensure that the practice of audiology achieves professional parity with other clinical doctoring and advanced practice professions. The article presents inaction on state-defined scope of practice as the financially prudent course. The evidence does not support that conclusion.

Recent actions by the U.S. Department of Education (DOE), omitting audiology from the list of professional degrees, should be an urgent call to reevaluate the value of the Doctor of Audiology (Au.D.) against the state-defined scope of practice for audiologists throughout the United States.[vi]

If state practice statutes continue to lag behind audiologists' doctoral training, the pipeline of Au.D. students will wane. Prospective students do not enroll in expensive doctoral training programs to be statutorily limited to a fraction of what they are trained to do. The contrast with optometry, podiatry, psychology, physical therapy, chiropractic, and advanced-practice nursing, professions that aggressively modernized state scope and subsequently grew, is stunning.

At the same time, hearing instrument specialists (HIS) are aggressively seeking to expand their state licensing acts to authorize them to perform services such as cerumen removal, tinnitus treatment, and aural rehabilitation, with some success.

The lessons learned from those professions are unambiguous. Audiology must advance and fully achieve its potential as a clinical doctoring profession, or risk becoming obsolete.

**"Valuing What We Do" includes a call to action that requires the very state scope-of-practice modernization that AAA dismisses as unworthy of audiologists' efforts.**

The central practical recommendation of "Valuing What We Do" is that audiologists should recognize the uncompensated evaluation and management work they already deliver and bill for it. Unfortunately, the AAA AMPLIFY-Your-Value strategy, outlined in the article, may serve only to amplify audiologists' legal exposure in as many as 41 states.

The article stipulates that the preferred pathway to payment for audiologists and appropriate valuation for audiology services is via the charging of office visit fees and/or the billing of evaluation and management (E&M) codes. Unfortunately, audiologists are only statutorily authorized to deliver *both* E&M services in nine (9) states: Alabama, Arkansas, Colorado, Georgia, Illinois, Maryland, Ohio, Rhode Island, and South Dakota. The other 41 states must modernize their state audiology practice acts to include one or both of these services before they could be legally performed or billed by audiologists.[vii]

**"Valuing What We Do" states that *'there is no knight in shining armor, who will right the world for audiology.'***

On that point, ADA agrees. ADA contends, however, that there are actually thousands of 'knights.' They do not wear armor or wield a sword. They wear scrubs and white coats, and they wield an otoscope. They are convening in droves on state capitals across the country to advocate for their patients and their profession. They are insisting, without reservation or hesitation, that their state audiology licensing statutes align with their education and training. They are dismantling systemic health inequities to achieve better access to care for their patients. They are, in practice, demonstrating the courage and compassion that is expected of audiologists as clinical doctors.

**"Valuing What We Do" states that advocacy efforts to modernize state scope of practice efforts are organically driven, with the encouragement of the ADA.**

Thank you for publicly acknowledging ADA's support of these state-driven efforts to modernize audiology practice acts across the nation. However, ADA is doing more than encouraging. ADA is making heavy investments of time, money, and other resources to fight alongside state advocates to ensure that both audiology and audiologists achieve their full potential.

ADA is also working to advance professional and public policy initiatives to ensure improved coverage and reimbursement for audiology services. *Audiology 2050*[viii], a comprehensive strategic roadmap, identifies seven mutually reinforcing principles for the profession's future:

- Scope of Practice Consistent with Other Clinical Doctors
- Standardized, Evidence-Based Clinical Practice
- Professional Workforce Including Extenders
- Audiologists Advance Professional Socialization Initiatives
- Audiologists Are Advocates and Activists for the Profession
- Achieve Medicare LLP Status
- Primary Care Entry Point for Auditory & Vestibular Conditions

These principles commit ADA to working with interested state organizations to ensure audiology practice laws include the language of *evaluate, diagnose, manage, and treat*; and to "expand and intensify education and training in pharmacology, imaging, and other areas of clinical focus to ensure provider readiness. ADA proposes that training *and* licensure laws should evolve together.

ADA's 2025 position paper, A Call to Action on Coverage of Hearing Care: Principles for Public Policies that Optimize Patient Outcomes,[ix] represents ADA's robust advocacy efforts to ensure that hearing coverage policies foster beneficiary access, transparency, fair reimbursement, and the autonomous clinical decision making for audiologists. That is the same destination the President's Message advocates. The "two efforts," framed as alternatives in "Valuing What We Do," are, in ADA's published vision, two integrated principles within a single strategy, each made possible by the other.

**ADA's reimbursement public policy and advocacy record is well documented.**

"Valuing What We Do," implies, by omission, that ADA is uninvolved in reimbursement advocacy. Yet the public record is clear. ADA has filed substantive formal comments on every major Medicare Physician Fee Schedule proposed rule for the past five consecutive years, including CMS-1770-P (CY 2023 MPFS, September 2022, accompanied by a legal memorandum from outside counsel), CMS-1784-P (CY 2024 MPFS), CMS-4205-P (Medicare Advantage, January 2024), CMS-1807-P (CY 2025 MPFS), and CMS-1832-P (CY 2026 MPFS, September 2025)[x]. ADA's most recent CMS advocacy efforts included recommendations against[xi] the implementation of new bundled hearing aid service CPT® codes and the sudden elimination of existing codes, resulting from an ill thought initiative driven by AAA and the American Speech Language Hearing Association (ASHA), over ADA's

well-founded objections.[xii] ADA also actively engages on advocacy issues related to Medicare Advantage, [xiii] and other commercial payers on behalf of audiologists. For example, ADA's attorney recently engaged with Anthem on the issue of Anthem's Unlawful Denial of Medically Necessary Audiologic Diagnostic Services— Medicare Advantage Claims.[xiv]

**ADA welcomes the opportunity to discuss Audiology 2050 and organizational advocacy initiatives with AAA leaders.**

ADA believes that in order for audiologists to be fully valued for what they do, the following must occur:

- Audiology program graduates must be well prepared clinical doctoring professionals,
- State and federal laws must accurately reflect the education, training, and qualifications of audiologists,
- Reimbursement structures must match the value of the services that audiologists deliver,
- Consumers must have streamlined access to the audiology services that they need for their good health and quality of life; and
- Hearing and balance conditions must be recognized as medical conditions and must be addressed along the continuum of care, beginning with preventive care.

ADA believes that Audiology 2050 provides a framework for success. It is not a single strategy, but seven interconnected pillars with numerous extended strategies that work together towards the objectives of patient well-being, audiologist well-being, and growth of the audiology profession.

ADA is grateful for the opportunity to correct the public mischaracterization of its strategy as was presented in "Valuing What We Do." ADA would further welcome the opportunity to meet with AAA leaders to discuss the Audiology 2050 framework and its organizational advocacy initiatives in more detail.

Respectfully,

Jill Davis, Au.D., President
Erica Person, Au.D., President-Elect
Amyn Amlani, Ph.D., Immediate Past President
Stacy O'Brien, Au.D., Treasurer
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[i] "Valuing What We Do," *Audiology Today*, March/April 2026, Vol. 38, No. 2
[ii] Cavitt, Kimberly M. ADA state-by-state review of Audiology Practice Acts, September 2025
[iii] https://www.provider.wellpoint.com/docs/gpp/MULTI-WLP-CR-ScopePrctce.pdf?v=202312170356
[iv] https://acaeaccred.org/wp-content/uploads/2016/07/ACAE-Standards-5.11NEW-WEB-2.pdf

[v] https://nces.ed.gov/ipeds/cipcode/cipdetail.aspx?y=56&cip=51.0202
[vi] https://www.federalregister.gov/documents/2026/05/01/2026-08556/reimagining-and-improving-student-education-federal-student-loan-program-final-regulations
[vii] See ii above.
[viii] https://audiologist.org/resources/advocate/audiology-2050
[ix] https://audiologist.org/_resources/documents/advocacy/audiology-2050/Call-to-Action-on-Coverage-of-Hearing-Care.pdf
[x] ADA formal comment letters to CMS, 2022–2025 (CMS-1770-P, CMS-1784-P, CMS-4205-P, CMS-1807-P, CMS-1832-P), which can be found at www.regulations.gov.
[xi] https://www.regulations.gov/comment/CMS-2025-0304-12117
[xii] https://mcusercontent.com/59d85b4d8bff8b5eb5cebbd43/files/39e358cc-ca85-986b-2f4d-33b80d265327/ADA_Communication_to_AO_04132023.pdf
[xiii] https://www.regulations.gov/comment/CMS-2024-0008-0268
[xiv] https://audiologist.org/_resources/documents/news/2025/ADA-Demand-Ltr-to-Anthem-RE-Medicare-Advantage.pdf ■

# Frequently Asked Questions Related to Evaluation and Management Code Use By Audiologists

BY KIM CAVITT, Au.D.

## What are Evaluation and Management (E/M) services and codes?

Evaluation and Management (E/M) are diagnostic services (and associated codes) provided by physicians and other qualified healthcare professionals where the provider evaluates the patient and creates a comprehensive care, treatment, and management plan that addresses the patient's chief complaints, symptoms, and conditions.

## What is a Qualified Healthcare Professional?

Per the American Medical Association (AMA; who owns the CPT code set and can dictate its use), "….other qualified healthcare professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service".

## Is this why it is important to have "evaluation" and "management" explicitly listed in audiology scope of practice?

Yes, because the code use requires that the provider meets the qualifications of a "qualified healthcare professional" and, in order to do that, they must be qualified by licensure and scope of practice. Otherwise, the audiologist could be practicing outside of their scope of practice and, as a result, may have difficulty obtaining legitimate reimbursement.

A health plan does not have to cover every item or service that is medically necessary but, if it is explicitly within a provider's scope of practice, they cannot technically disallow (unless specifically indicated in the provider agreement) collection of private pay reimbursement for the item or service if service was medically necessary, the requirements of the specific E/M code were met and documented, and the patient was notified, in writing, prior to the provision of the service and they accepted financial responsibility. This is important, for appeal, if the health plan denies the E/M claim or assigns it to contractual obligation.

The code use requires that the provider meets the qualifications of a "qualified healthcare professional" and, in order to do that, they must be qualified by licensure and scope of practice.

## When can E/M codes be legitimately utilized in audiology?

In my humble opinion, when medically reasonable and necessary. This typically surrounds the research evidence-based provision of care during diagnostic visits, such as communication and functional needs assessments, tinnitus evaluations, auditory processing evaluations, implantable device evaluations, vestibular evaluations, and implantable device candidacy evaluations.

It is also important that, if these codes are utilized, that they are utilized for all patients of this specific service type, regardless of payer or financial responsibility. Providers need to apply these codes consistently and not just when insurance coverage exists.

## What are the requirements for use of E/M codes by audiologists?

Audiologists need to meet the following requirements to appropriately utilize E/M codes:

- Allowance within scope of practice and licensure.
- Knowledge related to evaluation and management services and their associated codes.
- Medical necessity for the specific patient.
- Documentation, in the medical record, specifically related time and the required components of the specific E/M services, care plan, and code billed.

## What forms should I have in place when legitimately providing E/M service?

It depends on whether the practice is in or out of network and whether the E/M codes are covered services if provided by an audiologist for the specific health plan.

If a patient is being asked to self-pay for an item or service and being seen in more than 72 hours, a Good Faith Estimate is required, whether the practice is in or out of network.

If the practice is in-network and the patient is self-paying for a non-covered item or service, including Evaluation and Management services, a notice of non-coverage is required prior to the provision of care.

## Do health plans cover E/M services provided by audiologists?

Yes. There are many health plans across the country that cover legitimately provided and billed, medically necessary evaluation and management services rendered and billed by audiologists practicing within their state defined scope of practice.

## Can E/M be applied to hearing aid related visits?

In my opinion, no, as the provider will not be able to meet the minimum requirements of the code billed.

## Can I utilize E/M codes if I work in otolaryngology or for a hospital?

Maybe. It depends on 1) who is the rendering provider on the insurance claim and 2) whether, on the same date of service, another provider from the service location and/or billing facility billed an E/M service for the same patient. E/M services cannot be billed "incident to" or reported by another provider. The latter situation creates audit risk, especially if it is related to the same chief complaint, symptom, or condition.

## Are there any resources available to better understand these codes and their appropriate use?

Medicare Learning Network: Evaluation and Management Services

1997 Documentation Guidelines for Evaluation and Management Services

AMA Guidance ■

## PRESIDENT'S MESSAGE

*Continued from page 3*

Every time an audiologist meets with a legislator, mentors a student, serves on a state association board, participates in grassroots advocacy, or challenges outdated assumptions about what audiologists can and should do, they help move the profession forward.

Our future will not be handed to us. It will be built by us.

This work was on full display during ADA's Advocacy Day on May 13, 2026. I want to personally thank the passionate audiologists who traveled to Washington, D.C., met with legislators, shared their expertise, and advocated for the future of our profession and the patients we serve. Advocacy is most effective when legislators hear directly from the professionals delivering care in their communities, and our members demonstrated the power of those voices.

Their efforts produced meaningful results. Shortly following Advocacy Day, Representative Judy Chu joined as a co-sponsor of the Medicare Audiology Access Improvement Act (MAAIA). While there is still much work ahead, this achievement serves as a reminder that progress occurs when audiologists engage, educate, and advocate.

Together, we have the ability to ensure that future generations of audiologists inherit a profession that is recognized, respected, appropriately valued, and fully empowered to meet the needs of the patients we serve.

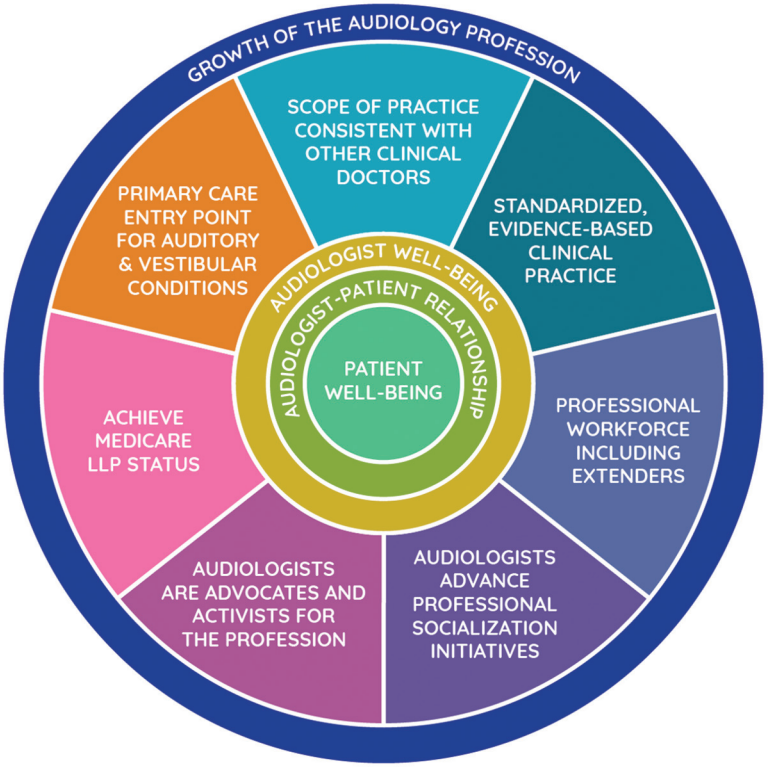
The future of audiology is not something that happens to us. It is something we choose. ■

## HEADQUARTER'S REPORT

*Continued from page 7*

If we achieve Audiology 2050, we will codify audiology's standing as a doctoring profession, with the roles, rights, and responsibilities worthy of clinical doctors. But, if we fail to act, or if we yield the future of the profession to the will and direction of others, we risk audiology's very existence.

Audiology 2050 is the vision. The *Audiology 2050 Hackathon* is our opportunity to build the playbook to achieve it. Scan the QR code for more information and register to join me there! ■

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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.**