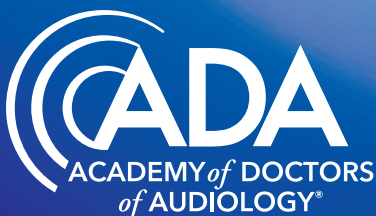


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Audiology PRACTICES

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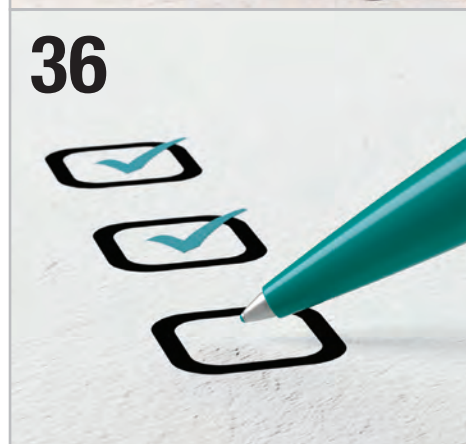
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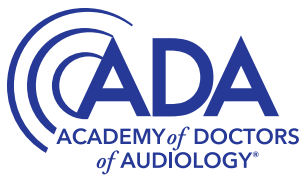
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Who Can Provide and Bill for What?

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

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Listen Up: Building Momentum Together

One of the things I love most about our profession is what can happen when we take action together. That is exactly what I'm seeing with Listen Up.



What began just a few months ago as a pilot program for a grassroots public health campaign, focused on hearing health, has moved remarkably quickly. Following our Kentucky pilot in May, Listen Up Florida, Listen Up Texas, and Listen Up Illinois are now underway, with more states on the horizon. Through public services announcements (PSAs), media outreach, social content, and community education, we are bringing hearing health into local conversations.

And this is more than an awareness campaign. It is about connecting people with local audiologists. Our profession is rooted in our communities, and the Listen Up campaign gives us an opportunity to make hearing health part of the healthy aging conversation on a much larger scale.

A Big Thank You to WSAudiology and State Associations

I want to take a moment to recognize WSAudiology for its tremendous support of Listen Up and its commitment to strengthening hearing healthcare and supporting local audiologists.

WSA has helped us move quickly from an idea to a campaign that is already reaching communities. Their partnership and investment are helping us build something with national potential while keeping local audiologists at the center of the message.

I also want to thank our partnering state audiology associations, the Kentucky Academy of Audiology, the Texas Academy of Audiology, the Florida Academy of Audiology, and the Illinois Academy of Audiology for advancing this initiative in their respective states.

We are truly grateful. This is an example of collaboration between organizations, audiologists, and industry that can move the needle on hearing health awareness among members of the public.

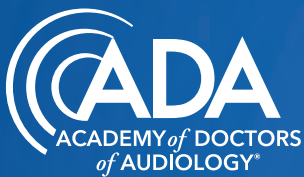
Now It's Your Turn

The real strength of Listen Up will come when every state gets involved.

ADA invites every state audiology association to bring your ideas, your relationships, and your communities to the table. Help us make this message relevant and visible where you live.

Kentucky showed us what is possible. Florida, Texas, and Illinois are showing us how quickly we can build on it.

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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:

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- 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!



Using DTx to Make Hearing Care Stickier

Nothing is more frustrating than thoroughly stepping a new patient through the process of using new hearing aids only to have them quickly abandon them a few days or weeks after the appointment. To drive the point home consider this: During the first-fit appointment, a clinician typically spends an hour fitting and counseling a new hearing aid wearer. But what happens the other 23 hours (and subsequent days before the next face-to-face appointment) often determines success. Today, smartphones and apps can extend care into these unseen hours, but several questions related to their effectiveness remain unanswered. Additionally, services like the one outlined by Allison Morris in this issue's lead article are geared to extend care beyond your four walls.

The Digital Therapeutics Alliance (DTA) describes digital therapeutics (DTx) as evidence-based software, most commonly in the form of smartphones and apps, used to prevent, identify, treat and manage a broad spectrum of diseases and conditions. Some common examples of DTx include Noom (weight loss), Headspace (mental health) and Propeller Health (asthma/COPD). Although it is tempting to think that DTx are direct-to-consumer, standalone tools, many DTx's are designed to be used in conjunction with traditional face-to-face care. DTx can be thought of as a remote extension of in-person care. This is certainly the case with the many remote care apps provided by hearing aid manufacturers as well as the myriad auditory training and tinnitus apps that are now widely available.

Let's take one example of DTx found in hearing care: auditory-cognitive training. (Disclosure: my day job is with Neurotone, an auditory-training company). As many know, this type of training has been found in hearing care for generations. Over the past decade, however, it has transitioned from CD-ROM and DVD-based to smartphones and apps. Intuitively, by placing the tasks conveniently in the hands of the patients, DTx would seem to be a positive change. So, what does the research actually say about the effectiveness of DTx in hearing care?

To explore this question, let's look at three specific angles: patient satisfaction, gamification, and personalization.

1. Patient Satisfaction.

Are patients who use DTx as part of their treatment plan more satisfied than those who do not?

Tye-Murray (2022) evaluated a DTx (Amptify) in 30 first-time hearing aid wearers and compared survey results of this group with a control cohort (watching closed-caption television for a similar timeframe). Participants using the DTx reported:

Continued on page 78



WELCOME

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A View from CTA's Health Week and the Health AI+ Summit



On September 8-9, 2026, the Academy of Doctors of Audiology (ADA) had an unprecedented opportunity to participate in the Consumer Technology Association's (CTA) flagship Health AI+ conference, an invitation-only gathering exploring the breakthroughs, business realities and policy decisions shaping the future of AI in healthcare, in Washington, D.C., as part of CTA Health Week. There, ADA was positioned alongside the American Medical Association's Center for Digital Health & AI as a lead facilitator of the conversations shaping how artificial intelligence is developed, deployed, and reimbursed across health care, including the delivery of audiologic services that ADA members provide every day.

During CTA Health Week, I had the opportunity to meet and engage with industry leaders, innovators, and federal officials with direct authority over how AI-enabled hearing devices, diagnostics, and clinical and administrative tools are approved, regulated, and reimbursed. Featured federal government presenters included Amy Gleason, the Centers for Medicare & Medicaid Services Deputy Administrator & Chief Product Officer, Dr. Rick Abramson, Director of the U.S. Food & Drug Administration Digital Health Center of Excellence, Dr. Rafid Fadul, Chief Medical Officer for the Advanced Research Projects Agency for Health, and Dr. Thomas Keane, U.S. National Coordinator for Health Information Technology for the U.S. Department of Health & Human Services.

Dr. Kevin Franck, served as an ADA representative for a CTA Congressional Health Briefing at the Capitol, and also shared ADA's perspectives on the panel "*The AI Divide: Who Benefits, Who Gets Left Behind?*" During the panel discussion, Dr. Franck was able to document structural policy weaknesses in Medicare coverage that must be addressed, including the barriers to access and care continuity for Medicare Part B beneficiaries with hearing and balance problems. By extending our advocacy efforts into the AI and health-tech policy arena, ADA aims to ensure that policy decisions from the payers, innovators, and regulators who will write the next set of rules reflect evidence-based practices in the delivery of hearing and balance care.

Other provocative panel sessions included discussions on whether and when AI should be allowed to practice medicine independently, how wearables and sensors are changing real-time care, ensuring patient agency and privacy in AI health applications, and the tension between state and federal AI policies related to healthcare delivery—all of which were relevant to the future of hearing and balance care, and the patients who rely on it.

ADA's presence at CTA Health Week reflects a deliberate strategy to ensure that audiologists have a seat at the table where critical paradigms will be created that impact the future of the profession. As AI tools move from pilot projects to the center of clinical practice, administration, coverage policy,

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AFTER THE FITTING

Why Patient Education Cannot End When the Appointment Does

Allison Morris, Au.D.

WE TEACH EVERYTHING ON FITTING DAY.

The research on what patients actually retain tells us that will never be enough. This is a case for extending education and support into the weeks and years between visits, and a model built to do it.

“No one ever showed me how to change the wax filter.”

I have heard some version of that sentence more times than I can count, and I suspect you have too. Here is the uncomfortable part: they were shown. I showed them myself, hands on, at the fitting, and had them demonstrate it back to me before they left. By the time the filter clogs, whether that is weeks or months or years on, two things have faded: how to do it, and the memory of ever being taught. This is simply how memory works after an appointment like this. A fitting asks a person to take in more than almost anyone can retain, and whatever does not survive that hour has nowhere to land afterward. I believe that exploring solutions to address this issue by harnessing new technology could be one of the most impactful shifts our field can make for our patients.

I should disclose; I am not a neutral voice on this subject. While I am a practicing audiologist, I am also a co-founder of Tascenda, a company built to support hearing aid users between visits.

FITTING DAY IS AN INFORMATION EVENT, BUT THE INFORMATION DOES NOT HOLD

Consider what we ask a patient to absorb in the fitting hour: sounds they have not heard in years, including their own voice, insertion and removal, cleaning, wax filters and domes, charging of batteries, an app if they use one, what acclimatization will feel like, what week two tends to bring, when to push through and when to call. Most of it is delivered in that one visit, to a person who is often in their seventies or eighties, at the very moment they are coming to terms with the emotional fact of wearing hearing aids at all.

We fit the device in an hour. The patient adjusts to it over months. The research on what survives that hour is humbling. Across health care, studies find that 40 to 80 percent of the medical information clinicians provide is forgotten immediately, and that almost half of what patients do retain, they retain incorrectly (Kessels, 2003). Spoken information fares worst of all. Margolis brought this literature squarely into our field two decades ago, estimating that patients remember about half of what we tell them, often inaccurately, and that the problem is structural rather than a matter of trying harder in the appointment (Margolis, 2004).

Read that way, the fitting is not a failed teaching event but an impossible one. The method is not the problem: we say it, we demonstrate it, we send it home on paper. The spoken instruction, though, is exactly what that forgetting research describes, and the handout, useful as it is, is fixed and one-way. It cannot answer the question the patient has after the office closes, or walk them back through the one step they forgot. No profession could deliver a new sense, a new device, and a dozen new skills across a fitting and a follow-up and expect all of it to hold.

40 - 80
P E R C E N T

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provide is forgotten immediately,
and almost half of what patients do
retain, they retain incorrectly.

HANDS-ON SKILLS FADE, EVEN IN EXPERIENCED USERS

If the problem were only memory for facts, written handouts would have solved it long ago. The hands-on skills decay too, however, and here the audiology literature is specific. When Desjardins and Doherty administered a practical skills test to experienced hearing aid users, people who had owned and worn their devices for years, performance on eight basic tasks taught at every fitting averaged just under 80 percent, with some participants managing barely half. Cleaning was among the weakest skills of all (Desjardins & Doherty, 2009). Later work using the same test found something equally telling: hearing aid users who had recently been reoriented on their devices performed significantly better than those who had not had an orientation in over a year (Desjardins et al., 2019). Larger survey work reaches the same conclusion: hearing aid management skills among owners are low overall, and those skills are associated with how patients fare with their devices (Bennett et al., 2018a, 2018b).

That brings us back to the wax filter. The patient was shown. The instruction did not survive the months between the demonstration and the first clog. There is a handout at home, and an instruction manual with it, but a filter is not what comes to mind when an aid goes silent. All the patient knows is that it stopped working, so they call the clinic. No one failed here. This is what happens when the teaching lands in the visits we have and the questions arrive in the months that we do not.



THE QUESTION ARRIVES WHEN THE OFFICE IS CLOSED

Put a new user at home in week three. The world still sounds strange because sounds they have not heard in years, their own voice among them, take time to become familiar. The reassurance that this is normal was covered at the fitting, one sentence among a hundred that day. Then something small goes wrong on a Sunday evening: the left device will not reconnect after a phone update, or an aid goes silent for reasons the patient cannot see. The office opens Monday.

With no one to ask, the patient is left to decide what to do next: wait until Monday and risk losing confidence, make an unplanned trip to the office for a problem that may not require a visit, or leave the aids out until they can be seen. A small unanswered question can become the reason devices are worn less or abandoned altogether, and the early weeks are when the habit of wearing them is still taking hold. Patients who wear their devices consistently tend to report greater benefit and satisfaction than those who wear them less often (Hickson et al., 2014), and a hearing aid can only help when it is being worn.

Success with hearing aids depends on far more than between-visit support. Word recognition, physical fit, dexterity, cognition, expectations, and support at home all matter. Every clinician weighs these factors, and we fit patients well every day who are navigating several challenges at once. The one part we cannot manage from the office is what happens after the patient leaves it.

A small unanswered question can become the reason devices are worn less or abandoned altogether, and the early weeks are when the habit of wearing them is still taking hold.





Patients benefit from ongoing education and support after the fitting. How does a busy practice deliver the support consistently and efficiently?

REINFORCEMENT BETWEEN VISITS WORKS

Here is where the literature turns hopeful.

When researchers in the UK built a series of short multimedia lessons for first-time hearing aid users, covering these same practical and adjustment topics, and delivered them for use at home, a randomized controlled trial found improved practical handling skills and knowledge, with high uptake and patients rating the materials extremely useful (Ferguson et al., 2016). A later trial found that delivering the education even before the fitting produced greater gains in self-efficacy and hearing aid knowledge by the day the devices arrived (Gomez & Ferguson, 2020). Re-instruction, wherever it has been studied, helps. For example, in one small randomized trial, new users who did not

receive targeted re-instruction declined in their use and care skills within four weeks, while those who did held steady (Alicia & Doherty, 2021).

An important aspect of one of the most influential contemporary audiology trials also deserves greater attention. In the ACHIEVE trial, which found no effect on cognitive decline across the full cohort but slower decline in a prespecified group of older adults at elevated risk (Lin et al., 2023), the intervention extended well beyond the provision of hearing aids. Participants in the intervention group also received a self-management toolkit with educational materials for home use, along with ongoing follow-up sessions with study audiologists throughout the trial. This level of structured, longitudinal support is not typical of routine clinical practice. An important question of external validity therefore arises: would the magnitude of effect observed in the intervention arm have been as substantial had participants received hearing aids and ongoing audiologist care, but not the structured

home-based self-management support and educational materials that accompanied the intervention? A trial frequently cited as evidence for the benefits of hearing care was, in many respects, also a demonstration of the value of sustained patient education between appointments.

Taken together, the evidence is consistent. We deliver essential instruction at the moment patients are least able to retain it, and reinforcement delivered afterward, in their everyday environments, works. The question is no longer whether patients benefit from ongoing education and support after the fitting; the evidence indicates that they do. The remaining challenge is how a busy practice delivers that support consistently and efficiently.



FROM STATIC RESOURCES TO A RESPONSIVE PRESENCE

Handouts, videos, and semi-annual hearing aid checks are the traditional answers, and they help. However, the field has also learned a harder lesson: evidence of benefit has not always translated into consistent real-world use. Digital education tools in hearing care have shown strong results in trials, but real-world uptake and adherence have been uneven among both patients and the clinics responsible for delivering them (Ferguson & Henshaw, 2015). The challenge appears to be less about the value of the education itself and more about how it is delivered. Traditional resources are often generic when patients' questions are specific and one-way when learning requires reinforcement. They rely on patients remembering where to find information and choosing to seek it out when they need it. Effective between-visit support must be accessible, practical, and integrated into the patient's experience of care.

The gap points to what real support through technology would have to do. It would reinforce the teaching from fitting day with the right information at the right time, in everyday language. It would fit into the patient's routine and be easy to access when questions arise. It would anticipate predictable moments in the hearing journey: adjusting to new sounds, understanding what is normal during acclimatization, learning device care, or knowing what to do when something does not work as expected. It would also know the limits of its role, so that anything requiring clinical judgment moves promptly to the clinician. Above all, it would meet patients where they are, offering multiple channels for support while feeling like an extension of the practice they already know and trust, and working for the whole caseload, including the patient who is uneasy with a smartphone.

There is one more requirement, one I felt myself. Many of us hold the follow-up close because these are our patients, and the instinct that no one else should be in those encounters comes from the relationship at the heart of hearing care, whatever the setting we practice in. The Sunday filter and the week-two doubt at nine in the evening, though, are moments no clinician can be present for in person, however devoted. What needs extending into those hours is your teaching, carried as part of your practice's care, with a straight path back to you the moment anything stops being routine. Letting go of the repetition is not letting go of the patient.



WHAT WE BUILT

That job description is the one I tried to fill. Tascenda is a virtual assistant that a practice offers its patients for the time between visits. It is powered by artificial intelligence. I am cautious by nature about AI anywhere near patient care, and that caution is built into what this is allowed to be: intentionally narrow, plain about its limits, and quickest of all to hand a patient back to a person when necessary. It is just as plain with patients, who are informed they are talking with a virtual assistant offered by their clinic: honest about what it is, while still feeling like an extension of the practice's own care. It exists to carry the teaching we do on fitting day into the weeks afterward.

When an aid goes silent on a Sunday, the patient can ask before deciding it is broken.

A patient leaves the fitting with a way to reach the clinic between appointments, under the clinic's own name, by chat or over the phone, with no app required. In the first weeks the assistant gives the teaching from fitting day somewhere to land: what to expect, how to handle and care for the devices, why the hard stretch is normal, all of it there the moment a question comes up, so the ordinary difficulty of adjusting reads as part of the process rather than a sign of failure. When the strangeness of week two raises a worry that something is wrong, the patient can ask that evening and get a straight answer instead of waiting days and losing heart. When an aid goes silent on a Sunday, the patient can ask before deciding it is broken. It turns out to be the wax filter, the one they were shown once and cannot quite recall, and after a short walk-through, the devices stay in use rather than landing in a drawer or on the schedule as a walk-in.

Where it stops is clinical judgment or anything that calls for assessment or an in-person visit, the patient is not offered a workaround. They are pointed back to the practice, and the team is made aware of what they described, so the right person can follow up and the concern does not wait until it happens to come up months later. That line, between what is handled by the virtual assistant and what belongs with the clinician, is the part of the design I hold most tightly. Our assistant lets the practice stay present through the ordinary weeks without asking the clinician to be reachable at every hour, and it carries the clinic's teaching into days the appointment book cannot reach.

The need for between-visit support does not stop once the first months are behind our patients. The skills data came from experienced users, people years into ownership, and the questions never fully stop; they only change. A phone update breaks a pairing in year two, dexterity shifts, the filter routine that held for a season lapses. So the same presence that carries a new user through the early stretch keeps answering for as long as the devices are worn, between every visit rather than only the first few, and the patient stays connected, the whole way, to the practice that knows them.

My co-founder and I presented this integrated approach in a clinical poster at AAA 2026.

WHAT IT MEANS FOR A PRACTICE AND ITS PATIENTS

For the patient, the benefit is simple: the teaching from fitting day is available again when it is needed, with support during the months when confidence is still developing.

For the practice, the impact shows up in three ways: protecting audiologist time for higher-value, billable care; reducing routine workload for support staff; and providing patients with ongoing access to support between visits to improve confidence, consistency, and outcomes with their devices. Routine questions, such as the pairing that will not connect, the rechargeable aid that seems dead but is only seated wrong in its charger, or the is-this-normal concern, can be addressed without automatically becoming a call, walk-in, or visit. When a clinician is needed, the contact arrives with context rather than as a vague voicemail or an unresolved issue. The result is a practice that can support the full lifespan of a patient's hearing journey, from new fittings to longtime users.

It works across every manufacturer a practice fits, and it is built to meet the privacy requirements that come with patient health information, because anything less has no place in a clinic. If this gap is one you recognize in your own patients, you can learn more at www.tascenda.com.

THE LONGER ARC

The fitting will always matter, and I will always love that hour. It is where success begins, and none of this diminishes the skill it takes. The teaching we do in that hour, though, has always deserved a longer life than our appointments can give it. Today, we have new ways to extend it. I find that one of the most hopeful shifts our field has seen because it does not ask the audiologist to do more in the room. It allows what we already teach to reach the place it was always meant to go: the patient's ordinary days, where hearing actually happens.

The approach may look different from one practice to the next, but the patient at the center is the same: someone who came to you to hear their life again, and who needs what you taught them to last a little longer than the appointment itself.

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Why Audiologists Resist AI

and What Practice Owners Should Do

Dr. Gleb Tsipursky

An audiologist hears that the practice plans to introduce artificial intelligence and imagines software second-guessing clinical decisions, recording private conversations, or diminishing hard-earned expertise. The owner imagines faster documentation and fewer hours lost to administration. Conflict begins when leadership treats one reaction as progress and the other as obstruction.

That mistake can derail AI adoption in audiology before anyone tests a useful workflow. A mixed-methods survey of hearing-health professionals found that respondents recognized potential benefits while emphasizing training, ethics, and protection of the clinician-patient relationship. Their caution did not amount to hostility toward innovation. It reflected a demand that innovation respect the conditions under which audiologists provide trustworthy care.

Practice owners should therefore interpret resistance through the lens of clinician trust and workflow integration. A skeptical comment often reveals an unanswered question about accuracy, patient privacy, professional responsibility, workload, or control. Leaders who diagnose that concern can design a safer and more useful implementation. Leaders who dismiss it can turn manageable uncertainty into organized opposition.

Resistance Usually Protects Something Valuable

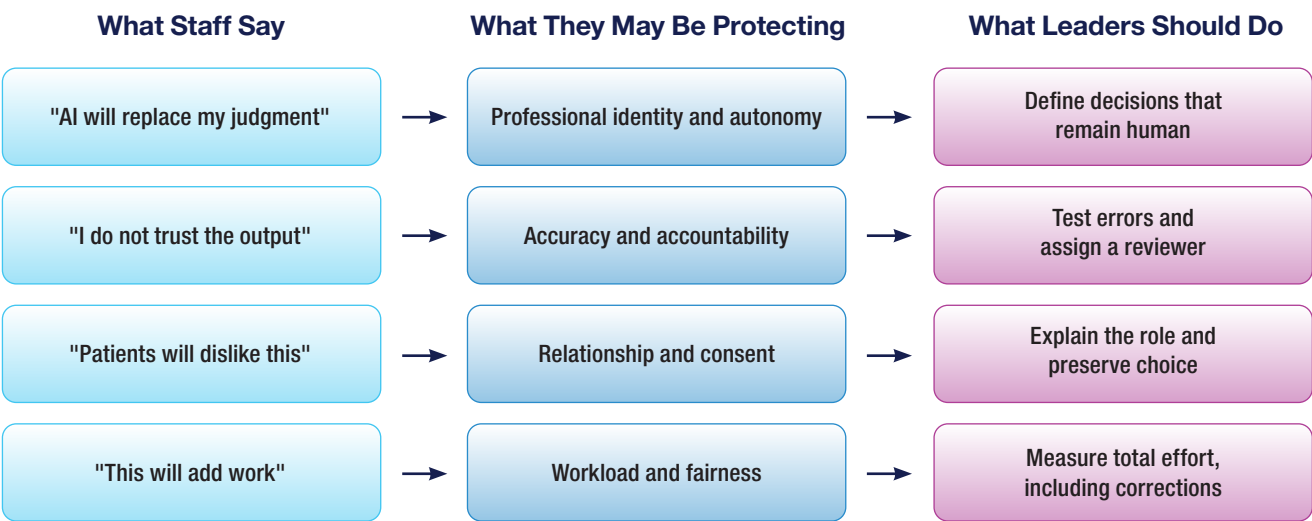
People rarely resist a tool in the abstract, especially when AI changes the clinician-patient relationship. They resist what they believe the tool will do to their work, status, relationships, or identity. Audiologists have invested years in clinical education and supervised experience. They build judgment by integrating test results, patient history, communication needs, family dynamics, treatment goals, and observations that may never appear in a structured field. When leaders present AI as a source of answers rather than a support for professional work, clinicians may hear an implicit claim that their expertise matters less.

This identity concern becomes sharper in autonomous practice, where ADA describes itself as a resource for practice ownership. The Academy of Doctors of Audiology defines its mission around practitioner excellence and professional autonomy. An AI rollout that centralizes decisions in a vendor system or pressures clinicians to follow opaque recommendations can feel inconsistent with that mission. Even a technically capable tool can fail when the implementation threatens the autonomy that audiologists consider central to responsible practice.

Resistance may also protect the patient relationship. Research on trust in hearing healthcare identifies communication, shared decision-making, technical competence, comprehensive rehabilitation, and a professional clinical environment as important contributors to patient trust. Audiologists may reasonably worry that screens, automated summaries, or AI-generated recommendations will distract from listening to the person in front of them. They may also worry that patients will question whether a recommendation came from the clinician or from a system they cannot evaluate.

A third concern involves responsibility and the profession’s established confidentiality obligations. AI can generate confident language that contains errors, omits context, or invents details. ASHA’s guidance on ethical responsibility for AI-assisted work tells clinicians to understand a tool’s limits, review generated text, correct errors, and ensure that relevant information appears before signing or sharing a document. The professional remains accountable. That creates a rational question: if the audiologist carries the risk, how much authority should the tool receive?

These concerns share a theme: audiologists want AI to support competence rather than dilute it. Figure 1 translates resistance into protected values and leadership responses.



Resistance becomes useful when leaders translate it into a design requirement.

Figure 1. Translate resistance into the value being protected and a concrete leadership response.

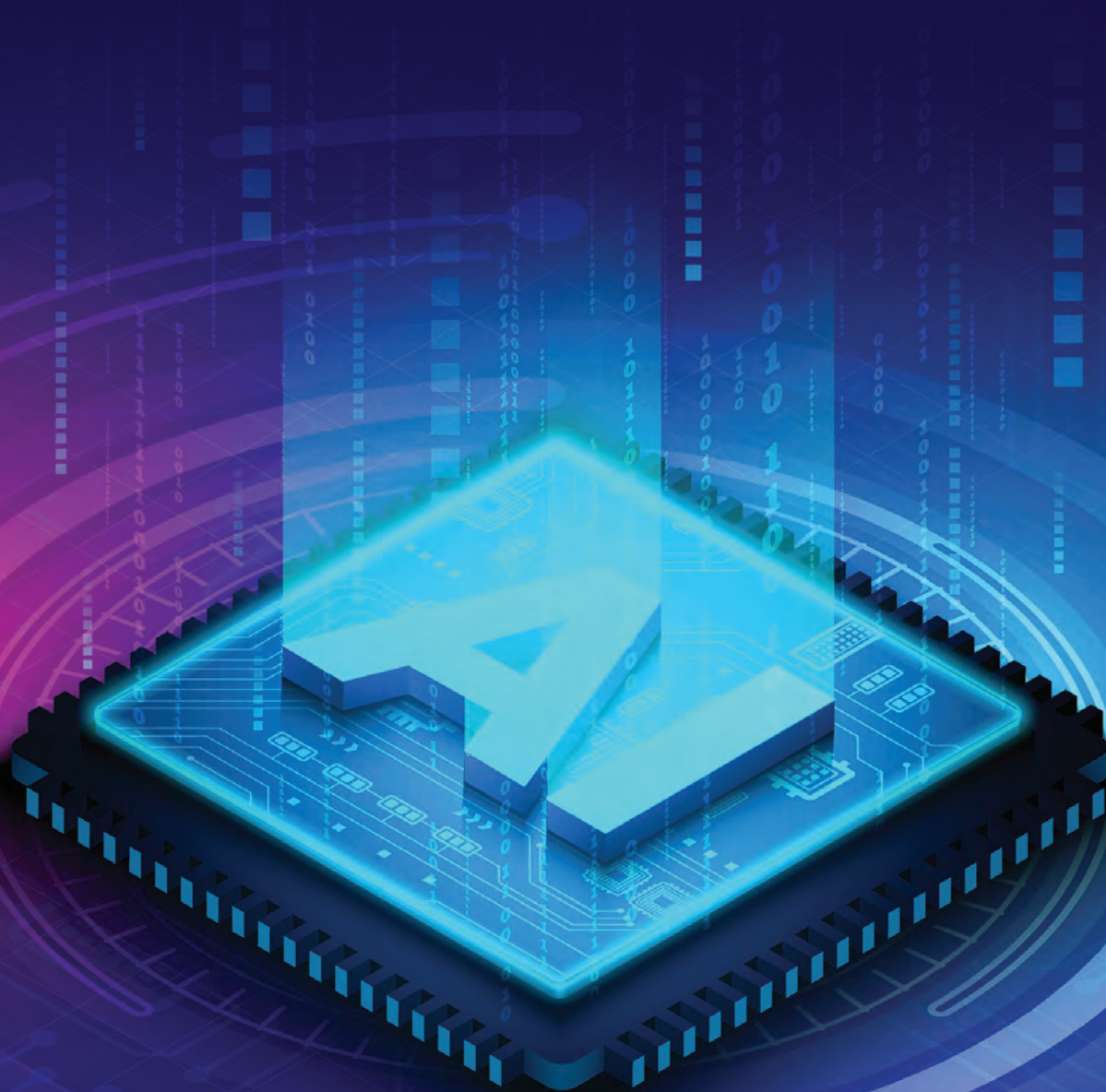
Avoid the Two Most Common Leadership Errors

Two leadership errors commonly intensify resistance. Overpromising turns one promising demonstration into a sweeping transformation claim, which gives staff more risks to imagine before the practice proves one benefit. Forced enthusiasm turns practical questions into a test of loyalty, driving uncertainty underground or hardening opposition.

A better approach starts with psychological safety for AI. A survey of speech-language pathologists and students found interest alongside limited clinical use and calls for guidance. Audiology teams need permission to admit uncertainty, identify errors, and challenge a use without being labeled resistant.

Ask staff what evidence, review rules, comparison time, or workload protections they need before trusting a use. Each answer becomes a design requirement.

Leaders should also distinguish between emotional reassurance and operational proof, using clear roles and measurable outcomes. Telling clinicians that a tool is safe carries little weight if nobody can explain where the data go. Telling staff that AI will save time sounds hollow if they must correct poor output after hours. Trust grows when the practice can demonstrate a controlled workflow, define accountability, and show actual results.



Start Below the Clinical Risk Line

The fastest route to useful adoption often begins outside diagnosis and treatment decisions. Generative AI can help draft an internal checklist, organize a staff meeting agenda, rewrite a patient handout in plainer language, create questions for vendor evaluation, or turn rough notes into a first draft of a nonclinical procedure. These tasks still require review, but mistakes usually carry lower consequences than errors in diagnostic interpretation or individualized treatment.

ASHA describes administrative and educational uses of generative AI while emphasizing that AI cannot replace clinical expertise, individualize care on its own, or interpret diagnostic data reliably without professional oversight. That boundary offers practice owners a sensible starting point. Use AI first where clinicians can evaluate the output quickly and where the final decision remains visibly human.

Figure 2 shows a low-risk adoption ladder. A practice should move upward only after it demonstrates accuracy, safeguards, and value at the previous level.

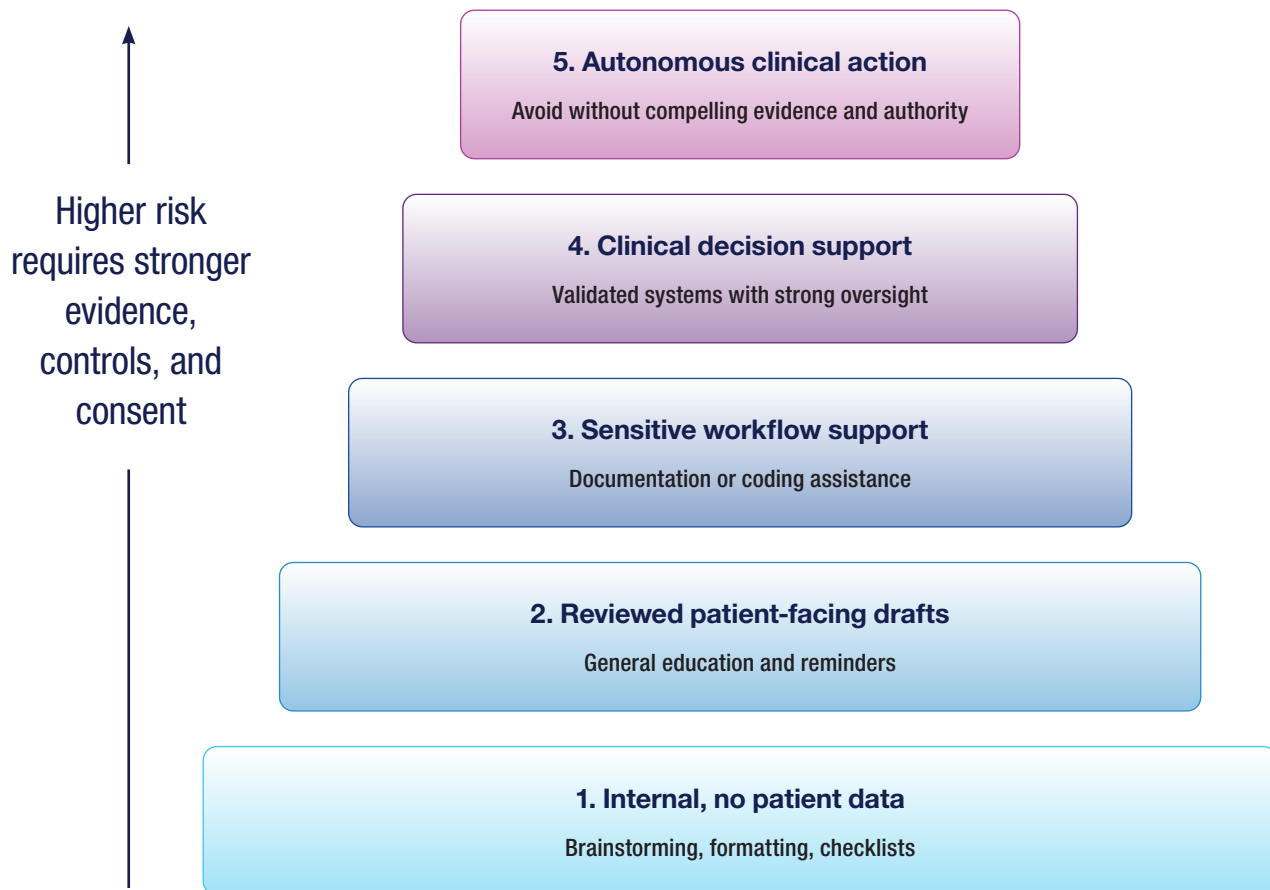


Figure 2. Move from low-risk, easily reviewed uses toward higher-risk applications only as evidence and controls strengthen.

The bottom level includes internal brainstorming and formatting with no patient information. The next level includes reviewed patient-facing drafts without protected health information. Higher levels involve sensitive information, documentation, coding support, or recommendations that could shape care, so they demand stronger controls. ASHA's informed-consent guidance explains that an audiologist considering AI speech-to-text during a cochlear implant appointment should verify legal and organizational requirements, explain how audio will be processed, and respect a patient's decision to decline. The example highlights a broader principle: convenience does not override consent or the patient's control over the encounter.

The highest-risk applications involve diagnostic interpretation, treatment recommendations, or autonomous communication that patients may mistake for professional advice, concerns reflected in research on AI as a third clinical agent. A 2024 scoping review found rapid growth in audiology AI research across automated audiometry, clinical prediction, imaging, and report generation. Research activity signals opportunity, but it does not mean every product has sufficient validation for every practice population and use case. Owners should require evidence that matches the intended setting rather than accepting a broad claim that a system uses AI.

Give Clinicians Real Control Over the Pilot

Participation changes the meaning of a project. An imposed tool demands compliance. A clinician-shaped pilot asks whether a workflow deserves a place in practice.

Choose a small team that includes a respected skeptic, a curious early adopter, and the person who performs the target task most often, following the logic of multidisciplinary AI risk management. The skeptic should have authority to stop or narrow the pilot when the team identifies a meaningful risk. The early adopter can explore effective prompts and workflows. The task owner can judge whether the output fits real operating conditions.

Then define a concrete problem. "Use AI more" provides no target. "Create a faster first draft of a general post-appointment instruction sheet while preserving accuracy and readability" gives the team a testable outcome.

Set a baseline before introducing the tool. Measure current time, rework, and quality. Without a baseline, a polished draft may feel faster while creating hidden review work.

The NIST AI Risk Management Framework recommends continuous attention to governance, context, measurement, and risk management. A small audiology practice does not need a large compliance department to apply that logic. It can name the owner of the workflow, document the permitted use, identify foreseeable harms, test output, and review results at a scheduled point.

Use a short pilot, often two to four weeks, with a limited number of cases or documents and a govern-map-measure-manage cycle. Require participants to record errors and near misses rather than quietly fixing them. An error log prevents the practice from remembering only successful examples. It also gives clinicians evidence that leadership wants accurate learning rather than a predetermined verdict.

Build Guardrails That Staff Can Actually Use

A policy that says "use AI responsibly" offers little guidance. Staff need clear rules for tools, data, prohibited uses, review, disclosure, and incident reporting.

Begin with data and a structured technology evaluation process. Audiology practices handle health information, financial information, recordings, device data, referral information, and details about family or communication circumstances. Staff should never assume that a consumer AI account provides suitable protection. They need a verified list of approved systems and a rule that prohibits entering identifiable patient information into unapproved tools.

Privacy concerns deserve direct treatment because they rank highly in research on machine learning and hearing-aid ethics. Audiologists in that work identified privacy, confidentiality, trust, professional responsibility, informed decision-making, and financial interests as important ethical issues. A practice that addresses these topics before deployment reduces uncertainty and demonstrates respect for professional judgment.

An abstract graphic of a stylized human head profile, facing right. The head is composed of a dense grid of small dots in various colors, including red, orange, yellow, green, and blue. The dots are arranged in a way that creates a sense of depth and movement, with some dots appearing to be in front of others. The background is a solid dark blue. The text is positioned on the left side of the image, within the head's profile.

Every AI-assisted
output should have
a named person
responsible for
checking accuracy,
completeness, tone,
and suitability.

Next, define human review. Every AI-assisted output should have a named person responsible for checking accuracy, completeness, tone, and suitability. The reviewer should have enough expertise to detect failure. A front-office employee can review the tone of a scheduling message, but a licensed audiologist should review clinical content. The tool cannot become the reviewer of its own output.

Define what the system may never do without explicit authorization. Examples might include sending patient messages automatically, interpreting audiometric data, recommending treatment, selecting billing codes, generating a final report for signature, or recording a patient encounter. The exact boundaries will vary by product, law, payer requirement, and practice policy. Written prohibitions protect staff from guessing.

Finally, create an easy reporting route and treat AI risk management as continuous. Employees should know whom to contact when a tool produces a concerning result, exposes information, or behaves differently after an update. The NIST trustworthiness criteria include validity, reliability, safety, security, accountability, transparency, explainability, privacy, and fairness. These concepts become useful only when staff can translate them into observable incidents and corrective action.

Train Around Workflows, Not Features

Generic AI training often produces temporary excitement and little behavior change, despite the need for critical appraisal skills for clinical AI. A trainer demonstrates dozens of functions, employees try a few prompts, and daily routines remain the same. Effective training begins with a recurring task and ends with a repeatable process.

For patient education, training should use the practice's review standards. Participants can compare an original handout with an AI-assisted draft, correct unsupported claims, adjust reading level, and document final review steps.

Hearing-health professionals have expressed substantial demand for practical AI training, with many respondents identifying professional organizations as an appropriate source. Practice owners should treat training as part of clinical and operational quality, rather than a one-time software orientation. Staff need opportunities to practice, compare outputs, and update procedures when tools change.

Training should build three habits: remove sensitive information unless the approved workflow permits it, provide clear context and constraints, and verify every factual statement and professional recommendation. It should also teach staff when to decline AI because a patient interaction requires undivided attention or a task carries too much context for safe automation.

Measure What Matters to Clinicians and Patients

Logins, prompts, and hours show activity rather than value. Measure whether the workflow improves time, quality, consistency, patient experience, or staff burden.

For an administrative drafting pilot, measure minutes to an acceptable final draft, number of corrections, and user-reported effort. For patient education, assess accuracy, readability, and whether patients ask fewer clarifying questions. For documentation support, track review time, omitted information, inaccurate statements, and any effect on attention during the encounter.

The goal should involve augmentation and preserve the dynamic trust relationships among patient, clinician, and AI. Research on patient acceptance of medical AI found that clinician presence, system performance, information about representative training data, and governance affected trust and preference. Patients do not evaluate a tool only by whether it exists. They evaluate the quality of the care arrangement around it.

This finding should push practice owners toward transparency and human-centered AI collaboration. When AI materially affects an encounter, clinicians should explain its role in plain language. They should clarify what the tool does, what information it processes, how the audiologist reviews its contribution, and what choice the patient has. The clinician should remain visibly responsible.

Figure 3 presents a continuous adoption cycle. The practice listens for concerns, selects one workflow, sets guardrails, practices in a controlled environment, measures results, and shares what it learned. The cycle then begins again with a better-informed team.

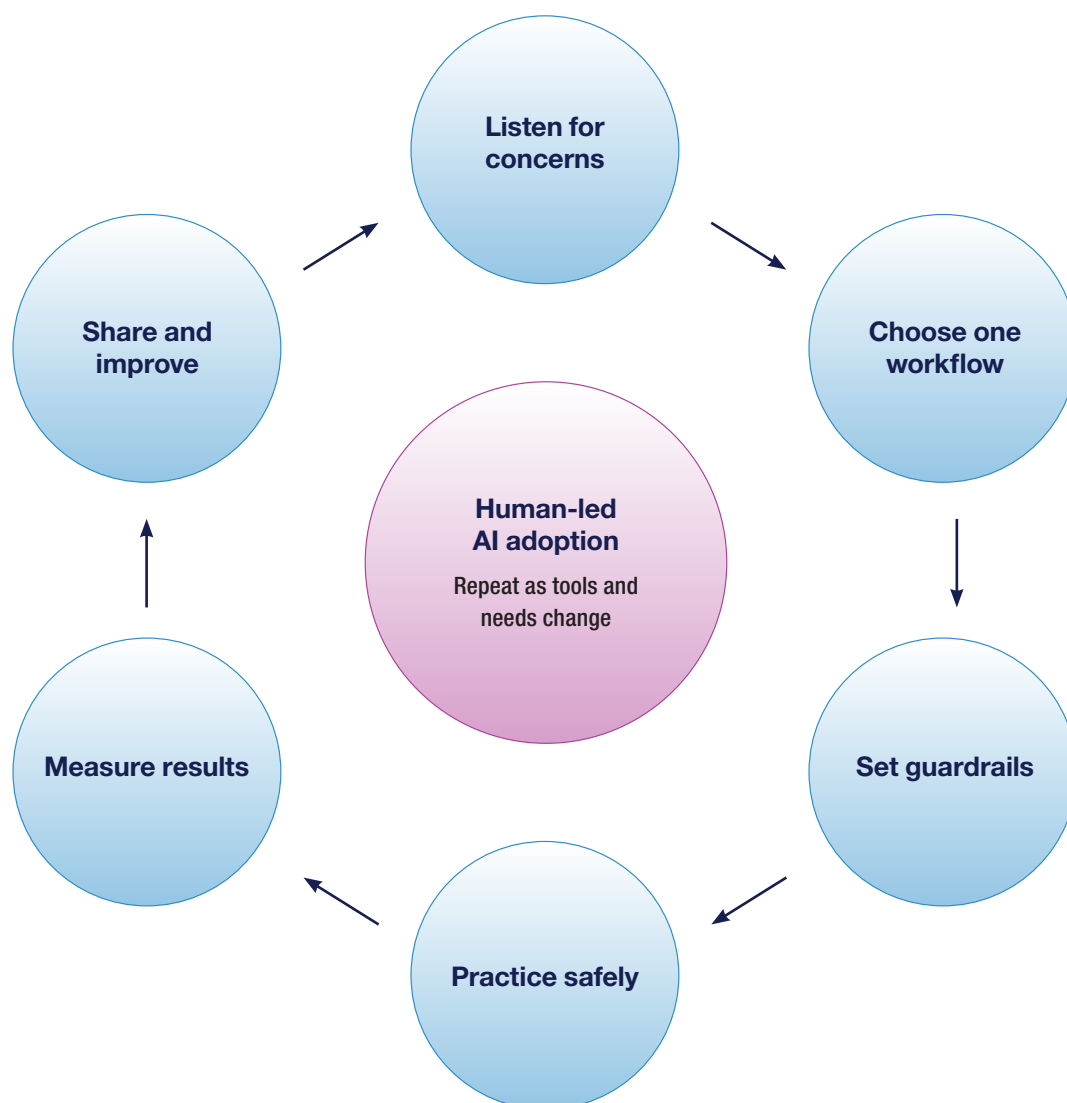


Figure 3. A continuous, human-led cycle for introducing and improving AI-supported workflows.

Use Skeptics as Quality Partners

The employee who raises the most concerns may become the practice's best quality partner, especially as implemented clinical AI evidence remains limited. Skeptics often notice edge cases, ambiguous accountability, workflow burdens, and patient reactions that enthusiastic users overlook. Leaders should give them a defined role in testing rather than treating them as an audience to persuade.

Ask skeptics to identify failure conditions before a pilot begins and convert them into test criteria. Concerns about omitted contraindications require a completeness review. Concerns about ambient documentation require observation of rapport and patient comfort.

This approach separates evidence-based caution from reflexive rejection. Some concerns will prove correct and improve the design. Others will diminish after controlled experience. Either outcome helps the practice make a better decision.

The World Health Organization's AI guidance for health places human autonomy, safety, transparency, accountability, equity, and sustainability at the center of implementation. Those principles align with the values many skeptical clinicians already defend. Leaders can reduce conflict by showing that responsible innovation and professional caution serve the same objective.

Make Adoption a Practice Capability

A single successful pilot does not create lasting capability, particularly as large multimodal health models create new governance questions. Practices need a repeatable method for evaluating new tools as vendors add features and staff discover new uses. The method should fit the scale of the organization.

Assign an AI lead or small review group, keep a register of approved tools and workflows, review vendor data practices, and retire uses that create more correction than value. A small practice can manage this with a one-page intake form asking what problem the tool addresses, what data it uses, who reviews output, what could go wrong, and how success will be measured.

Audiologists do not need to choose between professional autonomy and technological progress, a balance consistent with ADA's practice-focused professional mission.

The Academy of Doctors of Audiology's code of ethics emphasizes patient welfare, accurate information, professional competence, and ethical conduct. An AI process should strengthen those obligations. It should help audiologists spend more attention on care, communicate more clearly, or operate the practice more reliably. When it weakens accountability or encourages misleading certainty, the practice should stop using it.

Owners should frame responsible AI adoption as an extension of practice leadership. The essential skills include listening, change management, workflow design, risk judgment, training, and measurement. Software selection matters, but the human system around the software determines whether it produces value.

Audiologists do not need to choose between professional autonomy and technological progress, a balance consistent with ADA's practice-focused professional mission. They need an adoption process that protects autonomy while testing where technology can genuinely help. That process begins by taking resistance seriously.

The practice owner's job involves creating conditions where clinicians can examine a tool without surrendering judgment, patients can understand its role, and the practice can reject uses that fail its standards. Treating skepticism as design intelligence turns resistance into a safeguard and adoption into a professional decision.

Adapted from: *The Psychology of AI Adoption at Work: From Resistance to Results* (Georgetown University Press, 2026).

Dr. Gleb Tsipursky, a behavioral scientist called the "Office Whisperer" by *The New York Times*, helps tech-forward leaders stop overpaying for AI while boosting engagement and innovation. He serves as the CEO of the AI consultancy Disaster Avoidance Experts, and wrote eight books, including *The Psychology of AI Adoption at Work: From Resistance to Results* (Georgetown University Press, 2026). ■

AVOIDING THE CURSE OF BIGNESS

with Dr. Tiffany Inman

Who doesn't like the occasional trip to Costco, or enjoying their favorite caffeinated beverage at Starbucks? Easy to find, predictable and big. Big in the sense that they are just about everywhere. Big in the sense that the individual is often swallowed whole by the corporate chieftains who are looking to maximize profit and efficiency. Supreme Court Justice Louis Brandeis, more than 100 years ago, wrote about the curse of bigness. Brandeis believed that when businesses grew beyond a certain scale, they stopped being efficient and instead became bureaucratic, wasteful and disconnected from the people they service. Regarding their disconnectedness, there are plenty of examples in the delivery of hearing care services that reflect how size and scale can be a curse – a curse for both employees and customers.

THIS INTERVIEW WITH DR. TIFFANY INMAN IS THE ANTIDOTE TO THE CURSE OF BIGNESS. READ HOW THIS SO-CALLED "SMALLTOWN GIRL" STARTED HER OWN PRACTICE FROM SCRATCH AND HOW SHE MAINTAINS A CLOSE CONNECTION WITH HER COMMUNITY.



Q Brian Taylor (BT): Tell us a little about yourself. Where did you grow up? What influenced you to get into audiology?

A Dr. Tiffany Inman (TI): I grew up in a small farming town in Michigan with a single stoplight. When I was growing up, we lived with my grandparents, and they were my favorite people. My grandparents attended all my sporting events and school concerts and were deeply involved in my life. What we didn't know was that my grandpa had a rare condition called temporal bone encephalocele. His middle ear was slowly disintegrating, and he was losing his hearing. My family couldn't afford many things, let alone surgery and hearing aids. I saw my favorite person pull away from family and friends. Seeing his larger-than-life personality start to become small was the main motivation for working in healthcare and audiology. I wanted to give people the opportunity to stay connected to their favorite people. My grandpa is now my favorite patient, and I have been able to buy him a few new sets of hearing aids over the years and get him the surgery he needed to remake his middle ear.

Q BT: Tell us about your practice. How did you start it? When did it open?

A TI: I opened Inman Audiology in July of 2020 after being furloughed from a large industry organization. I knew I wanted to run my own practice and when student loan payments got paused, I took that money and took the leap. I started without business loans because at that point, banks and manufacturers didn't want to give a loan to someone who had never owned a practice before. So, I opened on a shoestring budget and didn't look back. Without loans, I was profitable with no debt, within the first few months.

Q BT: Tell us about the community you serve. Where is it located? What is notable about your community?

A TI: My practice is located in Oakland County, Michigan. The clientele I work with are primarily working age adults who are looking for white glove service, and support. We see a large number of patients with sound sensitivity disorders and specialize in tinnitus. Most audiology clinics see geriatric populations, and I do, too. However, in my area health is wealth and we see patients early in their journey and at a much younger age than the typical clinic. My patients want to stay on top of their health and tend to be more proactive.





I knew I wanted to run my own practice and when student loan payments got paused, I took that money and took the leap.

Dr. Tiffany Inman



Map courtesy of Maps of the World. <https://www.mapsofworld.com/usa/states/michigan/counties/oakland-county-map.html>

Q BT: Tell us about your staff. How many staff? What is their role?

A TI: My team has five members in total. Like most private practices, I was alone in the office for a while. After 10 months I hired my first employee, Bailey. She started as a PCC and is now an HI-S. She primarily does the office billing and clinical administrative duties. She has been with me for nearly 6 years now. Since then, I have been fortunate enough to add Dr. Tim Maxwell as a clinical audiologist and tinnitus

specialist, Fatma as an audiology assistant, and Bridget as my Patient Care Coordinator. They are vital members of Inman Audiology, and I could not do my job without them. After many missteps with hiring, I am now very diligent in my hiring practices. I have high expectations of my staff, but I offer high levels of support for them.

My practice emphasizes evidence-based care and best practices, so I make sure to have multiple assistants helping us do the things that you don't need to be an audiologist to do. They are the best parts of my office and do a beautiful job conveying the values of the practice.

Q BT: Take us through a typical week in your practice. What types of services do you provide? How do you divide your time seeing patients and doing administrative work? How much managed care or third-party business do you have?

A TI: My office does not see third-party patients. I made this decision January of 2025 when the administrative hours it was taking to see those patients no longer justified the amount we were being paid. We also did not feel like we were able to provide third-party patients with the same level of care as private patients and that didn't sit right with me. So, rather than just turning all my third-party patients away, I have worked with another local audiologist who can take third-party patients, and I refer them to her. Most patients stay with me, but I am happy knowing that the ones who need to leave to use their benefit, are getting great audiological care.

My average week is patient care Monday, and Wednesday through Friday, and Tuesday is clinical administration. Between Dr. Maxwell and I, we see 10-14 new evaluations per week and spend the rest of the time on follow up care, trainings, and cerumen removals.

We provide comprehensive audiological testing and treatment, including auditory rehabilitation services as well as sound sensitivity disorder testing and treatment, cerumen removal, custom hearing protection and cochlear implant evaluation and programming. When working with sound sensitivity disorders I found it vital to have resources in the community. For example, I have a local CBT therapist that sees my patients, as well as a neurologist and a sleep specialist. I am also working on finding or hiring an OCD specialist to work in my clinic.

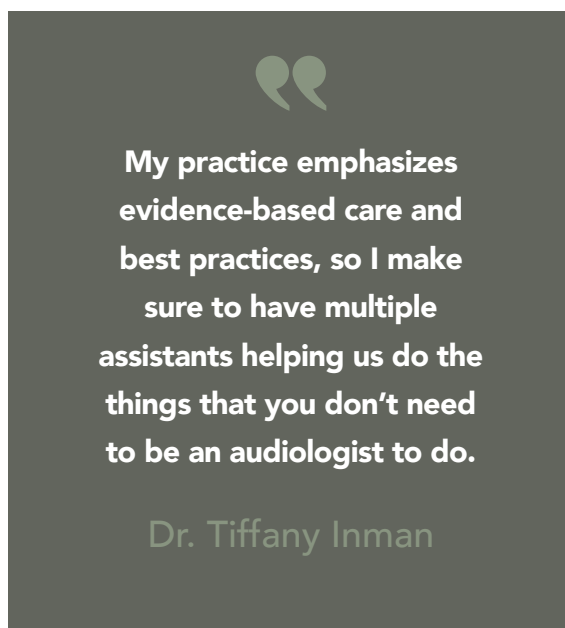
Q BT: How do you market your practice? What marketing tactics seem to be most effective?

A TI: We market in a few specific ways. Primarily, we send great reports back to referral sources and follow up with their referred patients' outcomes. I want the doctor who referred their patient to my practice to know that I value how they have integrated conversations about hearing healthcare into their practice and I want them to know the difference they are making for their patients. I also send out either my audiologist or assistant to drop off treats monthly. Importantly, I send the same treat every time. This way, whenever they see this brand of cookie, or this brand of snack, they know it is our office, even if we didn't get time to say hello.

I have also found success with hyper-local newspapers and social media. I make sure to post every single day. I split my posting between funny personality driven content and informative posts.

Q BT: Describe one or two things you do in your practice that make you different or unique?

A TI: We use best practices and we don't cut corners; we market that to patients and they respond to it. We also offer white-glove service, and that is something patients will not get at a big box or franchise store. In my practice we use a combination of bundled and unbundled services. This means that we can maintain profitability while also offering these services to patients without them feeling like they are being nickel and dimed.



Something unique to my practice is my employees. They are highly trained and highly educated. They all reflect Inman Audiology in all interactions with patients. From the first phone call to their checkout experience, every touch point will have the same level of care and kindness.



Dr. Timothy Maxwell
Inman Audiology

Fido

10:49

Friday, May 1

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TOM TOM BAKER

Q BT: How do you see the profession of audiology evolving over the next decade?

A TI: I am passionate about seeing audiologists fight for an expanded scope of practice. We are the experts of the ear, and we understand the complexities of hearing in a way that no other profession does. We hear all the time that ENTs tell our patients that nothing can be done about their tinnitus, or that all hearing aids are the same, so they send their patients to Costco. Of course they do; they are not educated on hearing and the auditory system in the way we are. We need to take our profession and make it into what it can be. We can only do this by working at the top of our scope of practice and fighting for our rightful place among other doctoral level clinicians.

Q BT: What are the biggest challenges you face as a small business owner?

A TI: My biggest challenge isn't what I thought it would be. My biggest and most difficult to manage issue is the amount of time it takes to maintain a business, while working for the business. I am my most expensive employee, and taking time away from the practice is difficult. Once your practice gets large enough, you need to spend more time away from it. When patients are used to seeing you, it can make the transition difficult. I could easily spend 4-5 full days on running the practice and being the boss, but I need to balance that with seeing patients and bringing in revenue. Making the decisions on when to step back and when to step in is the hardest part of owning my business.

Q BT: What are the biggest rewards?

A TI: Every day I get to come to a job where I can work using my core values and create a space for my patients, my staff and my community are put first. If you lay a strong foundation, you can employ other people who share your same passion. The core values at Inman Audiology are at the center of what we do. Seeing patients walk in our doors knowing that they are looking for the highest level of care and knowing that my staff and I are going to deliver that is a big reward.

Q BT: What advice do you have for aspiring practice owners?

A TI: Do it! There is no reason to not be in private practice. We get as much business training as any other doctor and yet we hold ourselves back. If you can be working just as hard for yourself rather than an ENT, but making all the profit, why wouldn't you? Who benefits from telling us that we won't get patients without the built-in referral source of the ENT? The ENT does, the hospital system does, other people do. I promise you there are patients that need to be seen and you will be busy. Patients will get better care when your time is not dictated by another professional's schedule. I didn't start marketing for my first two years; all my growth was organic from patients finding me while looking for alternatives. Start small and smart, be diligent and operate ethically. Most audiologists would be better served in a private practice setting than any other, and we know that patients are better served as well.

Dr. Inman can be reached at tiffany@inmanaudiology.com. ■



Sound Check

CLINICAL BULLETIN #9



The 18-item Revised Hearing Handicap Inventory (RHHI)

Brian Taylor, Au.D.

Following a laborious process, the National Academy of Science Engineering and Medicine (NASEM) recently recommended the RHHI as one of three meaningful outcome measures audiologists should use in their clinics to gauge the success of their treatments. The other two are the Words in Noise (WIN) test and the 24-item Abbreviated Profile of Hearing Aid Benefit (APHAB). Here we discuss the 18-item RHHI and how it can be readily implemented in the clinic. As the NASEM report clearly outlines, audiologists can implement the RHHI as a reliable, low-cost outcome metric in various settings and use it pre- and post- treatment measures to provide more targeted patient counseling.



Dillard, Matthews, and Dubno (2023) examined whether a person's self-reported hearing difficulties, measured with the Revised Hearing Handicap Inventory (RHHI), predicts hearing aid use as well as the traditional pure-tone average (PTA) hearing test. The researchers also identified score thresholds on each measure that best distinguish hearing aid users from non-users. They found that the Revised Hearing Handicap Inventory (RHHI) and pure-tone average (PTA) are equally effective at predicting hearing aid usage, with optimal cut points of ≥ 6 on the RHHI and ≥ 32.5 dB HL for 4-frequency PTA. Consequently, the study suggests that combining these objective and subjective tools increases predictive accuracy, offering clinicians a robust method for identifying candidates for hearing aid adoption. Using both measures together (RHHI and PTA) improved prediction more than either measure alone, suggesting that objective hearing loss and perceived hearing difficulties each contribute unique information.

When administering the RHHI score ranges from 0 to 72, with each item scored:

Yes = 4

Sometimes = 2

No = 0

Following intervention, when the RHHI is re-administered (say, at 6 weeks post hearing aid fitting) the patient score should be, minimally, 6 points better (lower score post-treatment) than the pre-intervention score. This would serve as evidence that the treatment has real-world benefit.

Clinicians are encouraged to copy the RHHI found in this article and administer it before and after intervention. Also, a growing number of entities are creating smartphone apps with the RHHI embedded in it (e.g., Lace Pro from Neurotone). Audiologists should also ask their office management software vendors to include the RHHI so that scoring can be done automatically.



Clinical Implications

- The 18-item RHHI is as effective as an audiogram for identifying people who are likely to use hearing aids and other forms of treatment.
- A post-intervention score of 6 or better (lower score denotes improvement) serves as documentation of real-world benefit.
- Because the RHHI is inexpensive, quick to administer, and does not require specialized equipment, it may be useful in:
 - Primary care settings
 - Community hearing screenings
 - Telehealth or remote hearing assessments

References

Dillard, L. K., Matthews, L. J., & Dubno, J. R. (2023). The Revised Hearing Handicap Inventory and Pure-Tone Average Predict Hearing Aid Use Equally Well. *American journal of audiology*, 33(1), 1–10. https://doi.org/10.1044/2023_AJA-23-00213

National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Meaningful Outcome Measures in Adult Hearing Health Care. Measuring Meaningful Outcomes for Adult Hearing Health Interventions. Washington (DC): National Academies Press (US); 2025 Jul 22. Available from: https://www.ncbi.nlm.nih.gov/books/NBK614264/?utm_source=chatgpt.com doi: 10.17226/29104

Clinicians are encouraged to copy the RHHI (right) and administer it before and after intervention.

Revised Hearing Handicap Inventory (RHHI)

Instructions: The purpose of this scale is to identify the problems your hearing loss may be causing you. Answer YES, SOMETIMES, or NO for each question. Do not skip a question if you avoid a situation because of your hearing problem. If you use a hearing aid, please answer the way you hear without the aid.

	YES (4)	SOME- TIMES (2)	NO (0)
1. Does a hearing problem cause you difficulty when listening to TV or radio?	___	___	___
2. Does a hearing problem cause you difficulty when attending a party?	___	___	___
3. Does any problem or difficulty with your hearing upset you at all?	___	___	___
4. Does a hearing problem cause you to feel frustrated when talking to members of your family?	___	___	___
5. Does a hearing problem cause you to feel left out when you are with a group of people?	___	___	___
6. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	___	___	___
7. Do you feel handicapped by a hearing problem?	___	___	___
8. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	___	___	___
9. Does a hearing problem cause you to feel uncomfortable when talking to friends?	___	___	___
10. Does a hearing problem cause you to avoid groups of people?	___	___	___
11. Does a hearing problem cause you to use the phone less often than you would like?	___	___	___
12. Does a hearing problem cause you to be nervous?	___	___	___
13. Does a hearing problem cause you to listen to TV or radio less often than you would like?	___	___	___
14. Does a hearing problem cause you to talk to family members less often than you would like?	___	___	___
15. Does a hearing problem cause you to want to be by yourself?	___	___	___
16. Does a hearing problem cause you to feel depressed?	___	___	___
17. Does a hearing problem cause you to visit friends, relatives or neighbors less often than you would like?	___	___	___
18. Does a hearing problem cause you to go shopping less often than you would like?	___	___	___

FOR CLINICIAN'S USE ONLY: Total score: _____

Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist

By Emilie Vos, Doctor of Audiology, Hearing Solutions, Downtown Toronto; Director, Canadian Academy of Doctors of Audiology

My grandfather Arie immigrated to Canada from the Netherlands after the Second World War with almost nothing and built a life on warmth, humour, and devotion to his family. He was the loudest person at every table, and the one who remembered your stories back to you.

The retreat was gradual enough that nobody named it. He began asking people to repeat themselves, then stopped asking. He moved to the quiet end of the table, then the edge of the room, then found reasons not to come. What looked like a personality settling into old age was a man running arithmetic none of us could see: the effort of a conversation he could no longer follow, against the embarrassment of answering the wrong question. Silence was cheaper, so he chose silence.

Then came dementia, and then Alzheimer's disease. We watched him deteriorate. It was only as that decline continued that anyone in our family thought to have his hearing checked.

By then it was nearly too late. He would not wear the hearing aids. The most connected person I had ever known had become difficult to reach, and we had arrived years after it could have mattered most (see Figure 1).

Long before I knew the word "audiologist," I watched my grandfather, Arie, lose pieces of the world around him: conversations, confidence, connection.

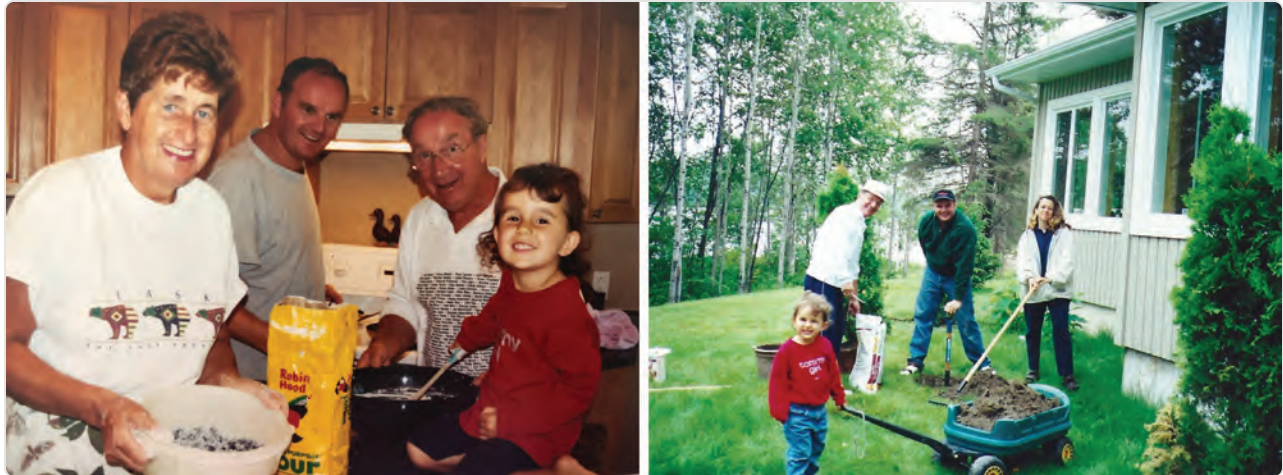


Figure 1
The Family Connection Behind My Career in Audiology

Note. Childhood photographs of Emilie Vos with her family: making blueberry pancakes with her grandfather, grandmother, and father (left), and planting trees in northern Quebec, where her mother's family is from, with her grandfather, father, and mother (right). Her grandfather's hearing loss and her grandmother's experience with tinnitus helped inspire her career in audiology and her commitment to helping families stay connected. Personal photographs courtesy of Emilie Vos.

I became an audiologist because of that sequence, and because it is the wrong sequence. Hearing loss should not be what a family investigates after cognitive decline has taken hold. It should be found and treated early, while it can still protect connection, confidence, and cognition. My grandfather did not lack access to audiology. Nobody around him, including a family that loved him, had a reason to think of it in time.

That is the part I want colleagues to sit with. Audiology occupies an unusual position in medicine: we intervene on one of the few modifiable risk factors for dementia, and the intervention itself restores the thing whose loss does the damage. Slowing the narrowing of somebody's world and returning them to the table they used to sit at is a rare clinical privilege. It is also worth nothing to the patient who never finds us.

This article is about visibility rather than clinical technique. It is not an argument for audiologists becoming influencers, and nothing here will suggest you chase follower counts or treat patients as material. It concerns something older than social media: how patients decide whom to trust with their hearing, their family's hearing, and their cognitive health as they age.

The first appointment now happens without you

For most of our history that trust was built inside the four walls of a clinic. You did good work, patients told their friends, and the friends called your front desk. That still happens, but it is no longer the whole story. Before a patient calls your office, they have almost certainly looked you up. Recent national survey data confirms what we see in our waiting rooms. The vast majority of Americans still turn to health care providers first, but 36% now get health information from social media at least sometimes, 22% from AI chatbots, and half say it is at least somewhat difficult to know whether the health information they encounter is accurate (Pew Research Center, 2026a; see Figure 2). A separate Pew analysis found that 40% of U.S. adults, and half of those under 50, get health and wellness information from social media influencers or podcasts (Pew Research Center, 2026b).

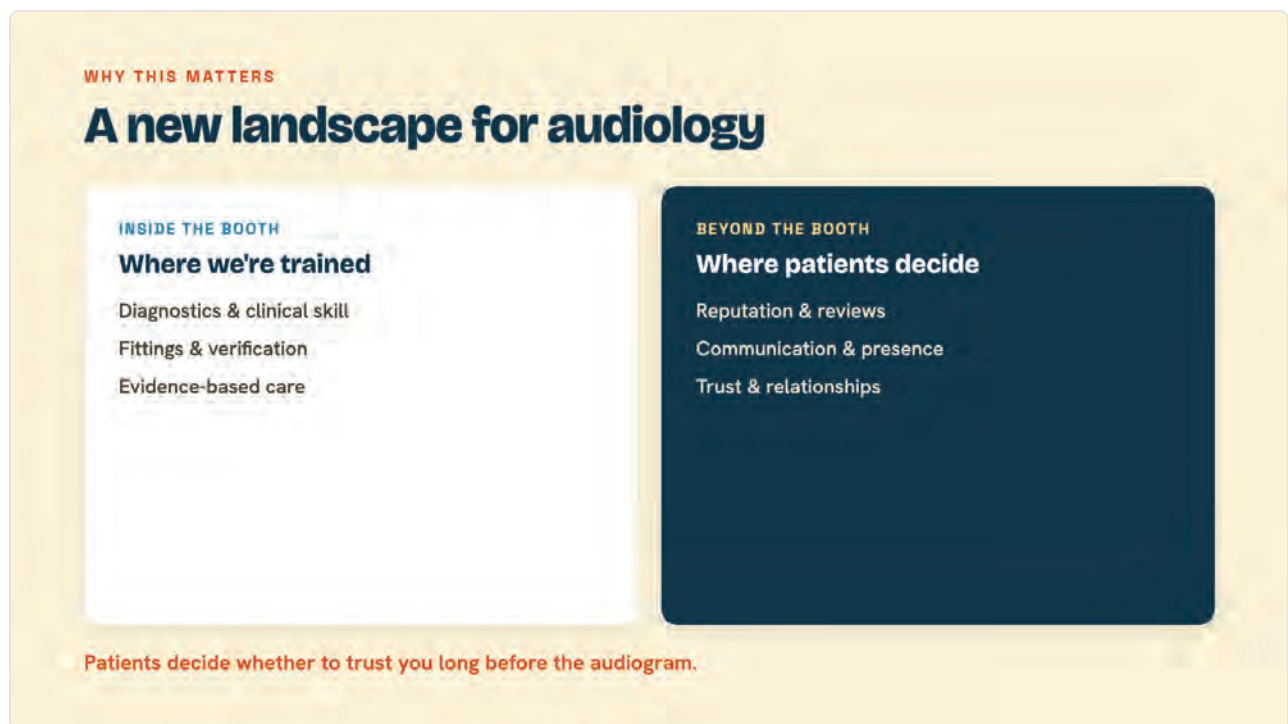


Figure 2

A New Landscape for Audiology

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15–17, 2026.

The implication is uncomfortable. Patients form an opinion of your competence before they have ever sat in your chair, assembled from whatever fragments of you are visible alongside a great deal of material produced by people with no clinical training. Whether we participate is optional. Whether it happens is not.

What professional visibility actually means

The word branding makes clinicians uncomfortable, so let me define it in terms our profession can use. Professional visibility is not self-promotion, follower counts, or performance. It is clarity about who you help, evidence of the expertise behind the claim, and enough consistency that a patient or referring physician recognizes you (Figure 3).

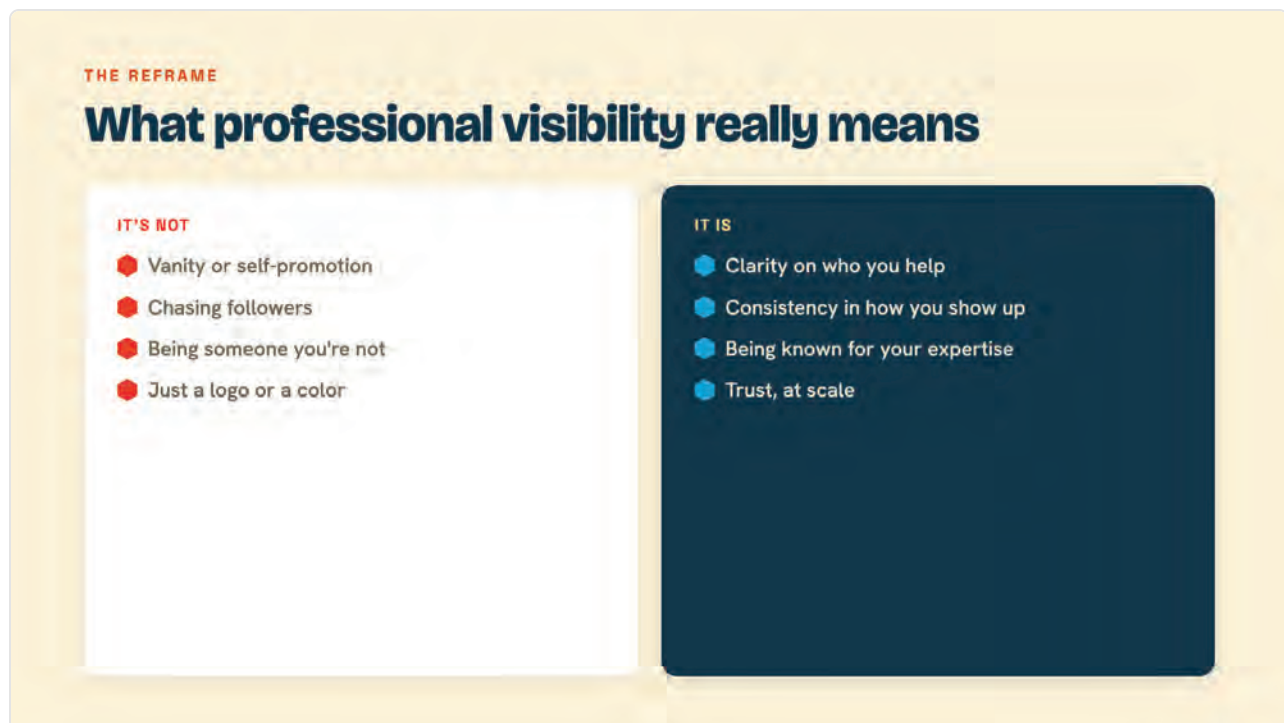


Figure 3
What Professional Visibility Really Means

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15-17, 2026.

Read that way, visibility is an extension of patient education, not a departure from it. The explanation you give four times a day in a sound booth reaches four hundred people when you record it once. The clinical content does not change; only the number of people who

hear it does.

Three things have to overlap for any of this to work (Figure 4). Expertise without visibility is a well-kept secret. Visibility without authenticity is noise, and audiences detect performance quickly. Authenticity without expertise is charming until it is wrong, and in healthcare somebody else bears the cost of being wrong. Remove any one circle and the whole thing collapses.



Figure 4

The Personal Brand Formula

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15–17, 2026.

The chain runs in order: visibility produces education, education builds trust, trust enables earlier presentation, and earlier presentation produces better outcomes (Figure 5). Every link belongs to the patient, the physician, and the community rather than to the clinician, which is the honest test for anything you publish. Content that serves nobody down that chain is promotion wearing an educational costume, and patients can tell.

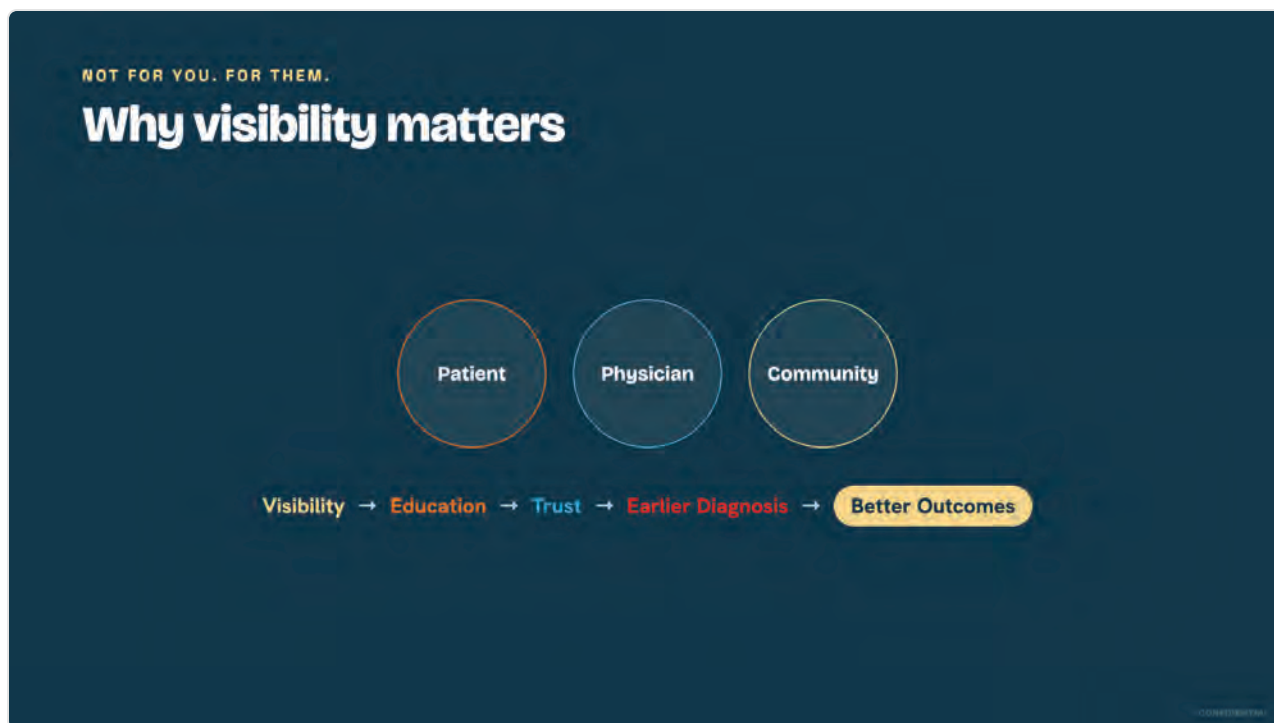


Figure 5

Why Visibility Matters

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15-17, 2026.

Patients do not choose the best clinician

Patients don't choose the best clinician. They choose the one they trust.

This is the line I keep returning to, because it is uncomfortable and true. Trust is not one quality either. It breaks into credibility, meaning you know your subject; reliability, meaning you show up consistently; and connection, meaning a patient feels like a person rather than a file. Expertise earns the first. Only visibility earns the other two at scale (Figure 6). Put another way: expertise plus communication plus visibility equals trust (Figure 7). Every clinician reading this has spent years on the first term. Expertise nobody sees is very hard for a patient to choose.

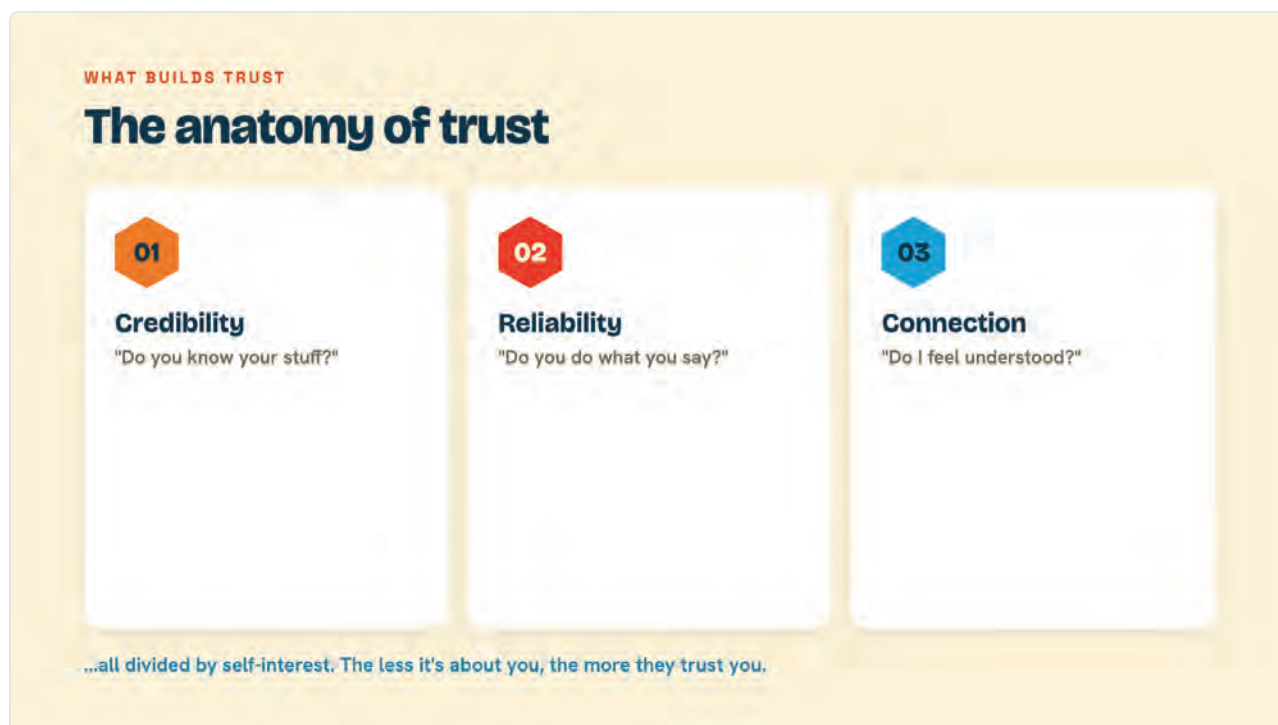


Figure 6

The Anatomy of Trust

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15-17, 2026.

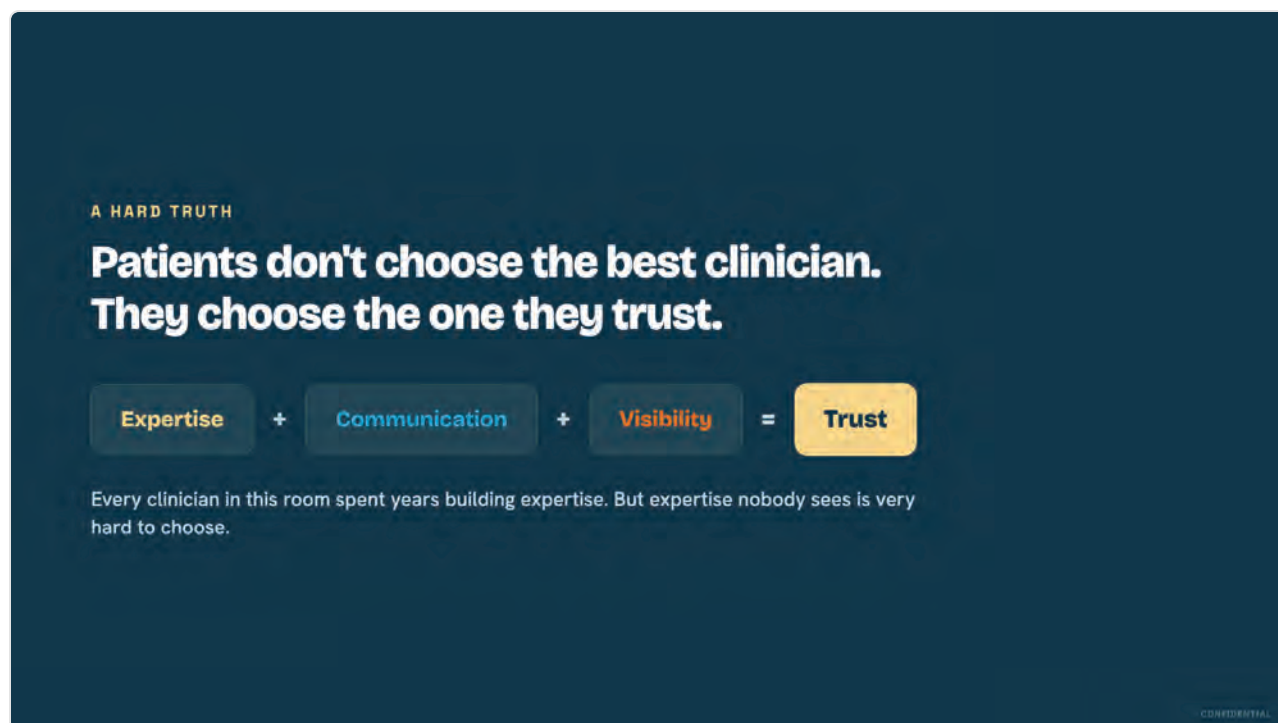


Figure 7

The Trust Equation

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15–17, 2026.

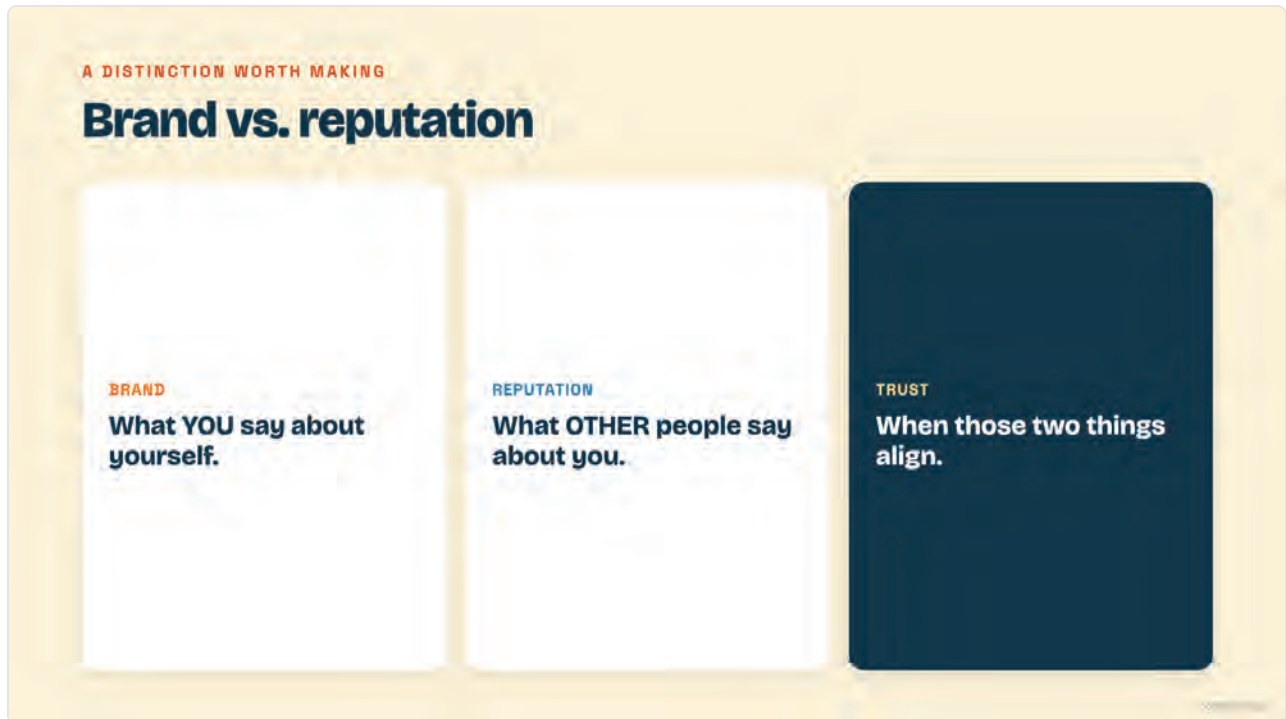


Figure 8

Brand, Reputation, and Trust

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15–17, 2026.

It is worth being precise about the terms (Figure 8), because clinicians use them interchangeably and they are not the same. Your brand is what you say about yourself. Your reputation is what other people say about you when you are not in the room. Trust is what exists when those two things align. We control the first almost entirely and the second barely, and the first shapes the second over time.

Most colleagues resist what follows: you already have a brand. Patients are forming an impression right now at every touchpoint you own, several of which you have never audited. Your Google reviews. Your website. Whoever answers your phone. Your waiting room. What

a colleague says about you at a dinner party. The only question is whether you are shaping any of it. None of this replaces clinical excellence; it sits on top of it. But a brilliant clinician who is invisible is, to a growing number of patients, indistinguishable from a mediocre one.

The cost of staying invisible

Consider the cost of invisibility, where the literature is blunt. Hearing aid uptake among adults with clinically significant hearing loss remains strikingly low, with fewer than one in five of those who could benefit actually using amplification (Chien & Lin, 2012). Help-seeking is slow even among those who act, with delays commonly measured in years rather than months (Simpson et al., 2019).

Meanwhile the case for intervening has only strengthened. Hearing loss is associated with incident dementia in a dose-dependent fashion (Lin et al., 2011); the Lancet standing Commission's 2024 report retains it among the modifiable risk factors that together account for an estimated 45% of dementia cases worldwide (Livingston et al., 2024); and the ACHIEVE trial found that hearing intervention slowed cognitive decline over three years in older adults at elevated risk (Lin et al., 2023). We are no longer arguing that hearing care matters. That argument is settled.

If the evidence is this strong and uptake this poor, the bottleneck is not clinical knowledge. It is communication. Staying invisible is not a neutral choice; the cost is paid by families who book the hearing test only after the decline has started.

This is also no longer a fringe position. In January 2026, Castle Connolly, the physician-ratings organization behind the Top Doctors network, published its first list of Top Doctor Influencers, recognizing credentialed physicians for translating complex medical topics into clear, accurate information rather than for chasing trends (Castle Connolly, 2026; see Figure 9). The profession that guards its credibility most jealously has begun formally recognizing clinicians for public education. Credibility matters just as much online as it does in the exam room.

THIRD-PARTY VALIDATION

You're in good company

Castle Connolly — the trusted physician-ratings organization behind the Top Doctors network — named its first **2026 list of Top Doctor Influencers**: credentialed physicians using social media to educate, not to chase hype.

WHAT EARNED THE RECOGNITION

Translating complex medical topics into clear, accurate information — without relying on hype or trends.

WHY IT MATTERS TO US

The industry is actively recognizing clinicians for exactly what we're talking about today — visibility built on real expertise.

Credibility matters just as much online as it does in the exam room.



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Figure 9

You're in Good Company

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15–17, 2026.

I did not start with audiology content

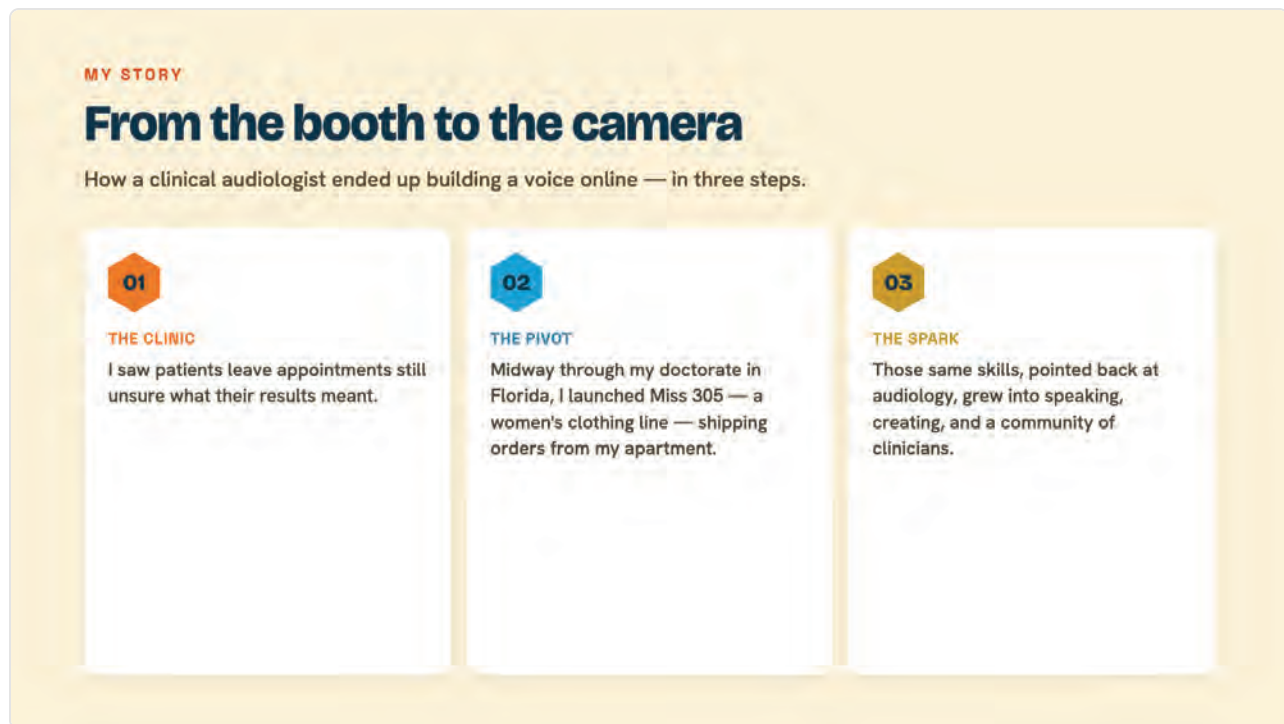


Figure 10

From the Booth to the Camera

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15–17, 2026.

Midway through my doctorate in Florida I launched a women's clothing line called Miss 305, shipping orders from my apartment between classes. I was, functionally, a fashion content creator (Figures 10 and 11).

THE MECHANISM, NOT THE LUCK

How it actually started

- 1 On a campaign shoot for Miss 305, the photographer told me I should be the one modeling the clothing — not just running things behind the scenes.
- 2 I stepped in front of the camera — posting myself wearing pieces from the brands I was retailing, and hiring other influencers for the campaign.
- 3 Other brands started reaching out to me, unprompted — so I started pitching deliberately.



This wasn't luck. It's a repeatable mechanism — anyone in this room can do it.

Miss 305 eventually closed — but I kept creating, and that's what carried into everything I do today.

Figure 11

Where My Personal Brand Actually Began

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15-17, 2026.

The line closed. The skill set did not. I learned how to hold attention, how to speak to a camera without stiffening, and how to stay consistent when nobody was watching. None of it appeared in my doctoral curriculum, and all of it turned out to be the same skill set I now use in the clinic: holding the attention of a frightened patient, and making the case to the adult child who thinks the appointment is unnecessary.

One lesson matters more than the rest. What grew that audience was not posting my own pieces; it was posting the other brands I was sourcing and genuinely liked. Being useful about someone else's product built more trust than promoting my own ever did (Figure 12), which is this article's argument arriving years before I understood it.

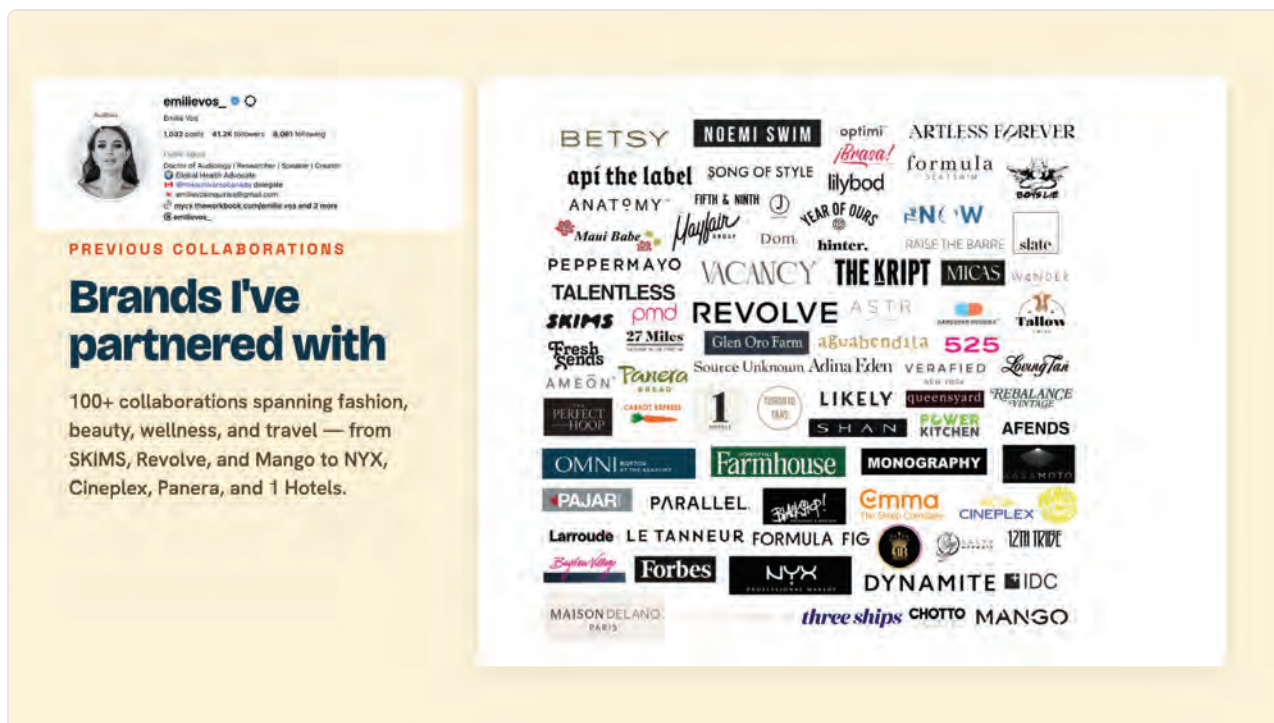


Figure 12

Brand Collaborations Preceding My Clinical Visibility

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15–17, 2026.

Nothing about this appeared overnight. It evolved, slowly, out of repetition.

Start with your pillars

Content pillars are the recurring themes your presence lives inside, so anyone who encounters you understands what you are known for. Without them, accounts drift into whatever feels urgent that week, and ambiguity is the enemy of referral.

Five work well in our field. **Educate**: how hearing works, and the myths patients arrive holding. **Connect**: the experience of care, described at the population level, so a reader recognizes their situation without any patient appearing in it. **Humanize**: the clinic behind the clinician. **Your niche**: the one subject you go deeper on than anyone else in your market, whether tinnitus, pediatrics, musicians, or cognition. **Lead**: where the profession is heading, and what our field should be arguing about in public.

My own five run wider: expertise and credibility, wellness and self-care, travel and lifestyle, creative work, and personality and real life. Only the first is strictly clinical, and that proportion is deliberate. Our profession carries an unspoken expectation that a serious clinician should present as nothing but a clinician. I have never fit in one box and no longer try to. Intelligence, ambition, wellness, creativity, and femininity can coexist in one professional identity, and flattening yourself into the clinical dimension does not make you more credible. It makes you forgettable, and forgettable clinicians do not get referred (Figure 13).

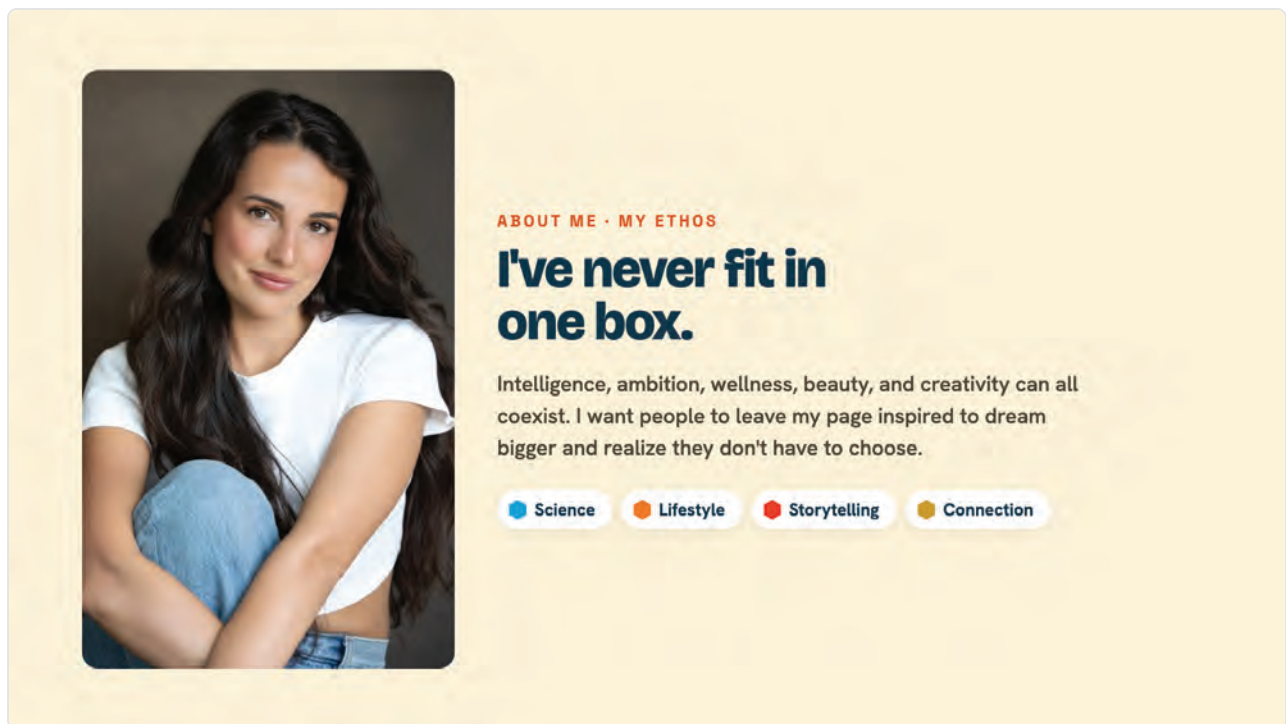


Figure 13

Why I Do Not Present as a Clinician Alone

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15–17, 2026.

"I could talk about science all day, every day, but people also want to know who you are as a person." —Rupa Juthani, MD (Castle Connolly, 2026)

The personal material is not a detour from the science. It is what earns a patient's willingness to hear the science at all.

The niche pillar outweighs the rest combined. General audiology content is interchangeable; depth in one area is what makes a physician remember your name when a particular patient walks in (Figure 14).

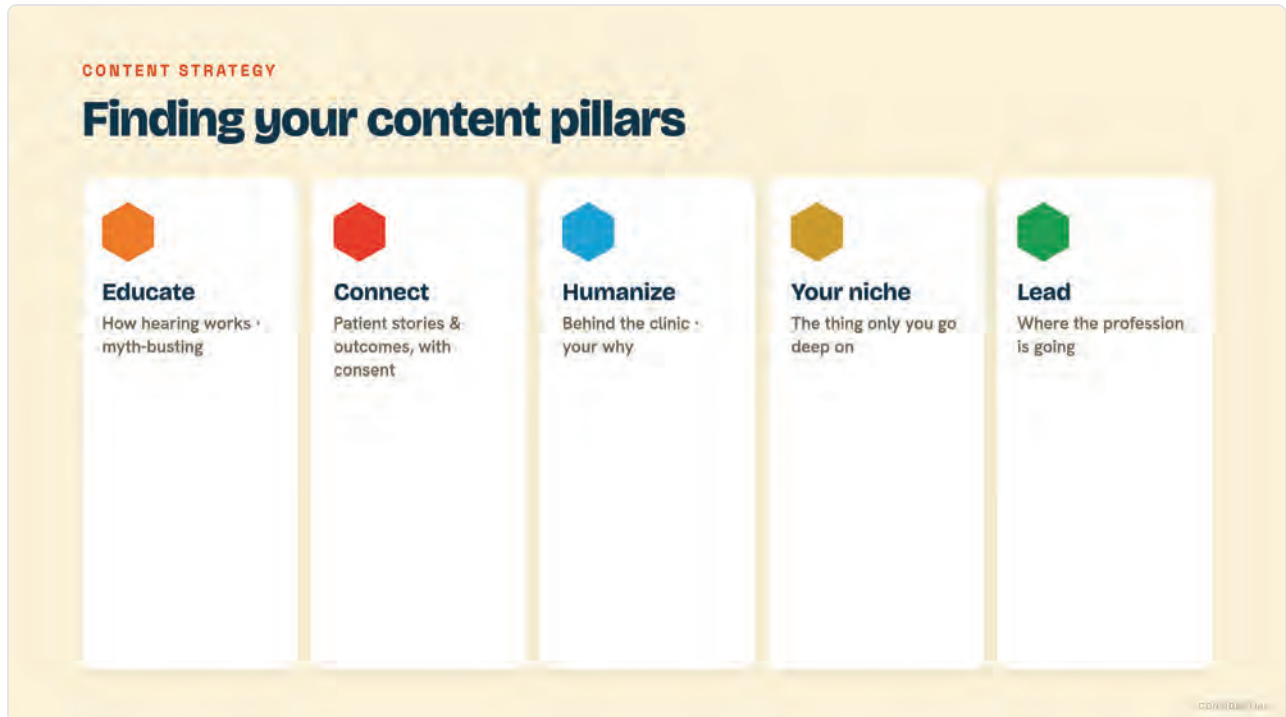


Figure 14

Five Content Pillars for a Clinical Practice

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15–17, 2026.

They ask, you answer

"They Ask, You Answer" is a philosophy developed by Marcus Sheridan, who used radical transparency about costs, problems, and competitors to save a failing business during the 2008 recession (Sheridan, 2019). The premise: identify the questions your patients are actually asking, and answer them more honestly than anyone else in your field is willing to.

In hearing healthcare that means answering what patients type into a search bar before they call. What hearing aids actually cost. The real difference between technology levels. Whether over-the-counter devices are right for them. Why a parent refuses to wear the devices

already in a drawer. Several of these make our industry visibly uncomfortable, which is exactly why answering them well is an advantage. The clinician willing to publish a straight answer about price will out-earn the one who makes patients call to ask.

One ratio is worth holding: educate first, promote rarely. Roughly nine parts education to one part promotion, with the promotion landing inside a relationship everything else has already built.

What this looks like in practice

A patient sat down recently and mentioned, unprompted, having booked after hearing me on a podcast. No advertisement, no referral, no directory listing. Twenty minutes of listening to me talk about hearing was enough to decide who to see, which is what that 40% figure looks like from inside a clinic. That episode cost an afternoon and it is still working (Figure 15).

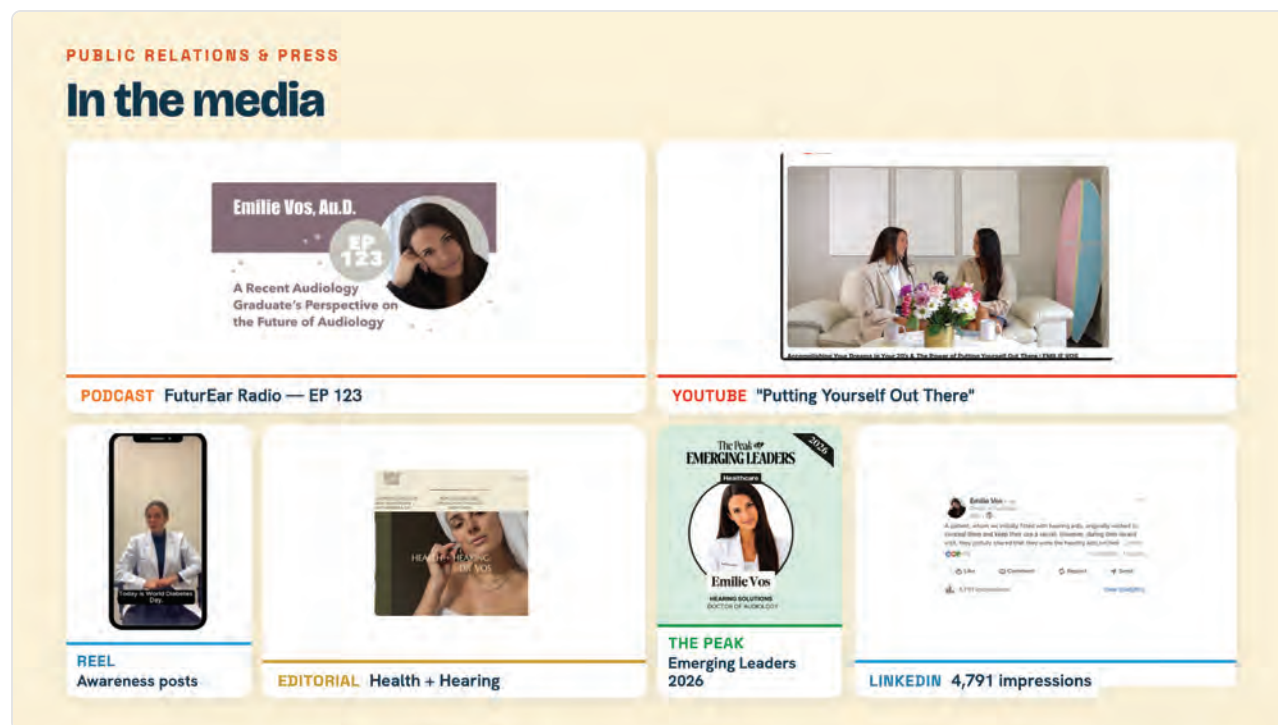


Figure 15

Visibility in Practice: Press, Podcasts, and Professional Platforms

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15-17, 2026.

The more significant example is professional. Several of my most valuable physician relationships began online rather than across a conference table. A physician sees a well-explained post, sends a message, and the relationship starts from mutual respect rather than a cold introduction. Over time that becomes a referral pipeline I never had to ask for.

LinkedIn deserves specific mention. It is not a platform of clinicians talking to clinicians; it is full of working professionals, many of whom manage, employ, or live with someone who has untreated hearing loss, and any one of them can become a referral source. Three things make a profile work: a recent professional headshot; a title of three or four words matching your actual credential rather than a string of letters; and a few real outcomes in place of your CV pasted in full.

In my experience, the platform where referral sources actually spend their working day is the one our profession thinks about last.

Doing this without compromising anything

Visibility and professionalism are frequently framed as opposites. They are not, but the boundary requires deliberate attention. Three rules have served me well.

First, patients are never content. Consent to treatment is not consent to publication, and a verbal yes in the exam room is not informed consent to appear online. That requires separate, specific, written, revocable permission obtained outside the clinical encounter, naming exactly what will be shared and where. Even then, ask whether the post needs a real patient. Almost none do.

Second, educate at the population level and treat at the individual level: online content explains how conditions generally work, it never diagnoses a commenter. Third, know your jurisdiction, because advertising standards, testimonial restrictions, and title conventions differ between regulators.

Within those constraints there is enormous room to be direct, opinionated, and useful. Being careful is not the same as being bland.

"Yeah, but..."

The same five objections surface every time I speak on this (Figure 16). They deserve answers rather than encouragement.

"I am afraid of being on camera." Your face is optional. Start with written posts, carousels, or voiceovers. Nobody requires a clinician to perform.

"I do not have time to film." Batch five clips in one slow afternoon and you have a month of posts. Most clinicians who believe they lack time lack a system.

"I never know what to say." Answer the question a patient asked you five times today. You are never short of material; you are simply not treating your clinic day as a content calendar.

"I feel like I am bragging." Sharing knowledge is service, not self-promotion. You are teaching, the same act you perform in the room, recorded once and delivered to more people.

"I post but I have no followers." One patient who books because of a post is the entire point. Followers are a lagging indicator of consistency, not a prerequisite for starting.

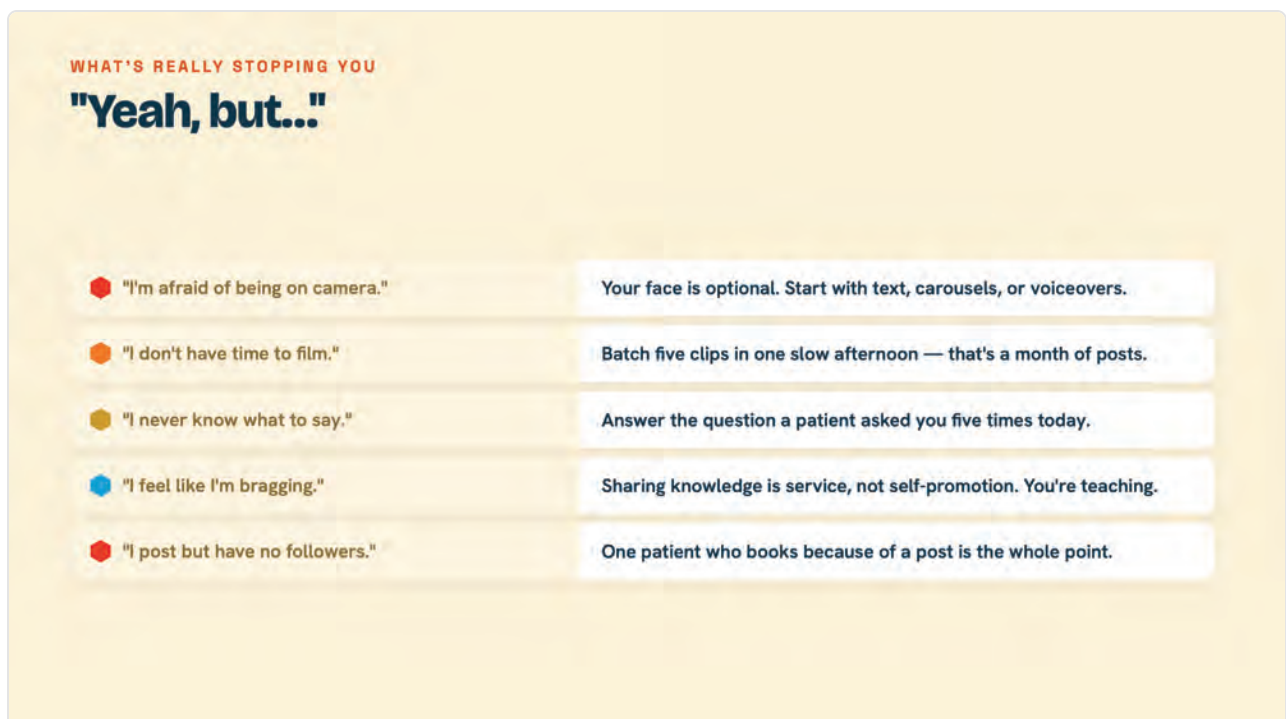


Figure 16

What Is Really Stopping You

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15–17, 2026.

Underneath all five sits the same thing, and it is rarely time and rarely skill. It is "what will people think?" Colleagues, patients, and your own inner critic stop more clinicians than any scheduling problem ever will.

That was my own largest obstacle. My biggest mistake was caring too much what other people would think (Figure 17): I believed I had to sound perfect and polished at all times, which made my content less relatable rather than more credible. What changed things was letting myself be human on camera. Vulnerability builds trust faster than perfection ever will, a sentence I would have called unprofessional a few years ago and now consider clinically useful. What works is explaining something the way I would explain it to a patient's worried adult child rather than the way I would write it in a chart note.

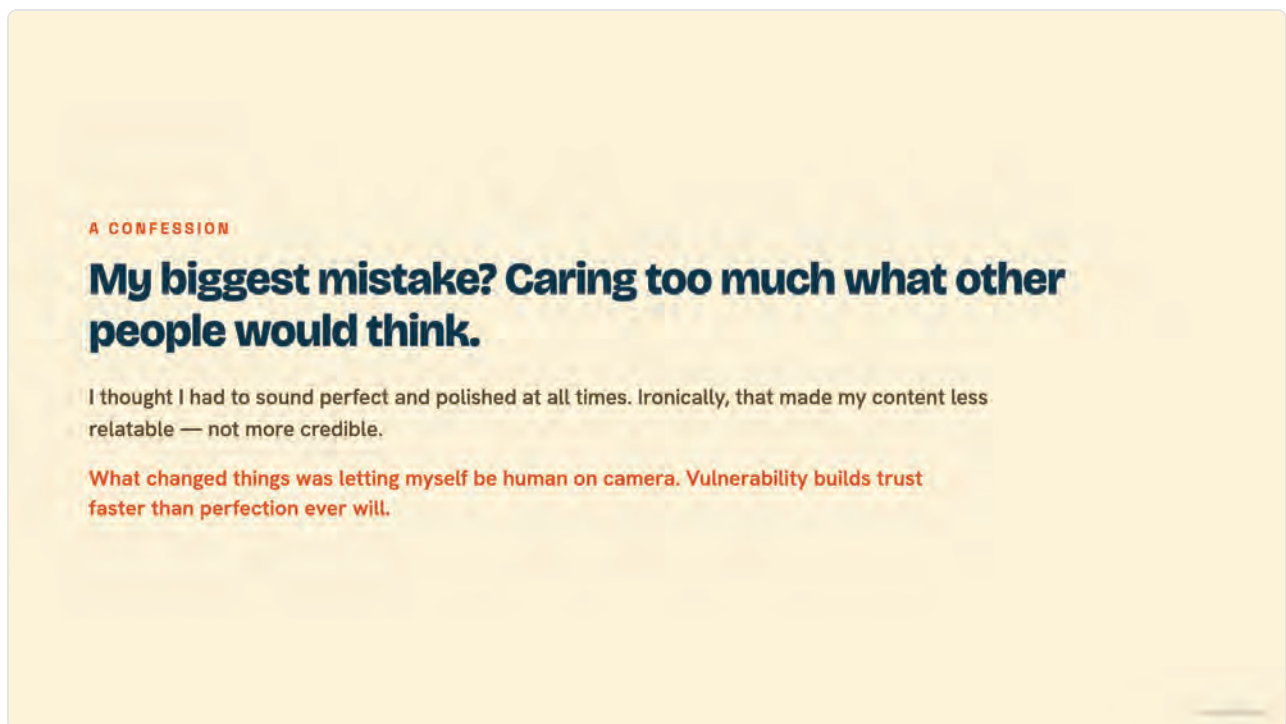


Figure 17

My Biggest Mistake

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15–17, 2026.

What artificial intelligence changes, and what it does not

One objection remains: none of this will matter shortly, because patients will simply ask an AI. I would put it the other way around. A patient can already ask a chatbot what tinnitus is and get a competent answer in seconds. That does not threaten audiologists. It threatens average information, which is a different thing.

Used well, these tools help a busy clinician: brainstorming topics from questions you already answer daily, tightening a draft you wrote yourself, generating captions and transcripts that make content accessible to the patients most likely to need it, repurposing one explanation into a post, a script, and a handout.

What does not transfer is responsibility. A language model does not know your regulator, cannot be held accountable, and will state something plausible and wrong with total confidence. Verify every clinical claim, never paste patient information into a tool you do not control, keep the words recognizably yours, and remember that accuracy is your obligation regardless of what drafted the sentence.

Generic content is now a commodity, and the differentiator has moved to judgment and relationship. AI will not replace audiologists. It will replace the clinician who was never visible enough to build a relationship, because for that patient there was nothing to choose between a search result and a person.

Three takeaways

Three things are worth carrying out of this (Figure 18).

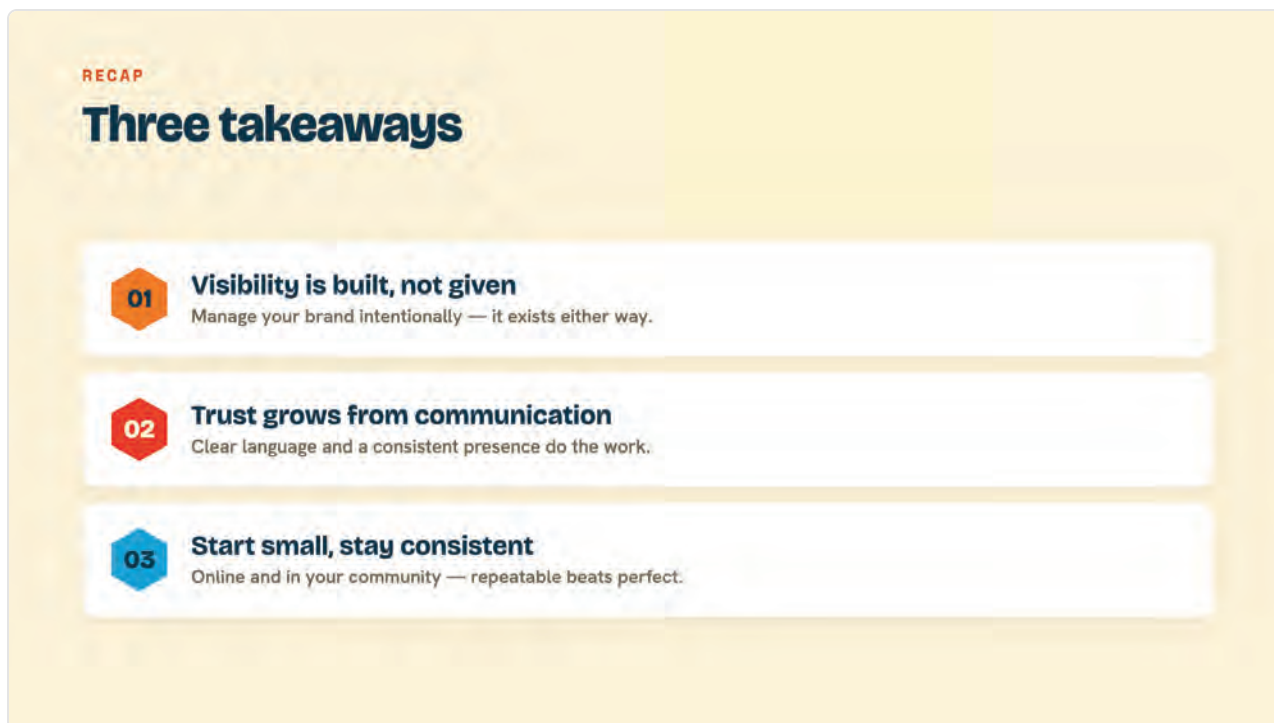


Figure 18

Three Takeaways

Note. Adapted from *Beyond the Booth: Building Visibility, Trust, and Influence as the Modern Audiologist* [Conference presentation], AudBoss Private Practice Summit, Los Angeles, CA, United States, July 15-17, 2026.

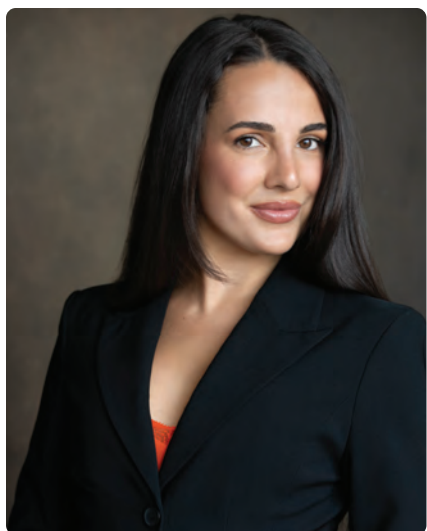
Visibility is built, not given: your brand exists whether or not you manage it. Trust is the mechanism, earned through clarity, consistency, and usefulness rather than volume. And start before you feel ready, because the only version of this that fails is the one that never begins. Google your own name and look honestly at what a prospective patient finds. Write down your pillars, then the five questions patients ask most often, in their words, and answer the first one. Then track what counts: how many new patients say they found you online when your front desk asks how they heard about you.

We spend years learning to explain hearing loss well. Visibility is the decision to let that explanation leave the room. It widens access for patients who would never have found us, educates the families who make the decisions, builds the referral relationships that sustain a practice, and puts audiologists, rather than algorithms or retailers, at the front of the conversation about hearing and cognition.

Because if you are the best audiologist in your city, but nobody knows who you are, someone else is helping the patients you were meant to serve.

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Emilie Vos, Doctor of Audiology, practices at Hearing Solutions in downtown Toronto, where her practice focuses on diagnostic care and the relationship between untreated hearing loss and cognitive health. She is a Director with the Canadian Academy of Doctors of Audiology, a published researcher, and a guest speaker. She presented "Beyond the Booth" at the 2026 AudBoss Private Practice Summit in Los Angeles, and was recently named second runner-up for Miss Universe Canada.

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ILAA Uses Time-Tested Strategies to Shepherd Ground-Breaking Legislation to Improve Transparency for Hearing Care Plans



Kim Cavitt, Au.D. and Natalie M. McKee, Au.D.

The State of Illinois recently enacted Senate Bill 2838 (SB 2838) making Illinois the first state in the nation to enact legislation specifically designed to strengthen consumer protections and improve transparency for hearing care plans also known as third-party administrators (Illinois General Assembly, 2026b).

The Illinois Academy of Audiology (ILAA) pursued SB 2838 after hearing repeated concerns from patients and audiologists about confusing hearing care plans, unclear benefit information, and unexpected out-of-pocket costs. The Academy worked with legislators and stakeholders to develop this first-of-its-kind legislation to ensure Illinois consumers have access to clear information about their hearing care benefits and can make informed healthcare decisions.



Senate Bill 2838 ensures Illinois consumers have access to clear information about their hearing care benefits and can make informed healthcare decisions.

Primary Tenets of SB2838:

- » If the hearing care plan does not cover any item or service (that means, the hearing care plan or discount hearing care plan is not paying the hearing instrument professional, in whole or in part, for the items or services outlined by the hearing care or discount plan benefit), the participating hearing instrument professional does not have to accept the rate assigned by the hearing care plan or discount hearing care plan.
- » If the participating hearing instrument professional chooses not to accept the rate assigned by the hearing care plan or discount hearing care plan for the non-covered/unfunded item or service, the hearing instrument professional must post, in a conspicuous place, a specific, exact written notice (outlined by the Act) and provide this notice in a written document to the enrollee/patient outlining that they do not accept the fee schedule for items and services provided prior to the hearing aid fitting, after one year following the initial fitting of the hearing aids, or after the allowed number of covered/included visits are exhausted (Illinois General Assembly, 2026).
- » Hearing care benefits must be communicated to the enrollee/patient and non-covered items and services must be identified in the marketing materials, contracts and plan documents.
- » Discount hearing aid benefits must not be represented as funded hearing care benefits. Hearing care organizations must clearly document the specific cost-sharing amounts of both in and out of network hearing care benefits and, in the case of discount hearing care benefits, the specific discounted amounts provided by preferred, participating providers.
- » Hearing testing, whether diagnostic or for the purpose of fitting or modifying a hearing aid, must be reimbursable, either by the health care organization, enrollee, or both, irrespective of whether or not the enrollee proceeds with the purchase of hearing aids.
- » If a hearing care plan or discount hearing care plan is owned or operated, in whole or in part, by a manufacturer of prescription hearing aids offered within the hearing care benefits, that must be disclosed to enrollees or potential enrollees, in its marketing materials and plan documents.

- » Hearing care plans and discount hearing care plans must comply with the Illinois Health Maintenance Organization Act. The plan must register with the Illinois Department of Insurance (Illinois General Assembly, 2026a).
- » It is unlawful practice under the meaning of the Act for any person to violate the Hearing Plan Contracts Article of the Illinois Insurance Code (Illinois General Assembly, 2026a).

How did ILAA get this accomplished?

First, ILAA has to give credit to the Illinois Optometric Association (IOA) and the creation and passage of the Vision Care Regulation Act of 2023. Their bill and its passage provided the initial idea and road map to creating legislation to regulate hearing care plans. It is also important to note that the ILAA and IOA are represented by the same lobbyist, James Morphew, who also happens to be a well-regarded attorney (Illinois General Assembly, 2023).

ILAA reviewed the Vision Care Regulation Act and first attempted to apply its tenants to hearing care, while trying to consider the differences and nuances between vision and hearing care and their associated benefit plans. Our draft language jumped off from the Vision Care Regulation Act but we focused our language on the desire to improve transparency in how the hearing care benefits are sold to and presented to potential members and beneficiaries and how those benefits impact provider operations and interactions. In short, a consumer protection bill.

ILAA has, for almost the last 20 years, approached legislation differently than many other states. In Illinois, we have followed a process, which we have outlined below. We followed this process with SB2838 over the course of 2 years with initial board discussions beginning in August 2024 and the Governor's signature making the bill a law, effective January 1, 2027, in August 2026:

1. ILAA has a legislative idea or initiative.
2. We discuss that idea or initiative with the ILAA board and membership (at our annual meeting and/or in a town hall).
3. We discuss the ideas or initiatives with stakeholders, including those who could, ultimately, oppose the ideas or initiatives. This typically does not involve the engagement of any national association; we focus on entities within the State of Illinois or whose business will be substantially affected by the legislation or initiative.
4. We take in feedback from all stakeholders and create draft legislative language.
5. The draft language is edited by our lobbyist.
6. The board of ILAA provides the initial approval of the draft language.
7. The draft language is then provided to all stakeholders prior to introduction of the bill. We will also provide language to national associations at this point and request feedback.
8. ILAA and its lobbyist negotiates proposed bill language with all stakeholders, including, sometimes, the State of Illinois. We focus, again, on stakeholders within the state. ***Compromises are made at this time.***
9. The board of ILAA approves the final, negotiated bill language.
10. Our lobbyist finds a legislator, typically on a committee of jurisdiction, to sponsor this pre-negotiated bill. Sponsors may exist in one or both chambers.
11. The bill is introduced and navigates through the Illinois legislative process, with ILAA leadership testifying. In this part of the process, we request support letters from stakeholders and other professional organizations.
12. The bill is passed and signed into law.



ILAA has, for almost the last 20 years, approached legislation differently than many other states.





Over the past 20 years, ILAA has shepherded or heavily assisted in the passage of the following legislation, using the approach we have outlined above:

- » Unlicensed, supervised audiology assistant, who functions under the supervision of a licensed audiologist (2008) (Illinois General Assembly).
- » One of the most expansive scope modernizations in audiology (2017) (Illinois General Assembly).
- » Prescriptive rights for hearing aids for hearing instrument professionals, including the creation of a first of its kind hearing aid prescription and hearing aid technician role, who functions under the direct supervision of a hearing instrument professional (2024) (Illinois General Assembly).
- » Birth to death optional (beneficiary must select a benefit with funded coverage) insurance coverage mandate for hearing aids (2025) (Illinois General Assembly, 2025).

Our approach is possible given the financial investment by ILAA and its members, engagement of ILAA board members and volunteers, the makeup of the Illinois legislature, the legislative processes of the Illinois legislature, our relationships with key legislators, and, most importantly, the knowledge, stature, and connections of our lobbyist.

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Natalie M. McKee, Au.D., is the owner of Bloomington-Normal Audiology. She serves as the Vice President of Government Affairs for the Illinois Academy of Audiology. Dr. McKee holds a Doctor of Audiology degree (Au.D.) from Salus University.

Kim Cavitt, Au.D., is the owner of Audiology Resources, Inc. Since 2001, Dr. Cavitt has operated her own audiology consulting firm, Audiology Resources, Inc., which provides comprehensive operational, compliance, and reimbursement consulting services to hearing healthcare providers. She is a Past President of the Academy of Doctors of Audiology (ADA). ■



HAVE YOU HEARD?

ADA Awards Inaugural Audiology Practice Accreditation to Coates Hearing Clinic

ADA is pleased to announce that Coates Hearing Clinic, with locations in Smithfield, Goldsboro, Lillington and Clayton, North Carolina, has become the first practice to earn ADA Audiology Practice Accreditation.



This milestone marks the first accreditation awarded through ADA's new program, which recognizes audiology practices that demonstrate policies, procedures, clinical protocols, facilities, equipment, and operations that meet ADA's accreditation standards in five major areas:

- » Rights and needs of the patient
- » Delivery of clinical services
- » Instrumentation, equipment, and facilities
- » Practice administration
- » Quality assurance and performance improvement

“Accreditation means that a practice has done the hard work of examining how it delivers care, manages its operations, protects patients, and measures performance,” said ADA President, Jill Davis, Au.D. “Coates Hearing Clinic has demonstrated *Excellence in Practice* and earned the distinction of becoming the inaugural ADA-accredited audiology practice. We congratulate the entire team on this important achievement!”

ADA Audiology Practice Accreditation is designed to strengthen and streamline practice operations while promoting consistent, high-quality audiologic care. The standards were developed through expert consensus and peer review, with research and evidence-based clinical and business practices serving as the foundation.

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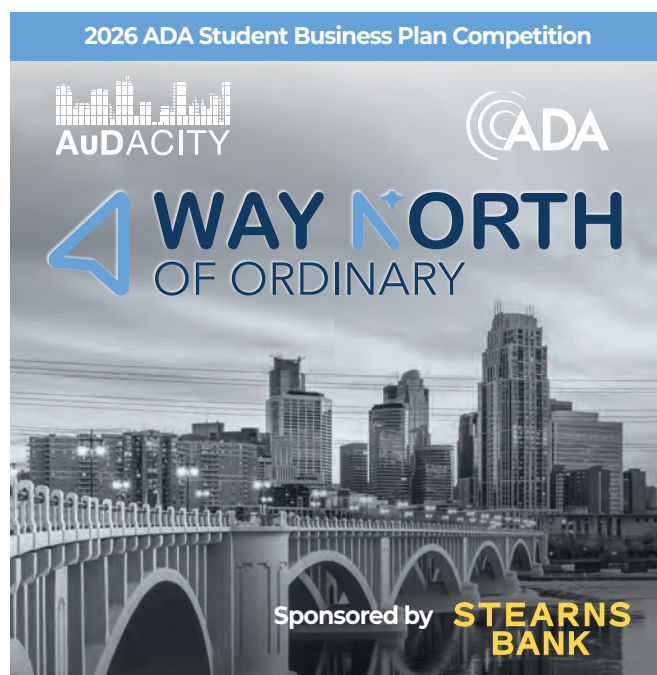
We’ve brought together an incredible team of providers and staff who are at the absolute top of their game.

”

“From the start, we’ve been committed to bringing world-class, evidence-based hearing healthcare to our community” said Dr. Kathleen Coates, co-owner and audiologist. “We’ve brought together an incredible team of providers and staff who are at the absolute top of their game. They all have a servant’s heart, and we couldn’t have accomplished this incredible honor without them” added Jordan Coates, CEO and co-owner.

For patients, ADA accreditation offers additional assurance that a practice has voluntarily undergone an external review and illustrates its commitment to patient-centered care, safety, transparency, evidence-based clinical protocols, qualified personnel, responsible business operations, and continuous improvement.

ADA Audiology Practice Accreditation is awarded for a three-year cycle. Accredited practices may display the ADA accreditation seal as a visible indication of their achievement and commitment to *Excellence in Practice*.



Three teams advance to the ADA Student Business Plan Competition Finals at AuDacity

ADA is pleased to announce that three teams have been selected to advance to the final round of the 2026 ADA Student Business Plan Competition:

- » **Team 1:** Josue Garcia Torres, MRC, CRL, Terp.Ed., University of Puerto Rico
- » **Team 2:** Courtney Greene and Alana Epstein, University of North Carolina at Chapel Hill
- » **Team 3:** Melanie Vazquez-Ponce, Syracuse University

The ADA Student Business Plan Competition finalists will compete head-to-head at the AuDacity Conference at the Hyatt Regency Minneapolis, October 1-4, in Minneapolis, Minnesota! The Grand Prize Winner/Team will receive a \$5,000 cash grant to be used to advance business objectives and enhance business and leadership skills. Business plans are judged on the following criteria: creativity, feasibility, completeness, cohesiveness, and professionalism.

ADA is profoundly grateful to Stearns Bank for its generous support of the 2026 ADA Student Business Plan Competition.



Meet the contestants:

Josué García is a third-year student in a Doctor of Audiology program at the University of Puerto Rico, Medical Sciences Campus. Has a master's in rehabilitation counseling from the University of Puerto Rico, Rio Piedras Campus, were supported by a scholarship from the Rehabilitation Services Administration. He is a licensed rehabilitation counselor in Puerto Rico and a sign language interpreter, which allows him to serve deaf and hard-of-hearing patients directly and without a communication barrier.



Courtney Greene is a fourth-year Doctor of Audiology student at the University of North Carolina at Chapel Hill, currently completing her externship at the Durham VA Medical Center in North Carolina. Her interest in audiology is shaped by her own experience with hearing loss. Diagnosed at age six and a lifelong hearing aid user, Courtney has a personal understanding of the impact hearing healthcare can have on individuals and families. She has a strong interest in all areas of audiology, with particular passions for vestibular testing and treatment, hearing aids, and cochlear implants, and she especially enjoys working with veterans and patients across the lifespan.



Alana Epstein is a fourth-year Doctor of Audiology student at the University of North Carolina at Chapel Hill. She is currently completing her fourth-year externship at Children's Healthcare of Atlanta, Georgia. She has a strong interest in all areas of audiology, with a particular passion for pediatric audiology and cochlear implants. Alana's passion for audiology is deeply personal. She was born profoundly deaf and received bilateral cochlear implants as a young child. Growing up, she had the opportunity to receive care through a private audiology practice, where her audiologist had a profound impact on her life and inspired her to pursue the field.



Melanie Vazquez-Ponce is a second-year Doctor of Audiology (Au.D.) student at Syracuse University. She is bilingual in English and Spanish and expanding her communication skills through American Sign Language (ASL). As a first-generation Mexican American, Melanie's personal and family experiences have shaped her appreciation for culturally and linguistically accessible communication, family support, and individualized hearing care. Melanie's clinical interests include cochlear implants, adult diagnostic and rehabilitative audiology, central auditory processing disorder, and tinnitus management. ■

Make a referral. Make a difference.



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.



My Analysis of the Question of 2026: Who Can Provide and Bill for What?

BY KIM CAVITT, Au.D.

We all know of at least one clinic who is allowing an audiology or medical assistant, technician, hearing aid dispenser, physician assistant or nurse practitioner to perform diagnostic hearing tests and hearing aid services. We know of audiology colleagues billing evaluation and management codes. It has become commonplace. The issue is whether or not the practice is legit.

First, I want to stress that I am not an attorney nor do I represent the final determination of any licensure board or health plan. It is ultimately important for each clinic to get their own final legal determination if they have concerns about their clinical practices. I am just documenting the landscape.

There are four considerations in determining who can legitimately provide AND bill for hearing testing (92552-92557), evaluation and management codes (99...) and the new hearing aid service codes (92628-92629, 92631-92632, 92634-92639, and 92641-92642). They are, in order:

1. Licensure

In the United States, each state and territory establishes, in Act and Rule, the scope of practice and exemptions to licensure of individual health care disciplines and professions. These scopes of practice determine the breadth of the practice of the discipline, who requires licensure and who can perform aspects of the discipline without licensure (exemptions). If it is not in a scope of practice, its provision may not be allowed. If an individual is not licensed or exempt, they may be practicing a discipline without licensure and those who hire and utilize them may be supporting the unlicensed practice of audiology, hearing aid dispensing and/or medicine.

It is also important to note that in most hearing aid dispensing licensure laws and scopes of practice, hearing aid dispensers can only perform hearing testing for the sole purpose of fitting or modifying a hearing aid. They cannot typically perform diagnostic hearing testing or other diagnostic or treatment services, irrespective of the level and type of supervision and the supervising provider.

Some states define the role of audiology assistant or hearing aid technician and some do not. Lack of mention does not automatically mean allowance; it can actually mean the opposite. As a result, it could mean supporting the unlicensed practice of medicine, audiology, or hearing aid dispensing.

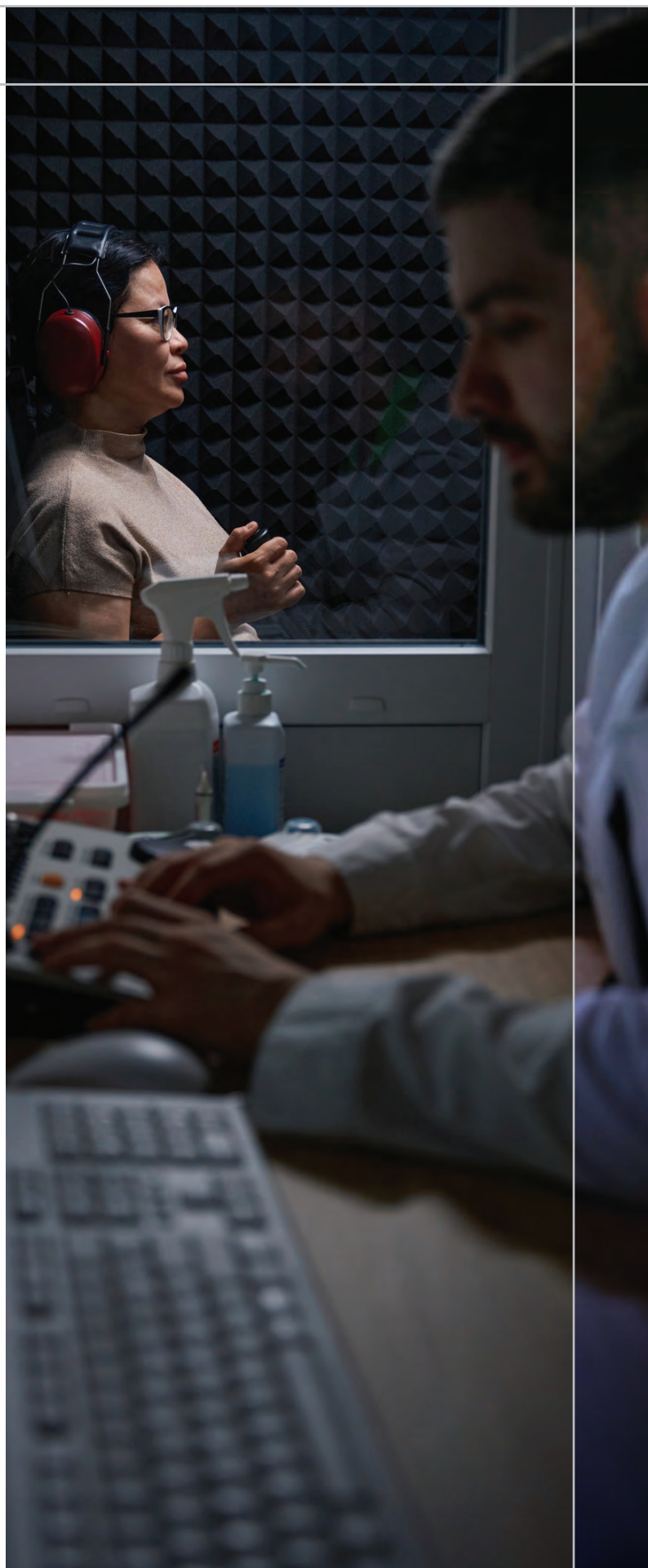
If you are unsure if licensure legally allows for use of an assistant or technician or allows for an item or service to be performed by a physician, audiologist, hearing aid dispenser, audiology or medical assistant, ototech, technician, physician assistant, or nurse practitioner, pose your question, in writing, to your state licensure board or legal counsel to provide a determination in writing. Malpractice insurance is typically null and void if the individual is practicing outside of their scope of practice.

2. Coding – Code Requirements

Current Procedural Terminology (CPT) codes have written descriptions, established by the American Medical Association (AMA), who owns the code set. In order to legitimately utilize a CPT code, the provider must meet the description, requirements, and limitations of the code.

Evaluation and management and hearing aid service codes have defined descriptions, requirements, and limitations, especially about who is allowed to perform the procedure. These codes indicate that the associated procedures must be provided by qualified healthcare professional (QHP). The American Medical Association defines a QHP as “A ‘physician or other qualified health care 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/her scope of practice and independently reports that professional service.” So, it is important that, before a service is provided or billed, that the individual providing the care meet the requirements of a QHP. That, as you can see, is determined by licensure, scope of practice, and how the service is billed to AAPC (2015).

If you are unsure whether the provider providing the service is a QHP for a specific code, pose your question, in writing, to your state licensure board, legal counsel, or contracted health plan to provide a determination in writing.



3. Coding – Modifier Use (Centers for Medicare & Medicaid Services, 2024)

There are three possible configurations of a CPT code. The first is the technical component (TC), which solely represents the clinical provision/performance of a procedure. The second is the professional component (PC or 26), which solely represents the interpretation and reporting of the test results. The final is the global (no modifier added) which represents the clinical provision/performance, interpretation, and reporting of the procedure by the same provider on the same date of service.

Some CPT codes allow for technical and professional components; some do not. Evaluation and management codes, hearing aid service codes, and 92552 (pure-tone audiometry, threshold; air only) through 92557 (Comprehensive audiometry threshold evaluation and speech recognition) do not allow technical (TC) and professional (PC or 26) modifier use. So, in other words, these procedures must be performed and interpreted by the same provider. The procedure codes do not allow provision of these procedures by two different providers or a technician.

4. Payer requirements

Payers typically require, for coverage, that medically necessary healthcare items and services be provided by qualified healthcare professional (QHP). Payers can and do qualify and quantify, in their provider agreements, administrative policies, and medical and coverage policies, who can provide covered services and whether or not those providers are required to be licensed and/or credentialed with the health plan.

“Incident to” billing is where a health plan explicitly allows certain providers to bill items and services under the National Provider Identifier (NPI) of a supervising physician. In “incident to” billing, the physician must provide some degree of supervision (as defined by the health plan) and/or documentation of the visit or encounter. Medicare,

Medicare Advantage, and Medicaid do not allow for “Incident to” billing of audiology services personally provided by an audiologist. Also, in general, for most health plans, nothing can be billed “incident to” an audiologist or hearing aid dispenser. This is important if an audiologist or dispenser is utilizing an assistant, technician or dispenser to provide covered services to a health plan beneficiary (Centers for Medicare & Medicaid Services, 2026c).

Medicare, Medicare Advantage (which follows Medicare guidelines for covered services), Medicaid (established by each state), Tricare and Veteran’s Administration Community Care (VACCN) have clear guidance on who can legitimately perform and bill the patient or the health plan for a given item or service. In general, hearing testing requires provision by an appropriately trained QHP. Some Medicare Administrative Contractors, specifically Novitas, is even more restrictive as to whom can perform hearing testing. Novitas, who administers Medicare in AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, Indian Health & Veteran Affairs, states that “Audiological tests require the skills of an audiologist and shall be furnished by qualified audiologists or by a physician who satisfies the “Training and Competency Requirements” as listed in this LCD” (Centers for Medicare & Medicaid Services, n.d.; Humana Military, n.d.; U.S. Department of Veterans Affairs, 2023; Novitas Solutions, Inc., 2019).

Commercial health plans can and do make their own guidelines and assign their own requirements. These can exist in their provider agreements, administrative policies, and medical and coverage policies. In general, for most health plans, providers must be credentialed with the plan to provide and bill the plan for covered services.

If you are unsure whether the provider providing the service is eligible to provide and bill for covered service or is allowed to have services billed “incident to” another provider, pose your question, in writing, to the contracted health plan to provide a determination in writing or have your attorney provide a legal opinion on the matter.

If you are unsure... pose your question, in writing, to the contracted health plan to provide a determination in writing or have your attorney provide a legal opinion on the matter.

My ultimate goal with this is to warn and protect both providers and patients. I am NOT trying to fearmonger or overstate my concerns. I have thoroughly documented my position throughout, indicated that I am not the definitive authority, and STRONGLY encouraged providers invest in formal legal guidance.

Healthcare audits, utilization review, and denials are on the rise. The reality is the inappropriate, unlicensed provision of care and inappropriate billing would be super easy to catch, especially in a world of automated intelligence (AI). I, literally, can think of many, many ways to catch these issues (as

they are that blatant) and I do not even have the resources and technological capacities of a state board or health plan. Physicians, audiologists and hearing aid dispensers have a ton of exposure right now as it relates to these issues. I am trying to get people to consider or reconsider the clinical and billing decisions they are making and the potential legal and financial consequences of those decisions if policies, guidelines, and requirements are not followed, are audited, or if patient or whistleblower complaints are filed (BHM Healthcare Solutions, 2026).

We are not immune.

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PRESIDENT'S MESSAGE

Continued from page 3

Now let's take Listen Up nationwide.

I am excited about where this is headed and grateful to everyone helping make it happen. Together, we can make hearing health impossible to overlook and make sure that when people are ready to take that first step, they know where to go: their local audiologist. ■

EDITOR'S MESSAGE

Continued from page 5

- 96–97% reported receiving benefit
- Over 50% said the DTx helped them adjust to their new hearing aids
- Improved confidence in conversations
- Better ability to engage socially
- High satisfaction scores (average 5.8/7) for both enjoyment of the program and willingness to recommend it to others.

Some of the reasons that the DTx group reported higher levels of success compared to the control group might be on account of the following on-demand availability of the following in the Amptify program:

- coaching and behavioral support
- ongoing engagement after hearing aid fitting
- education about hearing loss
- auditory training exercises
- communication strategies

2. Gamification.

Does the act of making the task more like a game improve its uptake or effectiveness?

All of us know that playing games is fun and rewarding in its own right. You might even know someone who's retired who plays hours of Candy Crush Saga or Wordle. When you take a careful look at the rewarding, dare I say, addictive nature of video gaming, you can see how incorporating a fun and engaging activity into a therapeutic task can be satisfying. Fun activities cause the brain to increase production of dopamine, a neurotransmitter associated with pleasurable emotions. There is plenty of research to show that playing video games increases production of dopamine. In turn, we know that increased dopamine levels enhance neural plasticity and that neural plasticity is enhanced as more efficient learning takes place. As a result, individuals who engage in gamified DTx might have better potential for receiving more benefit from their intervention because they are doing something that is intrinsically fun and rewarding.

One recent study illustrates this point. Ockelmann et al. (2025) evaluated a personalized, gamified digital auditory-cognitive training program in a randomized controlled trial of 54 older adults with mild-to-moderate hearing loss. Participants completed four weeks of home-based, adaptive training targeting auditory processing, attention, and working memory, while the control group received an active comparator (computer-based foreign language training). The DTx significantly improved naturalistic speech-in-noise comprehension and several cognitive functions, including working memory and selective attention, with some benefits maintained at two-month follow-up. Although subjective hearing ratings and standard speech intelligibility measures did not improve, the findings support DTx as an effective adjunct to hearing aids for enhancing real-world communication.

3. Personalization.

Can a personalized avatar, used as part of a DTx, enhance patient outcomes?

There is a growing body of evidence that personalized avatars (or embodied conversational agents) can improve engagement, and—in some cases—clinical outcomes in DTx. However, the evidence is strongest in mental health rather than in chronic disease management or audiology. Importantly, the benefit appears to come from personalization and therapeutic interaction, not simply from having an avatar.

Recent studies (Foran et al 2026; Shoshani et al 2026) suggest that allowing patients to personalize an avatar increases trust and engagement, which are mechanisms associated with better adherence to DTx. Relatively few clinical trials, however, isolate avatar personalization as the independent variable, so more work is needed to better understand how avatars and chatbots might contribute to patient hearing-related outcomes.

For now, it seems that DTx platforms with personalized avatars could theoretically improve:

- engagement with repeated training
- adherence to prescribed training schedules or doses
- motivation and self-efficacy,
- ultimately improving functional outcomes through greater treatment completion

Even though direct evidence in audiology is limited, the mental health literature shows that personalized, interactive avatars can enhance patient engagement and, in some interventions, improve clinical outcomes beyond conventional screen time on a phone.

What comes next?

While the face-to-face appointment remains the cornerstone of holistic hearing care, Digital Therapeutics (DTx) offer a powerful, evidence-based solution to extend support into the daily lives of patients. Research demonstrates that gamified and personalized digital tools significantly improve engagement and adherence from hearing aid use to auditory-cognitive training. As the evidence base grows, clinicians should proactively integrate these digital adjuncts into their treatment planning. By embracing DTx as well as other forms of care extenders today, you can effectively bridge the gap in service provision, empower your patients, and ensure that your prescribed treatment plan is sticky.

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HEADQUARTER'S REPORT

Continued from page 7

and product design, ADA is committed to ensuring that audiologists, and the patients they treat, are able to influence the decisions being made by payers, innovators, and government agencies.

ADA will continue to monitor policy and industry developments and outcomes from CTA Health Week (and beyond) so that ADA members have reliable, actionable information to use to practice, operate their businesses, and advocate for the profession of audiology. ■



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This new infographic from Hamilton® CapTel® explores the real-world impact of hearing loss in senior living communities. It's a compelling conversation starter for you, your patients, their families, and care teams – and explores the meaningful difference captioned telephone technology can make for seniors with hearing loss.

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