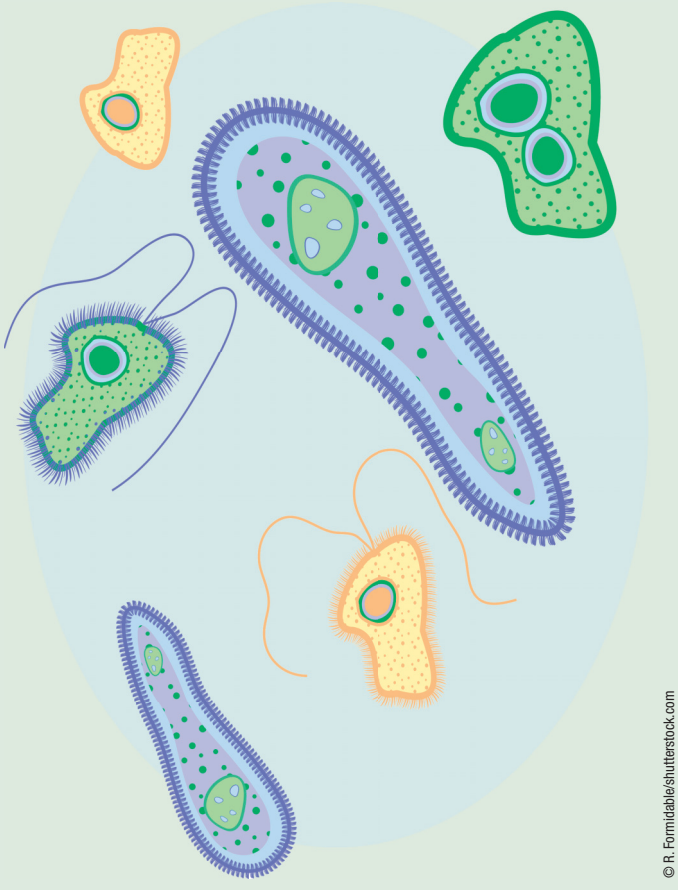
Are you a Paramecium Racer? An acronym points the way forward in hearing care

By Sara Bloom



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Are you a Paramecium Racer? A what? Sorry, but I had to do something to get your attention. Ken Smith says he's been screaming about this for years. Sergei Kochkin swears he'll continue shouting about this for as long as he's involved in hearing care, even if he has to fix it "one practice at a time." And no fewer than 14 holders of academic and professional doctorates co-authored the latest MarkeTrak report (see sidebar), which is largely critical of it. Is anyone out there paying attention to it?

The "it," critics say, is the process by which too much of the hearing care in this country is delivered. It's a process that results in a high rate of hearing aid returns for credit, a high number of high-priced hearing aids that end up in bureau drawers, and, understandably, a high incidence of unhappy patients. All of it—an industrywide perception of public discontent—can be summed up this way: Fewer than 25% of the people who need hearing help are receiving it.

Sadly, this percentage has edged up only slightly over the past few decades, a fact that points up the enormous unrealized potential in hearing healthcare and the low esteem in which the general public holds hearing care treatment. And, unless you are a Paramecium Racer, an acronym that describes the way forward in hearing care, you may be part of the problem.

A paramecium, you may recall from high school biology, is a living organism whose single cell contains all of the elements for life and perpetuation of the species. Admittedly, it's a stretch, but let us consider that a good hearing care provider, whether PhD, AuD, or BC-HIS, is a single individual who possesses all the elements of knowledge and know-how to treat hearing loss with amplification for improved quality of life and perpetuation of the discipline. A Paramecium Racer is one who is competitive in the marketplace, likely has a large and satisfied clientele, and is racing to increase market share and grow the profession. If you'd like to be a Paramecium Racer, read on.

For this article, *HJ* talked with a range of providers, each one offering advice in a specific area of the process or protocol required for a successful fitting, a profitable practice, and overall industry growth. Each of these areas contributes to the acronym "Paramecium Racer."

PROCESS, NOT PRODUCT

P is for process. Kenneth Smith, PhD, is president, with his wife, Beth Ehrlich, AuD, of the Hearing Center of Castro Valley (CA), with a satellite office in nearby Fremont. Smith's mantra is that dispensing has remained static for years because providers focus on products and features and not on process. "The product itself is irrelevant," he says. "Whether or not the patient is ready to accept *any* product determines the success or failure of the outcome."

To that end, the former president of the Academy of Doctors of Audiology (ADA) talks about "prequalifying" patients for hearing aid readiness. If patients aren't truly ready, he says, provide them with educational materials, but follow up months later to see if escalated hearing loss has prompted a greater willingness to accept help. Once the patient is ready, select the technology that corresponds to the patient's needs. Ascertaining where the problems are—background noise, listening to grandchildren, participating in meetings—leads to choices with a greater chance for success, he says. Size is another consideration. If dexterity is a problem, for instance, a small aid will frustrate the patient. A BTE may not work if the patient wears eyeglasses.

AURAL REHABILITATION IS KEY

AR is for aural rehabilitation, which Mary Anne Larkin, AuD, says was "drummed into my head in the master's program at Purdue University." Larkin, president of Advanced Hearing Care, in Mt. Pleasant, SC, agrees that an aural rehabilitation program takes up lots of a dispenser's time, but she says that for a fitting to be successful, especially with a new user, it's an essential part of the process. (The MarkeTrak VIII study reports that fewer than 20% of new users receive any form of audiologic rehabilitation, a major reason for fitting failures, the report concludes.)


Mary Anne Larkin

"New users need to learn about lip reading, about room acoustics, and how sound is distorted in some situations," says Larkin. "A good rehabilitation program addresses realistic expectations in difficult situations; patients learn how to position themselves away from the clatter of the kitchen in a restaurant and to seat themselves to facilitate lip reading—facing people rather than sitting beside them," she adds. She believes that common sense tips like that can help patients see that difficulties in some listening situations are not always the fault of the hearing aid.

Linda Remensnyder, AuD, agrees. "It's not necessarily a problem with the instrument; it's where you're sitting," she tells patients in her aural rehabilitation program. Similarly, she explains that it's unrealistic for them to expect to be able to carry on a conversation while driving in a car with the windows open. And she points out that Jack Bauer on *24* talks very fast, and the characters on *Glee* and *The West Wing* often talk with their backs to the camera. "It's no wonder you can't always understand the dialogue on these television programs," she says. "I can't either."

Complaints about poor hearing in church are so pervasive that Remensnyder, whose hearing is near normal, wears a hearing aid there to show fellow parishioners that it can be difficult for anyone to hear in cavernous spaces with vaulted ceilings. That's why she has pushed for installations of hearing loops in public buildings and insists that her patients' hearing aids be equipped with telecoils.

Remensnyder, founder and president of Hearing Associates in Libertyville, Gurnee, and Lincolnshire, IL, says that aural rehabilitation "changes the mindset" of patients by providing them with realistic expectations. AR helps them understand that amplification will help them hear better and will solve many of the problems they are having in listening situations. But, she adds, it will *not* restore the hearing of their youth, no matter how technologically sophisticated the instruments.


Linda Remensnyder

As a public speaker, Remensnyder captures the attention of her audience with an enthusiastic three-part presentation about hearing loss and communication strategies. She also tells listeners about protecting their hearing, assistive technology, and the benefits of hearing loops in large public halls. "Hearing aids are only a part of the solution," she says, pointing out that "multiple strategies need to be employed for the successful resolution of hearing loss and its impact."

ACTUAL LIFE EXPERIENCES

A is for actual life situations. Roxann Bonta is professional development leader for HearingLife, a hearing instrument brand of Otix Global. In 30 years of working for manufacturers in sales, product development, and marketing, Bonta says she has learned that patients don't necessarily want improved hearing per se; they want what better hearing allows them to do: to function better in specific listening situations they might encounter every day.


Roxann Bonta

To that end, as part of her training process, she encourages dispensers to introduce patients to actual life situations. Dispensers in Australia, for instance, the home of the parent company, take patients out of the office environment and demonstrate hearing instruments on the street with all the background noise, or in restaurants with the clatter of dishes and glasses. "You can't experience those situations sitting in a sound booth," she says. (Similarly, Remensnyder lends patients demo models of high-end hearing aids so they can experience the benefits of amplification in their own problem situations.)

Bonta acknowledges that manufacturers traditionally sell products, but she is beginning to see a shift in how products are marketed from a focus on technical features to how hearing instrument technology can help in actual life situations. Good business is not just number crunching, she says. "Patient care is the best business. The process is all about the human connection."

MANAGEMENT SKILLS

M is for management, says Larry Engelmann, AuD, president of Audiology Clinic in Oklahoma City and a former ADA

president. Unfortunately, business management is rarely a part of the academic curriculum, he points out; for the most part, he says, good management skills are acquired on the job, and some clinicians are better learners than others.

The most important part of the management process, he says, is to "position a practice as a quality establishment, a place where patients feel comfortable and confident that their specific needs will be addressed." It's up to the provider to build trust at the initial meeting, Engelmann says. He adds, just as people with heart problems would be less likely to search out the features of a pacemaker than to search for a qualified surgeon, similarly, hearing care providers should first listen to their patients' hearing problems, not promote the technological features of hearing aids.


Larry Engelmann

Even if patients are not quite ready to commit to hearing aids, Engelmann advises giving those prospects "your time and your respect." In the end, he says, those patients are not lost. "If I've managed my practice and my patients well, chances are in 2 or 3 years they'll be back in my office. Good practice management is part of the process that leads to success."

Mary Anne Larkin agrees, but acknowledges that many practitioners are enthusiastic in the beginning of a fitting, but fail to follow up to be sure the patient is happy 6 months, 2 years, and even 5 years later. And worse, she says, some practitioners sell a hearing aid and offer little or no follow-up. "Hearing healthcare is a process where the sale is never really over," she says.

EDUCATE AND COMMUNICATE

E stands for education. Beth Ehrlich, who shares a practice with her husband, Ken Smith, at the Hearing Center of Castro Valley (CA), sees education as a two-way street. The patient receives information about hearing loss and hearing help, and the dispenser gains insights about each patient's hearing problems. She relies on the COSI (Client Oriented Scale of Improvement) to ascertain why a prospective patient has come to her, what the problems are, and how she should proceed. With this mutual exchange, patients won't be coerced into accepting hearing help, but will choose it for themselves, eager for the benefits it offers.

As part of the education process, Ehrlich and many other providers interviewed for this article equip their office waiting rooms with hearing loops and make assistive listening devices, like TV Ears, available for patients to try. In addition, Ehrlich publicizes her practice's web site, which informs visitors about hearing, hearing loss, hearing protection, and solutions to hearing problems.

C is for communication. An office should communicate professionalism, says Alan Lowell, BC-HIS, ACA, of Daytona Beach, FL, a veteran hearing instrument specialist and a past president and now president-elect of the International Hearing Society (IHS). Lowell, who formerly chaired the National Board for Certification in Hearing Instrument Sciences, offers seminars for future dispensers. In them, he focuses on the skills associated with the verbal communication of knowledge to help patients make the right choices, as well as subliminal communication that occurs the moment a prospective patient enters the office.

Patients will look at the neatness of the office and at the types of reading materials offered, he says. They will judge the professionalism of the front-office staff by how they look and speak, and of providers based on whether they're dressed in jeans or other casual clothing or wearing a white lab coat. According to Lowell, "When people begin to explore hearing help, they're looking for reasons *not* to continue the search. Don't give them a reason," he says.


Alan Lowell

While dispensers must acquire knowledge and skills to be successful, most important, he says, is being able to communicate their knowledge in language that patients can understand. "Be brief and to the point," he advises. "The technology of hearing instruments today is extraordinary and versatile. Dispensers who understand it and communicate it well to their patients will experience the greatest success."

EVALUATE AND UPGRADE

I means intrinsic value. "Focus on the intrinsic value of the help you can offer," says Smith of Castro Valley. To some patients, "hearing" is an abstract concept, he says, pointing out that the operative word in hearing help is "understanding," not "hearing." He explains: When patients watch television or talk on the telephone, often they may hear yet be unable to understand. Once that concept is clear, patients will begin to recognize the value of the amplification providers are offering, no matter what the brand or what advanced features it offers.

Refocusing a patient's thinking from the instrument itself to its intrinsic value as part of improved quality of life is a big step in the process toward practice growth, Smith says.

U is for upgrade. Of all those interviewed for this article, Sergei Kochkin, PhD, executive director of the Better Hearing Institute, is the most critical of the incompetence he sees as insidious throughout the industry. He believes that many hearing aids are not fitted properly; that based on letters he receives, discomfort and dissatisfaction among patients are rampant; and that the benefit of amplification when not properly fitted is often minimal. "Upgrade your skills," Kochkin urges, calling on the professional organizations to police their members and audit their practices.

Also requiring upgrades, Smith and Lowell agreed, are waiting rooms and treatment rooms. Are they clean and comfortable, or shabby and worn out? Out-of-date models of testing equipment represent an even greater sin. If no equipment upgrades are visible, long-time patients may begin to wonder if the care they are getting has advanced at all in the years since they first came to the office.

MENTOR AND BE MENTORED

M stands for mentoring. Like education, where practitioner and patient benefit from the exchange, mentoring also works two ways, says Larry Farris, BC-HIS, ACA. Farris, who heads A & B Hearing Aid and Audiology Center, a six-office practice in San Antonio, serves on the IHS board of governors, and was recently named Dispenser of the Year by the Texas Hearing Aid Association. "You know how I was able to do all that?" he asks rhetorically. "I go to the national meetings, I meet people, and I talk to the experienced older guys. They've seen it all; they've dealt with the problems that crop up in every practice, and they're happy to help a younger guy make it in this profession. Those older guys, they're my mentors."

For his part, he mentors up-and-coming practitioners in the field. "This is an apprenticeship industry," he says, "and I think it's my responsibility to educate dispensers-to-be." He takes on several candidates each year, supervising their skills and techniques, teaching them how to connect with patients and build trust, and familiarizing them with the process of running a successful practice. He finds that nearly everyone who chooses this profession truly wants to succeed, and it brings him great satisfaction to see his apprentices go out on their own.

"You want to know my thoughts about process and industry growth? I can tell you in a word: 'mentoring.' Learn from others, and then teach what you have learned. That's the future of this business."

RAPPORT WITH PATIENTS

R is for rapport. Former ADA President Engelmann zeroes in on this word as a positive byproduct of following a step-by-step process that begins when a receptionist answers the telephone and schedules a patient's first appointment. Establishing rapport with the patient continues throughout the testing phase and while the provider takes a case history, listening to the patient's struggles with hearing loss and other health issues, he says. Rapport grows while the provider presents samples of different styles of hearing aids and discusses the capabilities of each, applying the inherent technologies to the patient's needs. "None of this guarantees that the patient will decide to accept hearing help or purchase a hearing aid, but the process definitely improves the odds. Each step solidifies trust," Engelmann says.

COSTS AND CARING ISSUES

A is for affordability. Engelmann acknowledges that hearing aids are expensive, but he insists it's a mistake to appear

MARKETRAK AUTHORS URGE COMMON SENSE PROCESS

According to the MarkeTrak VIII survey, reasons for dissatisfaction among hearing aid users include "poor benefit, poor fit, and comfort, and unsatisfactory performance in noise." Also contributing to poor market penetration, a report on the survey findings says, is negative word-of-mouth by patients and an indication by "more than half of all patients who own hearing aids that they would not repurchase their current brand." [1]

A conclusion reached by the 14 authors of the report, an impressive roster of prominent audiologists, is that "quality control at the point of dispensing has not kept pace with technological improvements." The report offers the following nine steps to a "common sense" process to fitting hearing aids:

COMMON SENSE STEPS

1) Evaluate and examine the ear; review the patient's history.
2) Test to acquire valid measures of the patient's hearing loss.
3) Select the correct technology for the patient, including the availability of a telecoil in the hearing aid.
4) Establish realistic expectations for amplification.
5) Perform quality control measures of the hearing aid, using a hearing aid analyzer prior to fitting.
6) Determine the valid gain and output prescription for the patient; verify via real-ear measurement (REM) with probe microphones.
7) Fine-tune the hearing aid fitting with available software based on patient input and patient-specific behavioral measures.
8) Validate the effectiveness of the patient's treatment by comparing before and after measures of speech or sentence comprehension in noise and quiet, using real-world performance metrics.
9) Provide counseling and aural rehabilitative services relative to the patient's specific needs, including care and maintenance of the hearing aid.

COMMON MISTAKES

The report also lists key mistakes clinicians make in the fitting process, including these:

1) Failing to verify the fitting with probe-microphone measurements.
2) Failing to understand when and when not to use an open fitting.
3) Wrongly accepting manufacturer defaults.
4) Incorrectly assessing the manual dexterity of patients.
5) Failing to validate the fitting.
6) Failing to counsel the fitting.

The complete report, titled *MarkeTrak VIII: The Impact of the Hearing Healthcare Professional on Hearing Aid User Success*, can be downloaded from the Better Hearing Institute (www.betterhearing.org).

—SMB

REFERENCES

1. Kochkin S, Beck D, Christensen L, et al.: MarkeTrak VIII: The impact of the hearing healthcare professional on hearing aid user success. *Hear Rev* 2010;17(4):12-34.

apologetic about the high cost. That attitude is wrong, he says, because it makes patients feel as though what you are selling is not worth the price. "Look at it this way," he says. "Do you ever hear people say, 'I want middle-of-the-road healthcare.' Of course not. People want the best healthcare they can get. If patients are looking for low price, I tell them to look elsewhere. In the end, he says, "the most expensive hearing aids are the ones a patient owns but won't wear."

Engelmann has a theory that if manufacturers produced only high-end instruments, the cost would come down. "They could reduce their own costs, because they would be manufacturing a limited number of models, instead of trying to appeal to all wallets. And those savings could be reflected in the lowered price of the better instruments." More importantly, says Engelmann, the affordability of better instruments would make many more people happy and, in the process, nurture growth throughout the industry.

CARING COMES FIRST

C means caring. Larry Farris constantly repeats the word in depicting his practice. "People don't care what you know; it's knowing that you care," he says. To that end, he says he demonstrates care for the patient in every step of his process—from how each patient is greeted, his interest in what the patient does every day, how the audiogram relates to the patient's activities, and how he's there to help the patient remedy the problem situations connected to a hearing loss. "I wouldn't be in this business if I didn't care," he says. As for his colleagues in hearing care, he says, "If they're not in it for the money, they'll make money."

AN EMOTIONAL PROCESS

E is for the emotional/psychological phase of fitting hearing aids. Larkin compares the stages of grief—from denial and anger to acceptance—to the steps patients pass through before facing their hearing problems. "Patients must be emotionally ready to embark on a hearing loss program," she says, pointing out that in addition to the physiology of hearing, most degree programs now include the psychology of hearing care as a step in initiating a hearing care program. Similarly, Lowell emphasizes the emotional/psychological side of hearing care in the seminars he leads for students wanting to enter the field.

Hearing loss tends to isolate people, to remove them from the conversation. This sense of isolation plays on patients' emotions and can increase insecurities, says Engelmann. As a counter measure, he always encourages new patients to come to the first appointment with a spouse or other family member. Validation of the help that will be forthcoming bolsters uncertainties and improves the rate of acceptance, he says.


Beth Ehrlich

Ehrlich agrees. "If a patient isn't emotionally or psychologically ready for hearing help, send that patient on his way" she says. "If you have to convince someone to accept hearing help, chances are the patient will be unhappy and will tell 13 other people that hearing aids don't work and are a waste of time and money." On the other hand, she says, "when patients are happy, they'll tell five other people how hearing better has improved their outlook, and you will have a patient for life. It's surprising how much a patient's emotional state enters into a successful fitting," she says.

And finally, completing the acronym, **R** is for review and renew. Arriving with your *Hearing Journal* every month is a copy of *eLearning*, a publication of Audiology Online. It lists a sampling of the online seminars and courses available for continuing education credits as well as for general information, review, and updates in the hearing care field.


Paul Dybala

Paul Dybala, PhD, editor-in-chief of Audiology Online, notes that a number of the courses deal with practice management—the one area that many interviewed for this article feel needs bolstering—including such subsets as marketing and business issues.

"The online courses are a great tool to supplement a university education," Dybala says, noting that the offerings are "a piece of the pie" in the industry's efforts to improve patient satisfaction and increase market share.

FINAL THOUGHTS

The May 2010 *Hearing Journal* Cover Story reported on the results of *HJ's* annual dispenser survey, which this year focused on a *Consumer Reports* (*CR*) article critical of the delivery of hearing care in this country. While many providers took issue with *CR* for casting an unduly poor light on the work of hearing professionals, other survey respondents acknowledged that all too many providers are less competent and not as devoted to the well being of their patients as they should be. The May issue acknowledged "some legitimate problems" and the *CR* assessment as "a wake-up call."

So, which of you are among those who need waking up? The prominent professionals interviewed for this article charge that practitioners who do not adhere to a process that involves a caring attitude, practice-management skills, and a great deal of follow-up with patients are asleep at the proverbial switch.

We hope readers had fun with our Paramecium Racer as an offbeat device to encourage positive adjustments in your treatment process. In time, new methods that put the patient first should produce affirmation of individual providers, positive feedback on their services, and a steady increase in the percentage of people receiving the hearing care they need.

Beth Ehrlich sums up the message succinctly: "Treat patients the way you would want to be treated."

Sara Bloom has been a regular contributor to *The Hearing Journal* for nearly 20 years.